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Reproductive justice: Holding the line and pushing forward

There are no adequate words for the plight of Gaza, but we must not be silent. In this issue of *Aotearoa New Zealand Social Work*, we take the unusual step of publishing two editorials, one of which introduces the theme of this issue -reproductive justice. In a second editorial which follows, "Justice for Palestine", members of the editorial board express unconditional solidarity with the people of Palestine at this pivotal time in history.

Saba (2023) writes about the Palestinian feminist movement, Tal'at (Arabic for "stepping out)," which embodies a sense of coming into view, of ascending, and rising (p. 647). Their slogan is:

> "There is no free homeland without free women."
>
> Tal'at, [is] a continuation and expansion of the Palestinian women's movement to include queer struggles and transnational solidarity. This provides a counter-narrative to Israel's feministwashing and pinkwashing propaganda campaign whose sole purpose is to protect its image on the world stage and attempt to legitimate its violent settler colonial policies. (Saba, 2023, p. 647)

As a group of feminist social work academics, in this issue we honour the women of Palestine in their struggle. We weep for the women living in the rubble of their homes, birthing in the dust with no medical care, struggling to feed their children, burying their loved ones under bombardment. We burn with anger that this is happening and urge all women across the globe to act to bring transnational feminism into this struggle. We condemn the powerful nations who are continuing to express solidarity with Israel, by vote and by the supply of arms and thereby are continuing to condone the violence towards the women of Palestine. There can be no reproductive justice without freedom, security and justice.

In our call for proposals for this themed issue, we framed our understanding of the topic by noting that there are three main frameworks for exploring reproductive health from a justice perspective, and with an intersectional lens:

1. Reproductive health, which deals with the delivery of accessible and responsive services;

2. Reproductive rights, which addresses regulatory issues; and

3. Reproductive justice, which focuses on movement-building in which the primary principles are: the right not to have a child; the right to have a child; and the right to parent children in safe and healthy environments (Ross & Solinger, 2017).

Ross (2006) also argued for "the necessary enabling conditions to realize these rights" (p. 4). Reproductive justice advocates argue that the ability of anyone to determine their own reproductive choices is linked directly to the socioeconomic conditions in their environment and, importantly, "these conditions are not just a matter of individual choice and access. Reproductive justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny" (Ross, 2006, p. 4).

We offered a wide brief for proposals as reproductive justice encompasses more than abortion and contraception. Birth care justice, maternal mental health, reproductive

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coercion (Burry et al., 2020) , sexual health, sexual violence (Le Grice et al., 2022) Rainbow health care, especially care for transgender people (Gomez et al., 2021), intersex people (Joy et al., 2023) , Māori and Pasifika women's reproductive, sexual and maternal health (Le Grice & Braun, 2017; Young et al., 2023), the needs and rights of young parents and parents with disabilities (Bloom & Morison, 2023; Maylea et al., 2023) or chronic illness, infertility and assisted reproduction (Webb & Shaw,2022), adoption, and the impact of colonisation on birth and parenting in Aotearoa and the Pacific can all be explored and studied within an intersectional reproductive justice lens. The right to parent, and to parent with the enabling conditions for a good life for children and parents brings child protection practices into consideration as parents who are exposed to state systems often enter a spiral of structural violence (Broadhurst & Mason, 2017; Morriss, 2018).

As noted by Ross (2006), the reproductive justice lens requires conversations and actions that move beyond and transform prior reproductive rights movements such as those centring notions of choice. It is "a political movement that splices *reproductive rights* with *social justice* to achieve *reproductive justice*" (Ross & Solinger, 2017, p. 9) conceived by Black women in the United States who argued that previous lenses did not adequately account for their experiences (hence including the right to *have* a child, and the right to parent children in healthy and safe environments alongside the right to *not* have a child). Critically, a reproductive justice lens recognises that reproductive rights are intersectionally located and that the experiences of white (and often straight, cisgendered, middle-class) women cannot stand as representative of *all* women. Reproductive justice requires an intersectional lens as it includes consideration for how power structures like white supremacy, capitalism and cisheteronormativity limit and create reproductive possibilities for differentially located populations (Tam, 2021).

For example, in Aotearoa—and likely many other settler colonial states—this is about recognising that wāhine Māori, unlike Pākehā women, have had their stories and specific knowledges silenced and colonised (see: Cleaver in this issue; Mikaere, 2011), their knowledge and advocacy appropriated, colonised and stolen (Le Grice et al., 2022; Murphy, 2011, 2017), and their fertility managed and suppressed (Morison et al., 2022). For social workers working in this context it means that work for people with reproductive concerns must be intersectionally differentiated as it will look different and require different actions depending on the person's social location. Put simply, when a person is situated in the intersection of the 'roads' of capitalism, white supremacy and patriarchy, they are far more likely to be 'hit' by the cars of classism, racism and sexism *at the same time*, making reproductive decisions and possibilities much more challenging to negotiate (Crenshaw, 1989).

While there are so many challenging issues of reproductive justice that are vital to further Aotearoa New Zealand scholarship and research, in this extended editorial we will discuss four important topics: Queering reproductive justice; period poverty; preconception and prebirth surveillance; and contraception.

Queering reproductive justice

Queer people accessing reproductive services often find themselves navigating spaces that have been designed for, and cater to, cisgendered heterosexual people. Queer scholars have responded to this challenge by explicitly *queering* reproductive justice (Falu & Craven, 2023; George, 2020; Tam, 2021). For example, Falu and Craven state that "queerness, to its fullest potential, is still not yet here until reproductive justice also encompasses queer lives, queer communities, and queer losses" (2023, p. 219). Part of this queering also means having potentially challenging conversations about technological advances in reproductive technologies as opposition can reify gendered and sexed binaries thereby "naturalising heterosexual reproduction" (Butler, 2004, p. 11). For example, a queer reproductive lens demands that scholars and activists to move beyond a biogenetic (where a person uses their own genetic material and/or organs to conceive and/or birth a child) lens for reproduction and consider (and enable) other possibilities which may also expand access and provide reproductive liberation for those who are not queer (Ferrara, 2023).

These conversations are not without their challenges, and require consideration of multiple factors—for example, the potential exploitation of egg donors and surrogates. However, an intersectional lens, and one that is explicitly queer, challenges (and requires) us to move beyond binaries and consider that while assisted reproductive technologies can be exploitative they can also be liberatory, and to position them as *only* exploitative potentially denies donor agency and restricts pregnancy to those who do not need assisted reproductive technologies (Lane, 2019).

In a climate where governments around the world are increasingly antagonistic towards queer people, especially those who are transgender, this means that those of us fighting for reproductive justice must consider how our activism and our scholarship might include or exclude queer perspectives. In Aotearoa, fights for reproductive justice therefore mean pushing back against our new right wing government's calls to have 'ideology' (references to gender and sexuality) removed from our relationships and sexuality curriculum (1 News, 2023). Such a move would see queer children denied even the small amount of knowledge they may currently receive to navigate puberty and relationships safely and respectfully, and would isolate whānau who do not represent the nuclear cis-hetero norm. Finally, such regressive moves would further threaten the sexual and reproductive health of those whose bodies do not conform to sexed norms—for example people with variations in sex characteristics who have genitals that do not 'fit' traditional contraceptive devices such as condoms (Berger et al., 2023).

Period poverty

Period poverty refers to the lack of access to menstrual products, hygiene facilities, waste management and education about menstrual health or a combination of these (Michel et al., 2022). While period poverty is a neglected and under-researched health and human rights issue, it continues to gain traction as a global concern. Given that on average, wāhine/girls/women/people who menstruate will have around 480 periods within their life course, period poverty presents a problem that warrants continued and timely attention.

An Aotearoa New Zealand survey by KidsCan found that 53% of wāhine/menstruators had found it difficult to afford period products while almost 25% of respondents reported taking time off work or school because of period poverty (KidsCan, 2018). Inevitably, school, tertiary education and work absences have a flow-on effect impacting learning and paid employment that ultimately compounds inequalities and the experiences of poverty. Socio-economically stressed households were most vulnerable to the experience of period poverty. Māori and Pasifika are over-represented compared to Pākehā (settlers) because of the persistent effects of colonisation, colonist practices and related harms. Beyond the matter of resources, efforts to manage the physical aspects of menstruation, practices of menstrual concealment, shame and stigma associated with menstruation and period poverty inevitably pose challenges to mental and emotional wellbeing.

In Aotearoa New Zealand, Ikura | Manaakitia te whare tangata, is a programme under the Ministry of Education that responds to period poverty by providing free products in all state and state-integrated schools—funding is in place until June, 2024. Ikura | Manaakitia te whare tangata offers more than material resourcing via its attention to the language, knowledge and status of menstruation. The name, Ikura | Manaakitia te whare tangata, has been intentionally cultivated in consultation with Roopū Te Ao Māori, mātaurangi Māori and rangatahi who participated in the pilot programme:

> 'Ikura' is a traditional name that is derived from the saying 'Mai-i-kurawaka' which literally means 'menstrual blood that comes from kurawaka' (the vaginal area of Papatūanuku).
>
> 'Manaakitia te whare tangata' means to uphold, enshrine and take care of the whare tangata (the house of humanity, womb, uterus, temple).

Te Reo has been employed for its potential to invert Western-inflected stigma associated with ikura (periods) and restore the symbolic meaning, knowledge and mana of menstruation (Ministry of Education, 2023). This responds to, as Wootton and Morison (2020) argue, a "politics of disgust" and the stigma associated with menstruation, where there are limitations to 'merely' providing period products to counter period poverty. Moreover, as Murphy (2017) shares, traditional Māori ceremonies and practices "reflect the positive and respectful attitude our tīpuna (ancestors) had toward menstruation as a symbol of the continuation of life" (p. 12). The holistic efforts of Ikura | Manaakitia te whare tangata are encouraging. However, there is also great concern.

Given the new Government's right-wing and thinly veiled (neo)-colonial strategies including its commitment to erasing sexuality, relationship and consent education in schools, abolishing Te Aka Whai Ora, the Māori Health Authority and minimising the use of Te Reo in the public sector (see 100_Day_Plan.pdf (nationbuilder.com), the continued support of the programme and its contribution to supporting reproductive health and well-being, enhanced access to schooling, responsiveness to financial strain and the addressing of menstrual stigma may be in jeopardy. What is to be done?

A reproductive justice approach lends itself to continued advocacy and activism for meaningful responses to period poverty. Wootton et al. (2020) argue for interventions based on a sexual and reproductive justice (SRJ) approach that:

- Shifts away from matters of hygiene and menstrual management to a focus on rights;
- Appreciates the intersectional nature of menstruation attending to social justice and social determinants of health; and
- Implements a participatory and empowering approach that is informed by specific and local knowledges.

Menstruation and the matter of period poverty must be centred as a health and human rights issue where menstruating bodies can be afforded unapologetic, empowered space in diverse avenues of social life.

Preconception and prebirth surveillance

As knowledge of conception, pregnancy, and child development have progressed, so has understanding of how the early years might impact on later health outcomes (Waggoner, 2017). As scholars have noted, this knowledge has put the gestating body, and even the pre-gestation body, under increasing amounts of surveillance (Budds, 2020; Waggoner, 2017). For pregnant and pre-pregnant people, this means self-policing one's body, behaviours and even thoughts and moods lest the body—the fetal environment—become potentially toxic. This situates the uterus as the original environment and thus a site of intervention—the body is optimised so that the fetus can be optimised (Joy & Beddoe, 2024 [in press]). Women, pregnant people who therefore do not (or perhaps cannot) do this work are then positioned as deviant, and/or monstrous mothers (Joy, 2022). Critical scholars working in this field, particularly within social work, note that this drive to early intervention and prevention thereby responsibilises mothers for structural conditions (Gillies et al., 2017; Joy, 2022). Such use of developmental science therefore responsibilises women for the effects of racism, classism, sexism, and even environmental pollution (Edwards & Gillies, 2019).

As Eileen found in her recent thesis (Joy, 2022), policymakers and practitioners are being increasingly drawn into these spaces with concerns being expressed for the *fetus* and, very rarely, the *mother*. For example, pregnant women were advised to not stress during pregnancy lest their stress create a toxic environment for the fetus, and in the most egregious examples, social workers positioned mothers, and not their violent partners, as failing to protect the fetus in instances of intimate partner violence. These notions of maternal impression on a fetus are not new; however, recent developments in science have reinvigorated them in ways that make pregnancy, and parenting, an unsafe time for many (Ballif, 2019), and thus also expand the fight for reproductive justice.

As Liz and Eileen note in a forthcoming book chapter (2024), child protection is governed by risk, often requiring a social worker to anticipate what might happen to a child. We ask if a pregnant person does not adequately manage risk, how might the state (and statutory social work) therefore respond? We suggest that social workers are being increasingly drawn into these spaces and this must be resisted. Instead, we suggest that such 'anticipatory work' needs to be viewed through a reproductive justice lens thus flipping the 'gaze' and responsibility back onto the state to ensure that families and pregnant people are supported with adequate housing, incomes, employment within a "decolonised, less patriarchal society where social workers do not need to worry about optimising fetal environment because the structural conditions for the parent, the mother, have been taken care of" (Joy & Beddoe, 2024 [in press]). Social workers thus armed with a reproductive justice lens can then advocate more broadly for a society that fosters a safe and healthy birthing environment for all *as a matter of child protection.*

Contraception

In the field of reproductive healthcare, there are many areas of contention. Contraception care, often lauded as the saviour of poor women, freeing them from endless childbearing, can also be a site of oppression and coercion. How free are all people able to exercise contraceptive choice, or indeed any choices about their reproductive and sexual health? In *Radical informed consent,* Goldblatt Hyatt (2023, p. 4) asks "how can we ensure that populations who have traditionally not had access to reproductive health services, abortion and healthy parenting environments are able to truly consent to their care?" Practice can be coercive without careful attention to the critical intersections of age, race, class and gender identities. The development of long-acting reversible contraception (LARC) provides a useful example. Morison (2023) and Morison et al. (2022) note that policies and practices around the prescription of LARC, are currently subject to critique for undermining patient-centred care by minimising choice and increasing the risk of coercion. Neoliberal policies may focus on risk and so-called vulnerable groups, targeting young, single, Māori and Pasifika women. Morison points to "power differentials in contraceptive consultations, characterised by limited patient engagement and subtle or overt pressuring of patients, especially socially marginalised women, to use/not use LARC" (2023, p. 539).

Social services are not innocent in this space either. Morriss (2018) notes that women accessing an intensive programme designed to work with women who have, or are at risk of having, more than one child being removed from their care were required to use a contraceptive implant for 18 months. They cannot access the well-funded resources without consenting to the LARC as the 'success' of the programme is predicated on women not having a child in their care or being pregnant, thus "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, p. 821). As noted above, poverty, colonisation, and other structural elements are invisibilised in this focus on control of the maternal body.

In this issue

In "He whare takata Wāhine Māori reproductive justice in the child protection system", **Kerri Cleaver** (Kāi Tahu, Kāti Māmoe, Waitaha) explores the question: What is the relationship between Indigenous women's reproductive justice rights and child removal in the Aotearoa New Zealand child protection system? Cleaver argues that reproductive justice in Aotearoa must be centred in Indigenous reproductive justice, challenging systemic state mechanisms that control wāhine Māori bodies contradicting the role as "he whare takata", the house of humanity. Cleaver centres atua wāhine pūrākau knowledge exploring the colonial project of child protection, shifting focus from wāhine as the holders of whakapapa. Cleaver provides a reflective, historical and contemporary analysis of complicit social work and settler state intervention on Māori bodies, with a particular focus on wāhine in the child protection system. The article draws on the research and knowledge collected by wāhine researchers over 30 years, drawing also on her doctoral study. This article will become a vital resource in the development of Indigenous reproductive justice within settler states and a rich source of historical material for current and future scholars and practitioners.

Ariane Critchley, in her article, "Pre-birth child protection and the reproductive rights of fathers", applies a reproductive justice framework to research findings about fathers of unborn children involved with the child protection system in Scotland. The article prefaces the findings of the research by succinctly describing the legal and ethical complexity of pre-birth child protection services, and by acknowledging the multiple and intersecting rights of those struggling to attain reproductive justice, including women and members of LGBTQI+ communities. They argue that the pursuit of reproductive rights of non-birthing heterosexual fathers contributes to a more holistic and transformative social work practice that best needs the care needs of children.

The key finding from the research is that unmarried fathers of children involved in pre-birth child protection service are typically denied the opportunity to exercise their parental rights and responsibilities. In Scotland, as in Aotearoa, children born to a married couple automatically attain a legal relationship with their children. This is not the same for unmarried couples however, who must jointly register the father of the baby. According to this research, which involved interviews with birth mothers and fathers involved in pre-birth child protection processes, a decision is often made by mothers, alongside social workers, not to legally register fathers. Analysis of the data collected for this research recognises a significant power imbalance between the social worker and the family in this regard, exacerbated by legal ambiguity and lack of legal counsel.

The author of this piece offers good arguments for applying reproductive rights and feminist lenses to the experiences of unmarried fathers involved in pre-birth child protection services. It is proposed that the practice of indiscriminately erasing fathers from children's lives can lead to marginalisation of fathers in general and jeopardises potential recovery from experiences which have led to issues, for example, family violence, underpinning concerns about the capacity to parent.

Critchley recommends that applying a reproductive rights lens to all parents involved in pre-birth child protection services offers more holistic and transformative potential. It recognises the power held by professionals in this space and argues for social work practice to be more active in enabling all conditions necessary to care for and raise children within their families and communities.

Eileen Joy, Katrina Roen and **Tove Lundberg** in their article, "Reproductive justice for children and young people with gonadal variations: Intersex, queer and crip perspectives", explored decision-making about surgery on their children and young people with variations in sex characteristics. Parents navigate complexity in both processing medical information and advice and thinking about children's bodily autonomy. Interviews with parents generated rich data where beliefs about able-bodiedness and the sex binary appear to influence their decision-making. Joy et al. employ crip, queer, and reproductive justice lenses to expand our understanding of what reproductive justice for all means in working with children and young people with sex characteristic variations. In conclusion, Joy et al. recommend that parents need to be given space, and opportunities to explore moving beyond narrow binary framings so they may support their children to make their own healthcare decisions when they can.

In "Fighting for women's rights and promoting choice: Implications for critical social work education", **Kim Robinson** and **Rojan Afrouz** focus on two women's movements, abortion rights in Australia and the Iranian women's protests, that have resisted dominant oppressive discourses pushing back on the regulation of women's bodies, choice, and reproductive rights. Robinson and Afrouz employ the theoretical lenses of feminist transnationalism and intersectionality to offer a critical analysis. They note that attacks on abortion rights in the United States of America have led to protests to protect women's reproductive right to choose and Iranian women have taken to the streets to demand their rights to gender equality and protest the systematic violence against women and their bodies. Robinson and Afrouz present an exploration of the contribution of women's activism to social work education, arguing that social movements can help us develop strategies of hope and collective action. A pedagogy of solidarity can both reflect and encourage activism in social work education.

In "Abortion counselling controversies and the precarious role of social work: Research and reflections from Aotearoa New Zealand", **Letitia Meadows** explores debates and controversies about counselling within abortion provision in Aotearoa New Zealand. Drawing on findings from a broader qualitative research project involving 52 participant interviews, formal and informal observation of practices, and analysis of service documentation, Meadows employs the concept of "boundary objects" from Star and Griesemer (1989) to account for diverse forms of abortion counselling that occur in multiple, but connected, social worlds. A reproductive justice lens is used to consider findings in light of recent legislative change in Aotearoa New Zealand, and the implications for service users and social work.

Meadows reports that efforts to standardise abortion counselling within law, policy, and practice guidelines have not prevented different versions of counselling by social workers, counsellors, nurses, medical practitioners, staff of community agencies, and crisis pregnancy services. A consequence of this proliferation of forms is that counselling has become a contested term while social work remains poorly integrated into service provision for abortion service seekers. Meadows makes a case for enriched care practices and highlights the potential for social work to support the well-being and agency of service users.

In "Menstrual concealment—"You can't just play the woman card"", **Elyse Gagnon** explores women's experiences of menstrual suppression within the New Zealand Army. Gagnon employed narrative interviews with 18 women currently serving in the New Zealand Army and nine key informants examining the influence of military systems, culture and processes on their experiences. Gagnon's participants described the convenience of not having their period in a military environment as their main reason for menstrual suppression, revealing their desire to 'fit in' within the current military culture while also having control over their own bodies. Decision-making about the management of menstruation was influenced by peers, rank, the environment, prior experiences, and the information provided to them by health professionals. In her preliminary findings from this study, Gagnon reports that military women are not only expected to retain feminine identity but also maintain body equivalence with men to ensure they are seen as equally operationally effective. Using a reproductive justice lens, Gagnon argues that without addressing menstrual stigma and the military structures, women will continue to 'choose' to conceal or suppress their period as suppression is presented as the only appropriate choice.

In their article, "Barriers to accessing assisted reproduction for diverse and minority groups in Aotearoa New Zealand: Findings from a qualitative study", **Rhonda Shaw** and **Edmond Fehoko** focus on fertility help-seeking experiences of underrepresented users of fertility care. The authors employ the concept of structural infertility to extend beyond social or medical constructions of infertility that privilege dominant ethnic groups, cisgender and/or heterosexual couples.

Consideration of structural infertility reveals how specific social and cultural constraints configure and impede reproductive choices and family-building aims. In this qualitative study, interviews with participants from multiple and intersecting identities including Māori, Pākehā, and Pacific ethnicities and diverse gender orientations revealed impactful challenges to reproductive decision-making and access to fertility treatment illustrated in themes of affordability, delays in the trajectory for resources and services and non-inclusive care. Participants emphasised the need for policymakers and fertility treatment providers to develop and engage in culturally responsive training that promotes inclusivity and an appreciation of diverse family arrangements.

In "'It helped that I'm a middle class, educated, white lady': Normative bodies within fertility clinics", **Lisa Melville** examined the experiences of queer women within fertility clinics in Aotearoa New Zealand. Melville used a qualitative, multi-methods approach, involving 27 face-to-face, semi-structured interviews and an online survey. Questions focused on the decision-making and experiences of lesbian women in conception, maternity, and family spaces. Findings indicated that the path through fertility clinics may be easier for those with privilege, presenting as white, wealthy, heterosexual, and feminine. Policies, the information provided, assumptions and behaviours were experienced as exclusionary. Normative understandings underpin the right to have a child, access to services, and the regulatory environment of assisted reproduction. Normative expectations present challenges on the road to parenthood, not only for lesbians, but for many others as these spaces can strongly reinforce narrow understandings of family.

In a Commentary, **Liz Beddoe** and **Eden Clarke** provide an update on abortion stigma in "A critical commentary: Abortion stigma standing in the way of reproductive justice". Abortion as healthcare is problematised within politically charged debates, leading to ongoing attempts to control access. Abortion as part of health care is often limited by stigma, place and culture, as well as the regulatory environment. Given recent changes to abortion law in Aotearoa New Zealand, Beddoe and Clarke argue that it is timely to review what is known about abortion stigma. They note that, while legal changes may improve access to abortion services, stigma continues. This commentary article reports on a rapid literature review of scholarly articles published between 2009 and 2023 that address abortion stigma. This review identifies two temporal frames: consistency of abortion stigma over time and changes over time. Three enduring themes were found in the literature, namely, the impact of religion/religiosity, the personification of the foetus, and secrecy. More contemporary scholarship addresses the intersectional dimensions of abortion stigma, considers the impact of the online environment, and a new focus on the wider targets of abortion stigma. Beddoe and Clarke suggest that social workers (and other professionals) will benefit from an understanding of how various forms of stigma impact on the lives of people we support who are considering, or have had, an abortion. Abortion stigma has similar impacts as stigma in mental health or disability and its elimination should be supported by social work.

In the first of three Viewpoint articles, **Tania Huria, Amy Beliveau, Olive Nuttall,** and **Sue Reid** offer a perspective on "Reproductive justice in Aotearoa New Zealand" from the standpoint of Family Planning New Zealand. The authors all work with Family Planning, Aotearoa's only national primary care provider of specialist sexual and reproductive health care—including health promotion which acknowledges that equity in access to sexual and reproductive health services, in addition to information and education, is essential to achieving reproductive justice. Huria et al. recognise that the reach of reproductive justice extends well beyond equitable access to health services but must include recognition of the circumstances that impact reproductive decision-making. Reflecting on the principles of reproductive justice, the authors suggest that one major step towards equitable reproductive autonomy is an all-of-government approach that prioritises reproductive justice in policy and decision-making. The racist legacies of colonisation limit the reproductive autonomy of Māori (Le Grice et al., 2022) and many other marginalised groups, including Pacific peoples, refugee and migrant communities, and diasporic peoples in Aotearoa.

Szu-Hsien Lu and **Liz Beddoe** shift our attention to a particular intersection of reproductive rights and disability rights in "Reproductive justice and people with intellectual disabilities in Taiwan: An issue for social work". This Viewpoint article explores the reproductive rights of people with intellectual disabilities who often face difficulties in establishing their right to family formation and parenting. In this article, Lu and Beddoe apply a reproductive justice lens to the rights of parents with intellectual disabilities. The authors summarise research on parents with intellectual disabilities noting the barriers faced, their needs and types of support they received, the developmental outcomes for their children, and some evaluation of support interventions. However, prior studies were primarily generated in high-income countries. This article presents an approach to planned research in Taiwan, recognising that the cultural context will be unique as prior research has shown that gender, traditional beliefs, family structure, and religious beliefs, all affect the experience of parenting with disabilities.

In the last of our Viewpoint pieces, **Eden Clarke** presents "Navigating the need for reproductive justice in a post-Roe v. Wade Aotearoa New Zealand". Clarke situates her discussion of the 'post-Roe' world within the tensions in social science between aims of objectivity in researching complex topics, where political neutrality is inadequate, and advocacy for social justice becomes imperative. Clarke makes a case for a divergence from *objective* science towards intersectional research and the recentring of social justice in abortion research to ensure gender equality in these precarious times. Academics have a unique opportunity to use their research to advance human rights and address barriers to their achievement.

Book reviews

In a great selection of book reviews, first up Eileen Joy reviews *Sexual and Reproductive Justice: From the Margins to the Centre*, edited by Tracy Morison and Jubulile Mary-Jane Jace Mavuso. Liz Beddoe reviews *The Turnaway Study—10 years, a Thousand Women and the Consequences of Having—or Being Denied—an Abortion,* by Diana Greene Foster. Blake Gardiner introduces *Social Work Histories of Complicity and Resistance: A Tale of Two Professions,* edited by Vasilios Ioakimidis and Aaron Wyllie. Lastly in this issue, Darren Renau reviews *When Social Workers Impact Policy and Don't Just Implement It: A Framework for Understanding Policy Engagement* by John Gal and Idit Weiss-Gal.

Conclusion

A heightened awareness of reproductive health care and reproductive rights embedded within social work education, research and practice is essential to promote human rights and reduce health inequalities (Gomez et al., 2020; McKinley et al., 2023). In a speculative ethnography, Came et al. (2022) explored the "dynamics of power, patriarchy, and health inequities across four decades" (p. 1541) and imagined a healthcare system in 2039 that would be good for all people in Aotearoa New Zealand: "A people-centred health system would have resourced space for woman's and whānau (family) health … better education around sex, pleasure and our bodies. There is free access to, and accurate education about, birth control and abortions" (Came et al., 2022, p. 1546). These aspirations are consistent with social work values. If social work is to make a genuine contribution to reproductive rights and closing the health gap in Aotearoa New Zealand and globally, then the principles of reproductive justice must be centred in social work consciousness (Beddoe, 2021). We launch this special issue as a starting point in raising awareness and encouraging future scholarship and research. Thank you to the contributors and the reviewers.

Liz Beddoe, Eileen Joy, Letitia Meadows, Kerri Cleaver and Yvonne Crichton-Hill

Special Issue Editors

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Justice for Palestine

The following additional editorial is from the following members of the ANZSW Journal Editorial Collective: Neil Ballantyne, Liz Beddoe, Kerri Cleaver, Yvonne Crichton-Hill, Ian Hyslop, Eileen Joy, Emily Keddell, Deb Stanfield and Shayne Walker. It has been written to express unconditional solidarity with the people of Palestine at this pivotal time in history. We are horrified by the indiscriminate death and suffering, as Gaza, walled off from a watching world, is (once again) bombarded by the Israeli military machine. There are no adequate words. Homes, refugee camp apartment blocks, bakeries, hospitals, schools, and ambulances have all become sites of screaming children and bloody suffering: unnecessary, pointless, *heartbreaking* terror. These are war crimes as defined by international law, through conventions, treaties, and customary law (Médecins Sans Frontiers, n.d.; International Community of the Red Cross [ICRC], n.d.).

We condemn the disproportionate horror perpetuated by the Zionist Netanyahu regime and we condemn the tepid response of social work bodies locally and globally. Statements from the Aotearoa New Zealand Association of Social Workers (ANZASW, 2023) and the International Federation of Social Workers (IFSW, 2023) do not appear to recognise that this is a struggle between an occupied people and an oppressive colonial state. We don’t condone the violent incursion, killings and kidnappings carried out by Hamas which unleashed the current fury of the Israeli state, but we unreservedly condemn the genocidal collective punishment of the Palestinian nation. We condemn the collusion of Western Europe, particularly the UK government and we condemn the way the US especially has unconditionally bankrolled a system of occupation and apartheid that has been systematically entrenched since the founding of Israel 75 years ago. We are sickened and appalled by the hypocrisy of the Western liberal powers. The mask has been torn. In December 2023, live on television, we are witnessing the US and its allies accept and obscure this horror in the name of geopolitical self-interest. Is this the world order we condone and celebrate?

Where there is occupation and oppression, there is resistance. The right to resist military occupation is recognised by the Geneva Convention (ICRC, 2002). Palestinian resistance will not be crushed by the indiscriminate killing of people shut in the enclosed prison which Gaza has become. The notion of destroying Hamas by bombing and shelling a densely packed, trapped, sick, hungry and desperate civilian population is as illogical as it is grossly inhumane. There is no safe place in Gaza. The world has watched as over 15,000 Palestinians have died: over 6,000 of the dead are defenceless children and the numbers tick over by the hour (Sawafta & Flick, 2023). Women are giving birth in hospitals without lights, anaesthetic or sanitation; the acutely ill are dying in pain (Ali & Chughtai, 2023). How does this make Israel more secure? The children who survive this living hell will not simply learn to fear an all-powerful Israel: they will be inscribed with a legacy of suffering, injustice and struggle.

If social work has anything useful to say in a world of division and inequality, where the security of capital and the political interests of the powerful allows for this barbarism, it must call for justice for Palestine. Social Work Associations, including the International Federation, like to be aligned with the abstract idea of social justice, but in reality are all too often complicit in oppression by taking neutral positions - calling for ‘both sides’ to develop mutual understanding and resolve differences. These messages are weak and unprincipled. They ignore the disparity of power. This is no time for neutrality. There is no neutrality in

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the face of the current slaughter. There is no neutrality in the face of genocide.

Many will argue, correctly, that the internal politics of Israel and of the wider region are complex. Oppression, revolt and asymmetrical warfare have shaped a long trail of suffering since the violent post-war partition of Palestine: the six day war which led to the occupation of Gaza, the Yom Kippur war, the Intifada uprisings. However all of this resistance and the cycle of punitive repression which has followed, stems from the same festering root of political and material injustice – the confiscation of land and the dispossession of the Palestinians to make way for the state of Israel. Agitation for the creation of an Israeli state was spearheaded by Zionist ideology as espoused by founding father and first Prime Minister David Ben-Gurion who described all Israelis as part of a standing army. Golda Meyer famously claimed that there was no such thing as Palestinians. The hawkish military strategist Arial Sharon founded the Likud party to which Netanyahu is heir.

Netanyahu continues to show no concern about the current war crimes, no interest in abiding by international law and no interest whatsoever in Palestinian statehood. The Israeli far right has always been quick to label any critique of Israel as antisemitic, invoking the moral revulsion of the Nazi holocaust. However, many Israelis and members of the Jewish diaspora internationally, reject the ongoing Zionist vision of an expanded biblical homeland – the colonial ideology that justifies a continuing settler push into the West Bank. The genocide must stop and we have to shout this from the rooftops. Joe Biden and other Western leaders have blood on their hands.

The idea that Israel can only be made secure from terrorist threats by more arms, more security, more US money is a toxic circular delusion. Israel exports arms and the technology of hyper-security across the globe, including the militarisation of Police forces in the U.S. (Loewenstein, 2023). Global justice in an unequal world is not served by the proliferation of weapons, prisons, and surveillance. There is common cause. The American Black scholar activist Angela Davis has suggested the current plight of Palestinians - how we do or don't respond, where we do or don't stand – presents a moral litmus test for social justice across the world ("Angela Davis: Palestine", 2023).

The violent displacement of the Palestinian people is a fundamental historical structural injustice which must be addressed. There will be no fair and lasting resolution until there is a free sovereign Palestinian state. We are witnessing a magnified eruption of the colonial logic of elimination; a logic that is inscribed in all the smaller acts of human rights violation directed to the management of the 'Palestinian problem'. It was Mandela who said that South African freedom could not be complete without the freedom of the Palestinians (duPlessis & Tassiem, 2023).

Israel isn't about to disappear from the map. This isn't a realistic or appropriate goal but the politics of the relationship between Israel and the West must be reconfigured. The US and Western Europe should be imposing sanctions rather than providing financial, military and political support to an oppressive regime. The hypocrisy of this position is not lost on the wider world. The current unconditional support for Israel is intolerable and the 'self-defence as a justification for mass killing' narrative is gut-wrenching.

Angela Davis is right. We are indeed at a crossroads in terms of global social justice and human rights. If social work can't advocate for a just settlement, if it can't name the abuse of power and self-interest that perpetuates the suffering of the Palestinian people, the global profession is morally bankrupt and simply part of the problem. The plight of Palestine is the legacy of a deep history of global imperialism and the Western world is deeply implicated in the current horror. We must all speak and act in solidarity with the Palestinian right to freedom and self-determination – we must all do what we can to stand on the right side of history.

In line with the Australian Social Workers for Palestine Position Statement we call for:

- A permanent ceasefire now.
- Immediate release of all children held as prisoners by Israel.
- The return of all hostages held by Hamas and Israel.
- Social work organisations globally, including the ANZASW and The Israeli Union of Social Workers to condemn the actions of the Israeli government.
- The New Zealand government to condemn Israel's war crimes.
- For the International Criminal Court to hold all perpetrators of war crimes to account.
- An International sanctions regime to break the systemic apartheid, occupation and genocide of the Palestinian people.
- International solidarity to provide a viable process for Palestinian self-determination.

There are no adequate words for the plight of Gaza but we simply cannot be silent. Lastly, from the pen of the Palestinian poet Mahmoud Darwish:

We Palestinians suffer from an incurable disease called "hope".
Hope for liberation and independence.
Hope for a normal life where we shall be neither heroes or victims.
Hope to see our children go to school without danger.
Hope for a pregnant woman to give birth to a living baby, in a hospital, and not to a dead child in front of a military control post.
Hope that our poets will see the beauty of the colour in red roses, rather than in blood.
Hope that this land will recover its original name: "land of hope and peace".
Thank you for carrying with us this banner of hope. (Darwish, n.d.)

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ORIGINAL ARTICLE

THEORETICAL RESEARCH

He Whare Takata: Wāhine Māori Reproductive Justice in the Child Protection System

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ABSTRACT

INTRODUCTION: Reproductive justice in Aotearoa must be centred in Indigenous reproductive justice, challenging social and government systems that seek to maintain control of wāhine Māori[1] bodies in contradiction to our role as *"he whare takata"*[2], the house of humanity. This paper seeks to answer the question: What is the relationship between Indigenous women's reproductive justice rights and child removal in the Aotearoa New Zealand child protection system?

APPROACH: Through centring our atua wāhine pūrākau knowledge, I look at the shift from wāhine as the holders of whakapapa[3], through birthing practices and knowledge keepers, to the focus of the Aotearoa[4] colonial project where women and children are controlled and punished. This article is a reflective, historical and contemporary analysis of complicit social work and settler state intervention on Māori bodies, with particular focus on wāhine and the child protection system.

CONTRIBUTION: The article draws on the research and knowledge collected by wāhine researchers in the last 30 years, alongside my doctoral study locating Kāi Tahu wāhine narratives, post-child-protection system. Attention is paid to the colonial agenda which started prior to Te Tiriti o Waitangi (te Tiriti) in the clearly scripted story that usurped wāhine and continues today in multiple forms, including the child-protection system.

Keywords: Mana[5] wāhine; Indigenous; settler colonialism; reproductive justice; child protection

What is the relationship between Indigenous women's reproductive justice rights and child removal in the Aotearoa New Zealand child-protection system?

I seek to answer this question, drawing the clear connection between wāhine as "*he whare takata*" (the house of humanity) and the current child removal practice. I review the current system changes against a growing body of knowledge that supports the need to disrupt the status quo where wāhine are othered and managed in ways that transgress who we are. The premise of this article is the right to give effect to Te Tiriti o Waitangi, visioning devolution, decolonising and creating systems where wāhine have reproductive justice. The approach taken is to support both devolution and decolonising while minimising harm in the current child-protection system transformation.

Settler colonial child-protection systems internationally continue to be exposed for discriminatory responses to Indigenous populations and continued high rates

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of removal of Indigenous children from families and communities (Blackstock et al., 2023). In the Aotearoa context, child protection sits within imperialist systems of established and repeated colonial violence where Māori ways of parenting were intentionally broken, the role of wāhine re-written to fit western ideologies and where paternalistic interpersonal violence is normalised (Jenkins & Harte, 2011). Indigenous peoples have navigated the shifting iterations of colonial violence in global parallel experiences for centuries, with multiple overlaps and mirroring across settler colonial Indigenous populations (L. T. Smith, 2013).

In the international Indigenous context, Aotearoa shares experiences of over-representation in the state foster system, disproportionally high rates of Indigenous baby removal, refusal to work with Indigenous constructions of family and, at the heart, the continued subjugation of Indigenous women (Blackstock et al., 2020; Krakouer et al., 2023; Whānau Ora Commissioning Agency, 2020). In this context and amongst rising Indigenous resistance in Aotearoa, following the media exposure of a Māori baby uplift now referred to as the Hawkes Bay uplift, several independent and significant inquiries were commissioned with resulting reports. The reports referred to are *Te Kuku o te Manawa* (Office of the Children's Commissioner, 2020a, 2020b); *Ko Te Wā Whakawhiti: it's time for change: A Māori inquiry into Oranga Tamariki* (Whānau Ora Commissioning Agency, 2020); and *He Pāharakeke, He Rito Whakakīkinga Whāruarua Oranga Tamariki Urgent Inquiry* (The Waitangi Tribunal, 2021). These reports expose the state as biased and unable to provide a service that understands Māori as Māori. They tell the story of a system that traumatises, stigmatises, and blames children and families in the system and our Māori communities for macro-level social inequity issues including poverty and violence. These inequities are embedded in our systemically racist colonial structures further complicating practice and policy responses which seek to address whānau dynamics while ignoring structural injustice (Ministerial Advisory Committee, 1986; Tinirau et al., 2021).

Wāhine relationship to colonial power and control

A nation is not conquered

Until the hearts of its women

Are on the ground

Then it is done, no matter how brave its warriors

Nor how strong its weapons.
(Mikaere, 2022, p. 5)

This Cheyenne saying relays the significance of women in Indigenous societies, holding together the ability to create life and therefore collectively survive. Removal of women's power in the colonial project is the only way it might succeed—when you remove women from power and authority you oppress the next generations (Atkinson, 2003). The removal of wāhine from power, colonising our knowledge, corrupting our stories, and binding our cosmological narratives to the patriarchy, severs our relationships in whakapapa to each other and to the land. This disruption creates confusion of rights and responsibilities in decision making, leadership and parenting, enacting violence that re-genders wāhine, tāne (Māori men) and tākatapui (Māori LGBTQI++) in complex ways that are difficult to unbind (Mikaere, 2022). The success of the colonial project is never guaranteed while wāhine continue to resist, as we survive as Indigenous, dispossessed, and controlled in the active colonisation *process.* This includes renewed subtle acts of violence that deny our Indigenous bodies full freedom and full status as human (Jackson, 2020). In Aotearoa, as we grapple with what a te Tiriti compliant society looks like, visioned in *Matike Mai* and *He Puapua* as constitutional reform, wāhine remain excluded from focus (Charters et al., 2019; Jackson 2020; Sykes 2022). Intersectionally, wāhine, shadowing global Indigenous and Black women experiences remain located as the *Other,* defined and represented by patriarchally embedded privilege that preferences 'Man', white women and then tāne, while continuing to deny wāhine recognition of rights and protections (Collins, 2022; Pihama, 2020). This power dynamic, control and authority has usurped wāhine in the current environment where Aotearoa exists.

He Whare Takaka

Reproductive justice is not just the ability to make equitable decisions about having, or not having, children; it is also the ability to care for children following birth as a choice (Ross, 2017). Focusing on wāhine recognises that at the centre of child protection are wāhine as *"he whare takata"*, the house of humanity. Centring wāhine is in alignment with the rights of mokopuna (children) and incorporates the understanding in the whakatauki (proverb) *"he kuru pounamu"*, children as the most precious treasure (Pihama et al., 2015). Mokopuna as taoka (treasures) are an extension of mana wāhine (wāhine knowledges and authority), the importance of wāhine and the preciousness of children are interwoven, one cannot exist without the other (Mikaere, 2017; Murphy, 2013). The co-existence of the intergenerational erasure of wāhine rakatirataka (leadership and self-determination) and the imposition of western parenting norms created the current loss of societal safeguards, knowledge transference and the relationship between *"he whare takata"* and *"he kuru pounamu"* (Pihama et al., 2022a).

The child-protection system in Aotearoa has continuously viewed wāhine as vessels for babies rather than rights holders, with the system perpetuating harm and conferring the brunt of the blame on wāhine for state removal processes (The Waitangi Tribunal, 2021; Whānau Ora Commissioning Agency, 2020). The child-protection system is the most recent iteration of an axis of subjugation on wāhine, as part of a whole of system history (Blackstock et al, 2023; Connor, 2014). The following literature review and analysis outlines wāhine pre- and post-colonial reproductive injustice experiences. The intersection of mana wāhine and state systems frames the connection between contemporary realities of wāhine reproductive injustices and the intentional colonial agenda.

Methodology

Mana Wāhine theory is the active claiming of wāhine in the Māori world with distinctive theory and analysis (knowing, being and doing) that incorporates the imposed colonial and structural experiences on wāhine, our experiences of decolonising and the enactment of tino rakatiratanga (Pihama, 2005, 2020). Pihama (2020) stated Mana Wāhine is about collective responsibility and wellbeing while Jahnke (2013) drew on the connection between wāhine and whenua (land) reminding us, through the whakatauki "He wāhine, he whenua, ka ngaro ai te tangata", that without women and land we will perish. Mana Wāhine is the representation of our tupuna (ancestors) wāhine, historical and contemporary, as leaders resisting both their own and future generational erasure of self and collective wellbeing. The many ways in which wāhine define and incorporate Mana Wāhine theory into research and practice reflects the multitude of realities that we live as wāhine.

Centring Mana Wāhine theory, *her*story is prioritised in an act of resistance against the patriarchy and white supremacy, to illuminate the woven experiences of wāhine in our reproductive journeys. This draws on wāhine work as the foundation recognising that it is wāhine who have sought out and claimed back *her*story from the deep analysis of passed down whānau stories, from snippets of written recordings, waiata, art and whakapapa.

Therefore, the methodological approach utilised sits under the epistemological position of Mana Wāhine theory, an umbrella term for wāhine analysis and our "complex lived realities" (Pihama, 2005). In using Mana Wāhine theory I intentionally draw on wāhine *her*stories and narratives, incorporating the importance of wāhine in pathways to a flourishing society. Embracing Mana Wāhine theory, a foundation of pūrākau wāhine atua (female creation stories) provides a mātauraka (knowledge) Māori understanding of pregnancy, birth, and post-birth. Utilising these narratives and the established work of Irwin and Du Plessis (1992), Mikaere (2017), Murphy (2013) and Pihama (2020), I present a Māori understanding of wāhine as "he whare takata".

The foundation of "he whare tangata"—the house of humanity

Wāhine hold reproductive power that is gifted through our whakapapa from wāhine atua, with the responsibility for continuing future generations (Mikaere, 2017; Murphy, 2013; Pihama, 2005). Our wāhine bodies are vessels of both tapu and noa (sacred and normal) and hold knowledges and strength (Pere, 1982). The efforts of settler colonialism, driven by white supremacist and imperialist notions of class, gender and race superiority, have not erased the truths held in our whakapapa that we are the house of humanity (Moreton-Robinson, 2000; L. T. Smith, 2013; Trask, 1999).

Throughout Māori epistemology we have many pūrākau (stories) demonstrating the power of wāhine and of our wāhine atua (deities); Papatūanuku, Hineahuone, Mahuika and Hinetitama to name a few (Ihimaera & Hereaka, 2019; Murphy, 2017). These pūrākau express foundational understandings of humanness spread across attributes of strength, mana, intelligence, courage, and fertility. The pūrākau acknowledge the rights and responsibilities of childbearing while demonstrating that wāhine are not constructed pre- or post-colonially solely as vessels, or baby factories for future ancestors. While we are more than just our ability to carry and to birth, we can acknowledge the privilege and space that wāhine occupy as the house of humanity. Distinction here recognises that childrearing and the conferred rights and responsibilities were shared equally across genders and parenting responsibilities should never be framed in western "motherhood" narratives (Jenkins & Harte, 2011).

