Achieving Reproductive Justice Within Family Planning

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KEYWORDS

• Reproductive health care • Reproductive justice • Abortion • Contraception

KEY POINTS

- Understanding the historical and present context to reproductive oppression is an essential component to provision of reproductive health care.
- The reproductive justice framework provides a structure for advocacy and clinical work that is centered on a person's desire to become pregnant, prevent pregnancy, and raise healthy families.
- Overlapping systems of inequity limit patient's access to comprehensive family planning services, such as contraceptive care and abortion care, in the United States and contribute to reproductive health disparities.
- Clinical care providers can advocate for dismantling injustice within reproductive health and family planning by leveraging power and privilege within health systems.

INTRODUCTION

Reproductive health care in the United States has a long and complex history. Contraception and abortion services continue to face a variety of limitations and are not always accessible to all people—especially those from marginalized communities. Owing to the long-standing history of oppression and inequality in reproductive health care, it is critical to approach the delivery of these services through a health justice lens. Using a reproductive justice (RJ) framework allows for a more holistic approach in addressing the multifaceted reproductive needs of both individuals and communities. To understand the reproductive experience within the United States, we must first acknowledge and unpack this complicated history so that we can better understand the present context and advocate for future changes in the reproductive health landscape.

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Defining Reproductive Justice

Family planning services has historically included contraception care, abortion services, and general reproductive care. When providing these services, there are three distinct frameworks that can be used in a complementary manner to decrease reproductive oppression and advance reproductive human rights. The three frameworks—reproductive health, reproductive rights, and RJ—were first analyzed in the 2005 essay "A New Vision for Reproductive Justice" by Asian Communities for Reproductive Justice, which is now known as Forward Together.[1] The first framework, reproductive health, focuses on service delivery and addresses the reproductive health needs of individual people. This framework focuses on expanding health care services and improving access to care, as well as on improving health data that is available to help improve health care delivery. The second framework, reproductive rights, focuses on the legal right to reproductive health care and the advocacy needed to maintain and fight for this right. The third framework, RJ, on which we will focus most in this article, uses community advocates and organizing to understand how the differing intersections of identity, environment, and society all interact to cause reproductive oppression. It also combines the ideas of social justice and human rights to achieve full reproductive autonomy.

The RJ framework transcends the traditional boundaries of the reproductive health and reproductive rights frameworks. At its core, reproductive justice is ensuring that each individual—regardless of their race, class, gender, or ability—has the agency to make informed decisions about their reproductive life and are able to access the necessary resources to make that choice. This framework was created in 1994 by a group of Black female activists who felt that the frameworks present at the time did not address the needs of people of color and their reproductive autonomy.[2] The reproductive justice movement has played a crucial role in advocating for the empowerment of individuals in making informed choices about their bodies and their families.

To understand how the reproductive justice framework came to be, we must first examine other reproductive health movements and the history that led to their creation. In the early nineteenth century, abortion was legal within the United States until "quickening"—the time at which a pregnant individual perceived fetal movement. Around the middle of the century, a campaign to criminalize abortion was initiated based on concerns about its safety and the provision of abortion care by homeopaths and midwives. This campaign was supported by physicians, who wanted to curtail the provision of reproductive health care by nonphysicians through the backing and support of countless local and national medical societies. Local medical societies also used the Comstock Act, a federal law that criminalized the use of the United States Postal Service to distribute information regarding sexual health, abortion, and contraception. The goal was not only to stop the advertising of contraceptives but also to limit the distribution of abortion information and discontinue the mailing of abortifacients.[3,4] The antiabortion campaign was also fueled by White Protestant families, who were concerned that continued abortion access would lead to a decrease in the birth rates within their communities and, subsequently, an increase in overpopulation of minority communities.[5]

In response to decades of antiabortion campaigns, the feminist pro-choice movement to support abortion and reproductive rights was created.[6] This movement focused solely on the idea of choice—specifically the ways in which choosing not to continue a pregnancy could facilitate the liberation of women and allow them to have full autonomy. It gained significant momentum in the 1960s and 1970s. In 1965, the United States Supreme Court's decision in *Griswold v Connecticut* gave

married couples the ability to buy and use contraceptives without government restriction, which overturned the prior Comstock Act.[7] Shortly thereafter, the Supreme Court ruled in the landmark decision of *Roe v Wade* in 1973, which legalized abortion in the United States. The time period after *Roe v Wade* highlighted the concept of reproductive choice, and the ability to decide what was best for an individual and their pregnancy. The pro-choice movement focused on reproductive decisions, but it did not account for the fact that choice alone is not enough in the fight for reproductive autonomy. During the 1970s and 1980s, women of color activists highlighted that people who come from historically marginalized communities do not have access to the same choices as those with privilege due to societal, environmental, and economic reasons.

