Reflections on Reproductive Justice in the United States from 1989 to 2024

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Article

Abstract

In 1994, *Women of African Descent for Reproductive Justice* came together to give voice and vision to the term Reproductive Justice (RJ) and its principles in anticipation of the International Conference on Population and Development and in response to the reproductive rights movement in the United States that white and wealthy women dominated at that time. As a nurse who has worked on the front lines, sidelines, and behind the scenes over the three decades since that auspicious gathering, this article relays some of my professional experiences as they relate to what I believe are among the most pressing issues we face as a global community and as nurses striving to manifest the principles of RJ. The article ends with a call to action for nurses, as there is no time to waste.

Key Words: Reproductive Justice, Reproductive Health, Reproductive Rights, Immigration, Maternity desert, Abortion, birth center, health equity, maternal mortality

Thirty years ago, *Women of African Descent for Reproductive Justice* came together in Chicago before the 1994 International Conference on Population and Development (ICPD), and, in response to the reproductive rights movement in the US at that time that white and wealthy women largely dominated, gave voice and vision to a new term and set of principles: Reproductive Justice (RJ). The four principles they laid out included the right to 1) maintain personal bodily autonomy, 2) have children, 3) not have children, and 4) parent children in safe and sustainable communities (Sister Song, n.d). Over the subsequent three decades, RJ has gained broad recognition and acceptance, including within nursing. In 2022, the American Nurses Association (ANA) acknowledged RJ's principles as "related to reproductive health in ways that could have nursing implications" (American Nurses Association, 2022). As a nurse who has worked on the frontlines, sidelines, and behind the scenes of RJ since before the term first emerged, in this OJIN piece, I offer a few reflections from my professional experiences in hopes they may provide other nurses with insights, inspiration, or sustenance to continue engaging in this important work.

Birth on The Border

My clinical involvement in RJ began in the late '80s as a volunteer at a small birth center on the border of Texas and Mexico. The birth center was founded by a group of devoted, strong-willed nuns who expressed their faith by providing community-based pregnancy, birthing, and postpartum care for people in that region. To realize their vision, they purchased a set of modular homes and placed them on the edge of a field near one of the small towns on the US side of the border to create a free-standing perinatal care and birth center. The center served people from both sides of the border, many of whom came from families that had lived in the region long before the Rio Grande was deemed a political border and disrupted the flow of people who had moved back and forth over those lands for generations. The birth center was nothing fancy, but it was safe and clean, and no one was turned away for their lack of ability to pay.

At that time, in "the Valley," as locals called it, people still regularly crossed between the two countries by walking directly through the river, often holding their belongings over their heads or carrying a child on their back, sometimes clutching an inflated inner tube when the water ran high. Many patients would arrive at the birth center, their clothes still damp from the crossing, seeking care so their children could have the best possible chance of a healthy start to life.

Ross and Solinger (2017) explain that an RJ framework goes "beyond the pro-choice/pro-life debate" by centering on the premise that "all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences" (p. 9). They assert that "achieving this goal depends on access to specific, community-based resources, including high-quality health care, housing and education, a living wage, a healthy environment, and a safety net for times when these resources fail" (p. 9). Even though the term and its principles had yet to be articulated, the nuns clearly had an intuitive understanding. They were committed to the ethos of RJ when they established the birth center, which they manifested through supporting people in having safe and dignified pregnancies and births, regardless of their economic means, citizenship, skin color, ethnicity, or insurance status. Little did I know then that the nine months I spent volunteering at the center would lay such an essential foundation on which to build my future career as a nurse.

Given the projected continuation and rise in displacement of human populations around the world, the global community faces new and unprecedented challenges in upholding the fundamental tenets of RJ.

Since the late 1980s, the demographics of and conditions for people entering the US from Mexico have changed dramatically. While historically, those who crossed into the US through the southern border came primarily from Mexico, Guatemala, Honduras, and El Salvador, in recent years, this demographic has shifted to include more people from other countries, in particular Venezuela and China, as well as more families and unaccompanied minors as opposed to single individuals (Gramlich, 2024). These trends reflect the larger global context in which political conflict, violence, persecution, human rights violations, and other disruptive events have forced more people to leave their homes and communities. Environmental events and conditions, including those related to climate change are also a major factor in both internal as well as cross-national displacement of people around the world. As of this writing, the United Nations High Commissioner for Refugees reports that one of every 69 people in the world has been forcibly displaced, a level twice as high as a decade ago (UNHCR, 2023). In June 2022, some 100 million people – an all-time global record – were displaced (United Nations Office for the Coordination of Humanitarian Affairs, 2023). The Institute for Economics and Peace has estimated that this number may be as high as 1.2 billion by 2050 (Institute for Economics and Peace, 2020). This unprecedented global dislocation of human populations is playing out along the US-Mexican border, including the southern tip of Texas, where the birth center is located (Isaacson, 2023).