The development of our mana as wāhine in creation is best exemplified in the many pūrākau of Hinetitama and her later identity as Hine-nui-te-po. In this one wāhine atua, we understand the rights of wāhine, supported by her grandmother, to assert "my body, my choice" when Hinetitama discovers the father of her children is also her father. Standing in her rakatirataka, Hinetitama regains control and mana by becoming the bridge between Te Ao Mārama and Te Pō (world of light and world of dark) (Murphy, 2017). This act of sacrifice and service is to mokopuna as future ancestors and holds important understandings of intergenerational responsibilities. It also demonstrates that body choices have always sat with wāhine.

The second relevant pūrākau relating to Hinetitama, transformed into Hine-nui-te-po, is her granting Māui (the trickster) eternal life. Eternal life is gifted by Hine-nui-te-po squishing Māui between her thighs where he becomes the first menstruation (te awa atua) carrying forward whakapapa (genealogy) for future generations (Murphy, 2013). The whakapapa, or blueprint for humanity, is cherished in the cycle of wāhine, menstruation becoming intrinsic to the essence of being Māori and our inter-connectiveness with the whenua, land. This is emphasised in terminology in te reo Māori (Māori language) where double-ups occur between both wāhine reproductive cycles and Māori societal structures and the land. Examples are whenua as both land and placenta and hapū as both tribal structure and pregnancy (Mikaere, 2000; Murphy, 2017).

Wāhine holding the power to create life does not pre-determine that wāhine are required to carry through every potential life, but rather that we remain the holders of the mana and responsibility, with the right to decide if the circumstances are right. Murphy (2013) argued that cultural truths of miscarriage, still-births and aborted foetuses were reframed by misogynistic colonial ethnographers as demonic—an example of shifting wāhine body choices from normal to dirty and evil. Murphy (2013) clarified that in her research the spectrum of living, potential and not living is carried in "he whare takata". Ramsden (2002) similarly describes wāhine as actors and participators with agency and refutes the idea of wāhine as chattels to breed and produce. Pregnancy, birthing, and post birth care has now been well *Re*-searched by wāhine providing Māori with *Re*-membered ceremony and rites asserting the centrality of wāhine in childbearing as more than vessels and in relationship with our whakapapa and atua (Murphy, 2013; Simmonds, 2014; Tikao, 2020).

Within te Ao Māori, following pregnancy and birth, there existed multiple ways in which the raising of a mokopuna could occur for all the reasons that exist in 2023; due to bereavement, family harm, parental separation or through whāngai, a process of strengthening kinship ties[6] (Jenkins & Harte, 2011; Mead, 1997; S. Walker, 2006). While these decisions are made at a whānau level, they were not made without consideration of the mana of wāhine. It is through colonial conquest of our tikaka (customs and protocols) and rakatirataka that these decisions have been taken and are now state-made decisions. In response to the conquest by western systems on our knowing, being and doing, unquelled wāhine resistance has engaged in 183 years of resistance in the very spaces we were and are rendered subaltern (Spivak, 1999, 2003).

The path of resistance

In the ground-breaking work of Hawaiian scholar Haunani-Kay Trask (1999), she asserted Indigenous women continue to maintain and hold culture together in the face of systemic colonial subjugation. Acknowledging the early erasure of generational voice and agency in the new patriarchal society, without voting rights, land rights or any structural supports, Trask maintains Indigenous women in this powerless space have nothing to lose and no incentive to comply with western hegemony (Trask, 1999). She stated it is in this space that Indigenous women have continued to practise culture, engage in subversive acts of resistance, and hold together culture and identity. The denial of rights for wāhine over time has equally not diminished the collective action of wāhine. We continue to challenge the patriarchal system, call out the intersectionality of oppression and push forward towards legislation, policy and practice that returns tino rakatiratanga and upholds mana wāhine.

The following section is in evidence of mana wāhine and presents the conflict between two world views. The resistance and insistence of wāhine to be recognised as "he whare takata" as understood in tikaka and *her*story is outlined. This is contrasted with the state system attempts to assert a continued colonial care discourse where wāhine require saving. When not deemed saveable, the state swings to intervening to "rescue" children. A chronological account of child protection *her*story since the arrival of Pākehā on our shores is presented below. The following account is a refusal to be the subaltern.

First encounters, Wāhine in the early colonial contact period, 1830s–

Strategies to enforce white supremacy on wāhine cleverly pivoted and changed according to the resistance and environment of the day. Wāhine moved through these pivots as community leaders in the early settler occupancy through advocacy for tāne Māori political inclusion, as land law/lore experts, as health advocates and, when required, as societal activists all underpinned by whānau, hapū and hāpori mauriora[7] (wellbeing) (Else, 1993; Pihama, 2005; Ramsden, 2002).

In the early years, from the 1830s, whānau societal structures across most of Aotearoa remained intact and wāhine focused on whānau and the implications of colonisation. These included impacts from inter-racial marriages, loss of lands and rising rates of illness (Else, 1993; Walter, 2017; Wanhalla, 2015). Inter-racial marriage and/or sexual abuse was fuelled by representations of wāhine as the exotic other. For example, the postcard trade of Indigenous women incorporated images of our wāhine tupuna as both sexualised bodies and available for marriage (Cleaver, 2020). Kāi Tahu historian Angela Wanhalla (2015) highlighted the outcomes of the resulting high rates of interracial marriage in the south which often left Kāi Tahu wāhine without their whānau and landless following their settler husbands abandoning them upon transfer of lands and resources. Through this time nationally, wāhine were self-advocating through the Native land courts for return of lands, demonstrating continued rakatiratanga practice and expectations that marriage did not cede rights and responsibilities to land (Walter, 2017).

While an abundance of non-Māori children required care and protection from the 1840s due to parental death, abandonment, and high poverty situations, mokopuna Māori continued to be cared for in Māori communities (Tennant, 2007; Whānau Ora Commissioning Agency, 2020). There was the belief by the settler state that Māori would die out and a lack of policy and practice directed towards relief in Māori communities guaranteed this as a likelihood. By the 1890s the mortality rate of mokopuna Māori was so high that 40% did not make it to their first birthdays (Else, 1993). The life expectancy of wāhine at this time was 25, three years earlier than tāne, Māori men. This increased in the following decade to 30 but with an increase in gap between wāhine and tāne then being five years. Locally, in Te Waipounamu (South Island), all our land had been sold or taken by the Crown with agreements that hospitals and services would be provided in our communities (Te Kereme, 1991). This was not delivered on, and exemplifies the colonial agenda targeting wāhine and mokopuna.

Assimilation, eugenics and social care, wāhine demanding space

In the early 1900s, social work was well established in other western and settler colonial countries while it was not until the 1950s that social work was formally introduced in Aotearoa. Prior to this, social supports were predominantly provided by nurses, teachers, and religious charity groups. These groups were dominated by non-Māori with a focus on settler communities and white society (Tennant, 2007). Wāhine were not visible across these sectors until much later with the Native School Act (1967) implementation actively denying access to tertiary education systems and defining wāhine as servants in the lower class (G. H. Smith, 2000). The native school system additionally eroded traditional wāhine practices enforcing western expectations of pregnancy, birth, and childrearing, including the shifting of birth practices to hospitals (Connor, 2014). This affected the ability to deliver the rights and responsibilities of "he whare takata" where defining need, access and delivery was predetermined by non-Māori and wāhine were excluded from a rakatiratanga role.

Early examples of exclusion, systemic racism and eugenic approaches to pregnancy, birth and post-birth can be found in Truby King's development of Plunket in 1906 (Connor, 2014). King advocated for selected race-based breeding programmes to protect the health and wellbeing of desirable women and children (Richardson, 2004). With this belief, the reduction of birth rates in Aotearoa and Australia at this time were met with legislation that incentivised non-Indigenous women with payments to have babies, while Indigenous wāhine were not included (Moreton-Robinson, 2000). Resistance and strength of wāhine at this time, was demonstrated through the work of Ria Tikini and Mere Harper, two Kāi Tahu midwives who negotiated and worked with Truby King for wāhine and mokopuna wellbeing (Manchester, 2020). We are often called on as wāhine to walk in conflictual spaces where we are not acknowledged as rakatira but required in service to our communities and our roles and responsibilities for future generations. These wāhine exemplify sacrifice and the rakatirataka of "he whare takata".

In 1908, the first registered wāhine nurse, Akenehi Hei, was mandated to work in Māori communities and slowly a wāhine nursing and midwifery workforce was established with hospitals eventually changing racist attitudes in the 1930s to allow wāhine in hospital nurse training (Tikao, 2020). Currently, we have a wāhine midwifery workforce that is only 6% of the profession (Tikao, 2020). This statistic is a direct result of generations of obstacles preventing wāhine from professionalising, alongside non-Māori, including preventing matriculation and denying wāhine entrance to tertiary education programmes. In cognisance with generations of wāhine nurses and midwives' ability to pass on and hold wāhine at the centre of reproductive processes are current advocates such as Jean Te Huia, Naomi Simmonds, Ngahuia Murphy and Kelly Tikao who breathe life into our mana wāhine traditions, hold the system to account and provide robust analysis of wāhine needs (Murphy, 2013; Simmonds, 2014, 2017; Tikao, 2020). Social work should learn from the advocacy demonstrated by Māori midwives.

In 1939, the introduction of the Māori quota system to educational training, led by the resistance of non-Māori to teach in native schools, enabled Māori to enter teaching, though this was mainly in native schools and dominated by Māori men (R. Walker, 2016). Education and health remain key indicators for mauriora and holistic wellbeing and wāhine participation in delivery and decision-making remain essential parts of a required shift in socio-economic disadvantage.

Parallel to the development of a social work system in Aotearoa in the 1950s, women-collectivised social care systems had been evolving through iterations of women-focused services; The Temperance Movement (1881), the Māori Women's Institute (1929), the Women's Health League (1937) and the still established Māori Women's Welfare League (MWWL) in 1951. Each version of social provision built on the previous in an intergenerational transference of dedication to the rights and needs of women, wāhine and mokopuna. Wāhine through these times continued to push for political authority, through the vote, alongside women and in attempts to influence policy and practice design. Wāhine sacrifice was again shown through these times, as women sought to restrict wāhine taking moko kauae (customary chin tattoo) in the Temperance Movement membership (Else, 1993).

The MWWL networks and resources enabled an impressive growth of membership and shared commitment to system transformation. This was responded to in a demonstration of explicit gender inequity by our own in 1953 when Māori men wrote to the Minister of Māori Affairs stating wāhine were usurping the authority of men and supported the Ministry with a withdrawal of funding to the MWWL (Else, 1993). The critique culminated in the Hunn report (1960) which suggested wāhine were outside of the scope of a women's role in attempting to influence policy (Hunn, 1960). Never deterred, wāhine in this time of financial sanctions and paternalism, took to the pavements with survey cards and completed the first comprehensive survey of Māori housing in Aotearoa providing evidence of a Māori housing crisis and demanding urgent action (Anderson et al., 2014; Hill, 2010). The survey followed the refusal of the government to accept the word of wāhine that Māori were experiencing overcrowding, inequitable housing and health and wellbeing impacts with urban drift pushing Māori from rural communities to Auckland and other cities. A clear example of the diminishing understanding of mana wāhine.

Social work complicity, wāhine bear the brunt

State social work developed from the 1950s from earlier roles such as welfare, educational and charity officers. These early roles can only be viewed as complicit with inequitable decision making and use of power and control over Māori embedded into legislation cross-ministerially with an active refusal to even acknowledge te Tiriti o Waitangi (The Ministerial Advisory Committee, 1986). Complicity includes social work participation in the mass adopting out from the mid-1950s of mokopuna Māori when the Adoption Act (1955) became law. Many Māori whānau remain unable to connect to hapū or iwi through closed legislation restrictions that have forever stripped rights to whānau, hapū and iwi structures (Ahuriri-Driscoll et al., 2023; Haenga-Collins, 2017; Newman, 2013). Adoption numbers peaked in the mid 1960s with over 3000 babies being adopted out annually, meeting the needs of childless adults, with little regard to whakapapa and the intrinsic link between wāhine and mokopuna (Whānau Ora Commissioning Agency, 2020). The result of adoption for wāhine was the total severing of whakapapa and breaking of relationships.

There is much we do not know of these adoption experiences as wāhine are now at ages that they are dying and earlier stories of the "fostering out" experiments have limited recording, with ethnic identity not acknowledged. The lack of choice and voice exemplifies an exploitation of wāhine in precarious living arrangements with compounding issues including poverty, housing, and violence. Inevitably in a settler colonial system where land, resources and power have been stripped from Indigenous women, we suffer the brunt of the system, becoming a precarious population manipulated and controlled. Rocha Beardall and Edwards (2021) drew the connection between women, land, and children as the sites of white supremacist efforts to displace and break the native family. The eerie similarity between the Indigenous experience in the United States, Alaska and Aotearoa is found across both countries in legislation targeting women, land, and children and in the rise of Indigenous children in fostering and adoption systems. The colonial foundation that lays way to policy and practice is the perpetuation of the narrative of *terra nullius* (nobody's land) and *filius nullius* (nobody's child) and the disconnection from wāhine, women to land and to our children (Rocha Beardall & Edwards, 2021). In the overturning of the *Roe v. Wade*, the US Supreme Court ruling particularly references the availability of childless parents and no children in the adoption pool in the United States, a dystopic reality driving legislative reform against reproductive justice. I assert that these factors have existed in multiple forms in Aotearoa and other settler colonial nations where Indigenous women fall victim to every system that could take away body choice and power from fertility decisions through to child rearing.

From the 1950s, post-World War Two, Māori youth and children become the focus of the colonial gaze and entry into state systems of punitive institutions and foster systems exponentially increased (Hyslop, 2022). Early state child-protection social work with Māori includes incarcerating our youth to experience what we now fully understand as institutions of abuse and torture in places, including Lake Alice Psychiatric Hospital and Epuni Boys home (Royal Commission of Inquiry into Historical Abuse in State Care and Faith-Based Institutions, 2020). The picture of subjugation is now all encapsulating. Through the 1970s and 1980s, child-removal processes replaced earlier iterations of adoption as the new assimilation tool, leading to growing numbers of Māori in the foster system and rising concern by Māori of racism in the Department of Social Welfare (Ministerial Advisory Committee, 1986). Māori questions centred on state-system mokopuna removal to non-kin, non-Māori caregivers, actions supported by the strategies produced in the Ministry of Māori Affairs Hunn Report (Hunn, 1960). Internally, in the child protection department Māori resistance strategies included a collaboration between Māori and allies in the Women's Anti-racist Action Group (WARAG, 1985) in Auckland and Maatua Whangai care networks providing care across the country. The WARAG group shone a light on internal racism and were instrumental in setting the scene for Pūao-te-Āta tū (PtAT) (Hyslop, 2022). The Maatua Whangai networks continued to provide Māori caregivers in Māori communities, underpaid and undervalued by the state, until this was shut down overnight in 1991 (S. Walker, 2006).

Significant reports and research on Māori and the child-protection system

The work completed by WARAG and a Māori Advisory group findings of institutional racism internally to the child protection led to a Ministerial Advisory Committee remit to complete a whole-of-country analysis and report on Māori experience of the state child-protection system, PtAT (Ministerial Advisory Committee, 1986). Pūao-te-Āta-tū provided clear evidence of institutional racism that extended across the entire public service sector and into society.

Pūao-te-Āta-tū provides a template of expectations on system transformation from 1986 until the 2019 legislation reform. This report was the backdrop to the creation of the Child, Young Persons, and Their Families Act, 1989 (CYP &F Act, 1989), which incorporated the concepts of whānau, hapū and iwi as well as direction towards engaging with Māori. The CYP & F Act (1989) is the precursor to the Oranga Tamariki Act (2019) and was revolutionary at the time, encouraging bi-cultural practice and expected opportunities of collaboration with Māori. The 2019 reforms follow decades of managerial reviews on our state foster system dating back to PtAT, cumulating in the White Paper (2012) and the Expert Panel Reports (Ministry of Social Development EP, 2015) which provided a set of recommendations to advance legislative provisions (Hyslop, 2022). All the reports between 1986 and 2019 focus on tinkering with the acknowledged broken system and implementing new managerialism and neo-liberal business and practice structures in the system (Hyslop, 2022). The system and practice tinkering sidelined growing issues of rising rates of mokopuna Māori in the system, the framing of women blaming and personal responsibility.

The Hawkes Bay uplift highlighted system and practice issues in a manner that society and government could not deny. In doing so, highlighting the enduring and continuing blaming of wāhine caught in the contradiction between "he whare takata" and colonially dispossessed. Over this time when women's rights movements were growing, PtAT, utilising a whole of Māori societal framework focused solely on whānau, hapū and iwi as the site for system inclusion and change. It is possible that this future signalled an approach of using whānau believing this terminology would also make space for wāhine. This will be further discussed in the accompanying article "He Whare Takata: Are wāhine Māori visible in Oranga Tamariki practice guidance?" which looks at our state child-protection system, Oranga Tamariki (OT), current practice guidance as it related to wāhine (Cleaver, forthcoming).

Responses from community organisations and Māori

In 2020, the Whānau Ora Commissioning Agency report, *Ko Te Wā Whakawhiti: It's time for change,* heard the voices of whānau and hāpori who had OT involvement relating to child removals (Whānau Ora Commissioning Agency, 2020). This evidenced consistent stories of wāhine experiencing whakapapa trauma, discrimination, blame for domestic violence and high levels of targeting and scrutinising (Whānau Ora Commissioning Agency, 2020). The report predominately uses the term *whānau*, incorporating a Māori view of familial relationships, though accounts featuring wāhine and young wāhine make up the majority of the stories told. The Whānau Ora report suggests whānau-centred, systems-focused, Kaupapa Māori aligned and mātauraka[8] Māori informed as the principles to underpin a way forward. A whānau-centred principle is central to a Māori worldview and understanding relationships in by Māori, for Māori, of Māori service delivery. However, I would argue, most workers in our child-protection system do not have the cultural skills necessary to understand wāhine as part of whānau, inevitably risking erasure and encompassment of a wāhine focus for a wider whānau and hapū approach.

The Office of the Children's Commissioner (OCC) completed a research project resulting in two reports, Te Kuku o te Manawa (Office of the Children's Commissioner, 2020a, 2020b). Like the research completed by Whānau Ora, the OCC engaged with the lived experiences of whānau affected by baby removals and with professionals working with OT. Wāhine reported interactions with OT as mana diminishing, where they felt judged and discarded when their babies were removed. The situations presented, not leading to pēpi (Māori term for baby) removal, were a result of strong advocacy from Māori social workers and midwifes. The OCC powerfully asserted mana wāhine narratives and rights, stating in Area of Change 1: "the system needs to recognise the role of mums as te whare tangata and treat them and their pēpi with humanity" (Office of the Children's Commissioner, 2020a, p. 20). This statement and the recommendations challenged the state to centre the relationship between mothers and babies. I assert an important nuance that, while centring wāhine, we must ensure we hold the state accountable for the intersectional systemic injustices of racism and sexism and recognise that our lived realities as wāhine are tied to the multiple ways we are transgressed against (Ross, 2017; Tinirau et al., 2021).

In November 2019, I led a Kāi Tahu centred participatory action research project to develop the Ngāi Tahu s.396 service, Tiaki Taoka, practice model and design. Section 396 services refer to mandated and accredited services under the Oranga Tamariki Act that take on the roles of caregiver recruitment, assessment, and support. These are minimal functions in the spectrum of the child-protection system but the piecemeal option that is open to Māori currently. Referencing the lived experiences of Ngāi Tahu foster system experienced youth and adults in roles (sometimes overlapping) of caregiver, professional, family member or youth in foster care, we heard what a Kāi Tahu service would look like meeting their needs. The principle of mana wāhine was a repeated theme through hui (meeting) and kōrero (conversations), and we heard many times that wāhine felt the brunt of the system. Wāhine asked us to design service and delivery to respond and address this. One of the insightful rakatahi (young people) told us "…it's so much harder to put families together once they have been separated" (unpublished, Tiaki Taoka). We were told of wāhine being dropped by the system once mokopuna were removed, we heard of the impact on wāhine of this and that OT did not accept the connection between wāhine and mokopuna. Examples were provided of southern Maatua Whangai from the 1990s where wāhine were welcomed into Māori caregiver homes, maintaining relationships with their children, and supported to make the needed changes required to regain the care of their children. Mana wāhine became one of the principles included in the service design of Tiaki Taoka because of the clear and articulate messages from our community. There are Māori s.396 services across the country which are equally identifying wāhine needs and practice alignment to "he whare takata".

The Waitangi Tribunal (tribunal for hearing breaches of te Tiriti against Māori by the state) heard an urgent claim following the Hawkes Bay uplift on the matter of baby removals. Over 18 months, the Tribunal heard from community, government, and individuals on the issue of te Tiriti o Waitangi breaches. Many wāhine told stories of ill-treatment and hard-handed OT practices that took their pēpi with no opportunity for return. In the final report, *He Pāharakeke, He Rito Whakakīkinga Whāruarua,* the Tribunal summarised multiple systemic breaches affirming the claimants and contending that the state had taken over the role of Māori and infringed on the kaik (village) (The Waitangi Tribunal, 2021). They recommended that the state fund Māori to provide for our own needs and step aside. A recommendation that has still not eventuated.

The last two items mentioned in this section are the Mana Wāhine Claim and *He Puapua* (Charters et al., 2019). Both the claim and the *He Puapua* report have significance for how we move forward in child protection with an intentional inclusion of wāhine as the holders of "he whare takata". In 1993, a group of wāhine filed a claim to the Waitangi Tribunal, the Mana Wāhine Claim (Pihama et al., 2022). Finally, in 2022, the Claim moved from collecting dust on a shelf to contextual hearings, a process of assessing the status of wāhine Māori pre-colonisation to benchmark breaches post te Tiriti o Waitangi. The contextual hearings included a wide selection of evidence across the country that supported the position of wāhine as leaders with authority and rights (Waitangi Tribunal, 2022).

He Puapua (2019) (government commissioned) provided a plan to realise obligations set out in the United Nations Declaration on the Rights of Indigenous Peoples (1991) (Charters et al., 2019). This report is the road map of how we shift the country from the current inequitable state of Crown authority and control to a partnership and equity of shared authority and power with hapū and iwi in a planned process over the next 17 years. *He Puapua* provides the template for how we think about child-protection transformation that supports the set-up and development of Māori organisations with the expected outcome of shared power.

Conclusion and recommendations

The evidenced *her*storical summaries demonstrate the past and current infringements of our reproductive rights as suffered in the child-protection system and more widely across government systems which enact socio-economic dis-advantage and harm on wāhine. Wāhine remain the driving force for enactment of our rights and responsibilities to whakapapa and mokopuna as future ancestors in terms of "he whare takata". The un-wavering passing on of this resistance, sacrifice and wero (challenge) is unmatched by any government recognition of wāhine as rakatira in the policy and practice space of wāhine, mokopuna and child protection. While we can appreciate our tāne efforts towards te Tiriti compliant partnership and decision making, the *her*stories and histories are divergent rather than united when wāhine are merely the recipients of decision making or minimally included.

Social work responses in a child-protection system require allying and advancing the repair of the societal safeguards that were the foundation that allowed wāhine choice, while also provided equity in childrearing. The destabilising of western notions of motherhood that (re)produces oppressive parental practices on wāhine, mokopuna, whānau and the whenua is required. In the spaces where wāhine bear the brunt of a system seeking to place parental blame, a shift toward wāhine agency and power must be the starting step. Wāhine as leaders across these spaces with mana wāhine as the key principle is central to change. In a ideal system that upholds mana wāhine and our interwoven relationships, wāhine are supported and strengthened as rakatira.

In focusing on bring forward the *her*storical colonially bound encounters, the conflicting world views within Aotearoa between western knowledge and Māori as it plays out across policy and practice is shown. As demonstrated, these conflicts sit in legislation, practice and in our everyday constructions of gender, including assumptions of leadership or rakatirataka. Any recommendation for social work must recognise the macro way in which erasure, silencing and ignoring wāhine as rakatira is embedded across all systems and must work at restoring mana wāhine and the essential foundation of wāhine as "he whare takata".

This is an essentially theoretical approach to changing social work thinking while advocating for macro embedded changes across government. It would require training and upskilling our workforce to know and understand *her*story and be able to interpret this into practice with the nuance of accepting a takata whenua (Māori), takata moana (our Pasifika relations) or takata te Tiriti (non-Māori) position, with differing leadership and allyship responsibilities. I would further recommend that wāhine are the only ones to lead this response, but that does not mean wāhine are responsible for the weight of the lifting. Knowing, being and doing sits with wāhine, but non-wāhine and non-Māori must authentically engage in this work if we are ever to have a just and safe community where wāhine have safe choices around our bodies, our reproductive rights, and the rights to choose parenting or not. Recognising that wāhine is inclusive of tākatapui whose value in leading work in this space is also well overdue.

In practical ways, this also requires a directed ministerial response that priorities wāhine leadership and acknowledges the foundation of wāhine and mokopuna wellbeing remains with our MWWL, Māori midwifes, Māori social workers and s.396 Māori providers. The only way to shift the power dynamic and address the past injustices is a following of the reports and recommendations following the Hawkes Bay uplift and start the process of devolution with a priority to wāhine who are already leaders in this space. A key part of this is to engage with the Mana Wāhine claim and commit to honouring the Waitangi Tribunal recommendations from this process.

This mana wāhine centred article accompanies a shorter article analysis of current OT practice and evidence centre documentation, *He Whare Takata: Are wāhine Māori visible in Oranga Tamariki practice guidance*, following the Hawkes Bay uplift, looking at how OT presents wāhine and "he whare takata" (Cleaver, forthcoming) This article exposes the continued concern that our child-protection system appears unable to pivot towards Māori ways of knowing, being and doing. The article provides evidence of continued erasure of wāhine and "he whare takata" and emphasises key internal system issues. It provides a supplementary look at the internal child-protection system and highlights the emphasis in this article that devolution and decolonising our child protection system is essential to wāhine and mokopuna mauriora.

In concluding, the issues facing wāhine date back to the usurping of our foundations and the replacement of these with western ideologies. The righting of this wrong requires individual social work dedication to rethinking child protection but also the commitment to advocate for system change that shifts power and resources from the state and from colonial systems to the centre of the whānau, wāhine.

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Notes

[1] Wāhine Māori will be referred to as *wāhine* from here on. This term in inclusive of our tākatapui Māori in line with our traditional ways and acknowledged acceptance of gender fluidity and self-identification. Non-Māori wāhine will be referred to as woman/en.

[2] Kāi Tahu dialect is used throughout the document. This replaces 'ng' with a 'k'.

[3] Whakapapa is defined as our relationships to animate, inanimate, living, and past, to each other and the environment. It includes genealogy that is both human and non-human.

[4] Aotearoa is used as one traditional name for Aotearoa.

[5] Pere definition of mana: "psychic influence, control, prestige, power, vested and acquired authority and influence, being influential or binding over others, and that quality of a person that others know she or he is".

[6] Whāngai is a Māori cultural practice of strengthening familial ties in the sharing of children to be raised either inside a wider family network or between hapū, subtribes. The key concept is that a child's family relationship is multiplied rather than transferred.

[7] Mauriora refers to the holistic wellbeing of a person, connected to culture, language, knowledge transmission, healthy environment, and their mental and physical wellbeing.

[8] Mātauraka Māori refers to the knowledge base form a Māori world view. This included but is not confined to pūrākau, wayfaring, mahi toi, waiata and whakapapa.

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ORIGINAL ARTICLE
QUALITATIVE RESEARCH

Pre-birth child protection and the reproductive rights of fathers

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ABSTRACT

INTRODUCTION: Whilst acknowledging that child-welfare-involved pregnant women occupy a uniquely precarious position in terms of their human dignity and rights, this paper focuses on the vulnerabilities of fathers of children subject to child protection assessment before the birth of a child.

APPROACH: This article draws on data from two qualitative research studies, both focused on social work practice in Scotland. The first study created ethnographic data with and about eight fathers who were experiencing pre-birth child protection involvement with their babies. The second study did not include fathers themselves, yet research data were created through interviews with 10 birth mothers, which reinforced findings of the prior research in relation to men being written out of planning and legal processes before their children were born.

FINDINGS: Taking a reproductive justice lens to the findings of the two studies reveals how this population of fathers are exposed to legal and social precarity in relation to their paternal role. Through the advice of social workers, women were encouraged not to name the fathers of their as yet unborn infants on their child's birth certificate, creating an immediate barrier to fathers' involvement.

IMPLICATIONS: The article demonstrates that a reproductive justice framework (L. Ross & Solinger, 2017) can be applied in order to understand how men's rights to parent their children may be compromised by child protection involvement in the family. Acknowledging the power held by social workers is a crucial first step in beginning to address the social inequalities around "reproductive destiny" (L. Ross, 2006, p. 4) experienced by fathers.

Keywords: Reproductive justice; fathers; pregnancy; infant removal

Pre-birth child protection involvement with families and the removal of infants from their birth parents have become a central part of the child protection response across international risk-focused child protection systems (Broadhurst et al., 2018, Griffiths et al., 2020, Keddell et al., 2023; O'Donnell et al., 2023). There is also evidence that in the family-service based systems of the Nordic countries, infants at risk are removed on child welfare grounds (Hestbæk et al., 2020). Clearly, this is an ethically complex area (Corner, 1997) and questions about the practice of pre-birth child protection involvement and infant removal have been raised over time (Barker, 1997; Broadhurst et al., 2017, 2022). The impact of infant removal on families is most fully understood in relation to birth mothers (Mason et al., 2019). More recently, the "collateral consequences" (Broadhurst & Mason, 2020) for fathers have

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been explored through research (Philip et al., 2020, 2021, 2023).

The experience for families of being subject to child protection assessment and living with the possibility of infant removal during a pregnancy is extremely challenging (Critchley, 2019a). For social workers too, the task of assessing risk to babies and of separating newborn infants from birth relatives can be highly stressful (Critchley, 2020). Beyond the impact on individual well-being, the nature of child protection intervention in babies' lives, being differentially focused on particular communities, introduces the possibility of group-based harms (Dettlaff & Boyd, 2020), through the erosion of trust between state and the community affected. Notably, in Aotearoa New Zealand (NZ), there have been recent policy and practice changes introduced to reduce baby removals (Keddell et al., 2021, 2022) in response to concerns about the over-representation of Māori infants in the child protection system (Office of the Children's Commissioner of New Zealand, 2020).

In this article, I will argue that fundamental questions of reproductive justice are raised by child protection processes that intervene in family life before birth, a time when infants lack legal personality and parents are unlikely to have recourse to legal advice. In child protection practice, all foetal life from the point of notification of pregnancy through to birth can be classified as an "unborn baby", who is considered to be the client of the social worker, and as an individual who may require protection. In practice, pre-birth child protection processes are enacted at a stage at which the pregnant mother intends to proceed with the pregnancy to term, and intends that, once born, the baby be cared for within the family. As such, expectant parents are likely to be comfortable with referring to the infant who will arise from the pregnancy as their "baby". However, it is important to recognise that the contested terminology used to refer to foetal life can convey both meaning and political positioning. In social work, the category of "unborn baby" differentiates the "foetal subject" in a way that lacks ambiguity or nuance (E. Ross, 2016). This categorisation of the unborn baby implies a quasi-personhood, creating a grey area for practices that may trespass (Weinberg, 2016) heavily on parental and community-based rights. Considering pre-birth child protection involvement through the theoretical lens of reproductive justice (Ross & Solinger, 2017) provides useful insight into the precariousness of the reproductive rights of child-welfare-involved parents. Although this is an issue that clearly concerns both women and men, in this article I will focus particularly on fathers.

In centring the reproductive rights of heterosexual men who are non-birthing biological fathers, I am not seeking to deny the struggles of other groups, which have powerfully informed the reproductive justice movement (cf: Solinger, 2002; Roberts, 2017; Ross, 2006). As Ross and Solinger explained, "all people experience their reproductive capacity according to multiple intersecting factors" (2017, pp. 65–66), and the reproductive interests of different groups can easily come into tension with one another (Russell, 2018). Queer scholarship challenges and expands reproductive justice theory and activism (Price, 2017), by widening the lens to include queer reproductive concerns, and acknowledge the contribution that queer reproductive struggles have made to the movement. George (2020) describes how the furthering of reproductive rights of one group can serve the interests of others, and offer glimpses of transformative ways forwards for all. In this article I focus on the experiences of non-birthing cishet fathers. This is not to deny the rights of trans parents, including birthing fathers, and their interests in bringing up children, or to ignore any issues particular to birthing parents, their bodies, and their rights.

The control of women's fertility and their pregnant bodies continue to be essential activities in limiting access to power and liberty (Ross & Solinger, 2017). Child-welfare-involved pregnant women occupy a uniquely precarious position relative to their human dignity and rights (Waterhouse & McGhee, 2016). Waggoner (2017) has argued that the fertile bodies of women are subject to societal scrutiny and control even before the onset of childbearing, with women held individually responsible for reducing and mitigating reproductive risks. Women's bodies and "choices" are frequently understood as being the site of the contested fight for reproductive justice. However, whilst Ross and Solinger emphasised women's embodied and personal experiences in order to demonstrate the importance of reproductive rights and autonomy (2017, pp. 58–65), from the contested site of fertile female bodies extends a movement that "demands sexual autonomy and gender freedom for every human being" (Ross & Solinger, 2017, p. 65).

Within this inclusive framework of reproductive justice, both the political contribution that is required of men in order to achieve this goal and the reproductive disciplining that men may themselves be subject to are "often overlooked" (Dukes & Palm, 2019, p. 712). This article is specifically concerned with the reproductive rights of men, and with the idea that fathers' identities *qua* fathers and their right to "parent children in safe and healthy environments" (Ross & Solinger, 2017, p. 65) can be compromised by pre-birth child protection assessment processes. In order to illustrate the risks to the reproductive rights of men that can be created through pre-birth involvement in their infants' lives, I will draw on data from two separate research studies, both undertaken in Scotland. Therefore, in the following section, I begin by outlining the Scottish legal and administrative context for the data presented, before briefly describing the methodologies for the two studies through which this data was created. I then go on to present relevant empirical findings about fathers of child-welfare-involved unborn and newborn infants, before considering the implications of these findings through a reproductive justice lens.

Legal and administrative context

Broadly, women in the Scottish legal context can be conceptualised as being afforded the protection to make choices around their own reproduction. Women can make decisions in relation to any pregnancy that reflect their sovereignty over their own bodies, including refusal of medical treatment believed necessary for foetal health (Scott, 2000). However, unlike in Aotearoa NZ (Snelling, 2022), abortion in Scotland operates under a system of exceptionality (Deutscher, 2008), whereby it is required of women that they provide evidence that they have sufficient grounds for ending a pregnancy in order to secure a safe and legal termination (Lavalette et al., 2022, p. 3). When women do choose to continue with a pregnancy in the Scottish context, at the point of birth, they become immediate bearers of parental rights and responsibilities in relation to any child born to them. It is at the moment of birth that both an infant's legal personhood and the rights and responsibilities of their birth mother towards them "crystalise" (Wilkinson & Norrie, 1999, p. 54).

Fathers occupy a more complex legal position. In Scotland, if married to, or in a civil partnership with, the mother, fathers automatically attain parental rights and responsibilities in relation to any biological child arising from the marriage or partnership. If the parents of a baby are unmarried, just as in Aotearoa NZ, in Scotland parental rights and responsibilities can be conferred on the father by joint registration of the birth by the baby's parents. If this process does not happen at the time of the birth, under Scots law, the father can ask the mother to sign a simple legal document conferring parental rights and responsibilities to him at a later date. A mother can transfer rights to the biological father of her child at any time, and these cannot then be revoked. If she does not consent, the father must apply to the court to gain parental rights and responsibilities. Online guidance provided by Scottish public services advises fathers that, “If you don't have parental responsibilities and rights, it's up to the child's mother to decide what's best. You have no legal right to make these choices” (Mygov.scot, 2021 , n.p.). In practice, unmarried men in the general population may be unaware of their lack of parental rights and responsibilities in relation to their birth children unless they have a particular cause to formally assert these.

In Scotland, as in all the UK nations, a baby has no legal personhood until the birth (Mason & Laurie, 2011, pp. 369–370). Nonetheless, it is possible for Scottish child protection processes to be enacted before the birth of the baby. An unborn baby understood to be at risk of harm can be considered at a Pre-birth Child Protection Planning Meeting (Scottish Government, 2021). At this formal meeting, a decision can be made to register the expected baby on the local Child Protection Register, which acts as a marker of risk to a child. If the unborn baby is registered, a series of regular multi-disciplinary meetings will follow. The parents are invited to these meetings, at which the plan for the child agreed at the Child Protection Planning Meeting is kept under review. Whilst no legal steps can be taken until after the baby has been born, the National Guidance for Scotland (Scottish Government, 2021) provides clear advice that pre-birth child protection meetings should create a plan for the unborn baby’s future care, agreed in advance of their arrival. This means that significant decisions can be made in relation to the baby during a period when expectant parents have no recourse to free legal advice or representation.

In Scotland, as in comparable legal and administrative systems, social work practice has developed such that practitioners behave *as if* the unborn baby were a legally distinct person and their primary client. In this way, pre-birth child protection involvement operates according to an established legal fiction. The common law *nasciturus* legal fiction developed in order to benefit unborn children and allows legal entitlements to be held in abeyance for an infant’s arrival and their attainment of legal rights. Child protection processes operate according to the same fiction, in that the baby’s right to protection from harm and state support is treated *as if* it existed prior to the baby’s attainment of legal personhood. This places parents in a potentially precarious position in asserting their parental rights and responsibilities This article seeks to explore the potential consequences of this position in relation to the reproductive rights of fathers.

Research methods

This article presents data from two separate research projects. The first was an ethnographic study conducted in a Scottish local authority between 2014 and 2015. Ethical approval for the research was provided by the ethics committee of the School of Social and Political Science at the University of Edinburgh. Over one year, the author observed key meetings including formal child protection meetings, and also shadowed more informal meetings with expectant parents and social work home visits to the family. Expectant parents were asked for consent to these observations and were invited to participate in one or more research interviews in relation to the child protection involvement. Social workers involved with the families were also invited to participate in research interviews. These semi-structured interviews allowed participants to reflect on the meaning of the pre-birth child protection activities for them.

The final research sample comprised 12 families, and the social work practitioners involved with their expected babies: in total 41 participants. Within the participating families, eight fathers were named and contactable. All eight provided their consent to participation in the research, and to being observed. In total, 20 observations were undertaken, and 31 research interviews were completed. All of the participating parents were invited to take part in a research interview. Two of the fathers participated in research interviews; both were interviewed twice. In comparison, six of the mothers took part in at least one research interview. The ethnography was designed to be responsive to the views and decisions of participants around the extent of their involvement in the research, and the available choices were emphasised at all times. This was particularly important in relation to expectant parents, who were experiencing a highly stressful intervention in their family lives. For full details of the research methodology, please see Critchley (2019b). Further details of the extent of the fathers' participation and the complexities of recruiting fathers to the study can be found in Critchley (2022a).

The second study was a Scottish Government commissioned project designed to explore the experiences that birth parents across Scotland have of child welfare processes leading to permanent separation from a child or children, and to map the available support services for those affected. Ethical approval for the study was provided by the Board of the Adoption, Fostering and Kinship Alliance (AFKA) Scotland, which was commissioned to complete the research. The project was initially designed to be participatory in nature, but limits to this aspiration were imposed by the global Covid-19 pandemic and the series of national lockdowns that were put in place to control this. However, participatory work has been possible in the dissemination phase of the work.

The final reporting comprised a review of the available literature on the topic, a description of the services for birth parents and family members available nationally, based on survey and interview data from practitioners, and a report of semi-structured research interviews with 10 birth mothers in relation to experiences of family separation in the Scottish context. Five of the mothers participating were accompanied by support or advocacy workers, and all interviews were conducted in 2022. The women who participated in the study were aged between 28 and 52 at the time of the interview, and their experiences of separation from their children spanned a considerable period of time. Nevertheless, there were no particular shifts in practice around permanent separation that were discernible in the interview data. Each of the birth mothers had between one child and five children, and therefore in total, 27 children were discussed in the interviews. Birth fathers were notable by their absence from the sample. Despite targeted attempts to recruit men to the study, all of the respondents were mothers. Therefore, the data presented from this study do not come from fathers directly and relate more to their absence than presence in the plans for their children. For further methodological detail, please see Part Two of Critchley et al. (2023).

Findings from the first study had been written up and shared by the time that the fieldwork for the second study was under way. Data analysis of the first set of findings had included a follow-up analysis of the ethnographic data, specifically as it related to fathers (Critchley, 2022a), prior to data destruction. Interview data from the second study was analysed by Mark Hardy and the author, and it was noted that, although fathers had not participated in this research study, data which related to fathers were present in the data set. These findings spoke to specific findings of the first study in relation to fathers' rights, which had been shared in conference presentations, but were as yet unpublished, and are presented for peer-reviewed publication here for the first time. Combining and analysing the two datasets together was impossible, as the first set of data had been destroyed as per the ethical approval for the study, due to its sensitivity. However, it was possible to consider data drawn from both studies as they related to men as fathers, through the theoretical lens of reproductive justice. The results of this analysis are presented in this article.

Findings

"They rule the roost": power and pre-birth child protection

This article is concerned with one important and shared finding of both the research studies described above. The central claim based on this data is that unmarried fathers can be, and are, erased from their children's lives and denied the opportunity to gain parental rights and responsibilities as a result of pre-birth child protection involvement. In the Scottish context, as outlined above, the usual way for unmarried fathers to gain parental rights and responsibilities for a child is by registering the birth with the mother. In common parlance, this is often referred to as the father being "named on the birth certificate". Pre-birth involvement with families has the capacity to interfere with this process. In the following extract of data from the study of pre-birth child protection, a social worker Emma describes her perspective on involving fathers.

> No, I think we do try to have fairly explicit discussions with both mums and dads. I don't know if it's something they see within themselves that actually dads are often a problem, and if they remove themselves from the situation, mum can get the baby back, and then they can get back together and then everything. So, you know it may be a view that how to circumvent the process that they don't necessarily want to get involved. But then one of my colleagues has a case where the wee one [baby] has gone to be with dad and he's doing very, very well. But that doesn't happen very often.
>
> (Extract from research interview with Emma, social worker to Jane and Hugh's unborn baby)

Emma is suggesting here that parents themselves sometimes agree between them that the father should appear as if he is not involved in the family. Particularly if the father is seen as a major risk to the baby, for example, in situations of reported domestic abuse. Emma suggests that child protection professionals would nonetheless try to involve fathers and assess their capacity to care for the expected baby. However, Emma goes on to acknowledge an imbalance between mothers' and fathers' legal rights in relation to infants. Whereas birthing mothers automatically have rights and responsibilities in relation to any child born to them, for non-birthing fathers this is only automatic if they are married to the mother. This means that many of the men that child welfare social workers encounter do not have a legal relationship to their child or children.

> And quite often Dads don't have parental rights and responsibilities. You know mums always do. So, from a legal point of view sometimes that is where we have to focus you know if we are thinking long-term and where we don't actually have to deal with removing a dad's parental rights and responsibilities, you know where they are not really doing the business there is perhaps less pressure on us to evidence that to the Court to remove rights and responsibilities that aren't actually there in the first place.
>
> (Extract from research interview with Emma, social worker)

As Emma highlights, parental rights and responsibilities that have never been granted to a father, do not then have to be removed in a court if professionals are later pursuing a permanent care arrangement outside of the birth family. There are at least two potential impacts of this situation in the short-term: Firstly, child protection professionals may be more likely to make mothers the focus of their work; secondly, fathers may find it far more difficult to oppose the plans for a child for whom they do not hold parental rights and responsibilities. Prior to the interview with Emma, I had observed a child protection meeting that was attended by the baby's mother Jane, health professionals, and

Emma herself as the social worker. The baby's father Hugh did not attend this meeting, although he had been present at an earlier child protection meeting, when it was decided to place the expected baby's name on the child protection register. In the meeting following this, when Hugh was not present, Jane was advised by professionals not to name him as the baby's father on the birth certificate. I asked Emma about this in the research interview.

> Researcher: That was something that came up in the Core Group Meeting, wasn't it? Was that Jane was specifically not going to register Hugh's name on the birth certificate and that was her choice in terms of the…
>
> Emma: Aha, yeah. Yeah, but she's not disputing that he's the dad and we would still invite him, still assess him, you know still involve him in the process. But yeah, thinking long-term as one of the possible outcomes, if he doesn't have parental rights and responsibilities, because that is always the first question our lawyers will ask, who's the dad? Has he rights and responsibilities? So they know whether they need to deal with that or not.
>
> (Extract from research interview with Emma, social worker)

It is important to recognise that the child welfare professionals at this meeting had the power to recommend whether Jane's baby would remain in her care following the birth. As Jane was motivated to have her baby home with her, the advice of professionals would hold great weight. Although Emma contends in the extract above that Hugh will still be involved, his rights in relation to the baby have effectively been erased by the advice given to Jane. These interactions happened at a stage when neither Jane nor Hugh was receiving any legal advice or any non-legal advocacy support. The implications of this erasure of a father's legal rights and responsibilities has both short- and long-term implications for him, for the mother and, crucially, for their as yet unborn child. The social worker participating in the research interview presented the practice as pragmatic and as ethically uncomplicated. The power that Emma and her colleagues held in relation to the family remains unexamined.