Given the limitations of the pro-choice movement and recognizing that the idea of choice did not fully encompass the reproductive experiences of women of color, activists of color—many of whom are associated with SisterSong, an Atlanta-based reproductive justice organization—called for a different framework to achieve reproductive autonomy. They envisioned a movement that focused not only on the choice to prevent pregnancy but also on living in a healthy environment devoid of racism, where people have access to medical care and stable housing. As a result, the reproductive justice framework was built, addressing all the necessary aspects to achieve reproductive autonomy and freedom. Its aim was to merge reproductive rights and social justice to create a framework that meets those needs. Reproductive justice is made up of several primary principles defined as: "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[2] SisterSong's executive director, Monica Simpson, recommends that in considering reproductive justice, "[we] consider the ways in which all social justice issues intersect and affect the way we are able to make decisions about our bodies and the creation of our futures."[8] In focusing on the greater structures and issues that lead to injustice, the reproductive justice movement widens the lens to encompass all reproductive issues, rather than focusing solely on abortion and contraception rights.

Historical Injustices

The reproductive ability and capacity of people of color has been governed for centuries by race, wealth, gender, and power hierarchies. Historically, reproductive health within the United States has been restricted by structural forces such as policies, health education, and health systems but also by societal discrimination such as racism and sexism that leads to injustice. Reproductive injustice can be pervasive and includes unequal access to reproductive health care, incomplete insurance coverage of services, and abuses within health care institutions such as provider bias, discrimination, and coercion. People of privilege and power, both inside and outside the medical establishment, have a history of exercising control over the reproductive freedoms of those with less power, leading to systematic marginalization of groups based on race, ethnicity, immigration status, ability, income, and education. To understand the history of reproductive rights in the United States, it is important to understand how reproductive freedoms were controlled since the colonization of North America. **Fig. 1** outlines some of the major reproductive justice legislation over time in the United States.

During colonization and in establishing an independent United States, Europeans acquired territory using not only military power but also reproductive control to establish dominance over indigenous and enslaved people. Colonizers used mass genocide to limit the growth of indigenous populations: "[Indigenous people] were hunted down

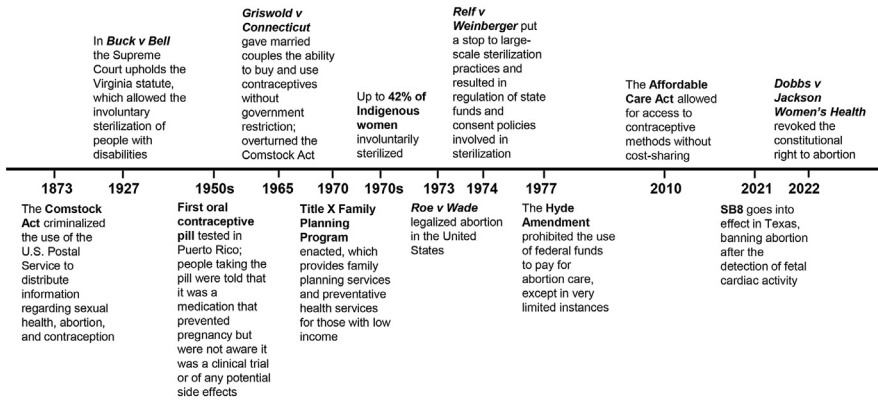

Fig. 1. Major legislative timeline of reproductive health care in the United States.

and slaughtered. [due to] the potential through childbirth to assure the continuance of the people."[9] In the eighteenth and nineteenth centuries, Indigenous American families were impacted by anti-native laws aimed at abolishing Indigenous American culture and the establishment of boarding schools to remove children from their families.[10] Not only were children discouraged from learning their native language, observing cultural practices, and maintaining contact with families, but they also suffered from atrocious physical and sexual abuses.