The mistreatment and detention of people entering the US who lack required legal documentation, also referred to as "unauthorized immigrants," is a long-standing practice in which violations of the basic tenets of RJ are common (Pepe et al., 2023). In recent years, some of the specific, systematic RJ transgressions that have been reported include abortion bans for unaccompanied minors, poor treatment of people who are pregnant, and extended separation of parents from their children who are being detained in unacceptable facilities (Messing et al., 2020). Given the projected continuation and rise in displacement of human populations around the world, the global community faces new and unprecedented challenges in upholding the fundamental tenets of RJ. As nurses, our Code of Ethics guides us to "practice with compassion and respect for the inherent dignity, worth, and unique attributes of every person," "collaborate with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities," and "and integrate principles of social justice into nursing and health policy" (American Nurses Association, 2015, p. v). The treatment – both now and in the future - of people seeking to enter the US to escape violence and other intolerable conditions in their homelands is clearly an issue on which nurses must act to uphold our ethical standards, as well as the principles of RJ.

Access to Abortion

Several years after working on the US-Mexico border, my involvement in RJ as a nurse took a new turn when I accepted a position at an independent abortion clinic in Boston. At that time in the early '90s, large protests in front of abortion clinics around the country were escalating, along with violent acts directed toward clinic facilities and the people who worked in them. The clinic where I worked was a prime target because of its high visibility on the edge of the historic Boston Common. Many mornings, when I arrived for my shift, I had to pass through a crowd of protestors to enter the building. While seeing and hearing their hateful stares and words was an occupational hassle I had to tolerate to get to my job, for the people coming to receive services, it was a life-altering decision point: Walk through and have the procedure they came for or turn back and remain pregnant. Though many bravely persisted and made it into the clinic, often when I saw them for their pre-procedure counseling, they were deeply rattled from the harassment and images they had been forced to confront to obtain healthcare.

On one cold spring morning, as I emerged from the subway, I noticed a particularly large crowd assembled in front of the clinic. In the center, a group of about 20 people had linked their necks together with bicycle U-locks to form a kind of human chain that extended to the clinic door, making it impossible for the police to move any one of them without causing severe harm. This effectively blocked everyone's access to the clinic. Assessing the situation, our staff quickly huddled at the side of the building and made a quick game plan. We identified many of the people there for appointments and let them know we would see them as soon as we could get into the clinic, no matter what time it was. After nearly five hours, the protestors finally handed over the keys and we went into the building. While a few patients had stayed, not surprisingly, most had given

up and gone home. For some, that day was likely a turning point in which their personal circumstances – lack of transportation or childcare, a rigid work schedule - or psychological factors - fear, guilt, limited support – kept them from returning or going elsewhere for the abortion they sought.

In a longitudinal study comparing people able to obtain an abortion with those who sought but were unable to end their pregnancy because of gestational age limits, Foster and colleagues (2022) found that those denied an abortion experienced more harmful long-term effects, including economic hardship and insecurity. Specifically, those "turned away" were more likely not to have enough money to cover basic living expenses such as food, housing, and transportation and to have lower credit scores, higher levels of debt, rates of bankruptcy, and evictions than the comparison group (Miller et al., 2023). Children born to people denied an abortion also fared worse, with a higher likelihood of living in poverty and experiencing poorer maternal bonding than those born following a subsequent pregnancy (Foster et al., 2018). The "Turnaway study" findings made me wonder about the people who didn't make it into the clinic that day or the many other days when protesters were out front. What harm have they and their children endured because they were prevented from doing what they felt was best for themselves and their families? It goes without saying, clinic protests are antithetical to RJ.

In addition to ongoing violence and public protests that have disrupted people's access to abortion in the US over the past three decades, the legal landscape has also become increasingly hostile. Since the landmark Roe decision in 1973, a steady stream of legislation – including but not limited to abortion – restricting people's ability to control their reproductive destiny has been introduced and passed in states across the country. The 2023 Supreme Court decision in the Dobbs v. Jackson Women's Health case, which overturned Roe v. Wade, was a culmination of this decades' long, multi-faceted erosion of the constitutional right to abortion. As of August 2024, 14 states have enacted a total abortion ban, and 27 have gestational age limits (Guttmacher Institute, 2024). Six of these states have no exception for the health of the pregnant person, 10 have no exception for when the pregnancy occurred because of rape or incest, and 13 make no exception for fetal anomalies (Gomez et al., 2024). Today, more than 25 million people with the capacity for pregnancy live in a state with an abortion ban (Mulvihill et al., 2023).