As Bill and Tracy, expectant parents who participated in the same study described, families are uniquely vulnerable in the context of pre-birth assessment of the risks to a baby.

> Bill: There's nae. There's nae [no] appeals system. There's nae, you cannae [can't] do nothing about it, they [professionals] rule the roost, that's it. What they basically say goes.
>
> Tracy: It seems like they just make up their rules as they go along. And just adding, and adding, and adding, there's never an end to the list.
>
> (Extracts from research interview with Bill and Tracy, expectant parents)

The lack of legal support and advocacy available to parents who are marginalised, often living in poverty, and unable to seek legal counsel appears in this context to be deeply problematic. Bill and Tracy perceived that they were disadvantaged by this situation, and that professionals held a huge amount of power in relation to their child and family. However, for the professionals who participated in the study, that power was not always fully acknowledged or reflected upon. This leaves significant room for "ethical trespass" (Weinberg, 2016) and the erasure of fathers from the plans for and lives of their children.

"It was just me and the social work": Parental learning disability and infant removal

When interviewing birth mothers for the second study described above, in which all the research participants had experienced permanent separation from a child, the practice of excluding fathers pre-birth appeared again in the data. In the following extract, Deborah describes events surrounding the births of her two daughters. Deborah's first daughter Rebecca was born in 2001, following a planned pregnancy, and remained in Deborah's care, with the support of Deborah's own parents, until Rebecca was 13 years old. At this point, Rebecca was placed in foster care and did not return home. Around this time, Deborah had a second daughter Celine, born to a different father who was considered a significant risk to both Deborah and to Celine. Deborah recalled that Celine was removed from her care directly from hospital, six hours after the birth, remained in foster care, and was later adopted with Deborah's consent. Deborah has a diagnosed learning disability and was taken under the legal guardianship of a Scottish local authority during her pregnancy with Celine.

Deborah participated in a research interview alongside an advocacy and support worker from a national member-led group for parents with learning disabilities. Talking about the period when her younger daughter Celine was accommodated at birth, Deborah stated that "I was on my own really. There was only me and social work'. Deborah had been 'disowned' by her father, her mother having died some years previously, and stated that 'I had no support at that time, no support whatsoever." In interview, Deborah conveyed the view that things may have been different if she had the benefit of advocacy advice and support then. As it was, she recalled attending the child welfare and protection meetings in relation to Celine alone, with the support of a social worker. When it came to the legal adoption of Celine, Deborah described the process as follows.

> Deborah: And then I signed all the agreed paperwork for Celine.
>
> Researcher: Did you have a solicitor? Did you have a lawyer that worked with you at all?
>
> D: No. No. Again, it was just me and the social work.
>
> (Extract from Research Interview with Deborah and Florence)

In the interview, Deborah described her feelings of isolation at the time of Celine's birth and the lack of support available to her, beyond that of social work professionals. Here, Deborah begins to describe her relationship with Celine's father.

> D: And when Celine was born, my mum had already died years before.
>
> R: Oh, I'm sorry.
>
> D: And Celine's faither [father], and Celine's faither's family didn't want anything to do with Celine neither. And he didnae [didn't] really want anything to do with Celine neither.
>
> R: And you had to get away from him as well by the sounds of it?
>
> D: Yeah.
>
> R: It wasn't good for you. OK, right. And was that thought about at all? Was it thought about that she could stay with her Dad, or her Dad's family, was that ever talked about?
>
> D: He didn't want, when social work went to ask them, none of his family wanted Celine.
>
> R: Yeah, 'cos I guess for some mothers that can be a hard thing, where actually they talk to the father, or they think, "maybe we'll try this".
>
> D: But Celine's Dad was never on her birth certificate. Because of concerns they had previously with his other child. Because he was on supervised visits with his other child. And social work was advising me not to put his name on the birth certificate because he had no legal

> rights with the child after that. Because social work came and told me, "Look Celine's dad wants to see, meet Celine". I was like, "No" I was like, "Give him photos" but I was like, "dinnae [don't] let her near him".
>
> R: What did you think of that advice, Deborah? Can I ask you that, what did you think of that advice about not putting his name on the birth certificate and, kind of trying to write him out really, wasn't it?
>
> D: I was fine because I did the same with Rebecca [older daughter], I did the same with Rebecca. Her dad wasn't about when Rebecca was born. So, I went back to my parents and again, I chose not to do that back then [approximately 23 years previous to interview], yeah, so it wasn't really, I was just more than happy to keep Celine.
>
> (Extract from Research Interview with Deborah and Florence)

Much as was observed in the ethnographic study in relation to Jane and Hugh's baby, Deborah described being explicitly advised by social workers not to register Celine's father on her birth certificate. Deborah's position is more complicated as she states she was under local authority guardianship at the time of Celine's birth. Without full details of that guardianship, it is not possible to know if there were any areas in which Deborah lacked legal capacity, and if so, what exactly these were. Celine's father had been charged with an assault on Deborah, and following this Deborah accepted direction from professionals about major life decisions, such as moving to a care facility in a different area. For Deborah, there was no clear distinction between accepting this guidance, and accepting social work advice in terms of who held parental rights and responsibilities for Celine. The power imbalance between Deborah and the professionals involved was very steep and it would have been difficult for her to go against any advice she was offered in terms of her daughter. The advice Deborah followed around Celine's father not being named on the birth certificate, meant that she alone could consent to Celine's adoption, when a social worker later advised her to do this. There was no other person with parental rights and responsibilities who could oppose the adoption, and Celine's father was erased from any further involvement in Celine's life. However well-intentioned the advice Deborah was offered may have been, in terms of Celine's father's assessed dangerousness to her and Celine, the child welfare and protection intervention with Deborah during the pregnancy effectively erased Celine's father from the legal processes that followed. In her account of this period, Deborah clearly stated that she did not have any independent advice or advocacy and was not instructing a solicitor. Deborah was advised by a social worker to "focus on herself" when she tried to "fight for a mother and baby unit" placement for her and Celine following the birth, where she could care for her daughter with support. However, no such facility was offered. Following Celine's birth, she was placed with foster carers. Deborah remained in a care home environment for a further nine years and left this less than a year prior to the research interview.

Discussion

Unbalanced power relations are at the heart of the observed and reported interactions between social workers and parents described above. There is much that is troubling in the findings shared in this article. However, focussing specifically on the legal position of fathers, the data presented show how fathers can be denied the opportunity to obtain legal rights and responsibilities for their children through advice given to mothers during the pregnancy. Whilst holding parental rights and responsibilities is not necessary for involvement in discussions and decisions about the care of a child, fathers who lack such rights can more easily be excluded by child welfare and protection professionals, as can their wider family and community.

Without parental rights and responsibilities, fathers lack a clear legal position from which to oppose decisions about their children's lives, including the decision that a child join a non-related family through legal adoption. This represents a significant constraint on men's rights to have a child, to parent that child, and even to confer on that child legal and social paternity. There is no straightforward way in which an expectant mother, father, or couple can seek or secure legal advice on this matter within the timescale of registering the child's birth, which must be within 21 days of the birth in Scotland. Seeking legal advice was not an option that most parents taking part in the studies reported on here were aware of or had tried to access around their child's birth. Rather, the mothers accepted the advice given to them by social workers around the registration of the birth and complied with the legal erasure of the fathers of their children.

Applying a reproductive justice lens to this problem is complex. It is crucial to acknowledge that reproductive justice as theory, praxis, and activism "predominantly focuses on the importance of including marginalized views and voices" (Liddell, 2019, p. 110). A reproductive justice approach requires engagement with the "damaging heritage" (Roberts, 2021, p. 61) of "the colonial legal apparatus" (Roberts, 2021, p. 60). Reproductive justice was built through the activism and organising of African American women who demonstrated the ways in which the legacy of that apparatus continued to deny women their full reproductive rights (Ross & Solinger, 2017). Using this work, and the analytical power of reproductive justice, to consider the rights of white heterosexual men can appear jarring and counter-intuitive. It might be objected that when social workers ensure that the fathers of infants at risk are "discounted altogether or seen as problematic" (Weinberg, 2016, p. 106), they are simply aiming to secure the safety of those infants, and that of their mothers. Through their work, social work practitioners can be understood as foregrounding women's rights, by enabling mothers to walk away from the fathers of their babies without legal entanglement.

However, there are two significant problems with reading social workers' advice to women not to name the fathers of their babies on the birth certificate as a feminist act. The first is that the outcome is to locate the responsibility for the infant solely with the pregnant woman, responsibilising her as a mother, whilst the responsibilities of the child's father are suppressed and erased. The second is that this is a practice that weaponises women's desire to care for, live with, or at the very least have ongoing contact with their children against them, in order to coerce a particular outcome. For the women who participated in the research studies reported on here, the power imbalance between them and the social work practitioners involved was very pronounced at the time the advice was given.

Pregnant women living with the threat of physical and sexual violence from their partners may be reluctant to discuss this with child welfare professionals, for fear of being blamed for a "failure to protect" the baby from the risks of assault (Ross & Solinger, 2017, p. 218). The stakes for women whose capacity to care for their baby is assessed by child protection social workers during pregnancy are undeniably high (Beddoe, 2022, p. 8). Disclosing experiences of intimate partner violence and abuse is a huge risk for women. In this context, it could be argued, as the social worker Emma does above, that erasing some men from their children's lives is safer and easier all-round. However, as Davis et al. argue, acting "under the pretext of ending gender violence allows the state to determine the nature of the problem, to decide on 'reasonable' solutions, and to categorize people as either deserving to be free from injury or not" (2022, p. 111). Under this reading, it is not only men's rights as fathers which are threatened, but also women's autonomy as mothers. In this process, the rights of both men and women to have and to parent children (Ross & Solinger, 2017) are compromised.

Any child welfare practice which fails to engage with men as fathers in a respectful and holistic way, is ultimately a practice which fails to grapple with the problem of male violence (Critchley, 2022b). It is a "business as usual" practice whereby fathers are hidden in the shadows (Ewart-Boyle et al., 2015; Gřundělová & Stanková, 2019), while women are held accountable for family safety. It is a practice that fails to offer those men who are a risk to their partners meaningful opportunities for change and also allows them to move on to father children with future partners, with little accountability. The foetal subjects who are viewed as the unborn baby clients of child welfare professionals may be imagined as untethered infants (Critchley & Keddell, forthcoming), but all children are tethered: to family, to community, to their roots. In Scotland, as in Aotearoa NZ, there is renewed commitment within legislation, policy, and practice to preserving children's relationships with their birth family and to prioritising care within kinship networks (The Promise, 2021). This commitment sits uncomfortably up against a practice with the potential to exclude fathers from their children's lives, from their infancy onwards.

When there is child welfare and protection involvement in the perinatal period, the reproductive rights of both women and men are at risk. Women are vulnerable to "pregnancy policing" (Ross & Solinger, 2017, p. 219) whereby their fitness to be mothers is held up to scrutiny. The risks to the reproductive rights of men in this context have been subject to less consideration. Yet men too can "face multiple diverse barriers to reproduction and parenthood" (Dukes & Palm, 2019, p. 715). Young men and men raising children in economic poverty can be easily marginalised within systems that are underpinned by assumptions of middle-class motherhood (Tarrant, 2021). Service investment in families by child welfare agencies is primarily in mothers, rather than fathers (Perez-Vaisvidowsky et al., 2023). Men who are separated from their children through child welfare proceedings experience the double-blow of the pain of that separation, followed by an almost complete lack of concern with their own welfare needs (Critchley, 2022b; Philip et al., 2020). This jeopardises the capacity of fathers to recover and address the issues that led to family separation, and ultimately to have and to parent children successfully.

Conclusion

In advocating for social work to engage with global threats to reproductive justice, Beddoe has argued that "social workers are in a good position to aggregate stories with a focus on social justice (health inequities, racism, poverty and so on) and human rights (bodily autonomy, choices about fertility and parenthood, and so on) in order to avoid the need for some people to be brave and lay out their private decisions to raise awareness" (2022, p. 17). In this article I have chosen to aggregate the stories of families and individuals encountered during two research projects. When these stories are considered through the lens of reproductive justice, it becomes clear that the rights of men, women, and their children are not being fully respected or realised.

As highlighted by Perez-Vaisvidovsky, fathers are part of highly complex configurations of care (2023, p. 10). Fathers who are written out legally, may nonetheless remain present in the lives and psyches of their children, and perhaps also in relationship to the children's mothers, despite becoming invisible to child welfare services (Brown et al., 2009) and in any legal proceedings. Where fathers do remain apart from their children, by dispensing with their participation at an early stage, an opportunity is lost to engage with fathers' grief at separation from their children, and to address the potentially long-lasting impact of this experience (Philip et al., 2023). There is an urgent need for expectations of practice to shift and for the inclusion of men as fathers to become the standard against which practitioners are held accountable. Significant failures to respect men's responsibilities and rights as fathers are described in this article, and the pre-birth child protection loopholes that enable such practices need to be closed.

Gomez et al. suggested that "both social work and reproductive justice share a commitment to furthering and shaping knowledge and practice towards a more equitable society" (2020, p. 359). In order to realise this aspiration, it is important to acknowledge that the social work profession has been, and continues to be, involved in coercive practices that threaten reproductive rights, rather than furthering reproductive justice. In this article I have focussed on the reproductive rights of men as fathers, presenting data that illustrate how these are made precarious through pre-birth child protection involvement with families. Recognising the power that social workers hold in relation to the reproductive rights of child welfare-involved parents within the perinatal period is an essential first step in beginning to change practice.

A reproductive justice lens not only brings clarity to social work dilemmas, by showing the harm that is done to individuals and families when reproductive rights are not acknowledged and respected. It also begins to shine a light on possible ways forwards in working with situations of intrafamilial risk. By engaging with the idea that child-welfare involved expectant parents "deserve the same sexual, biological, and affective relationships and opportunities as others" (Ross & Solinger, 2017, p. 203), it becomes possible to shift the professional gaze beyond the risks to the unborn baby to the needs of their mother, their father, and their wider family. To take as a starting point the enabling conditions that could empower expectant parents to care for a child; to offer a child what they can of themselves. Practice and policy that engages with families within a reproductive justice framework has the potential to be genuinely transformative, by focusing on the conditions required for children to be born, cared for, and raised within their families, and their communities.

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ORIGINAL ARTICLE
QUALITATIVE RESEARCH

Reproductive justice for children and young people with gonadal variations:
Intersex, queer and crip perspectives

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ABSTRACT

INTRODUCTION: This article draws on understandings from reproductive justice, crip and queer theories to discuss gonadectomy for children and young people with gonadal variations. Gonadectomy is sometimes performed on people with gonadal variations without their free and informed consent. Some parents report experiencing pressure to consent to such surgery when their children are young. We understand this to be an issue of reproductive justice.

METHOD: Semi-structured interviews were conducted with parents of affected children and young people ($n = 13$). Thematic coding was used to identify data relating to gonads, ovaries, testes and gonadectomy. The data were analysed using discursive questions drawn from a reproductive justice framework.

ANALYSIS: Parents' talk about gonads suggests a process of sense-making that can be emotionally challenging. Our analysis situates their talk within broader societal discourses of ablebodiedness and the sex binary. Parents explained their choices and decisions by centring various understandings. Some explained how gonadectomy made sense for maintaining binary sex and following medical advice. Others emphasised the child's consent and bodily autonomy. Our analysis draws out how parents' decisions navigate reproductive justice *and* injustice.

CONCLUSIONS: Dominant beliefs about ablebodiedness and the sex binary appear to influence and frame decision-making about the gonads of children and young people with variations in sex characteristics. A crip, queer, and reproductive justice lens allows us to expand understandings of reproductive justice for all and potentially helps to destabilise and disrupt the sex binary.

Keywords: Intersex; reproductive justice; crip studies; queer studies; intersex, gonads; gonadectomy; qualitative; variations in sex characteristics; differences in sex development; healthcare

This article focuses on part of the reproductive anatomy: gonads. People with variations in sex characteristics, otherwise known as intersex variations, sometimes have gonads that do not develop typically. We understand this as gonadal variation. In the context of gonadal variation, it is not unusual for children or young people to undergo gonadectomy, and this issue is at the forefront of intersex activism and advocacy. Within intersex advocacy, as within other areas of reproductive justice, consent and bodily autonomy are central (Bird, 2005; Orr, 2022).

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Many children and young people with variations in sex characteristics undergo surgery that compromises their bodily autonomy, and that is done without their full, informed consent (Karkazis, 2008; Lampalzer et al., 2021). Some parents feel pressured to consent to surgery intended to make their child's body fit sexed norms (Lampalzer et al., 2021). Such surgery can include procedures at various ages to *normalise* genitals and remove gonads (Hughes et al., 2006; Lee et al., 2016). While gonadectomy is often explained as an attempt to mitigate gonadal cancer risk we understand *all* such procedures to *also* have a normative function and therefore be an issue of reproductive justice. We bring queer and crip theory to bear on questions about removing children's gonads in the context of a variation in sex characteristics.

Situating ourselves

As researchers, our work is always situated (Haraway, 1988). As people, we selectively express or obscure facets of our identity depending on context. Research is no different, and while we as authors are all familiar with our queer and feminist identities—rendering queer theory and issues of reproductive justice familiar—we wondered exactly *how* each of us is positioned with regard to crip theory. We (have) experience(d) a range of conditions (autoimmune diseases, chronic back pain and long Covid) and feel that we could have a (very) limited claim on disability. For example, Eileen's understanding of the social model of disability deepened when she realised that, during the Covid pandemic, the *lack* of societal mitigations and precautions taken by fellow citizens felt (and was) disabling as she has multiple autoimmune conditions. In this instance, despite never feeling disabled *as a person*, she often felt disabled by her *environment*. We all sit in a *disability-adjacent* space (albeit often with the privileges to mitigate the effects of any disability) and note, like others, that we feel a sense of "trepidation about laying false claim to histories of oppression, as well as a reluctance to simplify complex ways of thinking, feeling, and behaving" (McRuer & Mollow, 2012, p. 10). We approach the space where reproductive justice, crip and queer theory intersect with reflexivity and (limited) knowingness.

Eileen and Katrina are based in Aotearoa New Zealand, where some Māori people with intersex variations identify as ira tangata[1]. While the data we analyse are from Scandinavia and the United Kingdom, we see this issue as global and, therefore, as having relevance for practitioners in Aotearoa New Zealand. There are no clear statistics on how many people have a variation in sex characteristics (although the 2023 Census aims to capture this data (Stats NZ, 2021)). Currently, parents in Aotearoa New Zealand can consent to medical treatment on behalf of their children until the child is 16 years or over, with no requirement for court involvement in cases where the child is likely to be sterilised (McGeorge, 2018). Aotearoa New Zealand's limited legal framework for protecting disabled children and those with variations in sex characteristics from unnecessary surgery has been noted and condemned by the United Nations Committee on the Rights of the Child (Breen & Roen, 2023; UN Committee on the Rights of the Child (CRC), 2016).

Clinical context

Gonads is usually understood as the generic term for ovaries and testes. Some young people discover that, although they have been raised as a girl, they have internal testes. Some gonadal variations can not be simply described as ovaries or testes[2]. Some people are faced with the possibility of gonadectomy either in childhood or youth. In the case of complete androgen insensitivity syndrome (CAIS), for example, gonadectomy was standard practice soon after diagnosis (Deans et al., 2012). This changed in the early 21st century with research documenting the "negative impact of gonadectomy" in people's lives (Duranteau et al., 2020, p. 4) and some clinics "postponing prophylactic gonadectomy" (Cools & Looijenga, 2017, p. 176) in the context of CAIS.

For some diagnostic groups, gonadectomy in childhood can be lifesaving. For other diagnostic groups however, the risk of childhood gonadal cancer is much lower than previously thought. Gonadectomy impinges on fertility, hormone production and bone health (Weidler et al., 2019). Living without gonads necessitates hormone replacement therapy which can be hard to manage and potentially debilitating. Gonads are sometimes removed without parents being made aware of the choices open to them, such as retaining the gonads until at least after puberty. Intersex youth have spoken out about inadequate communication of choices about retaining gonads[3].

For variations where gonadectomy was once routine, attending to reproductive justice concerns means taking a gonad-sparing approach whenever possible. Some centres internationally now take such an approach, depending on diagnosis and data about malignancy rates (Steinmacher et al., 2021). The latest research suggests that decisions should be informed by shared decision-making (Döhnert et al., 2017; Steinmacher et al., 2021; Weidler et al., 2019).

Queering and cripping reproductive justice

Black feminists were the first to articulate notions of reproductive justice (thus expanding thinking beyond that of the pro-choice movement), with initial framings centred around three key principles: 1) the right to have a child; 2) the right to not have a child; and 3) the right to parent in a safe and healthy environment (Morison & Mavuso, 2022). Since these initial conceptualisations, queer scholarship has sought to broaden its framing beyond the boundaries of binary sex/gender and heterosexual reproduction to explicitly include and address advocacy for people outside these norms (George, 2020; Lane, 2019; Price, 2017). Some queer and reproductive justice advocacy groups work with an expanded definition of reproductive justice that prioritises bodily integrity and autonomy (Price, 2017).

George's (2020) work expands reproductive justice to include queer considerations, acknowledging: "Even within the reproductive justice movement's expanded conception of reproductive rights, advocates tend to ignore the queer community's specific reproductive issues" (2020, p. 672). Even within queered and expanded notions of reproductive justice, reproductive justice for people with variations in sex characteristics remains relatively unexplored (Morison & Mavuso, 2022). When reproductive justice for people with variations in sex characteristics is discussed, it is often conflated with the needs of transgender people and centres biogenetic parenting and access to assisted reproductive technology (ART) (Johnson et al., 2017; Rowlands & Amy, 2018; Stritzke & Scaramuzza, 2016). While we acknowledge this is important, and access to ART for people with variations in sex characteristics *is* an aspect of reproductive justice needing further exploration, it is not the only area of concern. The few who clearly bring intersex healthcare into reproductive justice understand that intersex surgery implicates "the fundamental questions of autonomy, equality, dignity, and liberty on which reproductive decision-making turns" (George, 2020, p. 702).

A queer, crip approach to intersex

Crip theory, which builds on critical disabilities studies, is sometimes considered analogous to queer theory (Kalender, 2010). Both crip theory and queer theory problematise naturalised norms, and avoid assimilationist strategies frequently found in other approaches to, respectively, disability and LGBTQIA issues (Kalender, 2010).

A dialogue between queer and crip theories has been under way for 20 years (Cohen, 2015; Kim, 2017; Martino & Schormans, 2020; McRuer, 2006) with Orr (2022) bringing intersex studies into the discussion. Orr draws on Kim's (2017) argument about "curative violence" perpetrated against disabled people to explain how medical interventions (including gonadectomy) on people with variations in sex characteristics seek to 'cure' the 'problem' of variations in sex characteristics. Orr noted that these procedures, akin to interventions on disabled people, are violent and aim to bring bodies with variations in sex characteristics in line with binary sex characteristics, ablebodiedness and heterosexuality—thereby exposing the compulsory nature of all three normative states. They note, ironically, that such interventions can be disabling. For example, removing gonads requires subsequent lifelong hormone replacement therapy, which can disrupt libido and increase the risk of side effects and other conditions, *including* cancer (Orr, 2022). Orr acknowledges that medical professionals "probably believe that the procedures they endorse and perform are benevolent … [and are] the best course of action" (2022, p. 61), but the concern remains that parents often do not have all the information before consenting to the procedure on behalf of their child. This speaks to the societal context for *all* decision-making involving bodies with variations in sex characteristics. Decisions about 'what to do' with the gonads of a child or young person with a variation in sex characteristics are about individual decision-makers *and* the discursive conditions permeating these decisions. We hope that by bringing notions of reproductive justice into the conversation, we can create space for counter-discourse that might destabilise the compulsory nature of all three normative regimes: heterosexuality, ablebodiedness, and binary sex characteristics.

Crip and queer theory as a lens for reproductive justice

Using understandings from crip and queer theory, we understand that *any* surgery on the reproductive anatomy falls within the remit of reproductive justice. Following Morison (2023), we take a postmodern approach to reproductive justice, focusing on intersecting power relations, centring marginalised groups and taking a social justice approach. We draw from theories that stand "for the dismantling of hierarchies and structural inequalities" and "for the recognition of differences, which elude categorisation" (Leibetseder, 2016, p. 142), keeping in mind the way pathologising categories have been used to define and constrain queer embodied subjects, disabled subjects and intersex subjects, among others.

In using crip and queer theory, we are not making claims about whether those with variations in sex characteristics are necessarily disabled and/or queer. Like others (Cohen, 2015; Cornwall, 2016; Martino & Schormans, 2020; McRuer & Mollow, 2012) we claim that bringing these theories together and considering variations in sex characteristics allows us to see what benefits emerge from cripping intersex studies (Orr, 2022, p. 8).

Four reproductive justice principles (drawn from the above literature) underpin the current research:

1. Consent: We have concerns about parents' and caregivers' (in)ability to meaningfully consent to gonadectomy. Research indicates that for parents, these decisions are challenging with (mis)understandings about the sex binary featuring in decision-making (Lundberg et al., 2019).

2. Bodily integrity: We believe that decisions about gonadectomy compromise the rights to bodily integrity of children and young people with variations in sex characteristics.

3. Reproductive status: We problematise instances where organs are primarily defined by their reproductive status rendering non-normative reproductive organs 'dysfunctional'. Gonads have

important physiological functions and psychosocial meanings beyond reproduction. We draw from crip theory to suggest that for some children and young people with variations in sex characteristics, gonadectomy is "curative violence" (Orr, 2022).

4. The right to a supportive parenting environment: We are troubled by instances where parents do not feel they had a genuine choice about medical intervention (Freda et al., 2015; Lundberg et al., 2017; Sanders et al., 2011) and may be pressured by child protection workers to consent to surgery (Rubin et al., 2022). Some parents experience a lack of support when making decisions about surgery, especially when choosing not to consent. Any such pressure violates a key reproductive justice principle: the right to a supportive parenting and birthing environment (Morison & Mavuso, 2022).

The current study focuses on parents of young people who have been involved in, or are subject to, decisions about gonadectomy. This study examines how they talk about gonads and their decisions around gonadectomy.

Method

This research was carried out in Scotland, England, Norway and Sweden as part of the SENS project (4). The analysis reported here draws from interview data with 13 parents recruited and interviewed in England, Scotland and Sweden. All participants were recruited on the basis that they had a child with a variation in sex characteristics. Parents were recruited via support groups.

The semi-structured interview guide prompted participants to talk about their experience of their child's diagnosis and medical intervention, and to talk more broadly about their life in general. Participants were given a gift card of approximately £15. Interviews were audio-recorded and transcribed word-for-word. Potentially identifying information has been deleted, and pseudonyms have been used to maintain anonymity.

This research was approved by the UK National Research Ethics Services (REC: 11/LL/0385 and 11/LO/0384); the Joint Research Office at University College London Hospitals (R&D Project ID: 11/0143), and the Ethics Committee at the University of Surrey (EC/2012/52/FAHS and EC/2011/68/FAHS).

Analysis

The data were coded thematically through line-by-line reading and rereading to identify excerpts relevant to the topic of gonads, ovaries, testes and gonadectomy. The analysis is structured by a series of questions that were used to interrogate the data (Corbin, 2021) and that enable us to investigate how research participants talk about gonads. The first questions we consider about gonads are: what to call them, how to understand them, how to feel about them, and then how to decide about them. Such questions helped us to explore meaning beyond the biological function of gonads to the discourses present. This could be understood as a first layer of questioning enabling us to organise and describe the data in detail. The second layer of questioning provides the framework for our more theoretically informed analysis and, thus, questions about reproductive (in)justice (Morison, 2023). This is guided by the questions: (1) What types of reasoning come into play when parents talk about deciding for or against gonadectomy on behalf of their children? And (2) what implications does this have for consent, bodily integrity, and reproductive justice?

Talk about gonads

Making sense of gonads and cancer risk

The language people use when talking about gonads and how they struggle with language gives us clues about how people think about this topic, what they associate with gonads, and what emotions come into play as they address it. Gonad-talk also tells us stories about how people articulate ideas and navigate discourses about the sex binary and ablebodiedness.

The terms used for these reproductive organs (ovaries/testes/gonads) are important in three key ways: first, the naming of these organs can seem at odds with a person's gender, and this can be very meaningful for the parents concerned (Lundberg et al., 2019); second, talk about these organs is often paired with talk about disease (Orr, 2022); third and relatedly, the language associated with this topic can be stigmatising (Bird, 2005; Orr, 2022).

Most participants who grappled with what to call ovaries/testes/gonads were parents of children whose variation in sex characteristics led to medical investigations and/or interventions. At the same time as learning to talk about their child's reproductive organs, they were grappling with biomedical understandings of those organs' potential for becoming cancerous.

Kezia explained that her daughter "hasn't got ovaries because they didn't develop; she had gonads, which is what you have when you start developing as an embryo […] and [the gonads] just didn't develop into anything, so they had to be taken out. It had to be taken out because she had a gonadoblastoma on one of them." Kezia moved from talking about "ovaries" and "gonads" to talking about an organ that "didn't develop into anything" and that "had a gonadoblastoma". Parents sometimes access literature to learn about their child's condition and talk with medical staff. It was most likely through this process that Kezia learnt about foetal development and concluded that her daughter's gonads "didn't develop into anything". The language used to refer to these reproductive organs may have a bearing on the decisions that can be made about them. The reproductive organs of Kezia's child are conceptually moved into a space of the undeveloped, the indeterminate, which is linked with the spectre of cancer.

Jasper's interview also suggested a process of developing an understanding of his daughter's reproductive organs that conflicts with normative expectations of gender and sex. Early on, he said, "we call them ovaries," and then, referring to the finding of cancerous development, he said, "they … found the … infected, um … ovary we call it". By this stage in the medical investigations, it was presumably clear that Jasper's daughter did not have ovaries. During the interview, the researcher offered the word "gonads", to which Jasper replied, "Yeah, gonads is a better word, yeah." Jasper explained, "it was quite some time before somebody actually said, 'It's actually testicular cancer'". Jasper's engagement with the language used by health professionals led him to various interpretations relating to his daughter's internal reproductive organs. In the interview, he returned to this question of terminology, saying, "it isn't even testicular cancer, it's gonads, isn't it?". He worked to move away from culturally discordant language by simultaneously grappling with new medical terminology, information that his daughter's reproductive organs are not "ovaries", confusion over what that means if his *daughter* has gonads that are not *ovaries* (then what are they?) and the concerning news that they may be cancerous. Even though several years had elapsed since the medical procedures, Jasper still grappled with these terms.

Miriam seemed to juggle similar issues. In referring to medical specialists, she explained, "they couldn't call them ovaries. They were calling them gonads by then. But … [another doctor] said testicular cancer". When asked if she talked with anyone about this topic, Miriam said, "only with my husband", explaining, "I didn't even tell her brothers and sisters in detail". The naming and potential stigma around these organs become interwoven as parents try to make sense of what clinicians tell them and as they try to develop narratives to share with family members. Miriam then explained what she felt able to say: “if anyone asked, I just said she had ovarian cancer”.

Given that Miriam knew her daughter never had ovaries, this is an interesting narrative to develop for people who ask. Perhaps this reflects the stigma associated with gonads, especially gonads that defy sex/gender norms. Miriam’s narrative reveals that it may be less stigmatising to say that her daughter had cancer than it is to say that her daughter did not have ovaries. In effect, Miriam smooths the discordance by aligning the terms for other people.

The topic of cancer and the associated discourses of risk and pathology weigh into how people feel about gonads and what decisions they might make. Next, we examine the language people used to refer to cancer, risk and pathology and then consider experiences people recount about cancer.

Parents used a wide variety of words to refer to their children’s gonads as (potentially) pathological. Some said that the gonads “had gone to a gangrene” and were “infected” (Jasper), “hadn’t developed properly” (Nia), “had a gonadoblastoma” (Kezia) “will be completely non-functional” (Matthew), “could become malignant later on” (Sara) or had “a slight risk of cancer” (Robert). Parents also described what they and their children had experienced while the issue with gonads was being investigated medically. They explained, “it was a whirlwind” (Enid), “we have had all these investigations done” (Kezia) and “It took … the medical establishment a little while to get to the bottom of it” (Jasper).

This assortment of pathology descriptions and the whirlwind of medical testing provided the context within which parents tried to make sense of their child’s variation as well as new information about cancer and risk. To understand what is going on when parents are invited to make decisions about their children’s gonads, we must keep in focus parents’ new learning around gonads, as well as their response to cancer risk. These things will likely raise difficult emotions and weigh heavily in parents’ decisions about their children’s gonads and potential gonadectomy in a culture that privileges ablebodiedness and normative sex characteristics.

The emotions evoked in relation to bodies can tell us much about shared meanings (McDermott & Roen, 2016) and social norms (Ahmed, 2004). Parents spoke of their intense emotions when talking about gonads and gonadectomy. They referred to the situation as horrendous, their feelings of shock and desperation, and their experience of having wobbles and tears. Some parents described their worries and fears about what might happen. Tim, whose daughter was in preschool, described feeling “fearful” about how hormones from her gonads might “masculinise” her. He explained, “we were also worried that … somebody else would … see” the child’s genital appearance that varied from ‘typical’ female appearance. He concluded, however, “nobody noticed anything”. Nia also spoke about fears of what might happen, saying, “I thought she might feel more different if she looked different”, and about her daughter’s gonads, saying, “there is a fear of … them going cancerous”. In relation to fears about what the child might feel and what other people might think, other researchers concerned with intersex healthcare have suggested that “parents should question their own fears … because their child might not share those fears” (Lampalzer et al., 2021, p. 478).

We understand emotion and affect as integral to the sense-making process, especially when that sense-making involves the body. This follows Wetherell’s explanation of affect as “embodied meaning-making” (Wetherell, 2012, p. 4) and affective practice as drawing attention to the “relational negotiation of affect and emotion where people work together to make emotional sense”

(Martinussen & Wetherell, 2019, p. 109). Emotion and affect are important for what parents go through when told of their child's variation and how parents make sense of decisions about gonadectomy.

Explaining choices and decisions about gonads

Gonadectomy is the rational decision

In this part of the analysis, we examine how parents described decision-making about their children's gonads. This decision-making must be read in light of societal discourses framing sex/gender norms, ablebodiedness and the emotional context of gonads and cancer. Parents bear weighty responsibility to do the right thing on behalf of their children.

Nia explained that doctors recommended gonadectomy "cause they go cancerous". She said, "I felt quite happy with making that decision". She acknowledged things have changed in the 10 years since the gonadectomy: "there is *an argument* today that, that surgeons should not *advise* parents to do that and let the child make the choice for themselves later on" but still said, "we *felt* it was *right*" (italics our emphasis). Nia referred explicitly to argument, advice, and feelings of correctness, positioning parental decisions about bodily autonomy as subjective. Nia went on to note these are "big choices," but "even though I had wobbles about it and I was in tears, my husband [said] … 'we stick by what we agreed at the beginning.' And that paid off, it has hopefully." This could be interpreted as a strategy for managing uncertainty because abiding by the decision provides something to hold on to in the context of doubt and changing knowledge.

While willing to acknowledge this level of struggle and ambivalence, Nia repeatedly returned to a binary sex/gender rationalisation, explaining, "*we felt* it would mess [daughter] up more, um, being an in-between sex, that *we had to choose* one or the other. And *the evidence* that was given to us by the doctors … that she was being assigned as a female" (italics our emphasis). Here, Nia built an argument based explicitly on what "we felt" and on "the evidence". Her argument made sense so long as we understand sex as binary and the gonads as a threat to their daughter's binary sex.

On the one hand, Nia was open about her distress and ambivalence around the decision to go ahead with a gonadectomy in the first two years of her daughter's life. On the other, she repeatedly pointed to two underlying arguments for that decision: (1) the doctors recommended gonadectomy, based on the risk of gonadal cancer, and (2) retaining internal testes through her developing years might leave her daughter living "as an in-between sex". This is a familiar narrative in our data and is certainly not particular to Nia. It is, however, in contrast with some other parents we interviewed who gave clear rationales for not going ahead with gonadectomy.

Emphasising the child's consent and autonomy in decisions against surgery

Robert and Shirley centred consent and autonomy when discussing their decision-making. Robert said he did not want "to take decisions for my daughter", explaining, "that's a pretty important part of your body". He knew that "A lot of people decide, 'Well, it's part of me … I'm not losing it.'" Robert set limits on what *he* can decide *as a parent*. Shirley centred on the principle of gonad retention and letting the child decide later. She had read about adults who had experienced gonadectomy and could identify specific concerns: "despite hormone replacement therapy, it had negative effects. They felt less energy … less sex drive … there's negative things about it … there aren't any positives. I mean, the positives is that they [say] that it removes the risk of cancer … but I think with CAIS, the risk of cancer is very low … virtually 1 or 2%."

Shirley and Robert's accounts aligned with the reproductive justice principles of autonomy and bodily integrity (Morison & Mavuso, 2022). The way they spoke resonated with reproductive justice literature on parents reluctant to make fertility-related decisions on their child's behalf (Johnson et al., 2017, p. 404). They accepted that retention brought risk; however, the 'math' added up to the solution of centring their child's right to decide.

Juggling complex considerations of rights, "facts", and responsibilities

While Nia sat at one end of the decision-making continuum, and Shelley and Robert sat at the other, most parents seemed to negotiate a middle ground. Tim, for instance, described how the decision to remove their daughter's gonads was made "straight away", and they "pretty much tr[ied] to forget about it after that". He explained, "we can … live normally now until … ten, eleven" and then have "a serious discussion". Tim's explanation suggests that removing the gonads does not simply 'normalise' the child's sexed body. Instead, it seems to generate a little peace of mind. Tim explained that the pre-pubertal years would allow time to build an "open approach" to sexuality with their child to "broaden their mind".

Kezia's child had a gonadectomy early, and she found out later that this could lead to problems. Her explanation of the decision-making and later reflection is insightful:

> I am glad I didn't know [about potential problems] before [laughs] because I would have had issues with it, and that wouldn't be good if I had said no, don't do this, because I felt slightly pressurised into her having the laparoscopy, even though I said to them what is going to change in a year or two … shouldn't we wait for her to understand it better and give her own consent.

Kezia's experience reflects a common thread running through interview studies with parents whose children have gone through early surgery: parents do not always feel that they have given free and informed consent (Freda et al., 2015; Sanders et al., 2008), they sometimes feel pressured into 'agreeing' to medical procedures on behalf of their children, and they must live the rest of their lives with this knowledge. Such pressured decision-making violates not only the autonomy and integrity of the child but also the parent's right to parent in a safe and supportive environment.

Matthew explained the grounds for removing one gonad but said, "we're hoping we can keep one [gonad] to help … at least have a quasi-normal puberty". He explained the complexities of surgical decisions, saying they considered how it might be "even if [son] did wanna become a female". Matthew also explained that the decision was "fraught with … contentiousness. Between my wife and I" in relation to "the removal of the Müllerian structures"[5]. While Matthew "thought it was probably a good idea, [my wife] was not 100% sold … but … [the Müllerian structures are] underdeveloped, and … won't be of any use".

Matthew's account demonstrated the complexity of the decision-making required. Decisions about what surgery is deemed (un)necessary are layered and filtered through multiple discourses, including medical, parental responsibility, binary sex norms and bodily autonomy. He considered that leaving one gonad in place might allow the child to have "a quasi-normal puberty". Like Shirley and Robert, Matthew noted the reproductive justice principle of bodily integrity and autonomy—at least as far as the gonads are concerned. In making space for this, he also disrupted the sex binary by allowing for the possibility that his child may one day not want to be male. This is a complex juggling act; understandably, not all parents manage this.

Finally, Enid's description of the reasoning behind surgery for her child demonstrates a logic that is worth considering and contrasted with Matthew. She explained that, like Matthew's child, her child appeared to have one "functioning" gonad and one that is not. She said, "in his [the doctor's] eyes, if it's not really doing anything, it's worth removing because it's abnormal enough to potentially, in the future, be cancerous." Enid seemed concerned about receiving medical advice from someone who considers, "if you're already doing a surgery to remove one, if it's not useful, you might as well remove both." And, regarding the uterus, "if it doesn't have a purpose, and if it only can potentially cause infection, why not just remove it?"

Enid, like Matthew, juggled many complex considerations as she tried to contribute meaningfully to decisions about her child's health care. Both sought to retain one gonad and acknowledged that the child might want to make an independent decision about gender when they are old enough to do so. What was particularly interesting about Enid's account is her presentation of the surgeon's logic. The clear implication is that the surgical approach prioritises expediency: if doing surgery, we might as well take out everything at once; rather than prioritising the child's bodily integrity and the parent's and child's choice. This could be described as slippery-slope logic. This way of thinking may force parents into contentious discussions, and could lead to violation of principles of reproductive justice.

Reproductive (in)justice?

How adults make decisions about children's gonads raises questions about reproductive justice for people with variations in sex characteristics—especially children and young people. As we set out in the introduction, we have concerns about consent, bodily integrity, defining anyone through their reproductive status, and parental rights to a supportive parenting environment. These principles form the ground on which intersex human rights intersect with reproductive justice, and it is here that discourses of compulsory ablebodiedness and the enforced sex binary intersect.

Parents' decisions about their children's gonads occur in societal contexts that privilege specific ways of being a person, of inhabiting a body. Consideration of social context is critical to any reproductive justice analysis (Morison, 2023). Our data demonstrate that parents were conflicted over what was the *right* decision. Decisional 'rightness' involves present *and* future ramifications. This dilemma is common to all parents, considering the present *and* future child and potential ramifications (both from the child and wider society) (Ryan, 2020). Parents want to make the right decision, in part because (in Western culture) parents fear, not only judgement from their child (in the future), but social opprobrium if others perceive their decision to be wrong (Ramaekers & Suissa, 2011). Parents of children and young people with variations in sex characteristics must navigate these decisions in a culture that privileges those whose bodies align with the sex binary, ablebodiedness and heterosexuality. In this context, particular measures are needed to protect young people's consent and bodily integrity and to uphold parents' right to a supportive parenting environment.

Our analysis draws out distinct ways of thinking about childhood gonadectomy. These ways of thinking are embedded and located in the context of parents' bearing great responsibility. Some ways of thinking prioritise consent and bodily integrity, while others compromise these principles. These ways of thinking have broader implications for examining power, intersectional identities, and social justice, which are all foundational for reproductive justice. Table 1 sets out the reasoning that appears in our data and illustrates how that reasoning has implications for core principles in reproductive justice.

Table 1. Reproductive (In)Justice, Consent and Bodily Integrity

Promoting reproductive justice principles	• Wanting the child to be empowered to decide for themselves when they are old enough. • Striving to enable "quasi-normal puberty." • Exposing the child to respectful understandings about sexuality, gender and body diversity. • Wanting bodily integrity for the child.
Compromising consent and bodily integrity	• Utilitarian (able-bodied) approach: *If it's not working, take it out.* • Body-norm (able-bodied and dyadic) focused approach: *If it shouldn't be there, remove it.* • Queer fear: *We don't want our child to be in-between.* • No choice: *We went ahead with surgery without knowing about the options.* • Under pressure: *We felt under pressure to agree to surgery.*

The italicised phrases paraphrase data excerpts from this study.

The logic presented here is not novel—these arguments have long underpinned surgery on intersex children. Challenging this logic is central to seeking reproductive justice for children and young people living with variations in sex characteristics.

The current study raises questions about how we generally frame and respond to reproductive (in)justice issues. Understanding how gonads are positioned as dysfunctional for some people with variations has ramifications for how we think about other populations (for example, people with reproductive organ cancer, those experiencing menopause or infertility, and those who choose never to have children). Our analysis contributes to conversations about how to see people's bodies beyond their ability to procreate: gonads have meanings and functions beyond reproduction. Such discussions could destabilise the normative utilitarian able-bodied approaches we found in our data and disrupt the enforced sex binary (Orr, 2022). A reproductive justice approach to children and young people with variations in sex characteristics—such as that demonstrated by some of the parents we interviewed—would centre bodily integrity no matter the (dys)function and variation.

Our analysis demonstrates that issues of consent are bound up with complex and layered issues of power. Parents sometimes felt they had no choice and were pressured to consent to gonadectomy. Parents sometimes made hasty decisions about gonadectomy not just because of medicalised understandings about bodies but also a sense of queer fear. Parents need to be given space, conversational opportunities with co-explorations of understandings and time to move beyond these limiting framings *and* support their children so that they can make their own healthcare decisions when they are able to. Helping professionals such as social workers, and psychologists can assist parents to: 1) advocate for bodily integrity for their child; 2) question and potentially resist biomedicalised approaches; and 3) question their assumptions about their child's gender, fertility and variation. Such professionals can help define and demarcate a supportive environment for parenting—a fundamental principle of reproductive justice. (For guidance on this kind of psychosocial care, see[6].)