During this period, enslaved Black women also experienced dehumanization and reproductive control as White men, who claimed to own them, sought to restrict access to sexual partners, control birthing, and limit the ability to raise children throughout the trans-Atlantic slave trade and in the Antebellum South.[11] These practices were enacted through breeding programs, which became the only way for plantation owners to produce more enslaved people once the 1808 Ban on the importation of enslaved people was established.[12] As a result, thousands of Black enslaved women were subjected to violations of bodily autonomy including rape, assault, and forced reproduction.[13] With no rights and little power, enslaved women had few ways to regain bodily autonomy, but did so by seeking herbal remedies to attempt to prevent or end a pregnancy, often relying on the advice of elders or midwives within their communities.[12]

In the mid-1800s, medicine began to formalize with the increasing presence of organized medical societies and increasing physician credibility, along with the heightened importance on the reproduction of enslaved women in the United States for the perpetuation of slavery following the 1808 Ban. There evolved a shift in the provision of maternal and reproductive health care from midwifery care to physician-delivered care.[14] In fact, physicians sought to silence or repress midwifery expertise, claiming patients were "...exposed to the dangers of incompetence, ignorant, unclean midwives." Physicians began publishing new knowledge in periodicals and developed innovative treatments and surgical techniques aimed at improving reproductive function. The cost of formalizing gynecology, however, was borne by people of color who contributed to medicine, whereas they and their families simultaneously experienced reproductive oppression, racism, and enslavement.

Specifically, gynecology was built on experimentation on the bodies of enslaved Black women. J Marion Sims, known as the father of modern gynecology due to his contribution to the field, experimented on both Black and White women to develop new treatment options and surgical techniques for treating vesicovaginal fistulas. The purpose of these surgeries was twofold: to experiment with innovative surgical

techniques, while also attempting to relieve these women of their symptoms. The desire to relieve enslaved women of their symptoms was so that they would be able to return to their enslavers and continue to labor without disruption. Surgical techniques were refined by White physicians, often without their own knowledge or concern of the risks and consequences to the patient, and without informed discussion or consent.[15] In identifying potential surgical subjects, Sims and other practicing physicians would in some instances lease Black women from their enslavers. None of these surgeries were performed under anesthesia, even when its use became more widespread. One concern among the medical community was that anesthetic use increased blood loss, which was later debunked. In addition, there were gross underestimates of the pain experienced by those undergoing vaginal surgery. Finally, there was a widespread belief that Black people experience pain differently than their White counterparts, a notion that continues to be perpetuated in current medical texts but holds no scientific merit.

The development of surgical techniques for treating vesicovaginal fistula, which was a key factor identifying Sims as a leader in gynecology, is one of many examples of how the bodies of Black women were not valued and were viewed as disposable, only to be used to accomplish certain social, political, or economic agendas.[15] Many of Sims' subjects were not known by name, and only three enslaved women were recognized in historical documents: Lucy, Anarcha, and Betsey. Although many physicians, like Sims, have been celebrated for the knowledge and skills that informed the contemporary practice of gynecology, the field has not traditionally acknowledged those who sacrificed their bodies without consent to the acquisition of this knowledge. It is only more recently that discussions about this history have occurred within medical societies and have been woven into medical education in a way that honors the contributions of Lucy, Anarcha, Betsey, and many others.[16] It has also taken over a century for the medical community to begin grappling with the legacy of Sims and other surgeons.

In the early 1900s, reproductive injustices continued as eugenics movements spread throughout the world and eugenics programs were established across the United States. Eugenics was a movement seeking to limit the fertility of those felt to be "unfit" or "feebleminded" while supporting the growth of privileged communities—often White communities with high socioeconomic status. Eugenics programs were fueled by racism, with the belief that some groups of people should not procreate and that allowing them to do so could dilute the population. Thousands of people—often selected based on race, ethnicity, disability, or immigration status—were sterilized through these eugenics programs.[17] Physicians were complicit in coercive sterilization practices, and sterilizations often occurred without patient knowledge or consent. One notable case, *Relf v Weinberger,* shed light on these practices by highlighting a case of two adolescents who were sterilized without parental knowledge. This case put a stop to large-scale sterilization practices and resulted in regulation of state funds and consent policies involved in sterilization. The legacy of the eugenics movement influences contemporary reproductive health care, as we continue to observe ways in which fertility is devalued and even controlled among those who have been marginalized in society.