Since 1977, the National Abortion Federation (NAF), a trade organization that represents abortion facilities across North America, has been collecting data on violence and disruptions targeting abortion facilities and workers in the US. During this period, a total of 11 murders, 42 bombings, 200 arsons, 531 assaults, 492 clinic invasions, 375 burglaries, and thousands of other incidents of criminal activities directed at patients, providers, and volunteers have been reported (National Abortion Federation, n.d.). In 1994, in response to the rise in large-scale abortion clinic blockades like the one I described, as well as violence directed toward clinics and abortion workers, Congress passed the Freedom of Access to Clinic Entrances (FACES) Act, which established federal criminal and civil penalties for engaging in such acts (US Department of Justice, n.d.). Nevertheless, while this legislation has been substantial, it has not stopped clinic protests or violence toward abortion providers (people or facilities). Indeed, in 2022, the year the Supreme Court overturned Roe v Wade, NAF documented a rise in major incidents, including arson, burglaries, and death threats among their member clinics (NAF, 2022). They attributed this rise to the Dobbs decision and the wave of state-level abortion bans that followed, which "emboldened" anti-abortion extremists and allowed them to shift their focus to states where abortion was protected.

These state-level abortion bans and restrictions disproportionately burden communities of color because of more limited financial resources, access to transportation, and insurance coverage.

State abortion bans and restrictions are devastating to RJ, including making travel to another state necessary to receive abortion services. A recent study found that since the Dobbs decision, the proportion of people traveling to another state to obtain an abortion doubled from 1 out of 10 in 2020 to 1 out of 5 in 2023 (Forouzan et al., 2023). For many people, such travel presents an insurmountable barrier due to a range of personal and systemic factors, including age, physical or mental ability, fear, stigma, race, ethnicity, citizenship, gender identity, class, and others. These state-level abortion bans and restrictions disproportionately burden communities of color because of more limited financial resources, access to transportation, and insurance coverage. In addition, Black and American Indian/Alaskan Native (AI/AN) women of reproductive age are more likely to live in these states (Hill et al., 2024). When combined with existing racial disparities in maternal health in the US, these abortion restrictions move the US even further from realizing the principles of RJ.

Maternity Deserts

While access and the legal right to abortion have been steadily eroding in the US, a concurrent threat to RJ has been emerging in obstetric care. Between 2006 and 2020, over 400 hospital-based obstetric services across the country closed. Currently, some two million people with the capacity for pregnancy live in a maternity desert, defined as "counties where there is a lack of maternity care resources, there are no hospitals or birth centers offering obstetric care, and no obstetric providers" (Brigance et al., 2022, p. 2), including obstetricians, family physicians who provide birth care, or nurse midwives.

Rural communities across the US have been particularly hard hit by this trend, with 267 rural hospitals closing their obstetrics units between 2011 and 2021. The most cited reasons for these closures include declining birth rates, health workforce shortages, and economic factors, including the high cost of running obstetric and neonatal services and malpractice insurance (Topchik et al., 2024). At the state and federal level, policies, including low Medicaid reimbursement rates and anti-abortion laws that influence obstetric providers' willingness to practice in certain states, are also adding to this crisis (Sabbath et al., 2024).

As with abortion services, maternity unit closures result in longer travel distances and times for people who are pregnant and postpartum (Fontenot et al., 2024). For those with limited access to transportation or money for gas, caretaking responsibilities at home, a job that allows little or no time off for healthcare appointments, or a variety of other circumstances, extra travel can make showing up for recommended pregnancy care impossible. In obstetric emergencies - when every minute may be critical - longer travel times can have dire consequences for a pregnant or birthing person or neonate. Such factors contribute to the extant disparities in maternal and infant health outcomes in the US that negatively impact communities of color (Fontenot et al., 2024).

In Maine, where I was part of a research team that recently conducted a needs assessment of the maternity workforce in rural hospitals under a state Health Services Resources Administration Rural Maternity Obstetrics Management Strategies (RMOMS) funded initiative, 10 hospitals have closed their obstetric units since 2008. While these closures have not technically tipped any part of the state into the maternity desert classification, the effects are still chilling from an RJ perspective. As one of the most rural states in the nation, Maine has vast areas where the nearest hospital is hours away, even in good weather. Additionally, its many islands are home and workplace to people during the summer and year-round. For these populations, accessing healthcare - including any routine or emergency reproductive health services - often requires a lengthy boat ride or a flight.

In addition to rural populations, emerging evidence indicates communities of color are disproportionately affected by hospital obstetric unit closures, including in urban areas.