Conclusion: cripping and queering reproductive justice for all

Hegemonic sex binary and ableist discourses may support popular belief about the easy expendability of body parts that do not work as expected and dominate in medical settings—not only regarding variations in sex characteristics. The current study critically investigates the logic around childhood gonadectomy. We use crip and queer theory alongside a reproductive justice lens to show how young people's consent and bodily integrity are compromised in relation to gonadal variation.

Along with other authors (George, 2020; Orr, 2022; Price, 2017), we conclude that understanding of reproductive justice is enriched by crip and queer theory. In particular, we agree with George (2020) that "queer medical decision-making issues provide a clear opportunity from which the reproductive justice movement can build" (p. 702). Our analysis helps further understand coalitional opportunities between crip, queer and reproductive justice theories. We hope this analysis starts a conversation about centring reproductive justice for those with variations in sex characteristics that moves beyond the binary sex norms implied by discussions of pregnancy and ART *and* contributes more generally to conversations about reproductive justice.

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Notes

1. For an explanation of this term, see: https://www.intersexaotearoa.org/ira-tangata
2. For good resources describing variations more fully, see: https://ihra.org.au/18106/what-is-intersex/
3. Young people from North America https://www.facebook.com/watch/?v=10154742737199605, Europe https://interactadvocates.org/i-discovered-im-intersex-from-the-buzzfeed-video/ and Aotearoa New Zealand https://www.renews.co.nz/im-intersex-and-i-wish-doctors-had-left-my-body-alone/ have posted online about their concerns in order to raise awareness.
4. For more reporting of the SENS project, see:
   - **a.** Hegarty, P., Prandelli, M., Lundberg, T., Liao, L.-M., Creighton, S., & Roen, K. (2021). Drawing the line between essential and non-essential interventions on intersex characteristics with European healthcare professionals. *Review of General Psychology*, *25*(1), 101–114. https://doi.org/10.1177/1089268020963622
   - **b.** Joy, E., Lundberg, T., & Roen, K. (2023). Experiencing "the wrong kind of puberty": Navigating teenage years with a variation in sex characteristics. *Youth*, *3*(1), 465–476. https://doi.org/10.3390/youth3010032
   - **c.** Liao, L.-M., Hegarty, P., Creighton, S., Lundberg, T., & Roen, K. (2019). Clitoral surgery on minors: An interview study with clinical experts of differences of sex development. *BMJ Open*, *9*(6), e025821. https://doi.org10.1136/bmjopen-2018-025821
   - **d.** Lundberg, T., Dønåsen, I., Hegarty, P., & Roen, K. (2019). Moving intersex/DSD rights and care forward: Lay understandings of common dilemmas. *Journal of Social and Political Psychology*, *7*(1), 354–377. https:/doi.org/10.5964/jspp.v7i1.1012
   - **e.** Lundberg, T., Roen, K., Kraft, C., & Hegarty, P. (2021). How young people talk about their variations in sex characteristics: Making the topic of intersex talkable via sex education. *Sex Education*, 1–16. https://doi.org/10.1080/14681811.2021.1911796
   - **f.** Roen, K., Lundberg, T., Hegarty, P., & Liao, L. M. (2023). Whose responsibility is it to talk with children and young people about intersex/differences in sex development? Young people's, caregivers' and health professionals' perspectives *Frontiers in Urology*. https://doi.org/10.3389/fruro.2023.1089198

5. Müllerian structures might otherwise be called fallopian tubes and uterus, however Müllerian ducts develop into the vas deferens and seminal vesicles in 'male' development.
6. Guidelines can be found online, tailored for clinicians (http://www.accordalliance.org/dsdguidelines/htdocs/clinical/index.html) and for caregivers (https://dsdguidelines.org/). Resources have also been developed by community-based organisations such as dsdfamilies in the UK (https://dsdfamilies.org/resources) and InterACT in the US (https://interactadvocates.org/resources/intersex-resource-topics/intersex-health-and-sex-education-in-schools/). Intersex Human Rights Australia provides information about health, wellbeing, and peer support for intersex people (https://ihra.org.au/health/). Intersex Aotearoa offer a range of resources for raising awareness about intersex (https://www.intersexaotearoa.org/resources).

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ORIGINAL ARTICLE
THEORETICAL RESEARCH

Fighting for women's rights and promoting choice: Implications for critical social work education

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ABSTRACT

INTRODUCTION: In this article we focus on two women's movements, Abortion Rights in Australia and the Iranian women's protests, that have resisted dominant oppressive discourses and systems. These movements have pushed back on the regulation of women's bodies, choice, and reproductive rights, and are demanding social justice against violence, key areas of concern for critical social work (CSW).

METHODS: The theoretical lenses of feminist transnationalism and intersectionality will inform critical analysis based on our case studies describing activism on reproductive justice (RJ) and social justice.

FINDINGS: Both movements centre women's choice and control over their bodies—in one case, the removal of access to abortion in the USA (United States of America) has incited protests to protect women's reproductive right to choose, and in the other, Iranian women have taken to the streets to demand their rights to gender equality and protest the systematic violence against women and their bodies. Consideration of the contribution of women's activism to social work education is presented.

CONCLUSION: While these movements are not equivalent, they demonstrate political and collective activism to fight for women's right to choose. The article concludes with how social movements can help us develop strategies of hope and collective action. The pedagogy of solidarity and community of practice can amplify social work education to both reflect and encourage activism.

Keywords: Social movement; activism; feminism; transnational; intersectionality; critical social work

Gender inequality is an international issue with wide-reaching individual, political, social, and economic ramifications (Dominelli, 2002). The focus on gender equality has been the remit of international social workers for decades. Social work has highlighted how women face challenges in relation to employment and gender wage gaps, violence at both intimate and structural levels, and denial of basic education and health care, among other issues. Women's movements transcend national borders and show that collective feminist solidarity is required to promote long-lasting change. The achievements by women and feminists have informed policy and practice and are manifest across a range of disciplines including health, education, economics,

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politics, social work, law, and international relations.

As social work educators, we challenge key dominant discourses in society that continue to impact women including patriarchy, theocracy, and neoliberalism, among others. These narratives have shaped social work practice, policy, and research in recent decades. Much of the language used in neoliberalism refers to individualism and dominant political and economic discourses to justify the changes to facilitate efficacy and standardisation in micro-level establishment social work (Garrett, 2018). However, we believe that consideration of the macro lens is vital, in addition to the micro and meso levels, to critical social work (CSW) pedagogy. Social justice is a central principle of social work as evidenced in the International Federation of Social Work (IFSW) definition, and CSW challenges gender and structural inequality and addresses human rights through collective social movements and action at all levels.

This article presents two current social movements initiated by women to defend women's freedom of choice over their bodies and lives to achieve gender justice. We draw on feminist frameworks to examine the long-standing social activism to protect Abortion Rights in Australia, and the Iranian women's movement (September 2022–present). We want to acknowledge the participation of transgender people and people with fluid gender identities to the women's and other social movements and policy advocacy; however, including this history is beyond the scope of this paper.

The key three pillars of reproductive justice (RJ) include the right to have a child, to not have a child, and to parent a child in a safe and healthy environment (Beddoe, 2022; Hyatt et al., 2022; Lavalette et al., 2022; Ross, 2006). These conditions are framed as both structural and personal conditions, impacting women's ability to choose, and to counter oppression and neoliberal assaults on women's agency in relation to surveillance and control of them and their communities. We highlight and reflect on our lived experiences in the case studies of working in abortion services, advocacy for women's rights and choice, and supporting the women of Iran to exercise choice and freedom over their bodies.

We outline the conceptual frameworks we have drawn on that inform CSW and feminist practice including transnational and intersectional approaches, RJ, and women's rights. We then apply these to the two case studies of social movements noted above, both of which have pushed back on the regulation of women's bodies, reproductive rights and demands for social justice against violence, which are key areas of concern for CSW.

Background

CSW education, social movements and activism, and neoliberalism

CSW emerged in the 1970s, particularly in the United Kingdom (UK) and North America. The radical social work critique of social work and welfare, predominantly about social control of working classes and women, was built on previous activism by union members, suffragettes, civil rights activists and others throughout history (Bailey & Brake, 1975). In Australia, these same issues and debates on women's rights, workers' rights and conditions, and challenges to authority were emerging. The emergence of activism and radical social work in Australia can be traced to the introduction of progressive social policy and widespread social movements addressing health, education, and housing in the 1970s (Mendes, 2017).

CSW has the remit to offer resistance, lead, and promote social movements at all levels (micro, meso and macro), and critical pedagogy can prepare future social workers to highlight the extent and breadth of change required in activism within their organisations and social structures. Social movements and activism can play a critical role in organising and amplifying collective action for people's emancipation on a macro level (Garrett, 2018). Historically, social workers were strongly involved with activism internationally. For example, Noble et al. (2017) presented a collection of stories tracing the historical development of CSW education and activism in Australia. Their experiences indicated collective action and innovative approaches to social work were built on the social movements against racism (Aboriginal and Torres Strait Islander activism), feminist movements (women's activism on childcare, equal pay, violence, sexual assault, reproductive rights among others), ecological/Green movements (campaigns against deforestation and dams, protection of all species and animals), international development (support for refugees, independence movements across the world), and Lesbian, Gay, Bisexual, Trans, Intersex, Plus (LGBTQI+) activism for equal rights (marriage equality, rights and visibility). In addition, Zaleski et al. (2020) provided many examples of activism in social spaces in the international context. The central principles underpinning these social movements are human rights and social justice, the re-distribution of wealth and the promotion of peace and climate justice, which are aligned with CSW values.

As noted above, collective action is not new in CSW, which inherently has a progressive role that acts against inequality, injustice and oppression (Afrouz, 2022; Noble, 2007). Yet there is debate about social workers role in engaging with social movements and radical community development (Westoby et al., 2019). Neoliberal approaches dominate and underpin many mainstream and government-funded organisations with their emphasis on individualism and micro level modes of service delivery (Morley et al., 2019). We argue that neoliberalism results in significant challenges for collective action and social workers' activism which entails a shift from focusing on individual pathology to social reform within (or against) social structures and promoting egalitarian practices.

Noble et al. (2017) argued that increased social inequality and instability require social workers' radical activism. Noble (2007) identified four levels of action: substructural levels (dominant ideology); social systems and social arrangements level; social relations and everyday activities; and transnational relations. Social movements are located in personal, local and transnational contexts and are framed within "contemporary citizenship" (Noble, 2007, p. 98). This is intertwined with social media, particularly with increased global connectivity and opportunities for solidarity.

The inclusion of feminist principles into organisations and the achievements of women's health centres, centres against sexual assault, and family violence agencies all have a legacy of activist and collective action taken by those women forging new approaches to social work (Noble et al., 2017). Dominelli (2002) elaborated on the origins of feminist social work including liberal, radical, socialist, Black, anti-racist and post-modernist feminisms which form the basis of CSW. Her key messages are about promoting hope, transformative change, social justice, and human rights. The goal of CSW is emancipation from all forms of oppression, marginalisation, and exploitation. The fourth wave of feminism in the 1990s has been strongly associated with intersectionality and addressing issues of exclusion felt by many, including women of colour, younger women, and the LGBTQI+ communities (see Collins, 2019; Crenshaw, 1991; Phillips, 2022).

Intersectionality, transnationalism, and gender justice

Intersectionality "refers to the interaction between gender, race and other categories of difference in individual lives, social practices, institutional arrangements and cultural ideologies and the outcomes of these interactions in terms of power"

(Davis, 2008, p. 68). The term was first coined by Black scholar Kimberlé Crenshaw (1989) and further developed by other Black feminist scholars (e.g., bell hooks) to challenge the conceptual limitation of a single-issue analysis and has since been embraced by scholars across disciplines to advance social justice (Moradi & Grzanka, 2017). Within new women-led movements, intersectionality can help us identify and acknowledge differences among individuals, groups and communities that impact their access to services and power. Goethals et al. (2015, p. 229) noted that intersectionality seeks to illuminate various interacting factors that affect human lives and to identify how these different systemic conditions vary in place, time, and circumstance and intersect to reproduce conditions of inequality. For instance, intersectionality underpins the RJ movement, which aims to remove health inequalities and promote reproductive freedom (Ross, 2006). Hyatt et al. (2022, p. 37) noted that the RJ framework is focused on access to health care and resources, and the centring of the collective experiences of Black, Indigenous, and People of Colour (BIPOC), LGBTQIA +, people with disabilities, and people who are marginalized and disenfranchised. There have, however, been critiques made by queer scholars that the RJ movement has not been inclusive enough of queer needs and rights (see George, 2019).

Increasingly, feminist scholars are highlighting the connection between countries and movements across time and place, as modes of communication become accessible via digital platforms and social media (Turley & Fisher, 2018). The transnational feminist theoretical framework can help feminist social work to enrich its active role in social movements. Within a transnational lens, those issues are now recognised as interconnected violations of women's rights, with gender as a key factor continuing to be at the root of women's oppression. This framework helps us address key areas of concern facing women internationally and how galvanising collective solidarity is motivating this activism. Transnational feminism, with a focus on intersectionality (Crenshaw, 1989), and the emphasis on differences and diverse experiences of women and resistance (Zerbe Enns et al., 2021), aims to promote collaboration and solidarity across borders. This approach has particularly been developed to move away from the narrow confines of nation-states and shift the Global North focus of international solidarity. Mohanty (2004) claimed that solidarity can involve mutuality, accountability, and empowerment in the international context. Yet, the challenge for activists in this context is to focus on the local issues affecting them and their communities while also seeing the broader connections to international structures, such as capitalism and patriarchy, as they affect *all* women.

Fighting for "choice" in two social movements

Challenges and backlash against women's rights and women's resistance and freedom of choice continue to impact gender equality and the 21st century's shape of interpersonal violence (Zaleski et al., 2020). While the substantive issues in the global context seem overwhelming, ranging from environmental degradation, forced marriage, torture and trauma, rape, and sexual assault as weapons of war, and various forms of misogyny in social media and public life, the message of activism is still hopeful and progressive.

The following section will illustrate two social movements in which the authors are actively involved in addressing gender injustice and the violation of women's rights and freedom of choice.

Case Study One: Women's bodies, freedom, and choice

Iranian women's movement (September 2022-present) Rojan Afrouz

I am a Kurdish-Iranian Australian woman and social work academic living in Australia since 2015. Like many women activists, I have demanded a structural change in gender equality and gender justice in Iran since I was a social work student. Yet, the Iranian political system has shown no significant change or reform and has continued to implement discriminatory laws and systematic violence against women (Sadeghi, 2022; Sanasarian, 1982).

The women's movement in Iran has a long history, but the current unique women-led movement was sparked by the death in the so-called "morality police's" custody of a 22-year-old Kurdish woman, Jina (Mahsa) Amini, on 16 September 2022, after allegedly being assaulted due to wearing a loose hijab. Although protests began with people's anger against the morality police, the demands of protesters shifted to the broader issues relating to women's rights, women's autonomy, and freedom of choice. The feature of this movement is centring on women's rights and freedom of choice with the slogan "Woman, Life, Freedom." This slogan is from the Kurdish slogan "Jin, Jiyan, Azadi", popularised by Abdullah Öcalan, a Kurdish political leader, to centre women's rights and women's liberation at the forefront of people's liberation and systematic change (see Neven & Schäfers, 2017).

Historically, religious autocracy, political systems, and patriarchy have violated women's rights over their bodies in Iran. Some traditional and religious interpretations of women as sexually dangerous and seductive resulted in regulating women's bodies through clothing, veiling and gender segregation (Fathzadeh, 2022). Following the Iranian Constitutional Revolution (1905 and 1911), progressive activists, women's organisations, constitutionalist press, and poets have pioneered the discussion on women's rights and liberation (Amanat, 2017). However, in contemporary Iran and particularly within the last two political periods, veiling and unveiling have become a political decision, becoming tools of "a technology of power" to regulate women's bodies (Fathzadeh, 2022, p. 4).

The Modernisation and Westernisation project by Reza Shah enforced the Kashf-e hijab (unveiling) in 1936–1941 and introduced a compulsory unveiling policy to remove any symbol of the veil and hijab in public (Amanat, 2017). As a result, some groups of women, particularly those from more religious backgrounds, chose (or were forced to by their families) to stay home until the rules were eased in 1941. Following the Islamic Revolution in 1979, compulsory hijab was imposed, and new restrictions were introduced against women's activities (for example banning singing, dancing, cycling) and accessing abortion. In particular, women's veiling has become a part of the national identity imposed by the authoritarian regime (Chen, 2022). Currently, in addition to mandatory hijab in Iran, women's word in court is worth half that of a male counterpart, and they might be in an arranged marriage as young as 13 (Mohammadi, 2022). There are also other discriminatory laws against women, such as Marriage Guardianship, as a "virgin" girl or woman requires the permission of the father (or paternal grandfather) to get married, and a wife must obey a husband under Tamkin (sexual obedience). Following the Islamic Revolution, Iran recognised Sharia law as a base for Iran's jurisdiction system as a mechanism of control by the government and religious systems to impose power and suppress women's agency, gender equality and full participation in society. While the central focus of the women's movement is freedom of choice and control over the body, the discussion about the bigger picture of women's rights is yet to be fully embraced by the leadership.

The women-led movement has also prompted a backlash against the centrality of gender equality and women's rights, with some claiming that demands are more than gender equality now. While the centrality of women's voices and demands looked promising, there is uncertainty within this movement as the narrative of regime change in Iran is increasingly overshadowing women's voices and centrality within the movement. Although the slogan "woman, life, freedom" is still loud and clear and is widely accepted, some groups and opposition leaders, particularly monarchists (Reza Shah's grandson's supporters), have actively tried to remove gender centrality from the movement. Bhattacharjya et al. (2013) argued that, even if women are active in mobilising a social movement, gender justice and women's rights might not be recognised as priorities within the movement. Iranian women now face significant challenges to maintaining activism and advocating for women's rights to maintain the centrality of women's voices and their demands in this movement. In addition, women's contribution to leading this movement has been significantly impacted by the patriarchal domination of, and the brutal response by, the regime, as women have been subjected to torture, sexual assaults, and rape while in custody (Qiblawi et al., 2022). At the same time, women, including myself, have been subjected to online bullying and harassment in online environments from regime and anti-regime supporters due to advocacy for women's rights.

Thus, 10 months after the beginning of the movement, we face challenges and uncertainties about this social movement moving forward. Indeed, social justice within social movements can be long and difficult, and backlash is real, even though the movement identifies itself with the slogan "Woman, Life, Freedom".

Case Study Two

Women's bodies, freedom, and choice Abortion Rights Kim Robinson

As a newly graduated social worker in the late 1980s, I was excited to work in a Women's Hospital in central Melbourne, in the State of Victoria, Australia, providing support to women who requested a termination of pregnancy in the public health care system. The Pregnancy Advisory Service (PAS) was available to women via referral from their General Practitioner (GP) and they could see the doctor and/or a social worker if they wanted to discuss any issues related to their health and decision. There was a diverse range of older women, young women, and everyone in between, from all levels of society. Many of their stories stay with me, and their decision-making processes were often influenced by religion, economics, and their personal relationships. Invariably, women knew what they wanted to do, and our role was to provide them with a non-judgemental space to reflect on their decision. The women's health movement has a long history of promoting social equality and justice, and I felt proud to be a member, having regularly attended protests and worked as a volunteer in a support service for women leaving violent partners.

One of the most challenging parts of my job was walking through the lines of protestors at the hospital, bearing placards with blood, foetuses, proclamations of murderer, hell, and damnation, frightening all the women who entered. Women were often frightened when they came to see us, intimidated by the protestors, despite feeling confident about their decisions. In 1992, the Royal Women's Hospital successfully sought a permanent injunction against Right to Life Victoria, requiring them to protest across the road and not harass women and staff members. However, the fear of violence was always present in passing these anti-abortion protesters—and I do purposely not call them "right to lifers". In 2015, Victoria joined a range of States enacting Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015 (Vic). Since this time, I have continued to be active in women's health, regularly going on marches and rallies to support abortion rights and women's right to live free of violence in "Reclaim the Night", a march for women's safety in public spaces (see Hinman, 2018), and other events, along with being active in my social work roles. I have also contributed to research and policy-making on the issues of supporting women to live lives free from violence, and their right to choose.

Feminists have been advocating the issues relating to women's reproductive right to choose and access to safe abortion for decades. The landmark case in the USA in 1973, *Roe v. Wade*, supported the rights of women to gain access to a medical termination of pregnancy (abortion) was conferred by the US (United States) Supreme Court. This enabled women to exercise choice over their body and make independent reproductive decisions, albeit in the context of socioeconomic status and ethnic background. Australia looked towards the USA for inspiration in the women's health movement and historian Baird (2022) clearly documents the key role feminists have taken in promoting change and supporting the women's health movement in Australia. This is not without its challenges as the anti-abortion lobby has continued to be vociferous in their opposition to women's right to choose and, in 2011, killed a security officer guarding a clinic in Melbourne. Sifris et al. (2020) documented and analysed the legal and social implications of the safe access zones and legislative protection for women. They highlight the range of tactics used by those who confuse a foetus with a baby, and attack women who are terminating their pregnancy. The Victorian Act prohibits behaviour such as harassing or intimidating persons accessing a clinic; communicating in relation to abortions in a manner likely to cause distress or anxiety; interfering with access and recording a person accessing a clinic (See the Public Health and Wellbeing Act 2008 ss 185B(1)(a)–(e) (definition of "prohibited behaviour") (Victoria Government, 2008).

Events in 2022 in the USA have highlighted the fragility of the gains won by the feminist movements over decades when *Roe v. Wade* was overturned (United Nations, 2022).

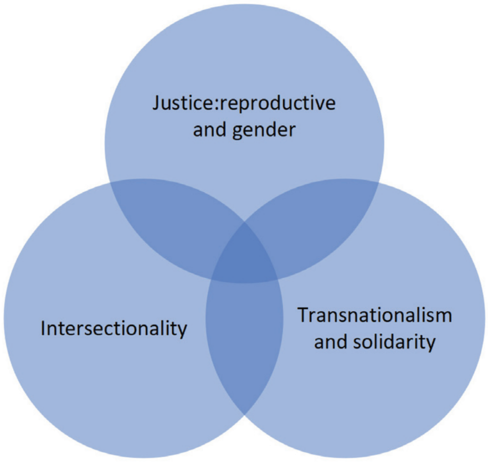

Figure 1: Three Dimensions of Feminist Analytical Frame

Women, allied health workers, counsellors including social workers, nurses and doctors face prison sentences for accessing and providing services, and women's health clinics have been forced to close (Lavalette et al., 2022). The United Nations denounced the decision as a "shocking and dangerous rollback of human rights that will jeopardize women's health and lives" (United Nations, 2022, para. 2). Recently, in Australia, there has been debate about the use of and access to non-surgical abortions, critical issues for women living in rural and remote communities. These are key concerns for CSW.

We draw on the three domains for the feminist analysis of the two social movements: justice: reproductive and gender; intersectionality; and transnationalism and solidarity, to assist us in analysing the similarities embedded in our case studies (see Figure 1). These dimensions provide lenses through which we can frame, interpret, and analyse the context of activism within the two social movements we have described. Moreover, they enable us to develop core values and principles of activism, through which we can articulate and provide recommendations for CSW education in the following section.

Justice: reproductive and gender

Gender justice can be achieved through transforming norms and legislation to maintain gender equality (Kabeer, 2012). Both movements discussed earlier aim to achieve gender justice via collective actions by centring on women's choice and autonomy about their bodies and their lives. However, we have elaborated on how patriarchal structures underpinning religious, cultural, and political institutions violated gender justice, freedom of choice, and access to reproductive health. In Iran, in addition to being forced to wear a hijab and the violation of women's rights to choose, women's contributions to social, economic, and political positions are controlled by the government through discriminatory laws and regulations and structural inequality. While the majority of university graduates are female in Iran, their labour force share is around 19% (Moghadam, 2018). Women who challenge the controls will be labelled deviant as a mechanism to suppress their voices (Sadeghi, 2022). As such, Iranian women are subjected to violence when they raise their voices against gender inequality and oppression. Those patriarchal constraints consistently target women's agency and decision-making in their everyday lives, making gender justice less achievable.

The violation of women's rights can be a serious obstacle to RJ. For example, The Turnaway Study (Foster, 2021) is a US-based prospective longitudinal study examining the effects of unwanted pregnancy on women's lives to describe the mental and physical health, and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term. They found that receiving an abortion does not harm the health and well-being of women, but in fact, being denied an abortion results in worse financial, health and family outcomes for them (Foster, 2021, pp. 21–22). As such, women who were prevented or denied access to an abortion were also more likely to stay with a violent partner and it creates economic hardship and insecurity that lasts for years. The results of the study (Foster, 2021) may be applicable to the lived experience of women internationally.

Thus, both social movements' emphasis on women's control over their bodies demonstrates how upholding a gendered lens and RJ can contribute to ending discrimination against women.

Transnational solidarity

Feminists' solidarity is central to many women-led movements. hooks (2014) highlighted the importance of "sisterhood" in feminist movements as a united front that can sustain the power of solidarity. Women activists from international communities must overcome the "alienation" of differences and acknowledge various oppressive factors that impact women's lives worldwide. Drawn from hooks' (2014) ideas of solidarity, we need to continue to build an international community of practice, shared goals, and an inclusive agenda to build alliances in the international context.

Through international collaboration and the transnational feminist framework, we can develop active solidarity and allyship to support women's movements in different contexts and share our experiences in fighting against gender inequality. So, while there is a risk of polarising debates and backlash, there is considerable support for these feminist movements through public rallies and online activities. We have seen high levels of activism in response to the overturned decision of *Roe v. Wade* in the USA by the international community. Gynecology Centres Australia (2022), a major provider of abortion services across Australia, notes that only with a minority exception, Australians worldwide and at home are appalled by the *Roe v. Wade* overturned ruling by the US Supreme Court. They cite the Human Rights Law Centre (HRLC): "devastating … highlights need for vigilance … abortion is healthcare. Access to abortion is a human right…" (n.p.).

Figure 2: Abortion Placard
Note. Photograph by Kim Robinson (July 2022).

Figure 3: Protest Image: Rojan Afrouz
Note. Rojan Afrouz (Translation: woman, life, freedom, solidarity with Iranian women from Greek Australians, October 2022).

Iranian women's voices have been raised with international support and solidarity, although Iranian activists believe that more could be done to support them and take action against the regime. Importantly, promoting Iranian women's voices from a Global South or a non-Western society could be an opportunity to achieve transnational feminists' goals, through which we can shift our focus from Western, wealthy, and colonial dominance to developing allyship with seldom heard nations and women (Zerbe Enns et al., 2021). As such, developing solidarity needs a deep understanding of the unique features of each movement, as the Iranian women's movement has unique characteristics based on its context of a Muslim-majority country. However, while RJ and women's rights to control their bodies and gender justice are experienced differently within various nations and countries, sharing strategies, and building solidarity can equip the women's movement to be stronger in their fight against gender injustice. To this end, online platforms and social media activism can broadly facilitate sisterhood and solidarity.

Intersectionality

It is also crucial to highlight the intersection of different forms of oppression and discrimination, leading to unique experiences of gender inequality in both movements. The intersections of race, sexual orientation, disability, class, and religion, among women can shape women's different experiences and exacerbate their experiences of oppression (Crenshaw, 1991). As such, Iranian women are diverse given their different social locations, socioeconomic status, and ethnic backgrounds and therefore experience oppression differently. Specifically, Baloch and Kurdish women's voices and lived experiences were not fully included in the major Persian media platforms outside Iran. At the same time, Kurdistan's major parties are mainly led by men and have not been inclusive to Kurdish women (see Boochani, 2023).

Likewise, women's experiences of RJ reflect the intersectionality of different experiences, as those from lower economic and social status and women from Black and ethnic minorities have limited access to health services and other social support. With the closure of abortion services, these women do not have the resources to travel interstate or abroad to have an abortion. This results in increasing numbers of "backstreet" abortions, including the deaths of women and often long-term injuries (Foster, 2021). While abortion is legal in Australia, the issue of accessibility and availability of abortion services, particularly for First Nations women, has remained an issue (Baird, 2022). Thus, extending access like other countries such as Sweden and Ireland where abortion is widely available at no cost, would mitigate these risks.

The intersectional analysis helps us contemplate a nuanced and inclusive approach to understand and address multiple forms of discrimination against women. The following will present recommendations to include social movements in CSW education to build on progressive, inclusive, and collective practices.

Including activism in CSW education

In this section, we argue that we can incorporate activism into the social work curriculum despite the demands and challenges we discussed within our case studies.

1. Educating for collective action in social work

Community development principles underpin much of social work in macro and meso settings to address structural inequality and gender discrimination, and promoting this in our teaching and learning, and fieldwork education is key. Social work education can utilise expertise and knowledge of previous social work colleagues in promoting collegial practice and research together. Social work has a long history of working in partnership across sectors and with communities, and with other disciplines, so developing strategies that support this practice is key to encouraging new graduates.

Creating a "community of practice" and connecting local practice to social movement strategies (Westoby et al., 2019) are ways of promoting collective action for women-led movements. Encouraging students to be more active in their communities and to focus on concerns key to them, such as gender equality and reproductive injustice, and being part of a larger voice are key to promoting change. Freire argued that critical pedagogy requires praxis, linking classroom activity with actual social movements (cited in Mayo, 1993), and we extend this argument to CSW activism and a focus on the analysis of power. Inviting students to engage in marches that we attend for International Women's Day, LGBTQI+ Pride events, and other movements are central to developing a community of practice. The following are a few examples of promoting activism in our teaching:

- adding and promoting information to digital teaching platforms and sites about events and collective actions;
- photos of SW academics and students together at events;
- creating relevant assessment tasks; for example, writing submissions to Royal Commissions/Briefing papers that advocate/align/and are in partnership with people with lived experience and on specific social issues (both authors use these assessment tasks in our teaching);
- online activism.

Nevertheless, we cannot advocate that activism is risk-free, and it is important to note that there are challenges for women being active, particularly in the online space (Afrouz, 2021). For instance, social media can increase our capacity to communicate, but it has also ushered in greater surveillance and backlash—as Ife (2017, p. 345) noted, "control of activism by the state and by other powerful coercive interests, globally, nationally and locally". Discussing safety and taking steps to protect the identity of activists is also crucial, as we (both authors) share how we maintain our safety in these two movements with students. Choudry (2020, p. 32) noted that all education, and human activity, is political and quoted British feminist educator Jane Thompson who argued, "Social change, liberation ... will be achieved only by collective as distinct to individual responses to oppression" (1983,170). Nevertheless, as educators we acknowledge the diverse views of students towards RJ, including transgender people, and the importance of developing respectful and safe social work practice in the future.

2. Pedagogy of solidarity

Creating a space for advocacy, allyship, and solidarity while looking at global women's movements is an important part of feminist social work. The goal of solidarity in social work education must be with an understanding of allyship and collaboration for social justice, relationships, ethical commitments and reciprocity, and transformative change (Gaztambide-Fernández et al., 2022). Gaztambide-Fernández et al. (2022) contended that our curriculum of solidarity should indicate that we are not alone; rather, our solidarity with people is relational. We can work alongside our social work students in seeking to transform the knowledge of solidarity and centre gender diversity and women based on our own experiences of being active in those movements. This will help social work students understand how to build a bridge between the academy and community and more importantly, that we as educators, should actively "dismantle the neoliberal, individualist, and competitive structures of academia" (Gaztambide-Fernández et al., 2022, p. 259).

3. Critical reflection and analysis

One strategy for teaching CSW is to use critical reflection to explore students' own position within international context of women's rights. Social work has key writers in this space of critical reflection across a range of areas of practice, and centres the need to unpack power, particularly as it relates to broad structural inequality (Béres & Fook, 2019; Mattsson, 2014; Morley & Macfarlane, 2014; Noble et al., 2016). Beddoe (2019, p. 106) argued that the importance of critical analysis is to equip "graduates with well-developed critical lenses to aid their thinking about the discourses of welfare that will impact on so much of their practice". Resistance and backlash are always a part of social change; they can be formal or informal and they can be diverse for all genders (Flood et al., 2021). Supporting students to "speak back to power" on these issues is part of our role as educators particularly in the RJ and women's rights space. As educators, it is central to our work to facilitate this process and support students both on placement and social work courses who confront right-wing, misogynist, and racist views.

4. Addressing neoliberalism

The neoliberal discourse of individual rights and action can play a significant role against collective action, particularly in the women's movement (Flood et al., 2021). Neoliberalism is one of the key challenges in CSW practice, policy, and research (Morley et al., 2019). It promotes individual responsibility over collective responsibility and tends to denigrate people on low incomes or living with disability (Garrett 2018), particularly women of colour, and especially Indigenous women in Australia and Māori in Aotearoa New Zealand. Neoliberalism favours the exercise of power and freedom to gain profit for self instead of collective actions to achieve universal women's rights (Chen, 2013). Social work students in Australia need to understand the nuances of neoliberalism, and acknowledge the international impact of religious autocracy, totalitarian regimes, and of both dictatorial and unstable government on women.

We need to draw on the examples of others who have gone before us, and to learn the lessons about the gains, while also addressing neoliberalism within social work organisations. Activist critical social workers are listeners, facilitators, allies, and advocates and can promote the voices of grassroots movements through their advocacy and online activism (Morley et al., 2019).

Limitations

We acknowledge that this is a piece of critical reflection, and it is not a scoping review or a systematic review of the literature. In addition, these social movements are very fluid and constantly changing, so what has been written here may change and be different at time of publication.

Conclusion

Activism and engagement with social movements are central to CSW and action for social justice. We provided two case studies of women-led movements, which centre on gender justice, freedom of choice and women's agency to control their bodies. Although the contexts of the two movements differ, we have integrated transnationalism, gender and RJ and intersectionality into our feminist analysis to develop international solidarity, centring gender justice and making the movements inclusive to all women. CSW education can integrate collective action and the pedagogy of solidarity and challenge the neoliberal agenda of social work education and practice that leaves little room for activism and collective effort for change. Social work should maintain its critical legacy and continue allyship with social movements to achieve social justice and social change. To this end, social work education can reflect collective action in social movements and continue to build and develop confidence and skills in social work pedagogy.

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Abortion counselling controversies and the precarious role of social work: Research and reflections from Aotearoa New Zealand

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ABSTRACT

INTRODUCTION: This article presents debates and controversies about counselling within abortion provision in Aotearoa New Zealand. Formal and informal counselling networks are described, where the role of social workers as providers of counselling services is precarious. Insights consider how service users may be more holistically supported when accessing abortion care.

METHODS: Drawing on findings from a broader qualitative research project involving 52 participant interviews, formal and informal observation of practices, and analysis of service documentation, the concept of boundary objects by Star and Griesemer (1989) is taken up to account for diverse abortion counselling practices that occur in multiple but connected social worlds. Revisiting these findings in the context of current abortion legislation and developments, a Reproductive Justice (RJ) lens is used to inform the implications for service users and social work practice.

FINDINGS: Past and present efforts within legislation, policy, and practice guidelines to standardise abortion counselling have not prevented different versions of counselling from being enacted by social workers, counsellors, nurses, medical practitioners, staff of community agencies, and crisis pregnancy services. This has resulted in the practice and the term *counselling* being contested. Participant accounts and observations revealed that multiple disciplines offer counselling practices while social work remains poorly integrated into service provision.

CONCLUSION: This article employs the concept of boundary objects to account for how variations of counselling have been enacted and disputed. The addition of a reproductive justice (RJ) lens with its attention to social justice is used to appreciate recent advances in access to abortion services alongside arguing for enriched care practices and the value of social work in supporting the integrated well-being and agency of service users.

Keywords: Abortion counselling; social work; controversy; boundary object

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The social work profession has contributed to counselling services in abortion provision in Aotearoa New Zealand for some time. However, counselling is an unregulated space and its presence as part of service delivery is precarious. The term *counselling* is a substitute for a diverse range of practices undertaken by an array of practitioners and lay counsellors who may not have a mental health and well-being background or formal degree in counselling. These practitioners include trained and qualified counsellors, as well as social workers undertaking counselling roles, medical professionals, community-based persons, and laypersons who enact their versions of the counselling. This article accounts for variances in what counselling is, how counselling is included in abortion service provision and the counselling-related practices that sit outside of this structured context. Contextual information follows concerning abortion legalisation and counselling requirements in Aotearoa New Zealand, and the social work and counselling role in abortion provision.

Abortion legislation and counselling requirements in Aotearoa New Zealand

Prior to the Abortion Legislation Act 2020, abortion regulation in Aotearoa New Zealand required that a woman must see two certifying consultants in order to access an abortion subject to legal grounds described in the Contraception, Sterilisation and Abortion Act 1977, and in section 187A of the Crimes Act including: serious risk to physical and mental health. The grounds for abortion were complex and subject to a degree of interpretation, where certifying consultants were required to make a judgment about access and the requests for services (Basset, 2001; Dixon, 2012). Most abortions, 97% from 2019 records, were performed on mental health grounds (Abortion Supervisory Committee [ASC], 2020). A referral from a general practitioner, blood test and swab results, and an ultrasound reading were typically required prior to the first appointment with a certifying consultant.

Concerning counselling, licensed providers of abortion services were required to advise women of the right to participate in counselling under Section 35 the Contraception, Sterilisation and Abortion Act 1977. Under Section 31 of this Act, it was the role of the Abortion Supervisory Committee to ensure access to counselling services that met professional standards (ASC, 1998, 2018). However, the nature and extent of abortion counselling services was mutable and determined by the policies and resources of different localities. The way in which counselling was integrated into service delivery determined the extent of this work, although counselling in abortion provision should comply with the *Standards of Practice for the Provision of Counselling 1998* (ASC, 1998) and updates included in the *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* (Standards Committee, 2018). According to these *Standards of Practice* (1998), counselling services should be delivered by qualified social workers and counsellors who participate in regular supervision and are affiliated with a recognised professional association, for example the Aotearoa New Zealand Association of Social Workers (ANZASW) or the New Zealand Association of Counselling (NZAC).

The Abortion Legislation Bill was passed in March 2020, removing abortion from the Crimes Act (1961). The oversight of abortion services shifted from the Ministry of Justice to the Ministry of Health (MoH). Abortion access became legislatively unrestricted in early pregnancy and services were streamlined for those seeking abortion services. The national abortion telehealth service, DECIDE, was initiated in November 2022 providing early medical abortion (EMA), a pill-based early abortion method via telemedicine responding to the need for improved timely and equitable access to abortion services (MoH, 2023). While service provision became more straightforward concerning a pathway of care, social support for those engaging with services remains precarious.

In the Abortion Legislation Act 2020, health practitioners must advise service users of the availability of counselling, although counselling is not a condition of service access. The *Standard for Abortion Counselling in Aotearoa New Zealand* (MoH, 2022) outlines what abortion counselling is, who can provide abortion counselling, and sets out the rights of people receiving abortion counselling (MoH, 2022). Specifically, those who provide counselling must be a supervised, qualified, and registered professional who has knowledge of this area of practice and does not hold any conscientious objection to abortion (see MoH, 2022, p. 2, and Appendix 2 for detailed information).

It is important to highlight that pre- and post-Abortion Legislation Act 2020, the translation of guiding documents into practices has not been, nor is it now, without its challenges and variations. Against the backdrop of the formal networks and guiding documents that frame the supervised, qualified and registered professionals involved in the provision of abortion counselling services, counselling is an informal and unregulated space. It is these informal practice variations within and beyond abortion provision and associated controversies that are the focal point of the research findings offered in this article.

Social work and counselling in abortion provision and beyond

Controversy about the place, presence and practices of social work and counselling as part of an abortion trajectory is longstanding and part of the politics of multidisciplinary care and social work efforts for professional inclusion (see Meadows, 2016). An ANZASW webinar by Whitcombe and Norton (2020) identified changes in the social work role following the Abortion Legislation Act 2020. They noted a reduction in the number of women engaging with social work services in the Canterbury region and raised concerns about holistic care and support for service users. The Abortion Services in Aotearoa New Zealand: Annual Report (MoH, 2023), stated that 21 of 31 abortion services provide in-house counselling while all services offer pre- and post-abortion counselling that is "generally accessible both in-person and virtually" (p. 44). There is scope to explore this further. In sanctioned settings, social workers and counsellors are involved in the provision of abortion-related counselling. The provision of counselling as part of multiskilled social work practice is a controversy in itself. In Aotearoa New Zealand, Booysen and Staniforth (2017) found that there were related and complementary practices between social work and counselling where social workers identified counselling practices as part of their work, alongside tensions concerning role boundaries between these disciplines. Indeed, as Booysen and Staniforth (2017) discussed, there is limited insight and guidance about the competency of social workers doing counselling as part of their practice. Thus, it is important to highlight the distinction between counselling as a profession and counselling as a diverse set of practices within and beyond abortion provision.

While the legitimacy of counselling as part of social work practice is complex, this complexity multiplies in abortion networks with regard to what counselling is and who provides it. Informal and unregulated counselling and support practices are also part of sanctioned service provision in intentional and ad hoc ways by medical professionals who have amalgamated counselling practices into their existing roles (Meadows, 2016). For example, Hannah et al. (2019) argued that, in women-centred abortion care, while formal counselling is valued from a nursing and midwifery perspective, providers should have the communicative capacities to engage in comprehensive "holistic dialogue" that responds to social, emotional and spiritual matters alongside clinical aspects of care (p. 5).

Outside of sanctioned settings there are multiple, competing, and contradictory ways in which counselling in abortion and pregnancy networks are practised. Varied forms of counselling are offered and provided by qualified counsellors, healthcare professionals, staff in social caring roles, and laypersons (Meadows, 2016). Community services offering counselling, information and/or support concerning pregnancy, as well as broader women's issues, also vary in their perspectives and responses to abortion. The differences concerning who performs abortion counselling and what form this takes are entry points for understanding controversies and disputes about counselling practices.

Reproductive justice

This article is anchored in the context of abortion provision including pregnancy decision-making, post-abortion counselling, and brief intervention. However, the social work and counselling input in this area of practice extends beyond this to include contraceptive matters, parenthood, support networks, issues related to interpersonal and/or structural violence, financial and practical resources, and indeed, the broad array of life challenges that people encounter. In this way, social work practice in abortion provision may be appreciated via a reproductive justice framework. Reproductive justice (RJ) has three core tenets that include: the right to have a child; the right not to have a child; and the right to nurture children in safe and healthy environments (Ross, 2007; Ross & Solinger, 2017). Further, the appreciation of social justice (Ross, 2007; Ross & Solinger, 2017) is relevant to social work and to abortion provision concerning how service users might be further empowered to navigate the conditions that impact their capacity to enact and participate in decisions about their own health care.

Related to RJ is a reproductive rights framework that advocates for the right to choose and the legal freedom to decide about one's own body. For example, The Abortion Legislation Act 2020 secured reproductive rights by shifting abortion from crime to care. However, what a rights-based framework does not attend to is that a decision to have an abortion (or pursue other reproductive trajectories) does not occur in isolation from a broader physical, social, cultural, material, and interpersonal context (see Chiweshe et al., 2017; Marecek et al., 2017). This is where a reproductive framework with its attention to social justice, (neo)colonial influences and intersectionality progresses the advancement and protection of rights by being responsive to the nuances of service users' circumstances, in particular, those most impacted by systems of oppression (Ross, 2007). As Ross (2017) stated, "the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access" (p. 4). Social work is well placed to progress RJ imperatives and continue the commitment to improving the reproductive lives of service users that a right-based approach has attained.

While this article does not go into detail about abortion counselling and social work practice with service users, the role of social work is addressed as a space for increased presence and accessibility and features in relation to RJ because of its person-in-environment approach and commitment to social justice. While there is ambivalence of social work to advocate for reproductive justice and reproductive rights (Younes et al., 2021), as Beddoe (2021) has argued, there is a need for reproductive justice to be prioritised as a key social work issue in order to address health inequalities. Reflections on the potential of an RJ lens are offered in the discussion section.

Roadmap

This article offers a specific account of how both sanctioned and informal practices of counselling were negotiated at a stand-alone South Island abortion service and beyond this setting in wider, informal, but related, networks. Understanding the controversies of abortion counselling and the contribution of social work is important for theoretical and practical reasons. First, this knowledge illuminates the relationships between disconnected practices at both local and national levels. Second, this knowledge may also support the development of care practices that respond in a holistic way to the service users who engage with abortion services.

The use of language is important to clarify. Within abortion provision the phrase "termination of pregnancy" (ToP) is common; however, as the study that this article draws from follows practices within and beyond health settings, the word *abortion* is used to reflect the combination of professional and lay language to do with abortion. For an in-depth account of language practices to do with abortion, see Meadows (2016). Further, to use inclusive language where those who have a pregnancy may not identify as woman/women, this article uses the term *service user*.

The following section considers selected literature. Then the research approach is outlined, and a description of the study is provided. The section thereafter presents a snapshot of relevant findings from research conducted before the 2020 change in legislation. The final section considers these findings in the current context and, as noted, employs a RJ lens to discuss the theoretical contributions and practical implications for social work practice and research moving forward. A case is made for reviewing the term *counselling* and its function. Further, for a proactive embedding of social work services in abortion provision as a means to enhance integrated care and culturally responsive service provision.