In the 1950s, emerging hormonal contraceptive technologies introduced a new option for fertility control; however, the cost of being a research subject was again borne by marginalized communities. Unfortunately, contraceptive clinical trials were wrought with ethical concerns, from study recruitment to informed consent processes, which echoed coercive sterilization practices of the past. For example, contraceptive researchers first experimented with hormonal medications among institutionalized women with mental health disorders in Massachusetts. Large-scale birth control pill

trials heavily recruited in communities of color and in Puerto Rico, where subjects were not compensated for participation[18] and trials were not subject to the same rules and regulations of the mainland United States. The first combined hormonal contraceptive pill was approved in 1960 and at first only available to married couples. However, unmarried people gained access to birth control methods in the following decades and benefited from the growth in contraceptive technologies that expanded options beyond the birth control pill. The progestin injectable, depot medroxyprogesterone acetate (DMPA), was widely used for contraception outside of the United States but struggled to achieve Food and Drug Administration (FDA) approval until 1992. Despite this, DMPA use was widespread among institutionalized populations and within the Indian Health Service[19,20] as a tool for menstrual control. Many who were treated with DMPA were not informed of its side effects—including its long-term contraceptive effect—or even notified of their participation in contraceptive trials. Ultimately, the full breadth of communities who unknowingly contributed to contraceptive science may never fully be known; consequently, there remains significant distrust of contraceptive technologies today due to these unethical practices.

As laws restricting contraception were relaxed and contraceptive use became more widespread, those holding power considered how to use it as a tool of reproductive control. Several politicians proposed to use birth control as a method of limiting family size to serve their own political agendas. For example, in the early 1990s, legislators in many states proposed dozens of bills that included financial or social incentives in exchange for utilization of Norplant,[21] a long-acting reversible contraceptive (LARC) device. Low-income communities were more likely to be targeted for these initiatives. Although these bills were ultimately not passed, they were problematic in that they devalued the fertility of those seeking social support programs, such as nutrition and housing assistance. Although these bills were not explicitly racist, they propagated an idea about who should and should not have children. Anthropologists first described this concept as stratified reproduction,[22] where the fertility of those with social and economic power is valued, whereas those without power are devalued. These disturbing patterns of reproductive injustices are pervasive and woven into the very fabric of US history.

Current Injustices in Family Planning and Their Impact

Given the nature of these injustices, it is hard to imagine that they could persist. Unfortunately, reproductive injustices continue to be perpetuated both inside and outside of the health care system. Although large-scale coercive sterilization programs were halted, more recent examples of sterilization without patient consent have been uncovered. One such example is the California State Auditor's report[23] of more than 100 sterilization procedures that were performed on incarcerated people in the early 2000s, which highlighted failures to document informed consent and/or to observe the 30-day waiting period. In addition, in 2022, a nurse whistleblower shed light on unindicated gynecologic procedures, such as hysterectomies being performed within an Immigration Detention Center. The resulting investigation revealed "female detainees appear to have undergone excessive, invasive, and often unnecessary gynecologic procedures"[24] and recommended against using the medical facility and physician for future detainee care. These examples highlight not only how the entire health care team may play a role in perpetuating injustice but also that health care systems and people within them can be instrumental in changing them.