In addition to rural populations, emerging evidence indicates communities of color are disproportionately affected by hospital obstetric unit closures, including in urban areas. Public health researcher Alicia McGregor points out hospitals that are most likely to close their obstetric units are often heavily reliant on Medicaid, which reimburses at lower rates than commercial insurers, and is more common among hospitals that serve a larger share of Black patients (Harvard T. H. Chan School of Public Health, 2023). To better understand how urban hospital obstetric unit closures affect people's experiences of perinatal care, McGregor is conducting a study in Washington D.C. in which the preliminary findings "point to a two-tiered maternity care system in the city, with low-income Black and Hispanic patients more likely to receive care from underfunded facilities." Furthermore, McGregor reports that "perhaps the most disturbing finding was that hospital overcrowding frequently forced patients to be diverted to another hospital while they were in labor."

As the country with the highest rate of maternal deaths of all high-income nations (Commonwealth Fund, 2024), the US is failing to uphold the most basic elements of RJ. While hospital-based obstetric care may only be one piece of the puzzle to solving this crisis, the continued closure of hospital-based obstetrics services in rural and urban communities is a move in the wrong direction.

Climate change: An Existential and Practical Threat to RJ

In addition to the erosion of legal rights and access to comprehensive reproductive health services in the US, over the three decades I have been a nurse working in this area, climate change has emerged as an existential threat to life on the planet and inherently to RJ, violating Ross and Solinger's (2017) fundamental tenet of "the right to parent children in safe and sustainable communities." It is now broadly recognized that climate change disproportionately impacts low-income and BIPOC communities around the world, including in the US (Abi Deivanayagam et al., 2023). When coupled with the mounting evidence that systemic racism and other structural inequities have historically and continue to contribute to poorer reproductive health outcomes in these populations, climate change is an issue that warrants urgent attention and action, including among nurses who care deeply about RJ.

While on the faculty at the MGH Institute of Health Professions (MGH IHP), I had the opportunity to serve on the Steering Committee for the Center for Climate Change, Climate Justice and Health, one of the first nursing-led initiatives in the US to focus on the impacts of climate change on health. The Center cultivated collaboration among nurse scholars, including among a subset of us interested in reproductive health. We decided to learn more about the intersections of climate change and RJ, develop teaching and learning tools, and publish on this topic. Through this scholarly work, I developed a sharper awareness of the specific and profound threats climate change poses to RJ. For example, I now understand that extreme heat events, air pollution, and other natural disasters that are on the rise due to climate change contribute to adverse pregnancy outcomes, including by increasing risks of preterm birth, low birth weight, and stillbirth (Pandipati et al., 2023).

Furthermore, because communities of color in the US already disproportionately experience poorer outcomes in these areas, climate change compounds existing inequities. Additionally, as previously discussed, weather-related effects of climate change, such as wildfires, floods, hurricanes, and droughts, contribute to the dislocation of human populations worldwide at unprecedented levels (Bekkar, et al., 2020). For these people, accessing routine and emergency reproductive health services, including but not limited to contraception, pregnancy, and abortion care, is often difficult (Domingue, 2023). Although health services are by no means all that is needed to manifest RJ, they are an essential component. Therefore, climate change presents both a practical and existential challenge to this movement. As nurses, we have an important role and responsibility to participate in efforts to address the growing climate crisis.

Conclusion: Hope and...

As a nurse, I have had the privilege of accompanying patients as they have navigated their reproductive journeys and an abundance of opportunities to collaborate with other clinicians, clinical educators, researchers, policy advocates, and activists committed to manifesting RJ in their unique ways. Reflecting on the three decades I have been involved in this work, I am both concerned about and hopeful for the future. The extent of the loss of legal rights and access to comprehensive reproductive health care over this period was unimaginable when I started my career. Similarly, I could not have imagined the depth and scale of the climate crisis at that time in my life. It is hard for me to imagine what the world will be like in 10, 20, or 50 years, much less in the 22nd century; I worry for those of us who are alive now and for future generations. At the same time, hope springs eternal, fueled by witnessing and learning about the amazing vision, creativity, and grit people bring to the RJ and Climate Justice movements, both in the present and past. The broad embrace of the term and awareness of RJ's principles, including in nursing, signals how far we have come since the late 1980s. Hearing student nurses talk about RJ and seeing what organizations like Nurses for Sexual and Reproductive Health (NSRH) are doing fills me with optimism about what our profession offers the world in these challenging times. As a nurse committed to RJ, I am called to continue engaging in efforts to manifest RJ and call other nurses to join me in this work. There is no time to waste.

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