Literature review:

There is limited literature that specifically addresses abortion-related counselling practices in Aotearoa New Zealand (see Kirk et al., 2018). Moreover, attention to abortion controversies tends to address *the* abortion controversy or debate that relates to the moral, ethical, and legal status of elective abortion rather than a specific conceptual lens through which to follow diverse counselling practices. Selected literature considers abortion counselling controversies with an emphasis on counselling instabilities and practice variations.

The controversial status of abortion counselling and its variability are argued by Hoggart (2015) as fundamentally political and mirror political positioning about abortion and competing agendas about what service users need. This includes abortion service providers and pro-choice communities where there is a lack of consensus about the scope of abortion counselling (Hoggart, 2015).

Tensions about the place and fit of counselling in service delivery are discussed by Kirk et al. (2018) in the Aotearoa New Zealand context, in that abortion counselling may be poorly integrated into the care pathway of abortion provision. An older source but relevant argument is made by Simonds (1996) who accounts for the mismatch between the scheduling of medical aspects of abortion provision and the contrasting longer duration of counselling sessions.

Kirk et al. (2018) highlighted the variations in counselling practices and processes in abortion provision within and between different localities. These variations involve poor alignment between legislation, policies, and practice including the quality, consistency, and availability of abortion counselling services (Kirk et al., 2018). Moreover, variations concerning access to counselling, particularly access in rural localities and in addressing complex needs, are signposted in research following the Abortion Legislation Act 2020 about the skills and willingness New Zealand of clinicians to provide abortion services in primary care (Macfarlane et al., 2023).

Macfarlane et al. (2023) highlighted the important role of Te Tiriti in ensuring the rights and safety of Māori in Aotearoa in service provision. They argued that abortion care should employ an equity lens that is safe and acceptable for Māori and Pasifika people. Moreover, that care should be personalised rather than folded into a business model (Macfarlane et al., 2023). Staying with the Aotearoa New Zealand context, Le Grice (2017) discussed that for some wahine Māori, there may be a mismatch between the notion of individualised decision-making and a reproductive decision-making as nested in a wider whānau context (Le Grice, 2017). "Given the pressures Māori have faced throughout colonisation, and the impact this has had on the relationships and whanau life of many (Le Grice, 2014), centring an individual Māori woman's perspective—her vantage point, circumstances and context, desires, dreams and reasons for having an abortion in context—is crucial" (p. 157). The Standard for Abortion Counselling in Aotearoa New Zealand (MoH, 2022) locates the counselling role in response to these concerns clearly indicating the continuing presence of institutional racism, and emphasising culturally responsive practice and Te Tiriti o Waitangi obligations.

Counselling outside the provider contexts includes services by crisis pregnancy centres and/or anti-abortion pregnancy counselling services. These less regulated crisis services may be perceived as less credible by abortion providers (Allanson, 2007), and may include practices of misinformation, deception, and efforts to dissuade pregnant persons from pursuing abortion services (Bryant & Swartz, 2018; Cannold, 2002) and/or delay access to health care (Rugrum, 2022). A distinction is made here between women/person-centred community agencies and services that support pregnant persons while upholding their reproductive rights, that is, service delivery that considers a full range of choices and evidence-based information concerning a pregnancy outcome.

Mainstream healthcare sites are not excluded from anti-abortion activism and further practice variances. Mavuso et al. (2023) examined anti-abortion counselling practices in three hospitals in South Africa. These authors challenged the meagre engagement with counselling as part of the World Health Organisation's (WHO) (2015, 2019) understanding of safe and unsafe abortion. Mavuso et al. (2023) argued that the quality and safety of legal abortion services are undermined by the emotional and psychological harms that anti-abortion directive counselling can incur for service users.

Given the limited literature available and the expressions of diverse and mutable counselling arrangements, further attention to understanding the nuances of abortion counselling and responding to concerns about potential harm is needed.

Theoretical approach: Boundary objects

This analysis of counselling engages the concept of "boundary objects" (Star, 1991, 2010; Star & Griesemer, 1989) as a site of collective action that gathers together different but intersecting social worlds or mediates, as Bowker and Star (1999) discussed, "multiple communities of practice" (p. 286). To break the term down a little, the word *boundary* as Star (2010) defines it, does not refer to a border per se but to a "shared space" and "object" refers to what is enacted rather than an object in a material sense (p. 603). Star (2010) stated that "[b]oundary objects are a sort of arrangement that allows different groups to work together without consensus" (Star, 2010, p. 602). In this way, the concept of boundary objects is useful for following the counselling that is connected to abortion provision and its differences.

Given that different groups may each hold and retain their own representations of an object, counselling can be treated as a boundary object that connects diverse actors (social workers, nurses, doctors, crisis pregnancy counsellors, and feminist health agencies) despite their differences in practices and perspectives. The insights of boundary objects allow various and but related counselling arrangements in abortion provision and different but connected counselling practices enacted in the abortion and pregnancy networks beyond service provision to be considered together. This approach allows a move beyond abortion pro-life and pro-choice dichotomies, and beyond the boundaries of the social work discipline to trace and account for diverse counselling practices that emerge in and through broader abortion networks.

The study

I had been employed at Lyndhurst, a first-trimester, stand-alone abortion service in Christchurch, for about a year prior to commencing a part-time PhD research project. I continued in a hybrid practitioner-researcher role at Lyndhurst for four further years, finishing my employment to focus more intensely on the writing up of the research findings. During this time, and following the 2011 Christchurch Earthquakes, Lyndhurst was relocated as part of Christchurch Hospital. Prior to the commencement of the study, I gained Ethics approval from the Health and Disability Ethics Committee and the University of Canterbury Human Ethics Committee. A locality assessment permitted the research to occur at Lyndhurst.

The methodological approach is qualitative and informed by actor-network theory (ANT). ANT is a methodological toolkit that extends conventional notions of the social world by orientating the researcher to how "the social" is relationally assembled as an assortment of people and things—of heterogeneous "actors" (Latour, 2005). The researcher is charged with mapping and following this collective action using description as the means of accounting for this work rather than by way of explanation (Latour, 2005). The focus of a descriptive account is on emphasising the *how*: how actors frame their worlds, how worlds are generated, ordered, and configured.

The overarching method was participant observation, which was suited to my immersion in the research setting and shifting position concerning my shifting participation in abortion provision and observer of complex day-to-day practices (see Law, 2004). Data were generated from the concurrent activities of research fieldwork and social work practice including formal and informal observation of practices within abortion provision, document analysis and 52 semi-structured interviews with service users, staff in abortion provision, health professionals connected to the service, protestors, and crisis counselling staff. Interview participants were invited to talk about their connection to abortion and this was explored in a semi-structured way and shaped by the participants positioning.

Data were analysed manually and thematically (Braun & Clarke, 2006) across the research process from inception to completion (Liamputtong, 2009). I sought to physically engage with the data from interview transcripts, descriptive memos, reflective writing, and key service, policy and legislative documents closely by seeing, holding, (re)cutting and (re)sorting the acquired data. The focus on counselling involved an array of related people, materials and practices that appeared and reappeared in the data yet I could not seem to firm this up. The ANT emphasis on tracing and following mediate action allowed me to see that counselling was not one stable and fixed thing but enacted through diverse actors and practices (see Latour, 2005). Aligned with an ANT sensibility, I did not follow this analytic process through to an explanation but relied on the mode of descriptive writing to "give voice" to research participants (see also Murphy & Dingwall, 2003) and make my case about counselling controversy and mutability. Note that I do not offer generalisations about abortion counselling nor have I sought to be representative about abortion concerns. The descriptive text and quotations provided do not attest to *the truth* about abortion-related counselling but are a capturing of moments and multiplicities.

Hybrid roles, blurry boundaries and multiple identities

It is important to acknowledge the hybridity of the practitioner-research role and the multiple identities that participants embodied. For my part, whilst I had many opportunities from Lyndhurst colleagues as an insider, it was also peculiar and a different dynamic to be researching in and being of this setting (see Meadows, 2016). Of note, care was taken to navigate the role of both social worker and researcher in an ongoing way. For example, I excluded from directly recruiting service users and did not make use of my appointments with individual service users to illicit and record data, although inevitably these experiential insights informed the research. Regular supervision and reflective writing offered a means of continued reflection on my hybrid role and supported accountability regarding the ongoing decision-making undertaken during the research process.

Concerning participants, I did not seek a specific number of participants from certain professional or service user roles nor did I aim to organise participants in this way. Rather, through the methodological activities of "following the actors" and connections between actors (Latour, 2005), it was apparent that many of the interview participants inhabited multiple identities at once, linking into various parts of the assemblage of abortion, past and present. For example, many participants were *composites*—they may have been a staff member at Lyndhurst, held a specific professional role at an alternative setting, may have connected with the position of recent or past service user, and/or be linked to a community agency. I could not always anticipate what interview participants would share; however, I did not seek to "tidy up" this complexity for the sake of order (see Law, 2004) and ultimately referred to particular roles and identities as these were foregrounded during the course of the participant's account. In this way, this ANT-influenced account mirrors a case study of how multiple professions interacted with the *object* of counselling and brought a local and specific version of counselling into being.

Findings

The following section describes some of the dynamic (re)configurations of counselling and *how* counselling is presented in the data. These findings draw from a broader thesis chapter about professional identity and social work where the argument is made that identity is dynamic—assembled, enacted, disrupted, and reassembled (Meadows, 2016). This argument applies to the notion, role and practices of counselling as this was followed in, and through, varying professional interactions and activities within and beyond the clinic setting. In line with the methodological approach of accounting for relational work between heterogeneous actors, counselling attributes include distinctly human qualities, such as empathy and listening, but also a wider range of effects: the way we are guided by training or professional documentation, the way parts of the body are engaged to "do" counselling work, such as ears to "hear someone out" and how counselling is relationally practised through the people, tools, materials and spaces. The concept of the boundary object is employed as a means to express these multiple but intersecting counselling arrangements.

Counselling within and beyond the boundaries of social work

At Lyndhurst, the site of this study, counselling services were formally provided by social workers and evolved over time from being routine, then voluntary—routine at the onset of a new medical abortion service in a new format as a psychosocial assessment with counselling available—then optional where women were to be made aware that counselling was available. This latter mode of counselling remains in the current setting at the time of writing this article and under the 2020 Act. Informally, varying counselling-related practices were enacted by a range of Lyndhurst staff. Counselling variations were also enacted outside of Lyndhurst in community settings including crisis pregnancy services.

Counselling as part of this abortion assemblage did not belong merely to the role and tasks of social workers but also to many other actors and practices. Social workers in abortion provision, nurses, and community counselling services assembled different versions of counselling that are shaped by specific professional memberships and configurations. The varying tensions about who should do counselling, what counselling should look like, and where this should occur, relates quite readily to the concept of boundary objects (Star, 1988, 2010; Star & Griesemer, 1989). Referring again to the work of Star and Griesemer (1989), "[b]oundary objects are objects which are both plastic enough to adapt to local needs and the constraints of several parties employing them, yet, robust enough to maintain a common identity across sites" (p. 393). In this way, as a boundary object, mutable versions of counselling unfolded across divergent communities of practice.

Counselling adaptations: "Part of our role is counselling too"

Within and beyond the clinic setting, counselling was loosely structured and often adapted when employed by diverse groups: an abstract object—but more tightly articulated and concrete in its use by specific memberships, such as the social workers who performed counselling tasks at the service with the requirements of employed roles, qualifications, and standards of practice. However, even in these more structured settings, counselling was taken up and adapted by different professional groups. A nurse at the service illustrates this below:

> I1: You know even from the nursing point of view let's face it, the counsellors do a fabulous job, you guys do a fabulous job, but, you know, part of our job is that counselling role as well, on a different level, well not that different, well there is that difference in that we're not trained in that [laughs] but there is a counselling role – it's a real hands-on role and there are times when people need you to just sit with them and just hear them out.
>
> (Interview 1)

The social work identity I held and the role I enacted in abortion provision was expressed by the participant as "counsellor". I held a degree in social work and membership of a social work professional body, yet, a sign indicating "counsellor" was attached to my workplace office door. Moreover, while the work that is undertaken was expressed as valued, and despite the sign on my door, I cannot claim the counselling role nor its practices. As described above, counselling was integrated into nursing practices, "part of our job is that counselling role", and thus, social workers as authorities in counselling in this setting is contested.

Linking back to Star and Griesemer (1989), as a boundary object, the action of counselling in the quote above appears to be located *between* medical and social worlds and is taken up and adjusted by the nurse as part of her nursing activities. As she articulates, the counselling employed is "not that different" except for the fact that nurses are "not trained in that." Nurses do not have the qualification that produces the counselling role at the clinic, as within the counselling network, being trained is imperative to acquiring employment as a social worker who engages (with some professional controversy) in counselling practices.

Role legitimacy: "The right person to do the job"

When counselling is assembled by other actors, such as the nurse above, the backdrop of social work legitimacy falls away. Counselling is reconfigured as something else. The nurse describes this counselling component as a “real hands-on role” where people need you to “just sit with them and just hear them out”. However, the nurse wears a uniform, holds different qualifications, carries, and uses various medical tools, and occupies different spaces within the setting at Lyndhurst, and these elements, in turn, configure counselling differently.

For the nurse above, counselling is referred to as a form of engagement—“hands-on” but, instead of hands and medical tools that focus on the bodies of service users, the ears are engaged to listen to women who enter abortion provision. The voice of the woman, her account, her story is what is taking primacy in this “counselling” role that the nurse enacts whilst the social work counselling “toolbox” that is comprised of, not only the voice of women, but a myriad of other actors, is displaced. While talking and listening practices are very much part of integrated care, that medical staff *do* counselling, and occupy this hybrid space, was not agreed upon by social workers.

> I52: ...it comes up often in multidisciplinary teams, “why don’t I do the social assessment, I’ve got the information here” and what I say to nursing staff is “look, it’s exactly the same, I can read the instructions and I can take blood pressure and I know how to draw up a syringe and I can give injections, I can do those things, the point is that I can do those things but I’m not trained to do those things. I don’t have the certificate that says I’m the right person to do those things, it’s not my role to do them”.
>
> (Interview 52)

Informal counselling networks: “counselling is a bit of broad term”

Linking again to the idea of counselling as a boundary object (Star & Griesemer (1989), counselling may be thought of as a common object that sits between groups, like in the example of the nurse who employed her articulation of counselling as part of her work. However, because abortion counselling lacks durability as a fixed professional practice that has authority only within certain spheres of work, other groups can pick this up and tailor counselling for their own needs whether they are medical or social actors, professionals, or laypersons. An actor from a women-focused community agency offers her account of this below:

> I3: I mean here we don’t have a formal set up, you know we don’t have someone come along formally to I guess enter into a counselling-type relationship, it’s more an on-the-spot thing so it’s a, probably a smaller version of what you do but you can do quite a bit in a small time to help people examine where they’re at.
>
> (Interview 3)

Outside of the formal counselling set up that the above actor refers to, this agency employs its own version of counselling: a “counselling-type relationship”. Other community settings, offer further variants within a particular structure and context that is tailored by this group. An example of this is articulated below:

> I4: We’re a 24-hour counselling service, counselling is a little bit of a broad term because we are not trained counsellors, but we’ve done a comprehensive 12 session course on pregnancy counselling.
>
> (Interview 4)

The language shifts here from abortion to pregnancy. As Allanson (2007) argued, pregnancy counselling that is conducted independently of abortion provision is often considered less credible by abortion providers (Allanson, 2007) or as a strategy employed by “anti-choice” actors to dissuade prospective service users from pursuing abortion as a pregnancy outcome (Bryant & Swartz, 2018; Cannold, 2002).

At Lyndhurst, and among several long-standing community women-centred organisations, this specifically concerned a distrust of community groups with 'pro-life' or religious associations. The term *false providers* is one of the ways that these latter groups are described in that they are thought to provide false information, block access to, and perpetuate myths about abortion provision (Allanson, 2007). The ascribing of this notion of *falsity* is an effort to secure a specific reality or *purity* about the nature of counselling that those in abortion provision uphold. At the same time, this notion refutes the lay efforts of those whose enactments of counselling conflict with abortion providers.

Counselling contrasts and contested practices

As became evident during this local study, the counselling at Lyndhurst acquired its own sceptics and there were other modes of counselling beyond the clinic, and counsellors who contested Lyndhurst practices. The following quote, part of an interview with a community pregnancy counsellor, draws attention to this:

> Letitia: I wondered if there were some similarities, like my role is a social worker/counsellor at Lyndhurst and there must be some similarities with what we do and some contrasts as well.
>
> I4: I think there would be many contrasts. We are there never to make up clients' minds for them and we like them to be fully informed, so when people ring us and say "I want an abortion", really, we would, if they were willing, give them the alternatives.
>
> (Interview 4)

The lack of consensus between groups is one of the elements of the boundary object (Star, 2010; Star & Griesemer, 1989). The lack of consensus between groups who enact the object of counselling (Lyndhurst and the pregnancy counselling service) was revealed in this arrangement. Whilst Lyndhurst social workers would argue that they, in fact, did not make up clients' minds for them and that they sought to fully inform clients, the community counsellor implies disagreement with this.

Indeed, as Law (2004) explained, laypersons, like the actor above, may be sceptical of the expertise that is claimed by those who hold authority and may question the interests that sit behind expertise. The community counsellor in the interview above makes it clear that the mode of counselling at this service contrasts with that which Lyndhurst provides. Moreover, we are alerted to the tailoring of the counselling that takes form in this setting, the localised adjustments that groups make for their specific needs (Star, 2010). When a client calls on the telephone and says they want an abortion, the othering of abortion is brought into presence. Not by stating that an abortion trajectory is made absent, but by saying, "really, we would, if they were willing, give them the alternatives" (Interview 4). The contrast between counselling at Lyndhurst and that provided in the pregnancy counselling service reveals these services as quite different objects. Likened to a boundary object, counselling in the pregnancy counselling service may not be enacted as a professional process according to the aims of social workers at Lyndhurst, but it proved to be adaptive as far as it mediated "talking work" across different communities of practice that, aligned or not, linked into abortion networks.

Thus, counselling to do with abortion was not contained within the walls of Lyndhurst or its rooms. Counselling was a distributed set of practices that were reworked and taken up by different actors across different sites. This reworking and appropriation of counselling by different groups produced tensions concerning the authenticity of counselling and which actors held the authority to provide this service.

Discussion: Abortion counselling (re)configurations and reproductive justice

The findings illuminate counselling as an unregulated space where counselling within abortion provision and outside of service delivery comprises of diverse set of practices that were contested, mutable and multiple. The consensus between participant contributions illuminated a lack of consensus about what the counselling role was and who should perform its activities. Different participants across professional and lay memberships, such as social workers, nurses, and community counselling services, took this role up and assembled their own version of counselling. The social work role of providing counselling services in abortion provision was shown to be precarious as this concerns role identity and legitimacy. The analytic description and participant quotations support the concept of the boundary object as a means to appreciate counselling as a site of intersecting communities of practice that can be considered simultaneously.

The findings exhibit alignment with arguments of variation and inequity of services where the integration of abortion counselling within service provision is at times at odds with service delivery within and between varying localities (Kirk et al., 2018; Macfarlane et al., 2023). However, these findings sit awkwardly alongside the recent aspirations for counselling practice in abortion provision. The Standard for Abortion Counselling in Aotearoa New Zealand (MoH, 2022) outlines and purpose and scope of abortion counselling including who can provide this, specifically outlining types of practitioners and knowledge and practice expectations. Attention is afforded to how abortion counsellors give effect to obligations under Te Tiriti o Waitangi and there is an appreciation of the intersectional spaces that service users occupy and their interface with a colonial-inflected health system. Guidance is offered concerning the delivery of abortion counselling services, cultural responsiveness and the rights of service users.

Alongside these in-depth and nuanced guidelines for counselling provision, there is a gap between the integration of social work services as part of abortion provision and the aspirations of The Standard for Abortion Counselling in Aotearoa New Zealand (MoH, 2022). Outside of immediate service delivery, counselling is a presence that exists on its own terms. In these spaces, there are versions of counselling that may, as Mavuso et al. (2023) suggested, undermine the efforts of abortion services to provide quality care and via directive anti-abortion practices, induce emotional and psychological harm for service users. Since (and separate from the undertaking of the initial research) the Abortion Legislation Act 2020 has provided impetus for improved and streamlined access to abortion in established abortion services and shifted the status of abortion from crime to health care. However, related to the research findings, counselling controversies continue and the contentious social and political landscape of abortion provision in Aotearoa New Zealand has not been erased. It is important to recognise that the presence and impact of other committed actors in this network, such as crisis pregnancy counselling services, actively advertise their services and seek to disrupt access to abortion provision and care.

There is space for further consideration of the access, availability and framing of social work and counselling services that respond to the political, psychosocial, spiritual and cultural complexities of abortion. There may be value in disrupting the mutability of counselling practices by reviewing the term *counselling* and how this reflects the social work and counselling roles in abortion provision. Further, there is scope to address the mismatch between a medically oriented provision of abortion services and the contributions of social work practice. Revisiting Ross (2017), "the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access" (p. 4). The recommendations for social work practice include continued advocacy for the presence of social work and counselling services to ensure that these are indeed available so abortion provision does not inadvertently maintain or intensify the disparities or oppressions of care and separate service users from the circumstances of their reproductive decisions.

Conclusion

Abortion counselling has been described as a contested set of practices that have been reworked and taken up by different actors across different sites, within and beyond the social work role. Findings from previous research have been considered alongside current realities that indicate that the peripheral and precarious position of social work in abortion provision is maintained concurrently with the legislative requirement that counselling must still be available. The offering of a counselling service in abortion provision, mutable or otherwise, is not a genuine option when social work is poorly integrated into service provision or off-site from a service where timeliness is key. In this way, social work has a role to play in progressing reproductive justice through continued advocacy to advance quality, skilled, non-biased, non-directive, and culturally responsive holistic care for service users of abortion provision.

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ORIGINAL ARTICLE
QUALITATIVE RESEARCH

Menstrual concealment—“You can’t just play the woman card”

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ABSTRACT

INTRODUCTION: This article explores women’s experiences of menstrual suppression within the New Zealand Army while seeking to understand the influence of military systems, culture and processes on those experiences. More specifically, it examines women’s desire for menstrual concealment and control over their chosen method of managing their menstruation.

METHODS: Data were collected using narrative interviews with 18 women currently serving in the New Zealand Army and nine key informants. Data were analysed using reflexive thematic analysis.

FINDINGS: Study participants described the convenience of not having their period in a military environment as their main reasoning for menstrual suppression. Whether supressing their period or not, women’s stories revealed their desire to fit in within the current military culture while also having control over their own body and decision-making. The decision on how they managed their menstruation was influenced by their peers, their rank, their environment, their past experiences and the information provided to them through briefings and visits with their medical provider.

CONCLUSION: The preliminary findings from this study suggests that within the military, women are not only expected to keep their feminine identity but also maintain body equivalence with men to ensure they are seen as equally operationally effective. Although women describe an expectation of menstrual concealment, women choose how they reach that expectation. A reproductive justice lens is used to argue that without addressing menstrual stigma and the military structures, women will continue to “choose” to conceal or supress their period as it is presented as the only appropriate choice.

Keywords: Menstrual suppression; military; menstrual concealment; menstrual stigma

The New Zealand Army (NZDF) is a combat ready force, meaning that they must be ready to conduct military operations whenever required to keep Aotearoa New Zealand safe and secure (NZDF, 2019). Operational readiness refers to the capability of the organisation to perform that task. This includes access to ships, weapon systems, technology, and other supplies and how prepared soldiers are to perform their assigned tasks (Duggan, 2021). Menstruation has been characterised as a challenge to operational readiness that carries a multitude of potential issues for the military. The supply and provision of menstrual products, deployment and field infrastructure, and field hygiene can bring operational and strategic challenges (Chua, 2020). In the military context, research has focussed on the inconvenience of

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menstruation and addressing the barriers associated with menstruating while in uniform instead of exploring women's embodied experiences. Increasingly, menstrual suppression is offered as a solution to the "problem" of menstruation in the military. Current research, particularly in the US, has investigated the acceptability and convenience of menstrual suppression for enhancing operational readiness (Philips & Lynn, 2021; Ricker et al., 2021; Trego, 2007).

Goffman (1963) defined stigma as a mark that sets people apart from others due to "an attribute that is deeply discrediting" (Goffman, 1963, p. 3). Menstrual stigma refers to the negative perception of menstruation and those who menstruate (Olson et al., 2022). These beliefs characterise the menstruating body as being abnormal and abject and reinforces stereotypes of menstruators as irrational, emotional and less capable (Johnston-Robeldo & Chrisler, 2020; King, 2020; Olson et al., 2022). Johnston-Robeldo and Chrisler (2020) assert that menstruation is more like a hidden than visible stigma due to the efforts that women put into concealing it. As Wood (2020) highlighted, women are most successful in their lives if they conceal their periods or at least, appear to be unaffected by the presence of menses. Hypervigilance is a noted consequence of the stigmatisation of menstruation as individuals seek to ensure their menstrual blood is concealed (Johnston-Robeldo & Chrisler, 2020). The self-monitoring undertaken by women aligns with Foucauldian concepts of self-policing (Foucault, 1979) which is seeking to produce a more docile, non-menstruating body as it it thought to be more well-suited for success (Kissling, 2013). A non-menstruating body is considered to be more docile due to the unpredictably of menstruation, with its potential for leaks and heightened emotions which would damage the presentation of a rational and self-regulating subject (Kissling, 2013). This stereotypical view of women on their period as being "oversensitive, unpredictable and verbally unpleasant" (Young, 2005, p. 118), has often accompanied the construction of women as abject and out of control during that time of the month.

In the workplace, these stereotypes and judgments are often used to dismiss women's anger and impatience and discredit their experience (Young, 2005). These stereotypes and stigma have led to unspoken rules and actions for the concealment of menstruation, described by Young (2005) as "menstrual etiquette". Menstrual etiquette, such as practices of concealing tampons on a trip to the bathroom, cleaning stained underwear, and discreetly managing the blood captured in menstrual cups are sources of gendered labour which, Young (2005) argued, oppress women. Removing the stigma that prompts practices of concealment is considered by Kissling (2006, p. 126, as cited in Robeldo and Chrisler, 2020), critical to achieving menstrual justice. Kissling (2006) suggested that achieving "menstrual justice", which is built from the concepts of reproductive justice, will mean that menstruation is no longer a shameful secret but a fact of life that need not be concealed. Menstrual justice would acknowledge access to menstrual products, pain management and open dialogue as a basic human right (Przybylo & Fahs, 2020).

In addition to menstrual etiquette, the introduction of menstrual suppression using COCs (combined oral contraceptives) and LARCS (long-acting reversible contraceptives), which include IUDs (intra-uterine devices), the contraceptive injection (Depo) and the hormonal implant (the rod) have become tools for menstrual concealment. These hormonal methods of contraception have provided women with options to have fewer periods a year or even the ability to eliminate bleeding altogether (Hasson, 2016). Menstrual suppression COCs are nearly identical to existing COCs, with only the regimen of pills with active hormone taken, instead of monthly planned "breaks" from hormonal pills (Watkins, 2012). This change in the use of COCs highlighted the possibility that always existed but was previously only considered unofficial or off label (Hasson, 2016). Hasson (2016) argued that, following the introduction of menstrual suppression through COCs and LARCs, the need to redefine menstruation by examining the many types of bleeding that we had understood as menstruation was introduced. Pill periods or withdrawal bleeding, meaning bleeding experienced while on a break of hormones, was developed to be understood and experienced as a regular monthly bleed. However, pharmaceutical companies have disclosed that pill periods are not in fact "real periods" and are therefore unnecessary (Hasson, 2016). Although this distinction might seem irrelevant, if the effects and experiences of bleeding are the same, this redefinition of menstruation, as it is understood in relation to COCs, is central to understanding menstrual suppression and its effect on gendered embodiment. Taking for granted what we understand as being menstruation obscures what could be learned from being open to a multitude of experiences of menstruation and its relationship to how women experience their monthly bleeding.

Menstruation is constructed through the material, social and cultural contexts in which it is experienced. The emergence of menstrual suppression as a choice for women is often framed as a simple preference or lifestyle which places the emphasis squarely on the individual (Liddel, 2019). Framing reproductive health concerns, in this case menstrual suppression, as a series of individual choices, negates the very influential role the military structures and culture has on these decisions (Liddel, 2019; Ross & Solinger, 2017). When menstruation is constructed as a barrier to operational readiness, menstrual suppression may become an expectation and responsibility of military women, rather than a choice. From a reproductive justice perspective, suppressing menstruation is not a neutral choice but one grounded in the gendered and hierarchical context of the military and the embodied experience of having a period in that environment (Ross & Solinger, 2017).

The menstruation practices of military personnel, the associated tensions concerning menstrual suppression and issues of choice are of relevance for the discipline of social work, specifically the field of military social work practice in Aotearoa New Zealand. In this context, the military social work service within the NZDF involves micro-, meso-, and macro-level interventions with individual personnel and their whānau and families. This includes both clinical social work services focused on assessment and treatment aspects of practice and occupational social work with an emphasis on the well-being of the person in the military environment (Nicholson et al., 2022). This article will conclude by exploring implications for social work practice and research.

Methodology

The qualitative data described in this article were collected as part of a larger study examining women's experiences of menstruation within the New Zealand Army and the influence of military structures and systems on those experiences. Adopting a narrative inquiry approach, and a liberal feminist theoretical lens, the research employed in-depth interviews to provide an opportunity for participants to narrate their own experiences (Freeman, 2019). Narrative research is a broad and varied methodology that puts stories and individual voices at the heart of the research. It leans on the complexity of stories to establish a greater understanding of a phenomenon or lived human experience (Creswell, 2007; Lewis et al., 2017).

Participants were individuals serving in the Army who menstruate currently or have done so in the past. Not all women menstruate and not all people who menstruate are women; however, all participants in this study identified as women. Therefore, the term *women* is used throughout this article when referring to participants. Moreover, when the term *men* is used, this article is referring to cisgender men, as, it should be noted, some men menstruate. Eighteen participants were recruited through purposive sampling at the different Army camps across New Zealand. The study was reviewed by the NZDF and organisational support was gained in 2019. Interviews with participants were undertaken between December 2019 and January 2021.

Narrative interviewing was chosen as the richness of the data collected through narrative research lies in the inquiry into the stories and analysis of voices. It goes beyond words into more expansive ways of interpreting individual experiences and understanding of a phenomenon (Murray-Orr & Olsen, 2007). In line with the aim of the study, the reflective nature of narrative research often leads to new insights, questions, connections and pathways for future research (Creswell, 2007). Narrative interviews ranged in length from 28 minutes to 1 hour 42 minutes.

Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2021) was adopted influencing thematic saturation considerations and the analysis of findings. As Braun and Clarke have suggested (2021), since codes and themes are driven by the researcher, it is impossible to know whether data saturation has been reached prior to undertaking thematic analysis (Braun & Clarke, 2019). In their 2021 article, Braun and Clarke suggest that Dey's phrase, "theoretical sufficiency" would be a more accurate alternative to capture the concept that the researcher believes they have collected enough data to build a depth of understanding (Braun & Clarke, 2021). Therefore, within this study, theoretical sufficiency was reached when interviews did not contribute any new information about the concepts or their dimensions (Schwandt, 2001) and when participants of diverse ages, ethnicities, ranks and trades had been recruited. Using a narrative methodology with reflexive thematic analysis ensured that the researcher reflected on their own biases, thoughts and experiences throughout the data collection and analysis processes. Prior to data analysis, all interviews were transcribed verbatim. Transcripts were uploaded into the qualitative analysis software publisher, NVivo. The use of this software facilitated the analysis process through the organisation of themes and codes.

Due to Covid-19 restrictions, many of the interviews that were originally going to be conducted face to face, needed to be conducted online, over Zoom. Although both options were always offered to participants, most chose to conduct interviews online for both safety and convenience. Being flexible in very uncertain times was crucial. Nevertheless, utilising this data-collection method led to an incredibly rich data set. To limit personal and professional harm, including the possibility of retribution, issues around confidentiality and safety were acknowledged and addressed prior to every interview. To protect the participants' confidentiality, pseudonyms were given to each participant as well as establishing ranges for age, rank and length in the military. As women are still only a small percentage of the New Zealand Army, even without providing their names, participants could still be easily identified through the additional information.

Ethical approval for the study was granted by the NZDF and exception by the Chair, University of Canterbury Human Ethics Committee Chair was provided on 12 March 2020.

Findings

Menstrual concealment, or the need for women to hide their period, was popularised by Wood (2020) who suggested that women's desire and vigilance to ensure their menstruation is kept hidden is not chosen but a "required self-disciplinary practice rooted in menstrual discourse that characterises menstruation as stigmatized, taboo, and therefore shrouded in secrecy" (Wood, 2020, p. 319). The experience of menstrual concealment was identified as central to participant narratives of menstruating in the military and is the focus of this article. Through reflexive thematic analysis, three themes were identified that explore the normalisation of menstrual concealment. First, the examination of participant narratives generated "menstruation as gendered embodiment" as a central theme which explores how menstruation is experienced, whether menstruating spontaneously or as withdrawal bleeding. Next, we explore the gendered pressure that military women experience to conceal their menstrual blood in the theme "'managing menstruation is basic self-care". Finally, women describe the relief that the technologies of menstrual suppression offer them from self-surveillance when exploring the theme of "the menstrual suppression imperative".

Menstruation as gendered embodiment

Participants' emotional responses to menstruation changed over time reflecting menstruation as a social and material construct (Hasson, 2016). When asked how they felt about menstruating, participants shared very different embodied experiences. Although no participant said outright that they loved getting their period—their responses were all very nuanced.

Olivia described feeling fortunate to have been able to experience having a regular cycle. Earlier in the interview, she explained that she had colleagues and friends whose experiences were very different to hers and, due to a variety of reasons, were unable to have children. Becoming a mother prompted her to reframe how she experienced menstruating as a form of gendered embodiment. She described it as something that she needed to go through to have children and was thankful to have that experience. "I'm happy that I don't have them anymore. In saying that, I thought it was a real honour, a privilege to have a period, because that's what allowed me to have children" (Olivia).

For Rose, menstruating was also a reminder of her fertility but, unlike Olivia, this experience of gendered embodiment elicited gratitude for *not* being pregnant. For Rose, her period was a visual reminder that she was not pregnant that month, and that periods were just an unfortunate norm. "I guess if anything, which is probably wrong, it's been a pain. […] it's been a blessing a couple of times, too, when I'm like 'Thank God I'm not pregnant.' […] It's kind of been like, you're a female. You have a period" (Rose).

Candace's perceptions of menstruation evolved over time. Initially practising menstrual suppression, was a positive experience for her, yet, in retrospect, she dismissed the experience of break-through bleeding while on her period as "weird" and not resembling a genuine period. When Candace ceased using contraception, she described feeling more in tune with her body, enjoying tracking her periods and understanding how her cycle influenced her moods and energy levels. She described this experience of gendered embodiment giving her a greater appreciation and understanding into how she functioned.

> After coming off the Mirena [IUD], I really liked getting it. […] all the years I'd been on contraception and stuff and I'd had these weird, crazy, brownish blood—and I didn't know what my body was going to do. I didn't understand my body very well, and I didn't understand my menstruation very well. […] When I see that, I'm like, "Oh yeah, I'm due tomorrow. That explains my mood. Cool". I just think of it as quite a big part of being a woman. (Candace)

As Candace described, having her period also made her feel like this was a "big part of being a woman". She appreciated feeling "normal" and was amazed to see how her body worked. The feeling of being part of something bigger than herself was not shared by everyone. Another participant, Katy, shared her experience with a chuckled and confusing tone—like she must be missing something! "I feel like I'm a traitor to feminism, but I hate it. I think because it was that it wasn't a milestone, it wasn't a thing. […] It's never been a bonding thing or whatever" (Katy). Her emotions regarding her period were influenced by how she thought it was going to be, as dictated by culture all around her, and it did not reflect her experience. Her reality was that menstruation was an "inconvenience, painful and embarrassing". Candace and Katy's experiences are reflective of the changing social construction of menstruation. As Przybylo and Fahs (2020) highlighted, there has been a wave of feminist authors calling on women to embrace their period. Although menstrual positivity has been presented as a way to counter the need for menstrual concealment, one of the unintended consequences, outside of marginalising women who do not menstruate at all, has been isolating women, such as Katy who actually would prefer to avoid menstruation altogether.

The unpredictability, especially in a military environment, was an aspect of menstruation that was difficult for Jasmine to manage. However, much like other participants, her experiences changed over time and were influenced by other factors. After being on the pill for years, when she stopped taking hormonal contraception, her period never returned. Despite numerous consultations with medical providers, almost two years later, her period still has not returned. Jasmine described previously having her period as "a real pain. Um, because it always seems to turn up at the wrong time. But now that I didn't have it now that I have it I really appreciate it".

This feeling of wanting to be in control of your body was a sentiment shared by other participants. In an effort to feel more in tune with her body, Emma would purposefully wait between depo [Depo-Provera, contraceptive injection] shots to ensure she had a period. This was her way of taking care of herself, and give her comfort that her body was still working "as it should". As she describes, "sometimes I would go over the three months with the Depo just to have a period […] I felt like I wanted my body to reset. I would purposely not go back after the 13 weeks just to have a period and then go back and restart again" (Emma).

Emma's experience reflects the negative menstrual suppression attitudes that has been highlighted in many studies both within a military context (Lawrence-Wood et al., 2016; Ricker et al., 2021) and a civilian context (Fleming et al., 2010; Spies et al., 2010). DeMaria et al. (2019) explained that women expressed concerns over menstrual suppression, believing that regular menses is natural, provides evidence of pregnancy prevention and that monthly bleeding was necessary to regulate the body of menstrual build-up. Despite this not being needed, these assumptions influence gendered embodiment and how menstruation is experienced. These concerns and desire for bodies to "reset" through menstruation is reflected in Emma's experience above. Despite recommendations from her medical professional, her need for some control over how her body functioned was prioritised.

Managing menstruation is basic self-care

The idea that women are responsible for managing their own menstruation was touched on by many participants. For example, Candace, likened being prepared to manage her period with bringing a toothbrush. By comparing menstruation to just another aspect of self-care, she asserts bodily equivalence, and more broadly, equivalence of women and men in the military (Chua, 2020). If managing one's period is as straightforward as bringing a toothbrush, men and women may be considered equally effective operationally. While Lili alludes below to the unpredictability of one's period, she explains that it is up to the individual to have everything in place to ensure they are not "caught out".

> I always make sure like I have enough with me just in case I happen to like get my period because it's not something you want to bring up with a random like commander like "hey I have to go back into camp to go to a shop". Yeah. So we're always going to be prepared. (Lili)

The way most participants spoke about managing their period was individualistic. The self-policing maintained that the responsibility to be prepared lay with themselves. For Lili, within the military context, being prepared ensured she did not need to need to communicate her needs to her commander. As Wood (2020), highlighted, women's bodies are viewed as sites of discipline that require constant management and containment in order to remain viewed as rational and self-regulating. In the military context, this meant continuing to be viewed as equally competent as those who are not menstruating. When participants were caught off guard, as Christine explains, several expressed disappointment in themselves and embarrassment that they did not have menstrual products with them. "I just completely forgot about [my period]. […] I forgot to bring tampons and I was super annoyed at myself" (Christine).

The feeling of not wanting to be caught unprepared and therefore, single yourself out was present in many of the participants' stories. One of the participants, Polly, described a time where after a heavy surprise period, she needed to self-monitor her reactions to ensure she did not bring any attention to herself. What she describes below is bloody mess that had the potential to completely go against the self-discipline and self-surveillance that Polly was striving to achieve. When the self-surveillance and discipline had a leaky outcome, she described feeling shame and even disgust in her situation. Nevertheless, this shame and disgust only led to her doing everything she could to continue the concealment imperative. Although she described disappointment in herself, she was not going to give any power to her chain of command to change their perception of her worth and work ethic due to her menstruation. While describing the situation, her voice was shaking and it was apparent that she was still affected by the story.

> You're up early in the morning, listening to orders, and I remember this one morning, I was just flooding, it was awful. Like, you know, you feel it. […] I thought, oh my goodness, this is very bad. Like what do I have to do? I have to sit through these orders and everyone's very serious […] I just need to go to the bathroom right now. But there were no bathrooms. So I had to go into the forest. And like try find cover and sort that mess out and work with the baby wipes. And you can't, like what do you do with it like I had to carry that rubbish on me, it was awful. […] what made it worse was that once I got back from sorting out my life, with the blood and everything, I get told off for being Like, "no one's going to the toilet!". Yeah, but I couldn't explain to the sergeant guy that I was afraid of that actually, I'm bleeding through my pants. Yeah, so that was horrific. (Polly)

When asked if she would do anything differently now that she can look back on the situation, she said that she would not. For Polly, although she was afraid, she was bleeding through her pants and feeling desperate to address the situation, managing her menstrual blood and concealing the waste seemed like the only option—even though she knew that she could be reprimanded for leaving to do so. It also was not as simple as going to the bathroom as there were none around! Polly's story illustrates key relationships and materials that influences how women described their experience with menstruation in the military. The power dynamics with her sergeant, the lack of accessibility of bathrooms, the structured nature of military life, the materials that she had at her disposal in the field, all played a role in her self-care and her decision to conceal.

The belief that concealment Is better than admitting to a menstruating body was further touched on by Candace who, even through intense menstrual cramps, felt that not completing a task was out of the question. Below, she describes how using period pain as an explanation for not doing physical training risks rendering women different or unable to perform.

> You don't wanna be pulling out of something for a girly reason. It's fine for me to say, "I don't want to do physical training today because I've busted my knee," but I wouldn't say "I don't want to do physical training today because it feels like someone's stabbing me in the gut." You kind of almost feel like you're just reiterating that women can't do this because our period is in the way. (Candace)

Candace's phrasing demonstrates the ongoing pressure military women feel to conceal, not just their menstruation, but evidence of their differences to their male counterparts. The following narratives shed further light on why someone in Polly and Candace's situation may be reluctant to reveal their menstruation. Although speaking individually, participants described their experiences as having the potential to affect their colleagues' views of all women, rather than just themselves. There is individual responsibility but collective consequences. Taking the reprimand or going through physical training, even while in pain, was seen to be a better alternative for the individual than bringing attention to the reproductive pain.

> You don't want to go up to an instructor and say, "Hey, this is my situation"' because then, one, you're singling yourself out. Everyone's going to go, "What are you leaving the field for? Why are you not sucking it up with us?" You're individualising yourself, which puts more attention on you. Why would you even say anything. (Nadine)

Candace had similar reflections to Nadine and explained that "if you're experiencing really intense lady problems, you don't want to have that conversation. You don't want to be like, 'Right now I've had a cyst rupture and my abdo is so severely sore'". Candace describes a very painful medical condition that is minimised by rendering it a generic "lady problem". Women described pressure to maintain menstrual concealment despite feeling severe pain and discomfort. For many women, this pressure contributed to a sense that having their period was a messy, difficult challenge.

Menstrual concealment was challenging and often came at the expense of participants' wellbeing. As Oxley (1998) described, the social construction of menstruation has framed it as something that requires women to engage in surveillance and control practices to keep it hidden from others. Concealing menstruation was seen as necessary for these individuals but was further amplified by not wanting to draw attention to their gender as a whole, rather than just themselves. It appeared participants had such a high standard for themselves that when others did not live up to that standard, they felt as though they were giving everyone else a bad reputation.

The menstrual suppression imperative

During interviews, most participants discussed contraceptive technologies such as IUDs, the rod or the pill. Through continuous exposure to hormones, these methods suppress menstruation. In the case of the pill, one skips the sugar pills which enable women to experience bleeding that echoes menstruation. Thus, for most participants in this study, menstrual management was synonymous with menstrual suppression, or at least, menstrual suppression in selected environments. As Rachel explains, the decision to use contraceptive mechanisms was described as one of ease and convenience. "I have just dealt with it by getting rid of it [my period] […] One of the reasons I got the Mirena [IUD]–was to make it a lot easier for myself" (Rachel). Tamara also suppressed her period for convenience. "Obviously, I didn't want to have my period while I was in the field, so I went on the pill for that. And then just stayed on the pill. I skipped periods like everyone does while I was on it" (Tamara).

Rachel and Tamara's narratives both relay an assumption that not having a period is desirable and normalised within their military context. As Tamara described, her use of contraception changed throughout her career. The decision to supress her period or not, was dictated by the type of work she was required to undertake. Through her story, Tamara has described the contraception paradox within a military context (Gomez et al., 2018). As Morison (2021) described, contraception can be a tool for promoting women's empowerment while also being a source of oppression for others. While the accessibility of contraception has meant significant economic gains for women and allowed for choice and control over their own fertility (Morison, 2021), these gains have also meant external power and control over women's fertility (Joffe & Reich, 2015). The decision to use contraception for menstrual suppression was heavily influenced by the military context. As Christine outlines below, especially when joining the organisation, women might be making decisions based on what they have been told or what they believe is best for the organisation, rather than what is best for them.