Being able to control one's ability to become or not become pregnant is a core component of reproductive justice; however, access to affordable contraceptive care remains out of reach for many people in the United States. From a federal standpoint, there are multiple policies in place that have led to decreased access to

essential reproductive health care. The passage of the Affordable Care Act in 2012 required states to expand Medicaid while also allowing for access to contraceptive methods without cost-sharing. Legal challenges resulted, with only 40 states expanding Medicaid coverage and leaving many without access to care.[25] In addition, religiously affiliated nonprofit and for-profit organizations upheld their right in court to refuse its provision. Limits on Title X funding, which funds a broad range of family planning services such as preconception health services, sexually transmitted disease testing, and contraceptive products,[26] have resulted in limited access to those in greatest need such as under- or uninsured communities. In addition, the Hyde amendment prohibits the use of federal funds to pay for abortion care, except in very limited instances (such as in situations where continuing the pregnancy would endanger a person's life). As unplanned pregnancy rates increase in the United States, along with increases in preterm birth and morbidity and mortality rates for pregnant and postpartum people, the lack of access to contraceptives and abortion care is particularly unjust.

As we consider the history of contraceptive care in the United States, it is no surprise that bias and pressure exist in care provision today.[27,28] LARC has been viewed as a powerful tool for preventing unplanned pregnancy; however, uptake has long been impeded by access to skilled providers and device cost. Several initiatives have used grant funding to expand access to LARC by providing free devices to low-income, uninsured patients (often referred to as the "LARC-first" approach). However, reproductive justice advocates and health care providers caution against this approach. It may not appropriately enable patient-centered, justice-informed care,[29] and does not acknowledge previous violations in reproductive autonomy and how bias can impact contraceptive recommendations and care. The "LARC -first" approach can also perpetuate the concept of stratified reproduction. Research shows that contraceptive providers do exhibit bias in making recommendations about intrauterine device (IUD) use depending on the patient's race, ethnicity, and perceived socioeconomic status.[28] In addition, studies have uncovered that patients experience undesired counseling approaches by their providers. In one study interviewing postpartum women about their experiences with contraceptive counseling, researchers found that women felt pressured to choose contraception. One subject described repeated attempts by her doctors to convince her to choose a method, stating, "They wanted to go with the IUD… they kept bringing it up over and over again." Others described being suspicious that providers were targeting patients based on race and/or ethnicity for LARC methods or potentially receiving financial incentives or "kickbacks" for placing them.[27,28] Other studies involving young women and Latinas accessing contraceptive care have revealed feelings of medical mistrust and perceived discrimination.[30] Given these findings, it is imperative that reproductive health care providers reflect on their own biases and develop approaches that mitigate these effects and prioritize a patient-centered and justice-informed approach.

In the last decade, abortion care has been significantly regulated and restricted, limiting access not only to abortion services but also to other types of reproductive health care. For example, 16 states have restricted the allocation of state funding for family planning services at private reproductive health clinics that counsel about abortion or offer abortion services.[31] There are also restrictions on funds typically used for sexually transmitted disease diagnosis and treatment. In addition, targeted regulation of abortion providers (known as targeted regulation of abortion providers [TRAP] laws) has led to an increase in state laws restricting abortion care and facilities that perform this care. Today, more than 20 states have regulations or policies that limit medical licensing, require physician admitting privileges, set building standards,

or require transfer agreements.[32] Although the stated intention of these laws is to improve the safety of abortion care, there is no evidence that health outcomes have subsequently improved.[33] In fact, these regulations have resulted in the closing of reproductive health clinics, which leads to access issues and delays in patient care.

It is also hard to ignore the impact that the Dobbs decision has had on reproductive access. On June 24, 2022, the US Supreme Court ruled in *Dobbs v Jackson Women's Health*, overturning nearly 50 years of precedent that was set by *Roe v Wade* and revoked the constitutional right to abortion. This decision returned the right to abortion up to each individual state, meaning that laws and access vary from state to state. Texas is one of the most restricted states in the country, limiting access to pregnancy termination for pregnancies less than 6 weeks or in cases of pregnancy threatening maternal life, and invoked this law about 9 months before the *Dobbs* decision. Regulations around referral to abortion services or assisting a person in Texas to leave the state to obtain abortion care have created strains on the patient–physician relationship. Texas has therefore proven to be a case study for poor maternal health outcomes due to its severely restricted abortion care.[34] In fact, several studies demonstrate that abortion restrictions result in higher rates of maternal and infant morbidity and mortality.[35] At the time of this publication, 14 states have complete bans on abortion care and many others have significant restrictions that make it difficult for patients to access care. This lack of abortion access not only challenges the concept of reproductive justice but also represents a larger public health and women's rights issue.