> Yeah, I guess my sort of the counter argument is that women join the organization in a very vulnerable and they're usually very young. […] when you're on recruit course and you're terrified and you just do what you've been told. You know that if a doctor, even if he's a civilian doctor and he tells you to go to the pill and you, you're going to do that […] you are not making the best choice for your body. You are just doing whatever it is in order to join the organisation and pass your recruit course. (Christine)

Kayla reinforced the contraception paradox as she describes that she got the contraceptive implant Jadelle® inserted as she was worried about the pressures of the military environment. However, the end result was that menstruation suppression led to a more convenient life, where she was able to focus on her training without needing to worry about managing her menstruation. "I was really concerned about it before I joined. And so I got the Jadelle® put in, right before I joined because I was really worried about having it during like basic training […] Which was great, it made life easier" (Kayla).

The decision-process to use contraception is influenced by a number of actors—from their peers to other women, to medical professionals, to the actual environment. Simple conversations with peers, such as one that Rose had, can become a device and a tool for women to make decisions regarding their care. "I think one of the females was telling me that she managed to skip, and I was like, 'What? You have this option of skipping? How have I not known this?" (Rose). For women in the military, the construction of periods as a direct threat to, figuratively, marching like a man, diffused responsibility to conceal menstruation to the individual woman. For Rose, discovering that technologies enabled her to do this more easily was a revelation that demonstrates the important role that communicating with her peers had on redefining her period.

Discussion

Participants, with little guidance from the researcher, explored stories related to menstruation throughout their military career. For many, these stories came to mind easily. They described them in detail and easily recalled events. For others, stories did not come so easily as they found it difficult to recall a time where their menstruation left a lasting impression. Nevertheless, there were common threads that weaved in and out of each story. This included their commitment to menstrual etiquette and menstrual concealment while exploring the relief that menstrual technologies can bring to the constant self-surveillance. Participant stories also highlighted the importance of maintaining bodily equivalence with their male counterparts, the pressure they experience to ensure that menstruation does not influence others' perception of them and more broadly, of women in the military as well as the role that the military environment played on their decision-making. These themes brought together unique and valid experiences.

Most participants in this study used a method of contraception for the primary reason of suppressing their period. Eliminating menstruation which, in turn, might eliminate its potential unpredictability and physical symptoms of discomfort and pain remained an attractive option for many participants. Within a military context, the accessibility of contraception for menstrual suppression empowered participants to do their job without the added consideration of managing their period. In contrast, menstrual suppression was not merely an action, but also a tactic employed by participants to avoid being marked as "other" (Jackson & Falmagne 2013; MacDonald 2007). Concealing one's menstruation, and thus gendered body, furthers the project of fitting within established culture without attracting any additional attention. Participants emphasised their individual role to ensure their menstruation was concealed while also policing others to ensure everyone was playing their part to keep menstruation, or more broadly, their womanhood, concealed. A few questions arise. If the established culture was different, would the choice be different? Is supressing menstruation empowering and liberating if it is only done in response to a culture that does not allow for another type of menstrual empowerment? The women's narratives described the norms as deeply engrained but contingent on the hierarchical and work context. The empowerment and relief that women experienced when supressing their period cannot be discredited. However, as the context of the military changed and the participants moved through the ranks, their decisions also changed. If they had access to a bathroom on a regular basis, weren't expected to be in the field often and could manage their own time at the gym, participants were less likely to choose suppression as an option for menstrual management. Participants' stories revealed their desire to fit in within the current military culture while also having control over their own body and decision-making. The decision on how they managed their menstruation was influenced by their peers, their rank, their environment, their past experiences and the information provided to them through briefings and visits with their medical provider.

Whether supressing their period or not, the decision on how to approach menstrual management was one of control. In a hierarchal environment like the Army, where much is decided for you, perhaps choosing to have a period, even while keeping it hidden, is just as important as opting for suppression. Despite the positive experiences of menstrual suppression, the notion that if one person can successfully conceal their menstruation while another cannot, perpetuates the idea of only one appropriate strategy when it comes to menstruation: concealment. This isolates and marginalises those who do not want to, or cannot, suppress their period. Therefore, are women empowered to choose how they want to experience their menstruation or are they guided in a way that exploits particularly gendered set of assumptions about female identity? Within a military context, framing menstrual concealment as an empowering choice might falsely offer women control over their own bodies. Expanding on the "tight-rope talk" identified by Sue McKenzie-Mohr and Michelle Lafrance (2011), where they described the adoption of a "both/and" position to counteract the either/or binaries when it comes to women and menstruation. Their research focused on the notion of pre-menstrual syndrome (PMS) where women are either described as being powerful agents or powerless patients. They argued that we can acknowledge both the materiality and discursive construction of premenstrual distress while also emphasising women's agency and power in understanding and coping with PMS. Moreover, women's emotionality is policed differently to men. For example, when a man's emotions fluctuate during a sporting event, he would be described as "passionate" while a woman whose emotions change would be considered "irrational" (Weigard et al., 2021). Within this context, the both/and is extremely relevant. Participant stories reveal that menstrual suppression is *both* empowering *and* a source of oppression. It is *both* an expectation *and* a choice. Embracing these seemingly contradictive notions allows us to both look towards ways of eliminating the source of oppression, without discrediting the positive experience of menstruation suppression that was described by many. We can explore how to ensure that many choices are offered, without discrediting the ones participants made with the information they were provided and the context they found themselves in.

Although menstrual concealment and suppression was normalised, the ability to conceal was a positive form of agency for many participants. Women described enjoying not needing to think about their period or how they would control it in different environments. Participants described feelings of relief when relaying the comfort of being largely relieved from this requirement of self-surveillance on top of the already complex environment they needed to navigate. Despite expectations conveyed through their stories, women made it clear that their decision to supress was mostly for convenience and ease. Therefore, the tension was not whether individuals in the military should supress their menstruation. It was whether women in the military have reproductive autonomy. Reproductive autonomy is the ability for individuals to make free and informed decisions about their reproductive health (Beddoe, 2022; Moore et al., 2010). As previously stated, from a reproductive justice perspective, suppressing menstruation is not a neutral choice, as it is influenced by so many external factors. As was highlighted in several other studies stemming from the US military (Brown, 2012; Lane et al., 2018; Monteith et al., 2017), to maintain body equivalence, women needed to suck it up and manage any unmet needs and challenges individually. Within a military environment, women can model hyper-masculine traits to fit within the patriarchal hierarchy (Koeberle, 2019). Fitting in within a military context, was often described as being synonymous with being "part of the boys". The data in this study identifies the emergence of menstrual suppression as an emerging norm aligned with the gendered environment of military operations. As Ross and Solinger (2017) stated, "the reproductive justice perspective draws sharp attention to the social context in which individuals live and make their personal decisions, it aims not for simple inclusiveness but for changing the rules of the game" (Ross & Sollinger, 2017, p. 117). In other words, to fully address the expectation of menstrual concealment and autonomy from a reproductive justice perspective, we need to rethink the military environment and established norms rather than focus on creating change on an individual basis.

Full visibility of menstruation is not the only alternative to menstrual concealment. As some participants described, if they had a choice, many would not choose to experience menstruation. As touched on in the findings, despite turning to concepts such as menstrual positivity, which is the positioning of menstruation as beautiful, natural and empowering, it is just as important to maintain a "cranky" approach to menstruation. Menstruation is both empowering and a pain. Przybylo and Fahs (2020) maintained that, just as much as we should celebrate menstruation, we should also invest in social justice, demand access to menstrual products and acknowledge the pain, discomfort and leakiness of menstruation. It is important for women to have access to comprehensive information about the benefits and risks of supressing their period as well as eliminating the stigma and gender inequalities that lead to menstrual concealment. Supressing one's period should be a conscious decision that considers a women's complete well-being in alignment with a reproductive justice framework (Kissling, 2016; Ross, 2017). It should be an active decision rather than a taken-for-granted norm. Achieving menstrual justice would mean that rather than menstrual concealment and suppression being both empowering *and* a source of oppression as well as an expectation *and* a choice, menstruation and menstrual management would simply be empowering and a choice.

The strength of this research lay in its unique methodology to explore this particular issue. Using stories to elevate lived experiences within the organisational context led to a rich data set that touched on much more than menstruation. A consideration for this study, as Kensinger and Ford (2019) described, is that people remember negative experiences more than positive ones. Therefore, there is a chance that the study has a negativity bias as women recall and share their more negative experiences with menstruation rather than positive ones. Moreover, given the unique context of Aotearoa New Zealand, there is scope for future research to explore menstruation in the military via an Indigenous lens.

Implications for practice

Social workers in the NZDF are responsive to the complexity of military structures and the military-related stressors on individuals and, in this way, are in a unique position to work alongside personnel, address the environment, culture and policies that maintain menstrual stigma and gender inequality and promote social change.

The concept of reproductive justice is of core significance to women's decision-making when it comes to menstrual suppression, but it is also closely aligned with the broader challenges faced by social workers who seek to reduce health inequalities (Beddoe, 2022; Liddell, 2018; Smith, 2017). The language of choice is often linked to empowerment. The concept of empowerment is central to social work practice and, in particular, the model of military social work in the NZDF. Empowerment uses a person-centred focus of support based on holistic well-being and aligns with the Aotearoa New Zealand Association of Social Workers / Te Rōpū Tauwhiro i Aotearoa (ANZASW) Code of Ethics (2019) in relation to the principle of *Rangatiratanga*, which promotes client empowerment and self-determination. In the social work profession, the navigation between choice and empowerment is a difficult one. Especially when navigating the contraception paradox, where menstrual suppression can be simultaneously empowering and controlling.

The findings of this research give voice to the embodied and nuanced experiences of menstruation for women in the military. Social workers have a role to work critically and radically to give voice to structural oppression and its impact on women while working towards normalising menstruation and confronting the practices of gender erasure in the military. Increasing access to nuanced accounts of menstrual suppression may allow social workers to advocate for change while preserving the status of individuals who must navigate their menstruation in a structurally oppressive context. There is also scope for social work to have a more active educative role with women in the military, with medical professionals and with the NZDF concerning the specific needs of women in the military and the workplace environment they are part of. If a choice must be navigated, and a decision is to be made to take up combined oral contraceptives or long-acting reversible contraception, what are the best options for a woman that take into consideration the present management of her menstruation and longer-term goals about her body? Social workers have a responsibility to advance social justice and human rights issues. The issue of reproductive autonomy is a human rights issue, and it is a key part of the fabric of a restorative justice framework.

Conclusion

Without viewing the organisation through a reproductive justice lens, this research would have been looking at women's experiences of menstruation in the military in a similar way as past researchers: as an individual experience. To remedy any potential inequities, there should be an emphasis on changing organisational processes and practices rather than individuals within the minority group (Acker, 2012). In 2012, Acker noted that gender practices are often invisible—which makes removing barriers and moving towards equity all the more challenging. This research did not aim to describe and outline the military structure—however, it has highlighted the impact of material structures on women's decision-making when it comes to menstrual suppression. The decision to conceal and suppress is not independent of the military environment. If we do not address menstrual stigma and the military structures, women will continue to choose to conceal or supress their period as it is presented as the only appropriate choice.

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ORIGINAL ARTICLE

QUALITATIVE RESEARCH

Barriers to accessing assisted reproduction for diverse and minority groups in Aotearoa New Zealand:
Findings from a qualitative study

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ABSTRACT

INTRODUCTION: There is now an extensive body of international research on fertility help-seeking. While this body of work has historically centred the experiences of dominant ethnicities and heterosexual and cisgender couples and families, our study attends to the experiences of individuals and couples from diverse and minority groups in Aotearoa New Zealand, for which, to date, there is little research. In the article, we report delays and disparities accessing assisted reproduction for these groups to advocate for fertility care based on reproductive justice.

METHODS: The article draws on semi-structured interviews and talanoa from a qualitative study conducted during 2020 and 2021 with 39 Māori, Pākehā, and Pacific people residing in Aotearoa New Zealand who have experienced fertility issues for social or medical reasons and have sought reproductive assistance, using a range of procedures and treatments, to create families.

FINDINGS: To better understand the reproductive journeys of people from these groups we report the challenges identified by study participants in the process of decision-making around accessing assisted reproduction and fertility treatment help-seeking. Importantly, we document a range of situational and structural fertility barriers that point to stratified reproduction relating to affordability, delays and long wait times for resources and services, discrimination, and non-inclusive care.

CONCLUSION: To address these issues, we recommend improvement to fertility treatment services and delivery that is culturally accessible, responsive, and equitable. This entails attending to the structural constraints that prevent people from accessing and obtaining the resources needed to realise their family building goals.

KEYWORDS: Aotearoa New Zealand; assisted reproduction; fertility barriers; qualitative research; structural infertility

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There is now an extensive body of international research on the use and uptake of assisted reproductive technologies (ART) in the social sciences. Much of this research has centred on high- and middle-income nations in the Global North such as the USA, United Kingdom, and parts of Europe (Shaw, 2022), and continues to focus predominantly on low fertility and ART access for heterosexual and cisgender couples and individuals (Tam, 2021). Unlike these studies, the focus of our project is on the fertility experiences of people from diverse and minority groups in Aotearoa New Zealand, stories that have been largely missing in the international literature. To address this gap—particularly in relation to the paucity of global research documenting Indigenous and ethnic minorities' experiences of infertility (Inhorn, 2020)—we contribute to burgeoning research in the local context with diverse and minority groups who have accessed assisted reproduction for the purpose of family building (see Foaese, 2017; Glover et al., 2007; Glover et al., 2009; Melville, 2016; Reynolds & Smith, 2012; Surtees, 2022). Our discussion includes a comparative overview of data from a qualitative study with same-sex couples, single people, older people, and Māori and Pacific peoples—individuals and groups who have historically experienced compromised or denied access to assisted reproduction. As our approach draws on a reproductive justice framework, briefly outlined below, the article concludes with recommendations for policy and practice. The recommendations build on discussion initiated in the "Expert views of assisted reproduction" study undertaken by the first author, which includes interviews with social work and psychology trained fertility clinic counsellors (Te Herenga Waka–Victoria University Human Ethics Committee approval 0000024373).

Literature

Reproductive justice calls for an analysis of the economic, regulatory and socio-cultural constraints on people's reproductive choices, enabling advocates "to make connections between the forces that shape [people's] opportunities, the conditions that affect [their] decisions, and the societal impact of the availability and use of certain technologies and practices" (Galpern, 2007, p. 5). To present our findings, we utilise a reproductive justice framework to address reproductive health and reproductive rights through the lens of structural infertility. Our approach highlights the importance of culturally competent and safe information about fertility treatment and services, the question of affordability and equity of access to reproductive services, and the ways people navigate the tensions between individual autonomy and socio-cultural norms relating to decision-making around family building and assisted reproduction.

Accordingly, we posit that compromised access to fertility treatment and ART renders participants in our study socially infertile under current policy, law, and practice. As Shaw (2022) defined it, social infertility is "an outcome of life chances and circumstances", encompassing a range of situational fertility barriers (Johnson et al., 2014) over and above factors such as delayed childbearing due to educational attainment and career success (Boddington & Didham, 2009). So, even where people experience medical infertility, they may also experience social infertility because their access to assisted reproduction is denied or compromised by structural, ideological, regulatory, and biological factors and constraints.

It is important to note that the term *social infertility* is often used in opposition to *medical infertility* by Aotearoa New Zealand fertility clinic websites and specialists (Fertility Associates, 2023a; Gillett, 2017). Drawing on the World Health Organisation classic clinical definition (WHO, n.d.), medical infertility is diagnosed as the inability to conceive after one year of unprotected sexual intercourse, or the inability to carry a live pregnancy to term. Social infertility, by contrast, is popularly conceptualised as a voluntary fertility outcome; thereby signalling a person's relationship status as single and/or their gender and sexuality as LGBTQ as a lifestyle choice or a personal preference. Defining medical infertility according to the WHO definition implicitly frames it as a planned event that affects cisgender women and heterosexual couples, potentially ignoring the experiences of cisgender men and LGBTQ people who form single- or multi-parent families outside the two-parent norm. In addition to being single or in a same-sex or gender diverse relationship, a person may be socially infertile due to financial insecurity, labour market precarity or unequal gender distribution of housework and childcare, which leads to low fertility rates and delayed childbearing. In this rendering, social infertility, which is impacted by age-related factors, is structural and not a choice (Shaw, 2022).

The concept of structural infertility, initially coined by Briggs (2018), takes us beyond the limitations of the medical-social binary. Building on Colen's (1995) notion of "stratified reproduction", which refers to obstacles hindering access to reproductive health, we use structural infertility to show how the interlocking effects of class, ethnicity, gender, generation, language, religion, and sexuality shape people's reproductive decision-making along stratified lines. This approach shows how the fertility issues and experiences of people in our study are structured by social and cultural constraints that limit or restrict their reproductive choices, thereby preventing them from accessing and obtaining the resources needed to realise their family building goals.

Method and ethics

The perspectives we present in this article are from 39 in-depth, semi-structured interviews of 45 to 120 minutes conducted in-person or via Zoom during 2020 to 2021. To ensure community safety and cultural sensitivity, our research approach followed the ethical guidelines outlined by the Pūtaiora Writing Group in *Te Ara Tika* (Hudson et al., 2010). This includes a combination of western ethical principles (consent, beneficence, non-maleficence and justice) alongside key elements of the *Te Ara Tika* framework: paying specific attention to whakapapa (building relationships and engagement between researchers and the community), tika (ensuring Māori participation, good research design and outcomes), manaakitanga (culturally safe behaviour, social responsibility and respect for persons), and mana (equity and distributive justice, including ownership of data and consent and reciprocity with Māori). Our research team includes members who identify as Māori, Pacific, Pākehā, and Tauiwi.

Because talking with people about infertility is a sensitive topic, one that is not openly discussed in Māori or Pacific communities, we were aware of the challenges around participant recruitment. To invite potential interviewees to participate in the study we used a variety of recruitment methods: social media platforms, university websites, a fertility consumer website, snowballing sampling, and word-of-mouth. Prior to recruitment, the team elected to interview participants from groups and communities with whom we had proximal identification. The focus on different cohorts in the study was therefore based on agreement about each of the researchers' personal and socio-cultural familiarity with specific groups and their positionality with respect to data collection (Bourke, 2014). We surmised that facilitating recruitment, cultural safety, rapport, and relationship-building with participants in these respective cohorts would assist inclusiveness. At the same time, because people's identities are fluid and relational it was important to recognise class, ethnicity, gender, language, religion, sexuality, and other categories of difference as inherently interconnected when representing participants' experiences accessing ART. The comparative aspect of the study meant that, within each of the cohort groups, participants occupy multiple intersecting identities. So, while the research team was sensitive to their own insider/outsider status from the perspective of study participants, we were also open to kōwhiringa (options) about who participants were comfortable talking with. Pacific participants were interviewed by the second author, who identifies as the team's Pacific researcher, but there were times when lesbian, bisexual, queer and Māori participants were interviewed by team members who identified as heterosexual, Pākehā and Pacific.

All participants were over 18 years of age, living in Aotearoa, and had attempted to create a family using a fertility service provider or assisted reproduction via donor insemination at home. Participants were spread throughout Aotearoa, with the majority located in major cities in the North and South Islands. Participants signed consent forms and completed a short demographic survey prior to their interview. Three interviews were conducted with participants who self-identified as Māori, 27 with Pākehā, and nine interviews, which employed a talanoa research method (Vaioleti, 2006) were conducted with Pacific participants. Some study participants identified multiple ethnicities. In this discussion, we refer to our participants' ethnicities as Māori, Pākehā, and Pacific, as this is the lens most interviewees prioritised when reflecting on their fertility experiences in our conversations with them. A total of 20 cisgender women participants identified as single mothers, two participants identified as cisgender men, and 10 participants identified as lesbian, bisexual, or queer. Participants' ages ranged from 33 to 59 at the time of interview, excluding one participant who was 28 years. Thirty-seven participants consulted a fertility clinic or GP (general practitioner/primary care physician) about fertility concerns at some point during their journey (ranging from one to over 30 visits); the remaining two participants did not consult a clinic.

The interview guide was designed to explore participants' views and experiences of their reproductive journeys, meanings around family and whānau, the significance of genetics for family-building, perceptions of fertility clinics, barriers to accessing treatment and suggestions for support and change when seeking assisted reproduction. Once the audio-recorded interviews were transcribed, they were sent to participants who requested them for checking. The data were then manually coded line-by-line from the transcripts and sorted into codes based on areas of relevance to the research questions and patterns across the interviews. The lead researcher and a research assistant discussed the relationship between these areas to identify candidate themes and subthemes. They then met to discuss and finalise the themes presented in this article (Braun & Clarke, 2013). In the article, we report aggregated findings relative to three overarching themes that represent key barriers presenting challenges for participants' decision-making and access to fertility treatment: cost, time, and non-inclusiveness. The study received institutional research ethics approval from Te Herenga Waka–Victoria University of Wellington (0000027702) and Auckland University of Technology (19/266 2019).

Study findings

Cost

Ability to pay has been identified in the international literature as one of the key barriers influencing the uptake of fertility treatment and ART (Connolly et al., 2010; Peterson, 2005). In Aotearoa New Zealand all three providers of fertility services (Fertility Associates, Fertility Plus, Repromed) offer private and publicly funded treatment. At the time of writing, Repromed advertises the cost of one in vitro fertilisation (IVF) cycle between NZ$11,500 and NZ$17,000, excluding genetic screening tests and donor treatment (egg, embryo, sperm) costs, and the cost of one cycle of intrauterine insemination (IUI) as approximately NZ$2235 excluding donor sperm (2023).

Cost was frequently noted as a significant impediment for our participants, including for 17 interviewees who had an annual income over NZ$100,000. One participant explained how they had to choose between accessing private fertility services and saving to buy a house, another mentioned having to use their redundancy pay-out, and one single mother re-mortgaged her house to afford treatment. Several single mothers mentioned that they were financially supported by family to assist with treatment costs, and others drew on savings they had set aside from established careers. Four Pacific participants (all of whom noted a higher average income on their demographic form than the general Pacific population) commented that it took months and years to save and secure the necessary funds, with one participant noting: "Even my first consultation was like $200 something dollars. It is expensive for a half-hour consultation." Participants also commented on the hidden costs of fertility treatment such as blood tests, sperm health supplements, preconception tablets, ovulation test kits, donor testing costs, costs of travel to and from the clinic, and time away from work.

While Aotearoa New Zealand offers publicly funded fertility treatment, many of our participants were ineligible due to not meeting Clinical Priority Assessment Criteria (CPAC) (Fertility Associates, 2023b). The criteria for public funding are strict and based on medical infertility. Patients must score 65 or more assessment points to be eligible for placement on the waiting list. The main barriers to public funding our participants discussed included not meeting Body Mass Index (BMI) >35 at first specialist consultation or >32 to receive treatment, age 39 years or younger for women (55 years for men at referral) (Te Whatu Ora, 2023), and lack of evidence trying to get pregnant.

None of the single mothers accessed public funding as they did not easily meet the CPAC. For single mothers and same-sex couples, the most difficult criterion to meet, aside from age, was being able to prove to fertility providers that they had been trying to get pregnant. Proof consists of evidence of 12 cycles of donor insemination, with six treatments at a certified Aotearoa New Zealand clinic, before being considered for funding.

Participants recalled costs for one cycle of IUI at around $1500 to $2000 and IVF between NZ$11,000 and NZ$15,000 at the time of procedure. Virtually all participants accessing clinic services needed more than one cycle of treatment, with several requiring a combination of IUI, ICSI (intracytoplasmic sperm injection), and IVF. All had to fund these services privately. One participant noted the cost of an ECART application for embryo transfer, plus additional counselling and legal fees, in excess of NZ$6000.

Three single mothers used overseas gamete donors they paid for. One, who accessed treatment in the United States, was able to access private health insurance to assist with costs. For another, the Medicare rebate system in Australia was used to reduce costs. The significance of cost is summed up by a single mother, who commented that investment is more than money, saying: "I've invested so much into this, and said 'no' to relationships and jobs and all of this, so do I just stop and finish with nothing, or give it one last shot?"

Time

Although ART reconfigure how to, when and who can constitute and create a family, temporal limits imposed in Aotearoa New Zealand around age impact access to public funding for fertility treatment as well as the success rate of various treatments (e.g., IVF success for women decreases after the age of 35 (Repromed, 2023a)). Participants drew implicitly on biological clock imagery to describe their reproductive time as "running out". The imposition of external delays such as long wait times for consultations and clinic appointments with wait lists of up to two years for IVF, as well as difficulties finding gamete donors, were therefore negatively connotated in participants' accounts. Clinic wait times for donor testing and consultation were an added stressor. Due to their relationship status, single mothers and same-sex couples in the study had to undergo the process of finding sperm donors. Many of the single parents spoke about their difficulty finding a partner to have children with, explaining how the expectation to have children added pressure on dating and contributed to their reasons for undergoing fertility journeys alone. One single mother commented, “I can meet a partner anytime but I’m actually running out of time to have a child.”

Ten heterosexual, lesbian, and queer-identified participants had pre-existing agreements with relatives, friends, acquaintances, or people they met online who were willing to donate their gametes. Donor insemination at home was not always successful, and some participants turned to clinic-based pathways for assistance. Several participants with known donors used a fertility service provider from the outset. Most participants mentioned long wait times for gamete donors as a barrier. This was significant for participants who sought identity-release clinic donors where age-related fertility decline was a key concern. As reported by MacManus (2017), participants confirmed that the wait time for enrolling and receiving donor sperm was between 1 to 2 years in many cases; although the Fertility Associates website now estimates wait times between 2.5 to 3 years (Fertility Associates, 2023c).

One participant advised starting the journey early if one is single and another said to go on a sperm waiting list by age 34 as waiting times for donors and appointments delay timelines. Some participants noted that the wait time for IVF donors was shorter than the wait time for IUI due to a minimum sperm count needed for IVF success. Those participants who chose to undergo at-home insemination, including participants who had previously sought clinic treatment, endeavoured to avoid costs and wait times for fertility services. Two participants explicitly wanted to create family by side-stepping the clinic and regulatory context. One participant reflected in the following quote: “I wanted to create a whānau with zero state involvement, I didn’t want legalities, I didn’t want lawyers, I didn’t want the state to have any control in how a family looked.”

Non-inclusiveness

In addition to anxieties and concerns around wait times impacting diminishing fertility windows, participants commented on the lack of culturally competent and safe fertility treatment in their interactions with administrative staff and healthcare professionals at clinics they attended. Most participants relayed stories about barriers to fertility services that included non-inclusive care, voicing accounts of discrimination they faced on their journey, in the clinic and regarding cultural, social, and professional attitudes. Pejorative comments in relation to age, weight, and sexuality were commonly cited. For example, ageist discourse was described by a participant who faced judgement from friends for having a child later in life. A couple of participants commented on their experiences of polycystic ovarian syndrome, impacting their ability to manage their weight. These, and other participants, spoke of the fatphobic remarks they faced from fertility clinic staff. A Māori participant recalled her GP saying: “Oh, well, it’s not hard to lose weight you know, if you just cut out carbs”, commenting that the GP regarded weight as the cause of her infertility and losing it as the solution.

Several same-sex couples noted the non-inclusive language used by clinics (e.g., assuming gender without asking) and the general discomfort they faced when accessing services and interacting with clinicians. Most participants touched on the cultural stigma of IVF and infertility, with two participants noting how they had to keep their journey a secret in the workplace. Some participants spoke about having to exercise self-advocacy with service providers and seek wider community support when they did face discrimination. Pacific participants who were affiliated with a Christian church commented on resistance from church leaders who did not approve nor agree about the use of ‘science’ to create a child.

Many of the single-mother participants spoke of facing discrimination for undergoing the fertility journey alone. Microaggression and insults came from workplaces, fertility clinic staff and health professionals, and public discourse. One single mother explicitly chose not to tell their work about the journey, and one mentioned how their co-workers assumed they had been 'knocked up'. One shared how a Plunket nurse had questioned her financial stability due to her single status, and another felt constantly discouraged by the clinic, being told by a nurse they were too old and that they were potentially taking someone else's 'spot' by trying. Another single mother found the antenatal clinic was uninformed about diverse family formations and assumed that all children had two parents. The antenatal clinic also provided misleading information, according to this participant, who filed a complaint. One single mother felt a sense of judgement from others for undergoing IVF and noted that people kept asking about the ethnicity of their child (as they had used an international donor). Two single mother participants noted how cis-heterosexual men are often praised for having children at an older age (e.g., well-known celebrities), yet the same praise is not given to women who have children later in life. A participant, who was over 50 years of age at the time of donor-conceived conception, commented:

> Some people told me that … I'll be an older mother and … I'll be dead before this child gets married, you know, that kind of thing. So, there's quite a lot of, anti-having a child at an older age, that people were quite vocal about.

Most participants commented on the importance of having a strong support network on their fertility journey and were selective about who they confided in as they were aware of how some external views were detrimental to the journey. Many mentioned the lack of support services and follow-up care during clinic treatment and at its conclusion, with some referring to silence around miscarriage and early pregnancy loss as an example (Shaw, 2020), as well as difficulties establishing ongoing contact with clinic-based identity release donors.

Pacific participants shared misunderstandings they received from their families and communities regarding fertility challenges, particularly around sex. For example, almost all encountered assumptions that consummating a marriage and having heterosexual intercourse will result in a pregnancy. One participant reflected on being told to have sex often to increase the chance of conceiving, remarking: "Our people need to be open to addressing infertility in a supportive way instead of just assuming that we pop out kids when we can or after sex. It doesn't work like that."

Discussion

A recent quantitative study concluded that "compared to overseas assessment, NZ fertility care is shown to be patient-centred" (Mourad et al., 2019, p. 271). Accounts from participants in our research confirm positive, patient-centred interactions with fertility counsellors in the local context. We have not presented these findings here. In this article, we focus specifically on a range of barriers impacting access to fertility treatment services in Aotearoa.

One of the most significant issues participants emphasised was the importance of cultural awareness and competency training for fertility clinic staff and GPs, including work on personal skills such as sensitivity and active listening. Several lesbian, bisexual, and queer participants proposed mandatory gender and diversity education for clinic staff as one avenue to achieving this. A few participants said that advocacy and awareness of infertility and social infertility would promote wider social acceptance of diverse forms of family.

Some participants cited informational barriers and suggested improvements to fertility service provision involving diverse language and ethnic representation on clinic websites. Several Aotearoa New Zealand fertility clinics employ doctors who speak Mandarin and Hindi. However, currently only one clinic, Repromed, employs a Māori fertility counsellor. Fertility Associates, which has clinics across the country, is the only provider to employ a Māori fertility specialist. While each clinic website references commitment to Māori cultural and traditional practices, and two clinics include a link to a Te Reo (Māori language) page, at the time of writing there is no information on these websites in any Pacific language (although there are links to pages in simplified Chinese and French).

Some participants commented on the austere aesthetic of the fertility clinic space and its design and décor as uninviting, uncomfortable, or too 'Pākehā'. While fertility clinic spaces are carefully designed to ensure privacy and discretion between patients and staff, our data indicate a need to 'colour in white walls' of the clinic to ensure people accessing these services feel welcomed and safe.

Several interviewees raised concerns around the lack of inclusive signage and the use of outdated terminology on clinic forms, an issue also raised by transgender and non-binary people accessing fertility preservation services in Aotearoa New Zealand (Ker et al., 2022). While some fertility clinics provide useful website glossaries of key treatment-related terms for patients, low fertility knowledge, health literacy and lack of cultural safety suggest these terms may have little meaning for those who do not speak English fluently or are uncomfortable with highly medicalised and clinical language.

Accordingly, participants commented that healthcare providers and policymakers need to consider how culture and ethnicity shape attitudes toward in/fertility to provide quality information, counselling, and procedures that are responsive to the concerns of diverse and minority groups. Given the success other projects have found by both making information accessible and appropriate and providing information leaflets in translated content (see Culley & Hudson, 2009), culture- and language-concordant care could assist to increase access to fertility treatment for the diverse communities in our study. Several Pacific participants also suggested that fertility clinics, GPs, counsellors, and religious leaders work together to ensure communities are provided with the information they need to make informed decisions around fertility treatment options.

Most participants were asked about the limits around public funding for fertility treatment services. Five single parents agreed that the age limit for public funding was too low and should be raised to above 40 years, with one participant suggesting 47 or 48 years. One single parent commented that society is shifting to older age of marriage and children, so funding eligibility criteria should shift to accommodate this. Participants also suggested that low-cost clinics, like those in Australia, be set up to accommodate the needs of LGBTQ people, single parents, and those from lower socio-economic backgrounds.

A key issue for many participants was spuriousness around producing proof of donor insemination for access to public funding. While single parents and same-sex couples must prove they have been trying to get pregnant for a year, GPs and clinics assume that heterosexual couples have done so if they claim this is the case. Our participants questioned this double standard.

While some participants were wary of regulating personal or private sperm donation, one participant supported a centralised system with donor information, including a database to record online sperm donors matched with women who had used at home insemination to ensure open disclosure for donor-conceived persons. Donor-linking recognises the importance of whakapapa connections for Māori, as legislated in the Human Assisted Reproductive Technology (HART) Act of 2004 (Daniels & Douglass, 2008) and aligns with international literature in sociology and social work acknowledging donative acts as relational decisions that not only implicate those immediately involved (donors, intended parents, donor-conceived offspring), but also donors' own families and social networks (Blyth, 1999; Nordqvist & Gilman, 2022).

Along with the eight Pacific women participants, two Pākehā and one Māori participant criticised the BMI limit, saying it was arbitrary and lacked evidential basis. They commented on the BMI requirements being too low, adding that this was inequitable for Māori and Pacific peoples who do not meet those requirements easily (see Parker & Le Grice, 2022; Shaw & Fehoko, 2023).

All study participants voiced that their reproductive journeys were difficult. While the ability to pay was universally cited as an impediment to accessing treatment, it was not the only barrier. Participants called on policy makers and fertility providers to produce and disseminate culturally appropriate awareness-raising information about fertility treatment, increase efforts to reduce lengthy wait times for consultations and access to donor gametes, improve donor disclosure processes, fund and provide access to counselling services during and after treatment, rethink public funding eligibility criteria, particularly around BMI, and provide mandatory education and training for health professionals working in the field to create non-discriminatory and inclusive care relating to service delivery.

Concluding comment

While trends relating to fertility rates in high income countries like Aotearoa New Zealand have been attributed to delayed childbearing for reasons to do with educational attainment, career success, and lifestyle decisions, the accounts of participants in our study show that involuntary childlessness and access to ART are not simply a product of personal choice. Rather, the reproductive self-determination of participants must be understood more broadly, in relation to structural constraints that prevent people from accessing and obtaining the resources needed to realise their family-building goals. The allyship and contribution of social work and counselling professionals who provide advice, information, and services to those seeking fertility treatment and assisted reproduction is key if we are to address these inequities and advocate fertility care based on the principles of a reproductive justice framework.

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Declaration of interest statement

The authors declare that there is no conflict of interest.

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“It helped that I’m a middle class, educated, White lady”: Normative bodies within fertility clinics

Lisa Melville, Te Whare Wānanga o Waikato | The University of Waikato.

ABSTRACT

INTRODUCTION: Fertility clinics, and the assisted reproductive technologies undertaken within them, hold the possibility of creating an eclectic mix of families. Fertility clinics are sites where several fields such as technology, ethics, profit, law, policy, and bodies, intersect with the construction of family. What might the experiences of queer women within fertility clinics in Aotearoa New Zealand indicate about how these fields collude and collide with the notions of the right to have a child, delivering accessible services, and how regulations are applied?

METHODS: This study used a qualitative, multi-methods approach. I conducted 27 face-to-face semi-structured interviews and ran an online survey (88 responses). Questions focused around the decision making and experiences of lesbian women in conception, maternity and family spaces.

FINDINGS: This research found the path to, and through, fertility clinics in Aotearoa New Zealand may be easier for those who embody privilege, that is those who present as white, wealthy, heterosexual, and feminine. Exclusions are practised through policy, wording, inference, and behaviour.

IMPLICATIONS: Fertility clinics demonstrate the inequity of reproductive justice. Normative understandings underpin the right to have a child, accessible services, and the application of regulations. These understandings work to trouble paths to parenthood, not only for lesbians, but for many others within and across a variety of other groups. Access to, and movement through, these spaces can strongly reinforce narrow understandings of family. Fertility clinics not only create families, but also reproduce particular types of family.

Keywords: Heteronormativity; queer; lesbian; family; assisted reproductive technologies

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Fertility clinics are of particular interest when discussing reproductive justice, reproductive health, and reproductive rights, as they are places whose primary concern is to (re)produce families. Fertility clinics are also spaces where a number of fields intersect with the construction of family: technology, ethics, profit, law, policy, and bodies. Practices in fertility clinics are not inert, but are shaped by cultural and kinship ideas and beliefs (Hargreaves, 2006; Michelle, 2006; Nordqvist, 2011; Thompson, 2005). Fertility clinics are therefore spaces that demonstrate what is deemed ‘family’ and create and reinforce family legitimacy.

Fertility clinics reproduce more than just families. One of the debates around Assisted

Reproductive Technologies (ARTs) is whether they are “innovative ways of breaking free of bondage to old cultural categories of affiliation or whether they are best denounced as part of a hegemonic reification of the same old stultifying ways of classifying and valuing human beings” (Thompson, 2005, p. 177). Theoretically, this question can be easily answered: the technology itself provides for any number of permutations and renditions of family. ARTs procedures can challenge biological essentialism of family through the separation of motherhood through egg, gestation, and biology. Situations that exist in the utilisation of ARTs (such as a woman carrying the embryo of her mother and step-father) also challenge biologically essentialist understandings of (in that situation) daughter, husband, father, grandmothers, aunt, and child (Thompson, 2005). ARTs destablise assumptions about family and biology (Epstein, 2018).

Fertility clinics have been critiqued, however, for both serving and reproducing a particular *type* of family (see: Lttichau, 2004; Michelle, 2006; Millbank, 1997; Short, 2007; Statham, 2000). They “reproduce more than humans: they reproduce consumer marketplaces, normativities, notions of belonging, and intensifying inequities” (Mamo & Alston-Steppnitz, 2015, p. 521). These normativities have included (and still include in some places) rules around access to fertility clinics (for instance being married; see Lie & Lykke, 2017), conditions for public treatments (for example the use of BMI which is based on a normative White body; see Shaw & Fehoko, 2022), and the expense of private treatment.

Brown and Perlesz (2008) remind us that family “is a culturally dominant idea or world-view that bestows legitimacy, privileges, and resources on some family arrangements, *whilst withholding them from other[s]*” (p. 287, emphasis added). The laws, policies, practices and assumptions of family mean that fertility clinics bestow on some people the ability to create family, while excluding others. Garwood (2016) recognises fertility clinics “have been set up to deal with heterosexual infertility, [and] implement a heteronormative understanding of fertility” (p. 11). Fertile lesbian bodies queer these spaces of infertility, and lesbians utilising fertility clinics can highlight normative assumptions underpinning who is being privileged when considering the rights to have a child, the delivery of accessible services, and how regulations are applied.

There are seven fertility clinics in Aotearoa New Zealand, operated by three different companies, and located in five of the six most populated cities. Repromed, Fertility Plus, and Fertility Associates all have clinics in Auckland (the largest city). The largest company, Fertility Associates, also has clinics in four other cities: Christchurch, Wellington, Hamilton and Dunedin. Fertility Associates also has 11 satellite clinics (which offer consultation services only).

The study

This article draws from my PhD research (Melville, 2021) where I examined how lesbians’ experiences of conceiving, being pregnant, birthing (and also sometimes not conceiving, not being pregnant, and not birthing for one partner) and mothering both reinforce and trouble the normative gendering of bodies and spaces. I conducted 27 face-to-face, semi-structured interviews, 16 with one person (either a sole-parent or one partner from a couple) and 11 with couples. The interview questions focused on how people started their families, how they decided who the donor was going to be, and their experiences with fertility and maternity services. I also ran an online survey at the same time, based around the same lines of inquiry, with 88 responses. The study received ethical approval from the Waikato University Ethics Committee on 12 January 2016.

I used the term *lesbian* when recruiting for the participants, however, not everyone in the research identified as a lesbian. In terms of sexuality, over half of respondents I interviewed (52%) self-identified as 'lesbian' while another quarter (24%) self-identified as 'gay'. The remainder (24%) self-identified as 'queer', 'mostly lesbian', or 'queer/lesbian'. In terms of gender, everyone self-identified as female. These, then, are not the stories of non-binary or gender diverse people. They are the stories of some lesbian and gay and queer women, and I use the terms 'lesbian' 'queer' and 'gay' throughout, not because they are interchangeable, but because if I use the term 'lesbian' as an umbrella term for them all, I obscure some voices, which are already marginalised. By using the different descriptors, I pay homage to people's different identities, as well as acknowledging people may choose to identify differently at different times and in different spaces, and perhaps direct attention to the fluidity of sexuality.

Discourse analysis and thematic analysis were used for analysis. Both of these types of analysis are not about uncovering *the truth* but more about the way participants construct their own realities and identities. I utilised three different types of themes: literature-based, question-based, and emergent. Before undertaking the interviews, I created documents based on common themes from relevant scholarship (literature-based themes). I also created documents based on themes derived from the interview and online questions (question-based themes). Lastly, during the interviews I added themes that were data driven—commonalities that arose across discussions with participants (emergent themes).

Examining bodies

Human Geography is a field which recognises bodies can be used to "highlight relationships between power, knowledge, subjectivities and spaces" (Johnston, 2005, p. 106). This interaction between bodies and the spaces they move through can expose power and privileges that exist. Spaces are not inert but are produced and maintain cultural norms, with many geographers focusing particularly on the assumption of heterosexuality (see: Browne & Nash, 2010; Butler, 1990; Hubbard, 2008) and how the realities of bodies demonstrate the gendering and heteronormativity of spaces (see: Johnston, 2016; Longhurst, 2001; Watson, 2005).

Heteronormativity is the assumption that heterosexuality is the only sexuality. However, heteronormativity also promotes one particular heterosexual norm, which marginalises many other heterosexual identities and practises (Richardson, 2004, 2005). Although geographers may focus on the heteronormativity of space, Valentine (2000) reminds us that spaces are produced in a variety of ways and "the identity of spaces, like the identities of individuals, are always cross-cut with multiple contradictions and tensions" (p. 5). A space is not just 'heteronormative' or 'queer', just as "masculinities are culturally constructed in relation to femininities and other social identities (class, race, sexualities)" (Gorman-Murray, 2008, p. 368).

This crossing and combinations of identities ties into *intersectionality*, a term coined by Crenshaw. Crenshaw (2017) defined intersectionality as:

> a lens through which you can see where power comes and collides. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things.

Intersectionality recognises unique oppressions exist, and also they change when in combinations. A second aspect of intersectionality that Crenshaw mentions is that it "is not only about multiple identities but is about relationality, social context, power relations, complexity, social justice and inequalities" (Hopkins, 2019, p. 937). Similarly, in discussing hegemonic heterosexuality Allen and Mendez (2018) also took into account spheres of ability, class, ethnicity, nationality and race. Specifically focusing on fertility clinics, Gabb (2004) suggested ethnicity, wealth and geographical location could impact on the choices of lesbian couples wanting to have children.

Paying attention, not only to the spaces of insemination, but also to the bodies involved in insemination may reveal new ways of knowing and understanding, as well as problematising boundaries and binaries. Examining lesbians' experiences within fertility clinics, developed to recreate the normative heterosexual family, may expose underlying assumptions about family, about mother, and about bodies (Longhurst & Melville, 2020). Geography also works from a strength rather than a deficiency approach, allowing for the possibility that these families might have much to offer understandings of family and kinship.

Findings

Queer women often find fertility clinics to be awkward spaces. The normativity clinics both ensconce and are ensconced within, make it difficult for people to create alternative family formations. I examine four aspects that create a path of privilege through the clinic: wealth, definitions of infertility, gender normativity, and definitions of family. Lastly, I look at how privilege is extended to the families that are created in fertility clinics.

"Money is a deciding factor. And that sucks"

Eligibility for free public funding for fertility treatment is based on the scoring system Clinical Priority Assessment Criteria (CPAC). One of the requirements of CPAC differs depending on sexuality. Heterosexual couples must have been trying to get pregnant unsuccessfully for one year. Like heterosexual couples, lesbian couples must also have been trying unsuccessfully for a year, however six months must be within an authorised fertility clinic. Lesbians therefore need to be able to cover the costs of six months of treatment before they can access state funding. One month of Intrauterine Insemination (IUI) (the cheapest form of assisted reproductive technology offered) costs NZ$1720, plus NZ$0-500 for medication (Fertility Associates, 2020). (There are also additional costs such as appointments, sperm storage, blood tests, travel to and from the clinic, which are not considered here.) While funding is never guaranteed, heterosexual couples can be expected to be assessed, whereas lesbian couples require at a minimum NZ$10,320 before they can get to this initial stage.

Paula (queer Pākehā in her late 30s and mother of one[1]) mentioned this injustice:

> There's a real base line frustration, the whole thing that basically you have to pay thousands of dollars for a privilege that heterosexual couples at least get a head start. It doesn't work for all of them, and I don't make assumptions about fertility in that way, but at least they get to have a head start and so it kind of feels a bit "on the nose" [unfair] I think … it does grate a little bit that you have to pay from the get go for a process that you physically, mechanically you can't do.

Kelly (a lesbian Pākehā in her late 30s and mother of one) mentioned how much the basic cost of the clinics cost their family:

> Going down that track is very financially costly. [Our child] owes us heaps of money. We've got all the bills so we're gonna give them to him when he's 21 and say guess what mate [laughter]. $28,000 [approximately US$19,000] thanks very much.

Megan (a Pākehā/New Zealand European/New Zealander in her late 40s and mother of one) also mentions the cost for her family:

> The criteria for getting funded fertility help are atrocious for lesbians. We took seven years to get pregnant, and spent $30,000 [approximately US$20,000] before we were eligible for funding. … Given

> that women are generally paid less than men, I think that lesbian couples are probably less wealthy than heterosexual couples, and so this requirement to spend so much money on self-funded inseminations discriminates against us.

The intersection of sexuality, financial resources, and gender (through the gender pay gap) all impact on disadvantaging queer women seeking to create a family.

Kelly jokes about being unable to get pregnant, as many of the women did: "We've been trying for five years, it hasn't worked, I don't know why [laughter]." But she also recognises the social injustice of this distinction between queer and straight couples:

> We did feel a bit ripped off about not being able to get funded in the same way that a straight couple would. So that was one thing that I just thought "oh this doesn't seem fair to me". It should be funded for lesbian or gay men at the same as it is for straight people who are not able to conceive a baby because I'm not able to conceive a baby with a female partner. It's impossible so I should be able to get funding to do that, the same way as a straight couple.

Kelly and her partner Shannon eventually did get public funding. The reason for their funding had nothing to do with a system recognising inequity or seeking to counter-balance the impact of intersectionality:

> We actually had to say that Shannon had been trying with her ex-partner who is a man and that what's got us [the funding].

Kelly and Shannon received public funding to create their family because of Shannon's prior relationship with a man. Being heterosexual outside the clinic is rewarded inside the clinic.

Queer couples therefore have financial considerations that most straight couples do not. Their available financial resources impacts on their decision making about how they might create their families. Although Catherine (a gay Pākehā in her early 30s) and her partner Margaret (a gay Māori in her early 30s) initially considered a clinic, they did not use one:

> … and so we started to look at different ways of having children and cause we were students at the time, or I was working fulltime and you were still studying? We were really poor, well that's ridiculous, we were just, we didn't have a lot of spare money and so going through [a fertility clinic] just seemed so expensive to us.

Catherine acknowledges the use of "really poor" was an incorrect framing of their financial situation, highlighting that if fertility assistance was beyond the financial means of a family who have some discretionary income, then fertility assistance must be out of reach for a vast number of people.

Many women seemed very aware of the consequences of the cost, not just for them, but for others wanting a family. Paula realises it would affect some heterosexual couples, but not to the same extent:

> [Money] is a similarly limiting factor for some [straight] couples but I guess because they can get pregnant outside of the clinic, the people who are being disadvantaged, [it] is a much smaller proportion of them.

Paula acknowledges that financial resources affect people's choices in how they create their families: "money is a deciding factor. And that sucks." She continues, recognising both the emotion involved in creating families and her privilege:

> I mean Susan and I are incredibly fortunate that … you know we earn generous salaries but actually I don't think it's right. I know how gut

> wrenching it is to be able to afford this and to do it, and just know that it's your biology and your chances and your rah de rah de rah that affect the outcome. For me to have considered that money might be a limiting factor, that would just be devastating.

This lack of choice to use fertility assistance is not limited to gay women, but these comments show how lesbian couples' access to fertility clinics is limited through their gender, and therefore potentially receiving less in wages due to being women, as well as their sexuality, where the privileges of heterosexuality outside the clinic are also rewarded inside the clinic.

Kelly also discussed how money impacts decision making:

> It means that people that don't have the resources can't make the same choices that I can, as someone who is fortunate enough to have resources. It's stink. … Because then you're probably more likely to put yourself in a difficult position perhaps than if you do have the you know you might end up who knows you could do all sorts I'm sure you understand what sort of things [laughter]. And then you get yourself in trouble … As I said having a child is complicated enough as it is without anything else going haywire.

Kelly highlights the point that the clinic can be a safe space for creating a family and removing the clinic as a choice potentially places people who want to create a family in more dubious spaces and situations.

Examining medical infertility

Teresa (a mix of four Eastern and Western European identities in her early 50s and mother of one) said online she "resented having to pay when straight couples who lacked viable sperm didn't". Heterosexual women in a relationship with someone whose sperm is not viable do not usually have to pay for the service. Women in a relationship with another woman (who, it can be argued, also does not have viable sperm) have to pay for the service. Teresa is calling into contention the distinction between 'medical infertility' (for instance a physical condition such as low sperm count), and 'social infertility' (an outcome of life chances and circumstance).

'Medical infertility' is not an objective medical term or biological definition, but "equally a socially constructed phenomenon existing within a complex matrix of historical and socio-cultural specificities" (Statham, 2000, p. 136). For instance, the factors or causes of infertility are often unexplainable as "many couples will not have a clear-cut infertility diagnosis—over 50% in fact" (Fertility Associates, 2019). So even though access to fertility treatment is often framed under a rhetoric of medical infertility, which works to easily exclude gay and single women, straight couples are given access even though under the criteria for medical infertility, more than half of them are not eligible.

Analysing court cases in Australia, Statham (2000) made the same point that infertility is a fluid construction, and not based on the biological capabilities of the body but rather the context of the body. She examined two examples: firstly, where a heterosexual woman had an infertile male partner, and secondly, a woman with a female partner who was seeking sperm.

> In either case, the "medical (in)fertility" status of the recipient, considered as an individual, is identical. The telling difference, however, is that infertility is (socially) constructed so as to legitimate and protect the integrity of the exclusive couple relationship in the former case (the heterosexual couple is infertile) but not in the latter (the lesbian woman is not). (p. 138)

Infertility is not therefore solely an embodied medical condition. In the scenario above the straight married woman's body is fertile, as in the lesbian woman's body. The medical condition of both bodies is the same. Due to the combination of legal and sexual privilege, one body is given access to fertility treatment, and one body is not. The difference between infertile and fertile bodies is therefore not simply an easy medical distinction.

"They don't look like the mother role."

Gender normativity means ascribing to the body and actions of one of the binary genders—male or female. As people tend to interact with clothes on, it is the outward portrayal of male or female—people's appearances—that provides the information to pigeonhole someone as male or female. Within the context of Aotearoa New Zealand looking 'female' can cover a wide range of appearances but within the space of a fertility clinic this idea of 'female' is closely interwoven with ideas of 'mother'. For instance, a lesbian who adapts appearances that would score highly on a 'feminine' scale (i.e., who wears lipstick and frocks), seems to have no problem moving through the fertility clinic. A lesbian who adapts appearances that wouldn't score highly on a 'feminine' scale (i.e., wears trousers, has short hair) or would score on a 'masculine' scale (i.e., wears a tie, is muscular or bulky) may encounter more resistance.

Vanessa (a lesbian NZ European in her early 30s and mother of one) and her partner Cassandra had an easy experience within the fertility clinic. As a queer woman, she thought this was due to them both being gender normative:

> We've had really good experiences as a lesbian couple in general because we're not stereotypical. Visually we're not [identifiable as two queer women]. People are often surprised, so I could say probably quite confidentially that we've had pretty good experiences because of that.

Similarly, Kitty (a lesbian Western European/Pākehā New Zealander in her late 30s and mother of one) says that she is "reasonably feminine, and yeah, could pass as straight". Kitty and her partner Polly found their journey through the fertility system reasonably straight forward. In comparison, friends of theirs, who present as "quite butch", were finding the clinic quite difficult. Kitty muses:

I do notice there is often a bit of distinction between how people generally treat women who present as quite feminine. … versus those that present as really quite masculine and butch. And I have noticed, not just with parenting or anything, but generally, the more sort of the butch ones get a rawer deal you know.

She continues:

> I mean it's a totally uninformed opinion, but I wondered if, I don't know, maybe that's part of the cold shoulder [my friends are] receiving from [the fertility clinic]. [They] don't look like the mother role.

Kitty suggested that being lesbian and not gender normative may present roadblocks within fertility clinics, where heteronormative ideas of women, femininity and motherhood are interwoven. Michelle (2006) argued that while ARTs can broaden new territories for mothers, regulations reinforce particular interpretations of bodies by

> … attaching individuals to specific identities, and establishing norms against which individuals and their behaviours and bodies are judged and against which they police themselves. (p. 26)

Bodies themselves are not impartial, but spaces of cultural interpretation which privilege different representations, depending on gender norms. As McDowell (1995) pointed out: "masculine characteristics and attributes have different meanings depending on their embodiment in male or female bodies" (p. 71), so having short hair or wearing a suit often elicits different understandings depending on whether the person is male or female. Johnston (2016) called for more recognition of where the privileges of being-cisgender are played out, and Kitty and Vanessa highlight fertility clinics as one such place.

Kitty and Vanessa's experience also demonstrate how access to ARTs can work to ensure gay and lesbian families reproduce dominant behaviours of heteronormative families (Jones, 2005), and this reduces their ability to deconstruct or broaden notions of family. Therefore, homonormative lesbian couples who may be given access are

> … conforming as closely as possible to dominant ideals of the family as a middle-class, self contained economic unit, perhaps even mimicking the traditional division of domestic labour in which one partner works while the child bearer is a stay-at-home mother. (Michelle, 2006, p. 28; see also Dempsey, 2004)

In this way, lesbian families may become "families in drag" (Malone & Cleary, 2002, p. 274). This performance actively "serves to both reinforce familial ideology and further marginalise those unable or unwilling to conform so successfully due to their socio-economic class, ethnicity, lifestyle choices, or political beliefs" (Michelle, 2006, pp. 28–29). Heteronormativity provides a particular heterosexual norm, which marginalises many heterosexual identities and practises (Richardson, 2004) and also imposes particular gendered identities and practices, which marginalise many heterosexual women who do not subscribe to these notions of 'femininity' (Rich, 1980). Heteronormativity also marginalises men who do not subscribe to notions of hegemonic masculinities.

Queer families and their use of ARTs can also be regarded as transgressive:

> As a route to conception, donor insemination transgresses conventional discourses concerning conception, and also those concerning parenthood, family structure and kinship connectedness. Moreover, it enables reproduction beyond conventional gendered and heterosexualised reproductive regimes. (Nordqvist, 2011, p. 115)

That is, as well as disrupting heteronormative understandings of family, queer families also disrupt gender roles within families. Similarly, heteronormativity is maintained by not recognising lesbian and gay families as 'family', and so situating both heterosexuals and queer families within 'family' consequently broadens understandings of family.

Within fertility clinics then, queer families are "enabled by both complicit acceptance and active negotiation of these structures" (Mamo & Alston-Stepnitz, 2015, p. 521). Just as ARTs can be used in a way that is normative and a way that is transgressive, when queer families utilise ARTs they can similarly be regarded as both normative and transgressive.

Intersectionality can be seen operating in fertility clinics, where different axes of embodied subjectivity intersect to give rise to a wide range of experiences for lesbian mothers. Lesbians are a "doubled subject" (Johnston, 2005; Probyn, 2005), in that their bodies are an intersection of both gender and sexuality. However, some lesbian women utilising fertility clinics recognised that although they are queer, other embodied identities provided privilege that helped them pass through the fertility system more easily. Danielle (a lesbian New Zealander/European in her early 40s and mother of one) was aware that her embodied subjectivity impacted on her experience of becoming a mother:

> It helped that I'm a middle class, educated, White lady so I kind of just shuffled along, and I'm a New Zealander so I sort of shuffled along in that general group pretty well.

Fertility clinics are spaces where embodiment impacts on experiences, or even the possibility of receiving treatment.

"They count lesbian families as two families."

Within Aotearoa New Zealand sperm from one donor is generally allocated to a maximum of five families. Fertility Clinics in Aotearoa New Zealand have different slightly different wording and forms for those donating sperm. Below are examples from two clinics:

> My sperm may be used for … (*maximum of five*) families.
>
> I request that the maximum number of families that may be created from my donations is: … (Maximum number of families allowed is 5).

The way these statements are worded situate the sperm donor as the creator of families. The sperm is centralised in the making of families and the inference is the sperm is making the families. There are alternative ways that an agreement can be phrased, that instead gives the sperm to the families, and leaves the making of families up to them. Examples I can think of include:

> My sperm may be given to … (*maximum of five*) families.
>
> I request that the maximum number of families that my donations can be given to is: … (Maximum number of families allowed is 5).

Using this language, the sperm is being given to other families (queer, straight, single, partnered) to be used by them to create their families, marginalising the sperm donor and centring those who will be named on the birth certificate.

The way in which "five families" is interpreted and applied within fertility clinics is heteronormative. While the language can seem clear, the application of this policy shows the tendency or the ability to interpret so the policy supports heteronormative definitions of family, as Kitty discovered:

> And we had to get a special compensation. We were the 5th and the 6th family 'cause they count lesbian families as two different families, which is bizarre.

Within the clinic environment, the word 'family' is used. However, as Kitty's experience exposes, the word 'family' has a working definition that is very heterosexual. The clinic actually means five women:

> I think in the initial consultation they explained that you could only do five families per donor and that there were four already. And I don't recall exactly what they said but I think the message was, because you're two women, two separate bodies, two wombs, you count as two families.

Kitty felt heteronormative definitions and practises of family were presented as status quo, which excludes her and her partner from being acknowledged as a family. It would be interesting to know whether a transgender man/woman couple, for example, would be subjected to this 'two wombs' application of family and be considered to be two families.

Hayley (a lesbian Pākehā in her early 40s and mother of one) also mentioned not being recognised as a family, and the financial implications of being classified as two families:

> I guess one thing that really got to me [about the fertility clinic] was this whole idea about what constituted family. So a sperm donor can only give to five women, but they use the word "family". And I challenged them on that, cause we have to pay for sperm for both of us. We had to pay twice because we were two women.

Hayley and her partner Kelsey, and Kitty and her partner Polly, are not a family within a fertility clinic. They are two families. Not only are their relationships being denied, in a place designed to create families, they are also financially penalised, needing to pay twice as much as a straight couple (if a straight couple is even needing to pay for treatment).

Dunne's (2000) study with lesbian mothers showed that there was the expectation from others that if the relationship broke up then "each [mother] will depart into the horizon with her own child" (p. 23), and this is also what Hayley experienced. As Hayley mentioned, she queried why she and Kelsey had to reserve two lots of sperm.

> The explanation [the nurse] gave was if we broke up, my child that I gave birth to would go with me and not with my partner.

This again demonstrates an understanding that lesbian families are not a family, with a potential mess if the parents separated. Instead, the assumption is biology creates an unbreakable familial unit between one woman and child, and denies any contribution from, or even the existence of, Kelsey.

"It seemed good from a legal perspective."

Given lesbians have other options for creating families why would they chose to use a fertility clinic, if they have to pay, and if they are not accepted as a family, and if their journey into and through fertility clinics may not be as smooth as that for normative bodies?

Reasoning is often related to seeking normativity, in order to have the privileges that heteronormativity imbues upon families. Luzia (2013), in her seminal work on lesbian-led families in Sydney Australia, found that these families had to work harder, not to be a family, but to be recognised and protected as one. In a review of literature about LGB families in Australia, Perales et al. (2019) reported that "the most prominent challenge reported by lesbian mothers was a lack of legal and social recognition of their status as a family, particularly the status of the non-birth mother" (p. 7). Allen and Mendez (2018) acknowledged that some people "now do family, gender, and sexuality in ways akin to heteronormative prescriptions, benefiting from social and legal progress" (p. 74) and Hubbard (2008) pointed out that "conforming to a heteronormative ideal may create any number of emotional and physical anxieties, therefore, but is associated with certain material privileges as well as political rights" (p. 643). Fertility clinics not only help to create families, they also legitimise families.

One privilege of heterosexual families is that the two parents are recognised, and these rights (and responsibilities) cannot be challenged by others claiming to be parents. For two-parent lesbian families, who have used donor sperm, but live in a society where biology is often regarded as the determinant of 'real' parenthood, the fertility clinic is a space that provides this privilege of undisputed parenthood. When Rebecca (a lesbian NZ European in her early 40s and mother of two) talks about the reasons they used the clinic, she mentioned the clinic as a space of distancing the donor from parental legal status: "it also seemed good from a legal perspective that [the clinic] recorded that they were donors not parents".

The protection the clinic provides is demonstrated through a court case in Australia. Lesbian parents were seeking to reduce the sperm donor's access to their child, and so the sperm donor bought the case to court to prevent this happening. Where the insemination took place was an influencing factor on the result of the case, and the judge not only denied the parents' request but increased the amount of contact the sperm donor was allowed. According to Dempsey (2004), part of the judgement rested on the fact the insemination was not done within the space of a clinic, and therefore the donor was not given:

> … the opportunity to be counselled and to overtly consent to the relinquishment of both the assumptions of kinship and parental rights and responsibilities. (p. 97)

Because the donor did not explicitly opt out, the judge reasoned, he had opted into fatherhood. The emotional impact such decisions can have should not be ignored either. Four months after this ruling, one of the mothers and the child were found dead in their home, in a presumed murder-suicide.

The clinic space not only works to situate the two mothers as parents, but also operates to exclude the sperm donor, on a number of levels. The physical presence of the person who donated sperm is removed, as well as any legal rights or responsibility. Queer mothers utilise the clinic space in order to be included within normative understandings of 'family' – that of having two, and only two, parents. In this way, the sperm donor is excluded from the family. Nordqvist (2011) argued that "clinics provided a framework of cultural legitimacy" (p. 127), conferring legal status on the queer couple and thereby recognising them within a heteronormative understanding of 'family'. Queer women conceive within a fertility clinic to ensure the recognition of both mothers as legal parents and to exclude the possibility of the sperm donor being included. This desire for legal recognition as a mother to your own child should not be underestimated as a factor in decision making.

Allen and Mendez (2018) noted how "some groups previously demarcated as 'deviant' are now do family, gender and sexuality in ways akin to heteronormative prescriptions, benefiting from social and legal progress" (p. 74). This demonstrates the fluidity of boundaries—what was previously 'heteronormative' has expanded, and a lesbian couple may benefit from heteronormative privilege of family. For instance, in Aotearoa New Zealand a lesbian couple can both go on the birth certificate and therefore be granted the privileges of their heterosexual counterparts—which is not problematic unless the sperm donor is not just a donor but also a (third) parent.

Another aspect that is distanced in fertility clinics is sperm. The body the sperm came from is absent, and the sperm itself is contained within vials and handled by professionals with gloves. Discussing why they chose the clinic, Rebecca says "we thought it'll just be less icky [laughter]". Nordqvist (2011) recognised that the clinic is different to the space of home when it comes to the presence of sperm: "the clinic did not only contain the practical and legal dimensions of donor conception, but it also stopped it from spilling over intimate, sexual and bodily boundaries" (p. 126).

Many stories of home insemination mentioned dealing with sperm were told with much laughter, as demonstrated by this conversation between Stacey and Kerry:

> Kerry It was fun for you dealing with sperm wasn't it?
>
> Stacey Oh it was disgusting [laughter]. It traumatised me … Yuck! No questioning my sexuality there whatsoever [laughter].

The clinic space therefore also offers lesbians, whose sexuality generally provides distance from sperm, a less hands-on approach to insemination.

Conclusion

Although not identical in their operations and services, fertility clinics in Aotearoa New Zealand are conducive to a normative body, one that is White, wealthy, straight, and gender normative, and this privileging of embodied subjectivities which support narrow understandings of heteronormativity make parenthood more achievable for particular bodies. Fertility clinics, and the normativity they both ensconce and are ensconced within, make it difficult for people to create alternate family formations, particularly safely and legally.

My research shows that lesbian, queer and gay women in Aotearoa New Zealand who used fertility clinics often found them heteronormative spaces. Consequently, clinics presume, and privilege, normative bodies and families and ignore other possibilities. Many of the lesbians I talked to were "White, middle class, educated" and could therefore choose to access and negotiate the clinic, even though the clinic itself often denied they were a family.

Fertility clinics are an example of a space where reproductive justice, reproductive health and reproductive rights are not universal, but instead operate as spaces of exclusion. The presence of lesbian bodies within fertility clinics highlights how notions of reproductive rights are not simplistic. Privilege and exclusion operate on a variety of levels (e.g., inference, behaviour, policy) and across many subjectivities (e.g., gender, sexuality, ethnicity). It was recognised both by those who used clinics and those who didn't that inequitable access was a social injustice, denying people a physically safe and legally clear way to create a family, and also denying others a chance of children. The paths to parenthood into, and through, fertility clinics are often troubled, not only for lesbians but for many others within and across a variety of other groups with non-normative and therefore non-privileged bodies.

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Note

[1] These descriptors throughout are based on the definitions participants provided of their ethnicity, sexuality and number of children.

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A critical commentary: Abortion stigma standing in the way of reproductive justice

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ABSTRACT

INTRODUCTION: Abortion is part of reproductive healthcare problematised within politically charged debates, leading to ongoing attempts to control access. The lens of reproductive justice encompasses the right to choose to have, or not have, a child, and the right to experience the enabling conditions to act on that choice. Abortion as part of health care is often limited by stigma, place and culture, as well as the regulatory environment.

APPROACH: In light of the recent changes to abortion law in Aotearoa New Zealand it is timely to review what is known about the impact of abortion stigma. Legal changes may improve access, but stigma endures. In a rapid literature review, we reviewed scholarly articles published between 2009 and 2023 that address abortion stigma.

FINDINGS: Our review identified two temporal frames: consistency of abortion stigma over time and changes over time. Within the frame of consistency over time, we identified three enduring themes in this body of literature, namely, the impact of religion/religiosity, the personification of the foetus, and secrecy. More recent scholarship addresses the intersectional dimensions of abortion stigma, abortion and the online environment, and the focus on the wider targets of abortion stigma.

CONCLUSIONS: Social workers benefit from an understanding of how various forms of stigma impact on the lives of people we support. Abortion stigma has similar impacts as stigma in mental health or disability and its elimination should be supported by social work.

Keywords: Abortion; abortion stigma; reproductive justice; reproductive rights

Recent social work scholarship has advocated for social work to affirm the principles of reproductive justice in social work education and practice (Beddoe et al.,2019; Beddoe, 2021; Goldblatt Hyatt et al., 2022; Lavalette et al.,2022; McKinley et al., 2023; Smith, 2017; Suslovic, 2018; Younes et al., 2021). The reproductive justice movement encompasses three primary principles: 1) the right not to have a child; 2) the right to have a child; and 3) the right to parent children in safe and healthy environments (Ross & Solinger, 2017). Ross (2006) argued for "the necessary enabling conditions to realize these rights," recognising that rights are insufficient for self-determination without access to resources (p. 4).

Over the last 10 years, we have seen abortion rights debated with many different outcomes across the globe. While more countries have legalised safe abortion, in other jurisdictions reproductive rights have been eroded and earlier gains lost (for example, in the USA, Poland and some other post-socialist Eastern

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European countries). Even where the right to abortion is protected in law, the exercise of this right can be prevented by socio-cultural, political, and religious beliefs and practices (IASSW Women's Interest Group on Abortion, 2023). Reproductive rights require the ability of pregnant people to access safe and legal abortion care without fear of judgment or punishment. In restrictive contexts, people may fear unwilling health providers who obstruct referral, judgment, and stigmatising attitudes, and may face the financial and logistical challenges of travelling for abortion care. Barriers to accessing abortion care, even when it is legal, can include fear of violence and reprisals, costs, lack of safe local services, and harassment outside facilities. As a result, people who are pregnant must travel regionally, or across state or national borders or, as a last resort, seek unsafe illegal abortion.

Such barriers and fears imbue the decision-making processes of abortion care with stress and anxiety (Mishtal et al., 2023). A recent editorial for the journal *Culture, Health and Sexuality* by Bateson and Mane (2023) introduces a collection of previously published papers that explore the experiences of people seeking abortion in contexts with restrictive abortion laws. Bateson and Mane describe the body of work presented in their retrospective collection with a focus on three themes relating to abortion access namely: autonomy, anxiety, and exile. These concepts are useful to consider framing of our introduction to this review. *Autonomy* refers to the right of people to make decisions about their own reproductive health without interference from the government or other institutions. Where people are forced to travel to other countries to access abortion care, there is a physical and emotional toll, and the experience may be imbued with feelings of *exile*. People who are forced to travel to other countries to access abortion care face isolation and loneliness in realising they cannot access care within their home country, where their support systems may be located. There are financial and logistical challenges inherent in traveling for abortion care raising levels of *anxiety*. There is a strong body of research on the impact of abortion travel (Bloomer & O'Dowd, 2014; Mishtal et al., 2023, Murray & Khan, 2020). In a recent article, Mishtal et al. (2023) reported on the experiences of 53 Irish women who travelled to England for abortion care in 2017 and 2018. Prior to 2018, abortion was banned in almost all circumstances in Ireland. These restrictive laws meant those wanting an abortion needed to keep their abortion decision and related travel a secret, often from friends and family, but significantly also from their healthcare providers in Ireland. Mishtal et al.'s study participants were forced to take a variety of steps to conceal their abortion travel, including using false names, paying for travel and accommodation in cash, and avoiding telling friends or family. They described feeling isolated, anxious, and ashamed while navigating the difficult financial and logistical travel arrangements to access abortion care in the UK.

Compounding all these logistical challenges to accessing a safe, legal abortion is stigma (Kumar et al., 2009). Recent law changes in Aotearoa New Zealand include decriminalisation, improved access to medical abortion, and some improvement in the protection from harassment of those seeking abortion care (Goodyear-Smith, 2023). In Aotearoa New Zealand research by Huang et al. (2019, p. 9) reported "from moderate-to-high support for legalised abortion regardless of the reason and high support for abortion when the woman's life is endangered". It is timely to examine abortion stigma to understand it better, as we propose that it is a significant continuing barrier to reproductive justice. Despite legal and social attitude changes in Aotearoa New Zealand, abortion stigma remains an element of healthcare that is of concern to social workers.

Method

This project has employed a rapid literature review, which—like a systemic review—is a holistic approach to the literature drawing on recent studies from which conclusions may be drawn in a systematic way, incorporating both recent materials and previous syntheses (Ganann et al., 2010; Siddaway et al., 2019). However, unlike a standard systemic review, a rapid literature review is conducted in a shorter time frame and is thus particularly suited to researching pressing and topical issues—such as reproductive justice (Ganann et al., 2010). Thus, over the course of three months, we sought to uncover the trends and changes in abortion stigma across time (i.e., 2009–2023), with a particular focus on identifying how scholars have changed their approach and understanding of abortion stigma in the past 5–10 years. To investigate this possibility, we conducted a sweeping literature scan of the abortion stigma research on Google Scholar. First, we aimed to uncover (a) the overarching themes of abortion stigma and (b) the stability of these themes over time. As such, to begin with, we did not constrain our search to any specific time point. Instead, we conducted a board search with various generic keywords, e.g., "abortion stigma" and "abortion attitudes".

Once we uncovered the overarching themes for our review (e.g., intersectionality), we started narrowing our research to more specific keywords, e.g., "abortion tourism". Likewise, because the main objective of this review was to reveal *change over time*, we subsequently restricted our search to only include research from the past 5 years (i.e., 2018–present). Our rapid literature scan gathered 35 journal articles. We then included a total of 20 articles that fit the scope of the present review (i.e., within the specified time frame, accurately discussed and defined themes and contributed to our understanding of either stability or change over time). We would like to note that these 20 articles informed our understanding and discussion of this paper's "abortion stigma themes". Additional foundational literature (e.g., Ross, 2006) was also drawn upon to provide a definitional basis for our discussion and provide further context throughout the paper. We argue that this method was the most relevant and effective for this commentary piece as it enabled a timely and holistic approach to understanding abortion stigma, whereby our literature search, themes and direction for the paper were guided by the emerging scholarship (rather than a predetermined objective). In this case, we are able to present an unbiased overview of the trends and changes in abortion stigma over the past 14 years.

Definitions of abortion stigma

In their 2009 review of abortion stigma, Kumar et al. reviewed international research and scholarship to develop an operational definition. Kumar et al. argued that abortion stigma is constructed locally through various sociopolitical processes. It is created across individual, community, institutions, government, and legislative levels and through discourses that frame it in particular ways. Kumar et al. (2009) proposed the following definition: abortion stigma is "a negative attitude ascribed to women seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (p. 628). Womanhood may be variably denied but Kumar et al. suggested three constructs that are transgressed by abortion: sex purely for procreation, the "inevitability of motherhood", and an instinctual drive to nurture the vulnerable (p. 628). Abortion stigma challenges beliefs about women's capacity to make "life and death" decisions for themselves. The patriarchal structure of power that underlines the challenge to women's agency over their own bodies (Came et al., 2022) is one that is served by the perpetuation of abortion stigma.

Abortion is socially located in deep-seated beliefs about sexuality, gender, parenthood and family. Patriarchy is maintained by promulgating an idea of abortion as *exceptional* (it happens rarely rather than being the most common gynaecological event experienced by women) and abnormal. One way of achieving this is by linking people who have abortions with the component of stigma that Link and Phelan (2001, p. 369) described as “a set of undesirable characteristics that form a stereotype”. Kumar et al. (2009) noted that, once the exceptionality of abortion has been established, it is easier to delineate the undesirable characterisation of people who terminate pregnancies as unfeminine and monstrous. Silencing then operates to keep abortions secret thus reinforcing abortion as exceptional. Finally, overt discrimination is enacted stigma, achieved through obstructing access, judgmental responses, inaccurate information, fear of ostracism, and ultimately fear of violence and intimidation. At a global level, abortion stigma may result in psychosocial, physical and socioeconomic barriers to reproductive health care with a downstream negative impact on the health and well-being of millions around the world (Kumar et al., 2009). Even campaigns for change that use the language of advocating for abortion to be *safe, legal and rare* risk the “separation of some women’s decisions as being morally distinct from or morally superior to the choices of other women, with stigmatising effects (Cullen & Korolczuk, 2019, p.16).

In the second review consulted, Norris et al. (2011) explored the discourses of “good” and “bad” abortions. Commonly, and unsurprisingly since often a majority of people support safe legal abortion (Huang et al., 2019), early abortions for reasons of health or foetal abnormality are deemed less “bad” while later and/ or repeat abortions are deemed “bad” with imprecations of the present person’s moral character. Norris et al. (2011) rightly also pointed out that not all people who have abortions experience more than transient stigma, if any, and it may not impact their self-concept. Many women may feel absolutely no shame/regret about abortion and the stigma, for those women, is externally driven by abortion discourse. Moral distinctions about the decision to terminate may be made by women who have an abortion, regardless of their prior stance on abortion. Notably of course, abortion can generally be kept secret so the stigma may be largely “felt” rather than “enacted” (Scambler, 2009) unless disclosed.

Finally, it needs to be noted that abortion stigma is compounded by other injustices under patriarchal capitalism (Ross & Solinger, 2017). Poverty, racism, the consequences of colonisation, intimate partner and family violence, trans- and homophobia, and ableism meet reproductive health at the intersection of people’s lives (Strong et al., 2023). The religious right-wing ideology that infects so much of the contemporary world employs abortion stigma as another tool of oppression to keep women and non-binary people in their place and control their agency.

Abortion stigma themes: Consistency over time

Religion

Arguably, the most consistent theme over time is the weaponisation of institutional religion to undermine access to abortion and perpetuate abortion stigma via Christian churches. Bloomer et al. (2023, p. 2), for example, noted that “[I]n Western countries the control of abortion which has gone hand in hand with religious morality typically stems from Catholic theology and evangelical Protestantism”. Broadly speaking, people rely on the reverence of traditional family values and sexist gender roles to disparage women seeking abortions (Abrams, 2015; Bloomer et al., 2017). Indeed, motherhood is revered and seen as an innate role for women to uptake, whereby any deviance from that promotes the rhetoric of the *bad mother* or *bad women* such that women who do not uptake this role are criticised and demonised (Bloomer et al., 2017). In a similar manner, because religion promotes "sexual purity", motherhood is often seen as a natural punishment for women's moral indiscretions (Norris et al., 2011). Notably, despite a move away from institutional religion in recent decades, the (Catholic) church still holds power. And it is this power that determines what is socially and politically acceptable (e.g., many of our policies are still influenced by Catholic theology; Bloomer et al., 2017; Cullen & Korolczuk, 2019; Sorhaindo & Lavelanet, 2022). As such, research has remained vigilant on the effect of institutional religion in producing abortion stigma over time.

The personification of the foetus

An interesting sub-theme of institutional religion is the personification of the foetus. While arguably a small sub-theme, this idea often emerged throughout the literature review as a natural by-product of Western Christian religious teachings. Indeed (Christian) religion typically highlights the sanctity of life, with the argument that life starts at conception. This rhetoric promotes the attribution of sentience to the foetus—for example, calling the foetus a "baby" and saying it can feel pain. Language such as "the unborn child" pervades the media, and doctors' offices, impacting attitudes to abortion (Mikołajczak & Bilewicz, 2014) and consequently promotes the *abortion is murder* discourse. Unsurprisingly, this works to stigmatise (a) women who seek abortions and (b) abortion providers (Hoggart, 2017; Norris et al., 2011). Notably, the personification of the foetus is typically associated with Western Christian religious teachings, with the scholarship largely negating the impact of other religious denominations or Indigenous teachings on abortion stigma. That said, there is some recent traction in considering the impact of intersectionality on abortion stigma (see the following themes in "change over time").

Secrecy

Another key theme that remains consistent over time is the secrecy of abortion. That is, abortion is a concealable experience that—for many reasons, including religiosity—women often hide. As a result—despite abortion being very common—abortions appear uncommon (Abrams, 2015; Bloomer et al., 2017; Norris et al., 2011). The overarching secrecy means that women who do disclose their abortions are seen as deviant. This creates a concerning cycle that perpetuates silence and stigma (Cockrill & Biggs, 2018). That is, because women fear being criticized for their abortions—and anticipate a non-supportive environment (Cockrill & Nack, 2013)—they stay silent. This suggests the need to highlight that "normal" women have abortions. Linking to the following themes, this form of resistance has been successful online and through popular media (Cockrill & Biggs, 2018). And, as with many of the following themes, emerging scholarship highlights that abortion silencing is more salient and detrimental to certain intersections of society. Intersectional research finds that silencing and misrepresentation of abortions is more harmful to those in lower socio-economic circumstances as they already have more restricted access to reproductive health care (as compared to those at more privileged intersections (see for example, Bloomer et al., 2017).

Abortion stigma themes: Change over time

Stigma online

There is an increased discussion regarding how abortion stigma is displayed—and resisted—online. Firstly, research has started to consider the ways in which popular media (e.g., television and films) depict abortion. Typically, popular media displays abortion in ways that (re)produce abortion stigma and focus on women suffering from post-abortion trauma (Sisson & Kimport, 2014). In tandem, because of the secrecy surrounding abortion, women struggle to gain support from friends and family and consequently may turn to anonymous online forums to gain advice and support for abortions (Jones et al., 2023). As a result, more recent research focuses on the use of online forums to counteract abortion stigma, with Lands et al. (2023) suggesting that women gain a sense of community and (much-needed) emotional support from online forums. This is a refreshing divergence from the typically hostile and misogynistic discourse of online spaces. Nevertheless, it is important to remember that anonymous online spaces can still (and do) enable a space to perpetuate harmful abortion stigma. This represents an interesting duality (that is not present in other themes), whereby online depictions and discussions of abortion represent both the agent of stigma and change. Given the growing uptake of online spaces in the 21st century—and the new emergence of qualitative methods that enable the investigation of online spaces—we would argue that this is one of the most pronounced changes over time and will continue to be a rising area of research.

We also note that, given the positive effect of online forums in fostering a sense of support for those seeking abortions—and that most people gain their information from the news and/or popular media (Barthel et al., 2019; Matei, 2014)—it is important to consider the ways in which the popular media can be utilised to increase abortion support. That is, as opposed to myopically depicting post-traumatic abortion syndrome and traumatic abortions, we can display the more positive implications of abortion (for example, that show that many everyday women seek abortions) and subsequently rebut some of the secrecy—and associated stigma—of abortions. Indeed, reading about women having abortions increases abortion support and disclosure (Cockrill & Biggs, 2018). Even how we speak about abortion in the media can challenge abortion myths. For instance, using the word *foetus* instead of child/baby is anticipated to reduce the personification of the foetus, reduce abortion stigma and increase support for abortion (Mikołajczak & Bilewicz, 2014). Future research is needed to investigate how language and indirect online contact can reduce abortion stigma and increase abortion support.

Intersectionality and cross-cultural considerations

Initially, abortion stigma research focused mainly on Western, educated, industrialized, rich, and democratic (WEIRD) societies (Henrich et al., 2010), with a primary focus on the predictors and consequences of abortion stigma for middle-class, educated, and cis-gendered white women. After establishing some basic foundations of abortion stigma, researchers began to explore how abortion stigma changes at differing intersections of class, race, and gender identity. Emerging research suggests that—consistent with intersectional work in adjacent domains—abortion stigma is more salient for those facing more challenging intersections (e.g., poverty, violence, for women of colour; Kimport, 2019). Of concern, given the focus on WEIRD abortions, much of abortion activism has failed to consider the ways multiple identities interact to impact abortion access. While this approach has made activism more palatable to the public, it has failed to produce solutions and/or advocate for those who (typically) need safe access to abortions the most (e.g., those in low socio-economic positions or those who need to travel to access health care (for example, Cullen & Korolczuk, 2019; Mishtal et al., 2023). Thus, emerging research is attempting to investigate how to advocate for reproductive health care with an intersectional lens.

In addition, Strong et al. (2023, p.1584) noted that abortion policies are “embedded in historical, colonial, political, and social structures, which seek to control some peoples’ reproduction while encouraging others”. In the United States for example, Black women’s experiences of abortion are shaped by "normative frames placed on their lives and reproduction, including pressure to avoid pregnancy and use long-acting reversible contraception" (Strong et al, 2023, p. 1584, citing Brown et al., 2022). As such, colonialism's impact on reproductive health, justice, and cultural practice on Indigenous people is also the subject of significant recent scholarship (BlackDeer, 2023a, 2023b; Le Grice & Braun, 2017; Le Grice et al., 2022; McKenzie et al., 2022). For instance, considering that colonisation aims to push a Western Christian ideology (including the sanctity of life and personification of the foetus agenda) onto Indigenous communities, emerging work has started to explicate the tensions in Māori beliefs on abortion—many of which grapple the tension between protecting life and valuing the needs of a mother and whānau (Le Grice & Braun, 2017). In other words, the intersections of bodily autonomy may not always sit comfortably alongside Indigenous perspectives (especially in an ongoing colonial context) as Le Grice and Braun (2017, p. 57) noted, for some study participants "the concept of reproductive decision making in solitude was situated in tension". This is just one example of the emerging Indigenous research on abortion stigma. As noted earlier, we anticipate that this will continue to be a growing and fruitful area of research in the coming decade.

As noted in our introduction, emerging research is focused on abortion tourism—that is, the movement between states, cities, or countries to obtain an abortion. Unsurprisingly, research has consistently explored abortion tourism between countries where abortion was illegal (e.g., Cullen & Korolczuk, 2019). However, further research is exploring how people move within countries where abortion is legal, but where abortion access is not equitable across cities/populations (Mishtal et al., 2023). In other words, despite "progressive" laws, various intersections restrict abortion access (e.g., socio-economic or location constraints restrict abortion access). The recent reversal of *Roe v. Wade* has highlighted the relevance of this in egalitarian countries (or countries with more progressive legislation). Thus, while it is tempting to argue that abortion studies have always been interested in abortion tourism (see for example, Goodyear-Smith, 2023, on the Sisters Overseas Service in Aotearoa New Zealand), we have started to broaden our understanding of abortion tourism over time—namely, to encompass a more intersectional lens.

The target of abortion stigma

Research on abortion stigma began by investigating the impact of stigma on those seeking an abortion. For instance, research focussed on how factors such as abortion secrecy and religiosity provoked abortion stigma, undermined access to healthcare and produced poor health and well-being outcomes for those seeking abortions (Abrams, 2015; Bloomer et al., 2017). And, although this remains an important and sustained area of research, scholars have started examining the ways in which abortion stigma transcends those accessing reproductive health care to (a) the friends and family of abortion seekers and (b) abortion activists (Abrams, 2015; Norris et al., 2011). However, despite an increasing understanding that abortion stigma does (or is likely to) impact the friends and family of abortion seekers, the transcendence of abortion stigma is still an emerging area of research.

Noting that most scholarship on abortion stigma has focused on women who have abortions, Norris et al. (2011) extended their analysis to two further groups affected by abortion stigma, namely people who work in abortion health care and those who support people having abortions, partners, families, friends and advocates. Their support for, and participation in, abortion is mostly visible, although stigma might prevent openness in some situations. The first author of this article worked as a social worker in an abortion service and frequently made a decision not to disclose her employment, in anticipation of negative or uncomfortable responses.

Of course, the experience of stigmatising interactions for providers is not only about encountering unpleasant judgments about the health care they provide. These interactions threaten the adequate provision of services. Abortion services were originally established separately to other health services in order to ensure sensitive care, but this separation has had unintended consequences. Separate clinics exposed patients, their support people and staff to offensive and often abusive anti-choice protests and signalled abortion as an aberrant aspect of health care. Notably, Janiak et al. (2018) found a comparable level of stigma between providers working in hospitals and freestanding clinics and noted that hospital-based care providers likely encountered stigma within the workplace (from other medical and nursing staff) while the clinic staff faced regular anti-abortion protests at the gate. While working in a women's health setting, the first author also worked in a neonatal specialist care unit. A senior doctor remarked that he could not understand how she could work in both abortion and neonatal care. He found it "disappointing".

In addition, given the increase in online activism and the increased prevalence of the abortion debate in online spaces—particularly following the *Roe v. Wade* decision—future research may want to investigate how abortion stigma extends toward online activism. Research has made a solid start in outlining how stigma extends to abortion providers, often documenting how this restricts a willingness to perform abortion services (Kimport, 2019; Norris et al., 2011). It is likely that abortion stigma impacts online activism in a similar manner (Lands et al., 2023). Further investigating this possibility is vital, given the current attack on reproductive rights and the associated need for sustained activism that ensures reproductive justice.

Conclusions

Returning to the work of Bateson and Mane (2023), it is useful to revisit their themes of exile, autonomy, and anxiety in concluding this review. Exile in the work we have discussed in this introduction can be seen to be operating on more than one plane of experience. Exile in the form of imposed abortion travel—across borders, whether local, regional, or international—or by the pressure for disguising identity imposed by having to run the gauntlet of anti-abortion protests, is both literal and symbolic. To have to hide one's abortion choice, to fear both interference in a personal choice and judgment, and the anxiety this fear engenders is the embodiment of the structural violence present in all forms of reproductive injustice. The need for secrecy is a potent reminder of abortion shame. Covering one's face, lying down in the back of the taxi, or having to lie to manage travel across borders signify a symbolic form of exile. The pregnant person is disempowered and forced to make their true self invisible, their bodily autonomy is denied. This is at the heart of abortion stigma.

In light of this body of research, we have reviewed, what are the implications for social work? The IASSW statement on abortion on International Women's Day stated:

> Social workers need to understand how to promote reproductive rights and reproductive justice at the individual and structural levels. Social workers need to understand and challenge the stigma of abortion and the trauma that can be experienced when having to have a legal abortion, which is further complicated in situations where an illegal abortion is the only option. (2023, n.p.)

Social work values emphasise rights and social justice. The Code of Ethics values statement Ngā Tikanga Matatika Pou in Aotearoa for example, stated: "We accept persons for who they are, with positive regard and without judgement or moral or religious stricture" (ANZASW, 2019) and yet responses to discussions about abortion in online spaces has indicated that social work is not immune from stigmatising beliefs, and US research has highlighted the impact of social work religiosity on attitudes to abortion (Bird et al., 2018; Winter et al., 2016). In Aotearoa New Zealand, little is known about these impacts on social work practice. Further research is required to better understand social workers' attitudes and practices in relation to clients who seek or choose abortions. There is a role for the profession in leadership and education to centre reproductive justice in the social work curriculum with the intention to reduce stigma by situating abortion as healthcare and an essential part of reducing health inequalities (McKinley et al., 2023; Poehling et al., 2023). The very least we can expect of social workers is that they do nothing to perpetuate abortion stigma.

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Reproductive justice in Aotearoa New Zealand—A viewpoint narrative

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The term *reproductive justice* originated in the United States in 1994 (Ross, 2017; Ross & Solinger, 2017; SisterSong, n.d.). It was coined by a group of Black women who organised under the name Women of African Descent for Reproductive Justice (Zavella, 2020). These women recognised that the reproductive rights movement was not only led by wealthy and middle-class white women, but it was also focused *exclusively* on the needs and experiences of wealthy and middle-class white women. The reproductive rights movement did not value or account for the experiences of women of colour, other marginalised women, and trans people—or the unique threats that these people face to their reproductive autonomy. The reproductive rights movement was centred on the idea of "choice". However, the movement's leadership failed to acknowledge, or contend with, the barriers to choice that Black women, and other marginalised people, face. It had neither the will, nor the capacity, to address inequities that were not directly experienced by wealthy and middle-class white women. Ross (2006) argued that "the necessary enabling conditions to realize these rights are not just a matter of individual choice and access. Reproductive justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny" (Ross, 2006, p. 4). In stark contrast, the Women of African Descent for Reproductive Justice called for an intersectional approach—recognising their lived experience and the ways that multiple forms of marginalisation, and oppression interconnect and compound to exacerbate discrimination and reproductive injustice for specific groups (Collins, 2015; UN Women, n.d.).