Moving Forward Together

Although understanding the US history of reproductive health care is critical, many of these injustices continue to be perpetuated today. To achieve reproductive justice, systemic inequities must be addressed. There is a critical need for advocacy for policies and practices that ensure that all individuals not only have the resources and agency to make decisions about their reproductive lives, but they are also in safe environments to be able to do so. Below are some steps and considerations to achieving reproductive justice within family planning, which is represented in **Fig. 2**.

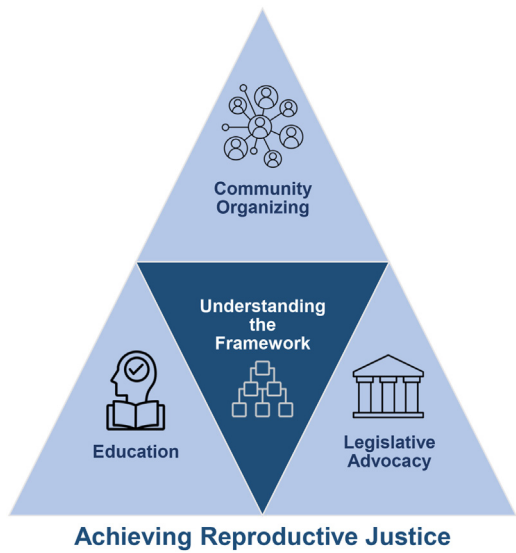

Fig. 2. Strategy to addressing reproductive justice.

1. Understanding the Framework: It is imperative for people to familiarize themselves with the reproductive justice framework. This framework focuses on using an intersectional approach that considers race, class, gender, and other social determinants and the impact of those factors on a person's ability to achieve reproductive autonomy. It also focuses on the entire reproductive experience, not just abortion and contraception care.
2. Community Organizing: We must support grassroot movements and community organizations that are fighting for reproductive justice and recognize that community organizing is at the heart of this movement.
3. Education: We must continue to educate ourselves and others about the history of reproduction within the United States, especially that of marginalized individuals. Understanding the previous history allows us to understand the context under which we are providing care and to avoid perpetuating mistakes of the past.
4. Legislative Advocacy: It is critical, especially in this time, to advocate both on a state and national level for affordable and accessible health care services, including contraceptive care, abortion services, fertility treatments, prenatal care, and postpartum care regardless of an individual's income or geographic location.

Achieving reproductive justice and integrating this approach into reproductive care is an ongoing process that involves addressing both immediate and long-term societal issues. It requires collective action, advocacy, and a commitment to interrogating and dismantling the systems in which we work and live to ensure that everyone, regardless of what identities they hold, can achieve true reproductive autonomy.

SUMMARY

The state of reproductive health care continues to be challenging with many similarities to the past despite continuous fights to make this essential health care accessible to all moving forward. As restrictions on abortion and contraception access continue, it is imperative that we understand the historical context of reproduction in the United States. The historical legacy of injustice still has a lingering impact on how people access reproductive health care. It also informs what we must do to ensure that harms of the past are not perpetuated. By understanding the historical context that led to the development of reproductive justice and its core principles, health care providers can strive to deliver equitable and just care that recognizes and validates the experiences of marginalized communities. Using a reproductive justice lens when providing family planning services allows us to address an individual's right to have or not have children. It also reinforces the broader social justice issues that intersect with a person's reproductive health with the goal of achieving reproductive liberation.

CLINICS CARE POINTS

- Obstetrics and gynecology practitioners must understand the historical context of reproductive oppression and injustice in the United States.
- The reproductive justice framework is a lens which recognizes a person's autonomy and right to become pregnant, prevent pregnancy, and raise healthy families.
- Many marginalized communities have suffered injustices and may continue to be negatively impacted by reproductive legislation that limits access.
- Clinical providers must advocate for dismantling injustice in reproductive health.

DISCLOSURE

Dr C. Loder is a Principal Investigator for Contraceptive Clinical Trials for Merck & Co, Inc and Sebela Pharmaceuticals Inc and is an Educational Consultant for the American Medical Students' Association.

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