Family Planning is Aotearoa's only national primary care provider specialising in sexual and reproductive health care—including health promotion. We know that equity in access to sexual and reproductive health services, in addition to information and education, is essential to achieving reproductive justice (Ministry of Health, 2023a). We also recognise that the reach of reproductive justice extends well beyond equitable access to health services. To achieve reproductive justice, we believe that the full range of issues and circumstances that impact reproductive decision-making must be recognised and accounted for. One key step towards equitable reproductive autonomy is an all-of-government approach that prioritises reproductive justice in policy and decision-making. In this article, we reflect on the concept of reproductive justice as it relates to Aotearoa, and the issues that fall within our area of work, including the right to have a child, the right to not have a child and the right to parent children in healthy, safe environments. We will also present ways reproductive justice could be furthered in Aotearoa.

Coloniality and reproductive justice in Aotearoa

Colonisation impacts the sexual and reproductive health and autonomy of Indigenous and diasporic people, (El-Mowafi et al., 2021). Moewaka Barnes and McCreanor asserted that breaches of tino rangatiratanga—

as ratified in He Whakaputanga and enshrined by Te Tiriti o Waitangi—are "… a central practice of establishing the colonial order in Aotearoa" (Moewaka Barnes & McCreanor, 2019). Colonisation in Aotearoa has had, and continues to have, a profoundly negative effect on Māori with breaches of treaty rights being a mechanism that denies the ongoing intergenerational impacts of colonisation, including impacts on poverty and access to education, health and other social services and the right to self-determination as Indigenous Peoples of Aotearoa.

Racist stereotypes about sexuality, reproduction, and parenting are another feature of colonisation and racism—they contribute to the stigma and shame that marginalised people can feel when they are seeking reproductive health services, social services, or related information (Ministry of Health, 2023; Thompson et al., 2022). Racism limits the reproductive autonomy of Māori (Le Grice et al., 2022) and many other marginalised groups, including Pacific peoples, refugee and migrant communities, and diasporic peoples in Aotearoa.

Reproductive justice and access to contraception

Before people in Aotearoa can fully express true reproductive and bodily autonomy, they must have ready access to effective and appropriate contraception. One quarter of respondents to a Family Planning contraceptive use survey reported that they were not using their preferred method of contraception (Family Planning, 2020). Despite the critical role of contraception, contraceptive needs in Aotearoa continue to be inadequately and inequitably met (Te Karu et al., 2021).

A body of research has identified many barriers to accessing contraception in Aotearoa, including: cost; a lack of primary care providers trained to provide a comprehensive range of contraceptives; a lack of youth-friendly services; poor referral pathways; and inadequate health literacy amongst both patients and practitioners (Messenger et al., 2021b.; Health Quality and Safety Commission, 2020; Lawton et al., 2016). Cost and time barriers are exacerbated when women and girls and people using contraception have to make multiple visits to a health practitioner—creating a compounding disadvantage for people poor in one, or both, resources.

Following PHARMAC's funding of hormonal intrauterine systems (IUS) contraception in 2019, Family Planning researchers observed a significant increase in IUS use (Messenger et al., 2021a). The percentage increase of IUS uptake from 2018/19 to 2020/21 was almost 400% among Pasifika clients, 200% among Māori clients, and about 140% among NZ European/Other. The positive impact that PHARMAC funding had on rates of IUS uptake amongst Māori and Pasifika indicates that cost had been a significant barrier to accessing IUS contraception for those communities. Clearly, financial barriers are not experienced equally.

When women and girls and people using contraception have access to a broad range of contraceptive methods, they are *not only* more likely to self-select the most suitable method—they will frequently continue using contraception, and avoid unintended pregnancy (United Nations, 2015). Unfortunately, in Aotearoa, people do not have access to a complete range of contraceptives. The contraceptive ring (Nuvaring), the contraceptive patch (e.g., Evra), self-injectable Depo Provera (e.g., Sayana Press), ulipristal acetate for emergency contraception, and several modern formulations of oral contraceptive pills (such as Qliara) are not currently available, or are not funded, in Aotearoa. These gaps in funded contraceptive access will impact some populations more than others.

For example, the emergency contraceptive pill that is currently available in Aotearoa has limited effectiveness for people over 70kg.

Ulipristal acetate is an emergency contraceptive that is *not* currently funded—despite the fact that it is known to be very effective with no weight limitations (Lee & Norman, 2022).

Access to self-injectable contraceptives would provide a useful option to people who use, or want to use, Depo Provera. Māori women and girls are more likley to use Depo Provera as their contraceptive (Ministry of Health, 2019). However, people who use Depo Provera are required to visit a health provider every three months to have their injection administered. This is a time and money barrier—in addition to any other barriers that a marginalised client may experience when visiting a clinic. A self-injectable could offer Māori increased contraceptive autonomy, and lower barriers associated with clinic visits. This is just one example of how policy decisions can compromise equitable access to contraceptives. We cannot achieve reproductive justice in Aotearoa without accounting for the experiences and needs of Māori and other marginalised peoples.

To achieve reproductive justice, it is essential that policies and practices do not explicitly, or inadvertently, prioritise one type of contraceptive over another. There is a lot of professional excitement about long-acting reversible contraceptives (LARCs) in Aotearoa and abroad—due to their effectiveness at preventing unintended pregnancy. Many people like using LARCs, and they have high rates of continued use after being inserted. However, we are concerned that prioritising LARCs could impact reproductive justice.

Prioritising one type of contraceptive limits contraceptive options. Limited options can manifest as medical coercion—people end up using contraceptives that they would not freely select, and that do not adequately meet their needs.

There have been some policies in Aotearoa that appear to incentivise LARCs. For example, there are policies that make LARC visits free for Māori and Pacific people, but do not extend the same support to consultations for other types of contraceptives. There have even been conversations at the national level about making health care consultations for LARCs free— potentially making them more accessible than other types of contraceptives (Ministry of Health, 2023; McGinn et al., 2021). Women and girls and people who need contraception—but cannot afford a consultation—may be pressured into using LARCs by this kind of selective funding policy.

Reproductive justice and access to abortion

A reproductive-justice-based approach to contraception would ensure that all people have access to the education, information, and services they need to make informed decisions about the contraceptive methods that work best for them. In addition to contraception, ready access to multiple methods of abortion, abortion information, education, and services is crucial praxis for reproductive justice and the right to not have children or have them when the time is right.

Abortion law reform in 2020 codified the autonomy of a pregnant person in Aotearoa to decide whether to have an abortion or not (up to 20 weeks' gestation) (Abortion Legislation Act 2020). Before this law change, every abortion had to be approved by two certifying consultants (doctors). The approval process robbed people of their bodily autonomy—and, in the case of Māori clients, undermined tino rangatiratanga (Laurence, 2019).

The 2020 law change has improved both personal autonomy over, and the provision of, abortion in Aotearoa. There is now a national abortion telehealth service, DECIDE, and, currently, people can self-refer to an abortion provider to have an abortion. However, there is still inequity in access to abortion—particularly for Māori and Pacific people. In the 2022 Abortion Services Annual Report, The Ministry of Health stated: “Māori and Pacific peoples accessed abortion procedures at later gestations compared with non-Māori, non-Pacific ethnicities. These findings highlight service access barriers continue to exist and disproportionately impact Māori and Pacific peoples" (Ministry of Health, 2022, p. 12).

Under the current system, primary care providers are not funded to offer abortion. With appropriate funding, Family Planning would consider providing early medical abortion (EMA) at more of our clinics, right across the country. With appropriate funding, more general practitioners and nurse practitioners—including Māori and Pacific providers—could provide abortion to people in more local communities.

Ideally, abortion would be another one of the many essential services that primary care providers offer. If abortion were provided as a primary care service, we would see improved access to timely abortion, a reduction in barriers to abortion, and greater de-stigmatisation of abortion services.

The theory and praxis of reproductive justice recognises, protects, and promotes reproductive and bodily autonomy for women and girls and pregnant people. For Māori specifically, mana motuhake, tino rangatiratanga, and whakapapa, must also be recognised and upheld.

The scope of reproductive justice extends beyond equitable access to abortion. However, while there is inequity in access to abortion, we will never manifest true reproductive justice. For true reproductive justice, people must be empowered to express full autonomy when they make fundamental reproductive decisions.

Reproductive justice, sexually transmitted infections (STIs), and HPV

Avoidable, unfair, and unjust differences (Ministry of Health, n.d.) in STI rates result in inequitable health outcomes that impact a person's ability to become a parent. There are many situations where STIs can compromise or devastate fertility—as well as create complications during pregnancy, birth, and beyond (Van Gerwen et al., 2022; Tsevat et al., 2017).

We know that 17% of untreated chlamydia infections will progress to pelvic inflammatory disease (PID)—which can cause ectopic pregnancy, and infertility, among other issues (Munari et al., 2022). One of the starkest examples of STIs' impact on reproductive health is congenital syphilis. Congenital syphilis occurs when syphilis is passed from a pregnant person to a foetus. Congenital syphilis can result in premature birth, foetal harm, and stillbirth (Cooper & Sanchez, 2018).

In Aotearoa, there is significant inequity in STI rates among Māori and Pacific women and girls. Gonorrhoea is contracted by Māori and Pacific women and girls at six times the rate of New Zealand European women. Chlamydia is contracted by Māori and Pacific women and girls at four times the rate of New Zealand European women (ESR, 2022). In 2020, there were eight cases of congenital syphilis. Six of these cases affected Māori women. The other two cases affected Pacific women.

These avoidable, unfair, and unjust differences in STI rates mean inequitable sexual and reproductive health outcomes for Māori and Pacific women and girls. They threaten Māori and Pacific women's right to parent. If reproductive justice is to be realised in Aotearoa, inequity in STI rates for Māori and Pacific women and girls must be addressed.

The Ministry of Health recently published The Aotearoa New Zealand Sexually Transmitted and Blood Borne Infection Strategy 2023-2030 (Ministry of Health, 2023b). Unfortunately, the strategy fails to clarify how initiatives will be resourced, or how they will meet the specific needs of Māori and Pacific women and girls. In 2004, at the first National Māori Sexual and

Reproductive Health Conference, Dame Tariana Turia said (Turia, 2004):

> I often think when I read through the statistics telling me that Māori experience gonorrhoea in higher numbers at a younger age than do non-Māori; Māori and especially rangatahi Māori are at greater risk of sexually transmitted infections; the rate of chlamydia for Māori (at 10.5%) is over two times higher than non-Māori (4.6%); that the tragedy of these statistics is lost when seen only in the context of epidemiological data.

In 2023, Māori and Pacific women and girls remain at a higher risk of STIs. Nothing has changed. The invisibility of Māori and Pacific women and girls in the New Zealand Ministry of Health Sexually Transmitted and Blood Borne Infection Strategy is deeply concerning. Failure to respond to the inequitable rates of STIs among Māori and Pacific women and girls leads to treatable and preventable negative reproductive health outcomes going unaddressed.

Across the total population of Aotearoa, HPV vaccination has led to a decrease in cases of cervical cancer (Innes et al., 2020). However, there is well documented inequity in cervical cancer outcomes for Māori and Pacific women. The relative inaccessibility of cervical screening, as well as treatment, for Māori and Pacific women, has led to inequitable mortality rates amongst cervical cancer outcomes (Lourie, 2020). Furthermore, when cervical cancer develops at an early age, it often compromises subsequent fertility—severely limiting a person's expression of reproductive autonomy (Somigliana et al., 2020).

Cervical cancer is a preventable condition that *can be eliminated* with readily accessible vaccination, screening, and treatment. Currently, most people must pay a standard fee to visit a health practitioner for a cervical screen. All national screening programmes in Aotearoa are fully funded—with the exception of cervical screening. This represents a failure, on the part of governing bodies, to realise reproductive justice.

Reproductive justice and gynaecological care

In Aotearoa, it takes approximately eight years to get a diagnosis of endometriosis after the onset of initial symptoms (Ellis et al., 2022). Untreated endometriosis can lead to complications that result in compromised fertility. Poor ovarian and endometrial cancer outcomes are a predictable result of inefficient referral pathways, and long waiting lists, for access to specialist gynaecological care (Ellis et al., 2023).

A lack of resourcing, a lack of providers trained in reproductive health, and the minimisation of women's health needs has resulted in the marginalisation of reproductive issues within the health care system. University of Auckland Associate Professor Monique Jonas—an expert in healthcare ethics—said the following about gender and access to health care (Venuto, 2023, np).

> One example that concerns gender relates to women's experience of endometriosis, which can be a very painful, prolonged, and seriously debilitating condition for some women. And what women find is when they report their symptoms, they are not always given full weight by doctors. They might not be believed. They might be seen as exaggerating these symptoms.

For reproductive justice to be fully realised, the reproductive health needs of people who are marginalised by misogyny in healthcare must be addressed and resourced. Readily accessible gynaecological care is crucial to reproductive justice in Aotearoa.

Reproductive justice and relationships and sexuality education

Relationships and sexuality education (RSE) aims to equip students with the skills and knowledge to "... develop healthy relationships, to become positive in their own identities, and to develop competencies for promoting and sustaining their own wellbeing and that of others" (Ministry of Education, 2020). Consent and bodily autonomy are key themes in RSE. Bodily autonomy and the right to give and withdraw consent is applied to various contexts in the RSE curriculum including, but not limited to, non-sexual touch, sexual encounters, medical examination, use of contraception, accessing sexual health services, the establishment and maintenance of healthy interpersonal relationships.

There are policies in place that are intended to support high quality RSE in Aotearoa. RSE is a required area of learning in *The New Zealand Curriculum*, and some excellent RSE programmes are being delivered by committed teachers and schools (Ministry of Education, 2020). The Ministry of Education resource, *Relationships and Sexuality Education: A Guide for Teachers, Leaders, and Boards of Trustees,* focuses strongly on consensual, healthy and respectful relationships as being essential to student wellbeing. It is available in two volumes: one for years 1–8, and one for years 9–13. The guide informs principals, boards and teachers on the requirements of the Education and Training Act 2020. It also assists schools to consult with their community on the ways in which health education should be implemented. Schools have a legal requirement to consult with their community on the health curriculum every two years (Education and Training Act 2020, s. 91).

Despite this, RSE is not *consistently* taught to a high standard. RSE is taught differently in different schools, and delivery frequently varies from teacher to teacher. Schools have the autonomy to include and exclude any part of the RSE curriculum, and their decisions may be impacted by real or perceived opposition from members of their community. The Education Review Office found that many schools struggle to teach this area of the curriculum (Dixon et al., 2022; Education Review Office, 2018). Young people—particularly Māori and Pacific, and queer young people—have reported that the RSE they received in school did not meet their needs (Education Review Office, 2018; Le Grice & Braun, 2018). Consistent access to high quality RSE education—particularly curriculums that meet the needs of Māori and Pacific, and queer young people—is essential to achieving reproductive justice in Aotearoa.

Reproductive justice, sexual violence, and intimate partner violence

Māori women, trans women, and disabled women are at greater risk of sexual violence and intimate partner violence than other women or genders (Te Puna Aonui, 2022). People who experience sexual and/or intimate partner violence are at an increased risk of unintended pregnancy, abortion, and reproductive coercion.

Reproductive coercion occurs when a person is pressured to continue with—or end—a pregnancy against their wishes. A Women's Refuge survey on reproductive coercion found that: access to contraception had been controlled by over 80% of the respondents' intimate partners (Burry et al., 2018). These results highlight reproductive coercion as a common feature of intimate partner abuse. If the results of the Women's Refuge survey are reflective of a wider trend (which we believe they are) the importance of providing readily accessible reproductive and sexual health services to people who experience sexual and/or intimate partner abuse is self-evident.

Inexplicably, readily accessible reproductive and sexual health services do not feature in Te Aorerekura—the National Strategy and Action Plan to Eliminate Family Violence and Sexual Violence (Te Puna Aonui, 2022).

Conclusion

With a reproductive-justice-informed approach, we can observe the intersections of oppression and disadvantage that limit free expression of reproductive autonomy in Aotearoa. It is critical that we employ the insights of reproductive justice in the pursuit of reproductive equity, and full bodily and reproductive autonomy. Contending with the function and effects of colonisation is critical to realising reproductive justice in Aotearoa.

Threats to reproductive justice manifest across policy, governance, and between individuals (in the case of sexual violence/ or intimate partner violence). Governance, policy, and individual action are all inextricably linked, and must be addressed with those interrelations in mind. The road to reproductive justice requires us to remove all barriers to reproductive autonomy that exist in, and between, each and every one of those domains.

Necessary changes range from ensuring equity of access to contraception and abortion, to ending intimate partner violence, and sexual violence. Review, development, and deployment of policies and practices in Aotearoa must be informed by the insights and methodologies of reproductive justice—with particular attention paid to the recognition and honouring of tino rangatiratanga for Māori. Family Planning asserts that policies developed with a reproductive justice methodology are crucial to manifesting reproductive autonomy and safety for all people in Aotearoa.

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Reproductive justice and people with intellectual disabilities in Taiwan:
An issue for social work

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ABSTRACT

People with intellectual disabilities face difficulties in realising their reproductive rights in different countries and may face challenges to their parental rights in child protection systems. Some studies have explored how parents with intellectual disabilities became involved in their parenting roles, the barriers faced, their needs and types of support they received, the developmental outcome for their children, and further research has evaluated supporting interventions. However, these studies were primarily generated in high-income countries, likely due to the social development of these countries and affected by how people with intellectual disabilities are perceived by each society. Assuredly, this issue needs to be explored in other cultural contexts because previous studies have shown that gender, traditional beliefs, family structure, and religious beliefs all affect the experience of parenting with disabilities. In this article, we first focus on reproductive justice and the rights of parents with intellectual disabilities. Secondly, we explain current reproduction-related demographic data and studies of people with intellectual disabilities in Taiwan. Finally, we discuss reproductive justice and its contributions to social work in Taiwan.

Keywords: Reproductive justice; parental rights; parents with intellectual disabilities; social work with people with intellectual disabilities; Taiwan

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In Taiwan, people with intellectual disabilities do not have equal rights to intimate relationships and parenting with other people. They may be questioned by their families, and professionals, and face negative public perceptions about whether they are fit to have intimate relationships and to be parents (C. J. Lin, 2010; Y. H. Lin, 2019). They are more likely to be stigmatised and are assumed to be a high-risk group likely to mistreat their children. Although the People with Disabilities Rights Protection Act (2007) has stated that government must provide marital and reproductive health counseling to people with disabilities, related policies or support rendered to people with intellectual disabilities in Taiwan is not fully realised (C. J. Lin, 2010). This critique has also been offered by international experts on disabilities when reviewing the initial report on the implementation of the Convention on the Rights of Persons with Disabilities in Taiwan. The government did not support parents with disabilities, and this deficiency led to their children being removed from them. Furthermore, sex and reproductive health education for people with intellectual disabilities and hearing difficulties is limited (Ministry of Health and Welfare, 2017).

Reproductive justice focuses on diverse reproductive experiences. It emphasises three core themes: the right to have or not have a child and the conditions needed to raise children in safe and healthy environments (Ross & Solinger, 2017). It goes beyond the discussion of reproductive rights and aims to present the diverse reproductive health experience, especially for women from a minority or marginalised background. Moreover, reproductive justice also casts attention on parenting rights.

Reproductive justice is all about power and its operation (Morison, 2021). Morison further explains that, when connecting this idea to reproductive issues, an analysis will reveal personal reproductive decisions that are influenced by multifaceted and complicated structures of power in our society. Therefore, by applying a reproductive justice lens to the parenting rights and needs of people with intellectual disabilities in Taiwan, social workers will be better able to understand and explain how multiple factors shape their intersecting parenting experience beyond an individual lens. Taiwanese social workers should be encouraged to consider how structures of power limit the reproductive and parenting rights of people with intellectual disabilities. Furthermore, social workers must reflect on the extent to which the assumptions and attitudes described above about the parenting potential of people with intellectual disabilities can dominate social work thinking in professional assessment and practice.

In Taiwanese social work, the women's rights movement, and the disability rights movement are relatively new ideas. However, the reproductive justice perspective will be beneficial for such rights-based discourses because it challenges the current belief that people with intellectual disabilities are asexual beings or are incapable of having responsible intimate relationships, marriage, and family life (Milligan & Neufeldt, 2001). Furthermore, it is argued that involuntary sterilisation has been applied to persons with intellectual disabilities due to this biased belief (Serrato Calero et al., 2021). In addition, a reproductive justice focus will also contribute to social work in its pursuit of social justice for people with disabilities—for instance, by inspiring social workers in the disability field to think about their clients' needs to have an intimate relationship and their rights to have families and children, and finally, supporting them to realise these rights (Wiseman & Ferrie, 2020). The main ideas of reproductive justice can also be used as a framework to examine the current disparity of reproductive health and family life between women with intellectual disabilities and other women in Taiwan.

Reproductive justice and people with intellectual disabilities

Historically, people with disabilities have often been infantilised, viewed as asexual, and often considered unfit for marriage and parenthood (Addlakha et al., 2017). This situation is especially notable for people with intellectual disabilities. Serrato Calero et al. (2021) conducted a systematic literature review on the topic of forced sterilisation of women with disabilities and indicated it is an international women's health issue. These authors also claim that understanding how the reproductive rights of women with disabilities can be removed is important for social work efforts to support the development of proper social policy and services to meet disabled people's best interests. Referring to people with intellectual disabilities, Rushbrooke et al. (2014) reported that people with disabilities may encounter adversities when they try to build intimate relationships. Their sexual and reproductive rights, including the right to form their own families, have not yet been widely accepted by their caregivers. Even today, as Wiseman and Ferrie (2020) indicated, women with intellectual disabilities do not share the same equal reproductive rights as their peers.

Focusing on rights and inclusion without the achievement of sexual and reproductive rights can also be seen in international examples such as Aotearoa New Zealand. For example, Aotearoa New Zealand has noted much progress in the human rights of people with disabilities in the achievement of deinstitutionalisation, with the closure of its last institution, the Kimberly Centre, in 2006 (Milner, 2008). Another positive change is that sign language has been identified as one of the nation's official languages. These all contribute to ensuring that people with disabilities share the same rights and support as others. Nonetheless, Hamilton (2015) conducted an online questionnaire ($n = 67$), with parents, family members of people with intellectual disabilities, activists, and disabilities-related support workers to explore their ideas about sterilisation issues and people with intellectual disabilities in New Zealand. Hamilton (2015) also approached 17 disability-connected non-profit organisations, parent organisations, three Hauora Wellbeing centres, the Human Rights Commission, and the Families Commission and collected 67 responses in total. The findings demonstrated that some support workers and families of people with intellectual disabilities still believed that sterilisation is required under certain circumstances, even though these are against the spirit of the Convention on the Rights of Persons with Disabilities.

Parents with disability

People with disabilities who are already parents are often perceived by professionals as parents without sufficient parenting competence, particularly when they encounter the child protection system. Research generated in the Western context supports this claim (Booth & Booth, 2000; Gould & Dodd, 2014; McConnell et al., 2011). Mayes and Llewellyn (2009) argued that people with intellectual disability were likely to encounter attitudes that they would not be "good enough parents", would be unable to learn and that there was "good evidence that the decision to remove a child from parents with an intellectual disability is more likely to be based on prejudicial views about the capabilities of these parents than on evidence of child neglect or maltreatment" (p. 92). Recent studies suggest these attitudes prevail; for example, in Australia, Collings et al. (2018) found that child welfare workers and courts hold assumptions that parents are incapable of parenting. A further Australian study by Fitt and David (2022) collated the views of parents with disability and their supporters from across Australia. They found that parents with a disability felt powerless and stigmatised within child welfare systems. This research supports an imperative that people with disabilities who are parenting need to be treated with an attitude of equality, respect, and non-discriminatory practice by the child protection system. Similarly, in Albert and Powell's (2021) US study that interviewed parents, attorneys, and social workers it was found that negative attitudes to parents exist within the child protection system.

In the United Kingdom, Franklin et al. (2022) applied an inclusive research method and interviewed parents with intellectual disabilities, reporting that when these parents encountered the child protection system, they initially believed that they received help. However, Franklin et al.'s participants did not recognise that they were undergoing assessment when engaging with child protection professionals. During the process, parents with intellectual disabilities did not share the equal right to speak and offer their opinions to the social service staff as other professionals have. They perceived that they were treated like children because of their disabilities. At the same time, feeling that they must demonstrate their capability and commitment to parenting for social services was very stressful (Franklin et al., 2022). In an earlier study, Gould and Dodd (2014) reported that mothers with intellectual disabilities felt a great sense of powerlessness that impacted on their ability to participate in decision-making, which was primarily controlled by powerful professionals.

Policy in Taiwan

In Taiwan, the reproductive issues of people with intellectual disabilities are less well documented. International experts on disabilities suggested change (Ministry of Health and Welfare, 2022). Disability experts recommended that the government collect data on sterilisation and abortion among people with disabilities. Referring to the currently limited research, which includes the perspectives of women with intellectual disabilities, Chou and Lu (2011) argued that women with intellectual disabilities still face forced sterilisation via surgical procedures. It is not unusual to see that these operations were not chosen by themselves, rather, these choices were determined by their relatives or spouses. In general, people with disabilities are looked after by their families in Taiwan. Their reproduction and desire for their own families are usually taken as personal matters, not public issues. This is another critical reason why this issue has been absent from the general discussion of disability rights until now.

The spirit of the Convention on the Rights of Persons with Disabilities (CPRD) promotes the achievement of full participation of people with disabilities in each dimension of society (Maylea et al., 2023). Since this Convention became included in domestic law in Taiwan in 2014, the rights and needs of persons with disability to have their own family and raise children have gained greater attention. For example, the League for Persons with Disabilities (2020) published a pregnancy handbook for women with disabilities and ran focus groups that discussed their intimate relationships and family experiences in 2023. The league is a cross-disabilities organisation in Taiwan that works on promoting the rights of persons with disabilities. At the same time, disabled people's organisations argue for a paradigm shift in our disability policy and service provision, from a welfare model to a human rights model.

However, these initiatives are not common throughout Taiwan. While reproductive rights are an essential element of full participation in social life, they often remain overlooked in Taiwan. Paying attention to the reproductive issues of people with intellectual disabilities must be a significant part of developing strategies for evaluating the status of human rights in Taiwan. Now is the time for Taiwan to join its international counterparts and urge the government to take action to achieve reproductive justice for people with intellectual disabilities.

Reproduction-related demographic data in Taiwan

Internationally, it has been difficult for researchers to provide an exact number of parents with intellectual disabilities (McConnell, 2008). In Taiwan, investigation of the living status of people with disabilities has been mandated by the People with Disabilities Rights Protection Act (once every five years) since 1994. However, sexual reproductive issues of women with intellectual disabilities attract significantly less attention at policy and practice levels (Chou & Lu, 2011). Insufficient demographic data collection about parents with intellectual disabilities is still noted (Chou & Lu, 2011; Hsu, 2016).

As well as the lack of demographic information on parents with intellectual disabilities, the studies on families led by them are also limited in number. We searched the Index to Taiwan Periodical Literature System using the keywords of "parents and intellectual disability" and only found one article focusing on parenting experience of parents with intellectual disabilities who engaged with child protection system. This lack of academic research in Taiwan appears to translate into a lack in social policy and social services for people with intellectual disabilities. This is a critical gap between the real-life experience of parents with intellectual disabilities and the current disability services for them.

Social work and the role in promoting justice for parents with intellectual disabilities

There is a role for social work in addressing these concerns. Health inequality is a primary concern of social work (Bywaters & Napier, 2009; Craig et al., 2013; Pockett & Beddoe, 2015). However, as Liddell (2019) indicated, health social work has not had a focus on reproductive justice, and this gap is increasingly recognised internationally as a challenge for the profession (Beddoe, 2022; Gomez et al., 2020; Lavalette et al., 2022). In Taiwan, it appears that social work professionals focus on rehabilitation services, employment training, and education for people with disabilities instead of reproductive issues. For instance, two major disability welfare textbooks for undergraduate social work students, which were published by Taiwanese scholars, do not discuss reproductive issues (Huang et al., 2015; Lin & Liou, 2014).

Bridging the core concepts of reproductive justice with the values of social work benefits people with disabilities and social workers. Theoretically, reproductive justice aims to deal with power inequality, shifting from individualised reproductive health problems to examining how social structures undermine reproductive health status and prevent equal access to reproductive health care. This corresponds to the social work core values and fundamental principles for practice (Hyatt et al., 2022). Furthermore, reproductive justice serves a broad range of populations, containing—but not only limited to—women. In recent years, it has been seen that reproductive justice was suggested to be an analysis framework for the reproductive rights of LGBTQ groups (Tam, 2021).

For social workers in Taiwan, first, adhering to the principles of reproductive justice would remake our image of people with disabilities and enlarge our understanding of our service users' family-related issues. Second, through improved insight, social workers can better approach, assess, and address our users' reproductive concerns. Third, an equal and non-discriminatory child protection system is what parents with disabilities/our users are looking for (Fitt & David, 2022). As noted above, previous studies have indicated that parents with intellectual disabilities are over-represented in the system in Western societies (Fitt, 2019). However, no data are available to determine whether Taiwan is in the same situation.

Furthermore, parents with intellectual disabilities are calling for their support needs to be adequately met. A British study indicated that parents expressed interest in getting formal support, emphasising that support services must be provided in a neutral and supportive way with no discrimination or stigmatisation toward them (Franklin et al., 2022). These concerns refer to an unmet service need in the field of social work with disabilities and the field of social work with children and families. In Taiwan, at this crucial time, the government and civil society both need to assure equal rights exist for people with disabilities to have intimate relationships, be parents, and have their own families. The enactment of CRPD, and the policy and services that it can support provide an opportunity for us to advance our work in Taiwan.

When a framework of reproductive justice is applied to disability policy and service development, the vulnerable reproductive rights of people with intellectual disabilities and the support needs of them and their children will start to be recognised. Taiwan's current inefficient demographic data will gradually improve. Further training on supporting the parenthood of people with intellectual disabilities for professionals will be arranged. Within the child protection service, for example, Hsu (2016) interviewed social workers in child protection agencies who work with parents with intellectual disabilities who argued that their knowledge and skills is inadequate to help them to engage with their service users. This finding echoes the work of Fitt (2019) who found that the newly graduated practitioners serving mothers with intellectual disabilities in Australia reported the same concerns about their preparedness to work with this population. Taiwanese social workers stressed that this group of parents needs long-term and cross-sectional support from professionals, their families, and the community (Hsu, 2016). This affirms what Keddell et al. (2023) indicated, that intensive and continuous work input and excellent engagement between social workers and parents are essential factors for improving parenting and preventing the removal of children from their birth families. If the reproductive justice framework raises awareness in child protection staff, they could step away from the prevailing assumptions about the parenting of parents with intellectual disabilities and challenge the current unfriendly system that pushes so many parents into a traumatic ordeal (Gould & Dodd, 2014). Although public discussion of reproductive and parenting rights of people with intellectual disabilities is in its infancy in Taiwan, there is a vital role for social work to contribute to the discourse.

Conclusion

Real inclusion means that people with disabilities are entitled to the same rights, can realise their rights, and have opportunities to participate fully in society. In other words, only when people with disabilities share the same reproductive rights and equal support for themselves and their families with others can the claim of equal social participation and inclusion be made.

Discussing disabled parents via a reproductive justice lens goes beyond women's rights. Such discussion ensures that people with intellectual disabilities can have equal rights with other people. In other words, reproductive justice is not only related to realising the rights of women, but also to people with disabilities. Such an approach can raise awareness within professional groups, civil organisations, and within the government. Therefore, a framework of reproductive justice should be introduced and applied to social work in academia and practice immediately to help social workers address the newly emerging service needs in Taiwan.

Note: Szu-Hsien Lu is a doctoral student at the University of Auckland. Her doctoral research will focus on this topic. Before she came to New Zealand, she was a licensed social worker and completed her training in social work and gender studies in Taiwan.

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VIEWPOINT

Navigating the need for reproductive justice in a post-Roe v. Wade Aotearoa New Zealand

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ABSTRACT

Although it is tempting to absolve Aotearoa New Zealand of reproductive injustice, conservative celebrations in response to the recent reversal of *Roe v. Wade* highlight an urgent need for abortion-focused advocacy in ostensibly *egalitarian* societies. Arguably, such advocacy could be catalysed within academia. Yet, navigating desires for social justice within disciplines that cherish apolitical science remains challenging. This article will unpack the aforementioned tension and discuss the author's experiences researching abortion attitudes and striving for social change in a post-*Roe v. Wade* Aotearoa New Zealand. A case is made for a divergence from *objective* science towards intersectional research and the recentring of social justice in abortion research to ensure gender equality in these precarious times.

KEYWORDS: Abortion; reproductive justice; gender equality

Despite progressive abortion legislation, the recent reversal of *Roe v. Wade* in the United States (US) has shaken the political climate in Aotearoa (McClure, 2022). More specifically, such a regression in human rights has sparked celebrations amongst conservative politicians and pro-life activists alike (Howie, 2022; Sedensky, 2022). And, with an increase in pro-life protests throughout Australasia (McClure, 2022), it is becoming evident that abortion attitudes fail to reflect the ongoing strides towards egalitarianism in Aotearoa New Zealand. With the associated threat on abortion rights looming, it is vital to consider the necessary steps to ensure reproductive justice.

Explicating reproductive justice

Reproductive justice refers to the achievement of reproductive autonomy with the explicit recognition that the "choice" to (a) have a child; (b) have an abortion; (c) safely parent a child; and/or (d) control birthing decisions is constrained by one's socioeconomic position and wider socio-political and cultural environment (Ross, 2006). Although reproductive justice encapsulates a multitude of intersecting parts, my previous experience with abortion research will steer this article toward a focus on abortion rights. More specifically, I will unpack my experiences researching New Zealanders' abortion attitudes following the reversal of *Roe v. Wade*. Special attention will be paid to the role of objective science and intersectionality in politically motivated research. The piece will conclude with a critical reflection on researchers' roles in ensuring reproductive justice.

Reflecting on "objectivity" in abortion research

To begin, it is important to recognise that the abortion debate has elicited an uneasy political climate since the early 19th century (Reagan, 1997). Consistent with feminists' struggles to achieve progressive abortion legislation (see Reagan, 1997), my gendered

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experiences (as a young woman) with reproductive healthcare provoked my interest in abortion research long before the reversal of *Roe v. Wade*. Nevertheless, the supreme court's decision instantly altered the severity and purpose of my research. It became clear that my work needed to do more than contribute data to the broader scholarship. Likewise, I needed to challenge the status quo and advocate for reproductive justice.

Such realisations came with a critical reflection of objective science and the ways in which (typically) quantitative researchers have been criticised for underplaying the political nature of their findings (Fox et al., 2009). Notwithstanding the qualitative and reflective aspects of this piece, I should note that I am primarily a quantitative researcher—and mirroring most quantitative work—have focused on illuminating social inequalities as a form of social justice (see Fox et al., 2009). Although I sustain that documenting reproductive injustice is a vital step in ensuring equality, it is becoming evident that cyclical theorising on inequalities—without advocating for political action—is motivated by desires to remain objective (Lazard & McAvoy, 2020; Teo, 2009). Such desires are concerning, given that my subjective experiences have undeniably shaped my political positions and related research (see Lazard & McAvoy, 2020). To these ends, I argue that attempts to produce objective research on the abortion debate would not only be naive and disingenuous, but would greatly disserve the multitude of feminist movements advocating for reproductive justice.

More specifically, although *apolitical* science has advanced the prestige of psychology (Lazard & McAvoy, 2020), I sustain that the fulfilment of human rights and sexual freedoms outweigh the benefits of objective science—particularly when considering that academics are uniquely positioned to influence political decisions on reproductive autonomy (see Beddoe et al., 2020). That is, the prestige associated with academia affords researchers (including myself) the ability to make political and feminist claims without being villainised and ignored (Filatoff, 2019).

With this reflection, I have had to (uncomfortably) navigate my desires for *prestigious* science with my aspirations for social justice. Admittedly, this process remains challenging—in part due to the enduring debate on how to evoke social justice within academia (see Fox et al., 2009). Echoing the tensions faced by other scholars, I am attempting to navigate academia's calls for two seemingly divergent attempts at evoking change: promoting transformative practices and illuminating inequalities (see Fox et al., 2009). It is not my intention to unpack this debate here. I do, however, suggest that any attempts to promote meaningful change require intersectional research.

Navigating the need for intersectionality

Despite ostensible rises in researcher reflexivity (see Lazard & McAvoy, 2020), efforts toward objectivity continue to undermine intersectional practices. Although difficult to define, intersectionality commonly speaks to the ways in which gender, race, sexuality, and alternative identities cannot be understood in isolation from one another (Collins & Chepp, 2013). Rather, the intersections between these identities produce unique and inequitable experiences whereby certain identities are afforded more power than others (also see Joy, 2019). It is this power (or lack thereof) that impacts people's ability to *choose* to have an abortion. For instance, despite the promise of equal healthcare opportunities under Te Tiriti o Waitangi, Māori rights to control their reproductive health are undermined by systematic racism (Reid et al., 2014) and a subsequent lack of understanding regarding Indigenous health outcomes (Reid et al., 2014) and perspectives on abortion (Le Grice & Braun, 2017). As a result, Māori face more barriers (e.g., geological barriers) to reproductive health care than Pakeha (Laurence, 2019). In other words, despite 'equal' access to reproductive services in Aotearoa, systematic oppression in other domains (e.g., racism) undermines the nation's progressive legislation and enables inequitable access to reproductive health care (Ross, 2006).

The prevailing inequities in reproductive healthcare (e.g., Harned & Fuentes, 2023; Laurence, 2019) have motivated me to renegotiate my historically pro-choice stance. Namely, I argue for a renewed focus on reproductive justice as it critiques the typical conceptualisation of choice and challenges the structural inequalities that undermine unimpeded autonomy in the 21st century (Ross, 2006). This refocusing is vital as my position as a Pakeha, cisgender, and educated woman affords me the ability to access abortion services, even in the case of reproductive restrictions (see Harned & Fuentes, 2023). Thus—coupled with a lack of reflexivity—it is important to acknowledge that myopic attempts at promoting the pro-choice movement may have difficulty in addressing the reproductive injustice endured by those who face more challenging intersections (e.g., those constrained by their socioeconomic position).

The discomfort in these reflections promoted my search for an equitable solution. Yet, upon further reflection, it is evident that we (as academics) should remain uncomfortable—and concerned—about contributing to a discipline that has a history of oppressing diverse voices and enabling inequalities (see Buchanan et al., 2021). Therefore, I do not desire to reconcile these discomforts. Rather, I contest that this tension holds us accountable and encourages steps towards increased diversity. Consistent with this perspective, Collins (2013) and Fox et al. (2009) argued that a first step in ensuring social justice is an explicit recognition of privilege and *intellectual activism*. Specifically, ongoing discussion and promotion of intersectionality within research constitute a form of activism that heralds similar benefits to collective action as it encourages the inclusion of various voices in academia.

Intellectual activism is not a silver bullet to the lack of diversity in psychology or a fast track to reproductive justice. But, given the recent pushback on reflexive practices (see Savolainen et al., 2023)—and that academics continue to be criticised for challenging conservative policies (e.g., Bhatia, 2023)—I argue that promoting intellectual activism is increasingly necessary to ensure reproductive justice. Additionally, despite ongoing struggles to promote social change—particularly in quantitative research—I argue that (most) academics are well-positioned to consider and integrate intersectionality in their research as a means of evoking change. It is, I argue, far more productive than the aforementioned debate between transformative and intellectual practices. This is not to suggest that we should remain uncritical of outdated research practices but to suggest that academics would be better off engaging in reflexive practices to promote diversity than encouraging an age-old debate that invites academic divisions.

Conclusion

The everlasting attack on reproductive justice forces us (as academics) to reconsider how we promote social change. Doing so requires a critical reflection on psychology's efforts toward objectivity and the ways such practices undermine intersectionality and opportunities for change. More specifically, striving for objectivity has strategically negated the privilege and power afforded to academics. Furthermore, overlooking the subjective nature of research restricts our ability to be reflexive and promote intersectional practices. Consequently, a multitude of abortion research remains inapplicable to those who face pervasive reproductive injustices. Although these practices cannot singlehandedly ensure justice, a divergence from objectivity towards intellectual activism is one avenue in which scholars could ensure diversity within academia and promote unimpeded reproductive autonomy in the 21st century.

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Sexual and reproductive justice: From the margins to the centre

Tracy Morison and Jubulile Mary-Jane Jace Mavuso (Eds.)
Lexington Books, Penn, 2022
ISBN: 978-1-7936-4420-6, pp.296, Hardback, $167.01

This book is an exciting and thought-provoking collection of chapters tackling issues of sexual and reproductive justice featuring contributors from Aotearoa New Zealand, South Africa, Australia, and Scotland. Editors Tracy Morison (Aotearoa New Zealand) and Jabulile Mary-Jane Jace Mavuso (South Africa) position this collection as considering areas in reproductive and sexual justice that have perhaps been overlooked and/or under-explored by others. Their clear introduction lays the groundwork for this collection by providing nuanced definitions of sexual and reproductive justice and then noting where the gaps and possibilities for new research might be located. Such an introduction not only sets the scene but is a valuable resource for anyone—researcher, student, social worker—who is interested in this field.

This editorial scene setting whets the reader's appetite for exploring the gaps in the existing literature. The first chapter (by Marion Stevens, Dudu Dlamini and Lance Louskieter) considers how South African sex workers experience sexual and reproductive oppressions. Here the importance of justice at every level in society is discussed with conclusions noting that, for these workers, sexual and reproductive justice cannot be separated from rights to safe working conditions (including decriminalisation and healthcare).

In Chapter Two, a team of researchers from Aotearoa (Jade Le Grice, Cheryl Turner, Linda Waimarie Nikora, and Nicola Gavey) discuss an issue with relevance beyond sexual and reproductive justice. The authors link these (in)justices to broader macro-level injustices: whose knowledge counts and is counted in community and government-led interventions? Through pūrakau(1), we hear how Māori community leaders developed and sustained a programme for their community to tackle sexual violence, only to have it appropriated, commodified and ultimately removed from their community by government agencies. The authors ask essential and broader questions about how and why Indigenous knowledge can be divorced from its context while also clearly articulating an injustice as "Indigenous leadership and self-determination [must be] taken seriously in the pursuit of protecting future generations of Indigenous people from sexual violence" (p. 55).

The following four chapters cover insightful discussions about navigating the complexities of sexual and reproductive justice for adolescents with intellectual disabilities, gender-affirming healthcare, gender-affirming mental healthcare, and finally, the reproductive agency and desires of teenage boys who become fathers. All these chapters have a South African context; however, the issues discussed have relevance for practitioners in other locations. For example, in the chapter about intellectual disabilities, there is a valuable discussion about how key workers treat these young people as asexual and, therefore, not needing information about sexual and reproductive wellbeing. Such assumptions often lead to adults making decisions for these young people without gaining their consent—thus breaching their human rights.

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Chapter Seven, by George Parker, is a compelling and insightful exploration of fat reproductive embodiment. Drawing on data from semi-structured interviews with fat pregnant people in Aotearoa New Zealand, Parker discusses how being fat during pregnancy is a location of intersectionally differentiated oppressions and, thus, is a site of reproductive injustices. Parker explains the work that fat pregnant people have to do while under the gaze of intensified bodily surveillance and notes the guilt and personal responsibility they feel. They conclude that such responsibilisation of fat pregnant people does not, and cannot improve either "maternal [or] child health but in fact undermines it" (p. 132) and instead proposes that we rethink (and reject) how fat pregnant bodies are constructed as unsafe and instead adopt a macro, contextualised view of the factors leading to more positive health and wellbeing outcomes in pregnancy.

Parker's chapter is followed by one discussing obstetric violence and then two offering different constructions of motherhood. These two latter chapters provide an interesting and fruitful juxtaposition for readers and centre on the reproductive justice principle of being able to parent in a supportive environment. The first, by Kristina Saunders, centres on the experiences of working-class mothers in Scotland and how they both resist and reinforce (neoliberal) ideals of mothering and the second, by Andrea Alexander, explores how young mothers and *their* mothers are stigmatised for, and responsibilised by, teen pregnancy. Both chapters ask critical questions about how we can support different stories of motherhood and parenting and thus build and contribute to reproductive justice.

The next chapter will be welcome to anyone involved in sexuality education for young people and adds to the literature that problematises current provisions by situating it within a sexual and reproductive justice framework. The authors here, discussing sexuality education in South Africa, note that it relies on strict gendered binaries and stereotyped ideas to regulate young bodies. This narrative will be familiar to anyone currently working in this field when it seems that discussions about young people, sexuality and gender are "space[s] where a moral panic related to sex, gender, and reproduction is articulated" (p. 198).

I particularly enjoyed the final three chapters of this book as they each had insightful takes on sexual and reproductive justice from very different contexts. The first explored constructions of idealised motherhood in court cases of infanticide in the South Pacific. The authors examined judicial files from 59 cases spanning from 1961-2019. They found that these mothers were positioned as particularly mentally unwell as they could only be considered through a lens of idealised motherhood (because only mentally unwell mothers could murder their children). They noted that this positioning swept away considerations of other factors, such as abuse and their ability to make sexual and reproductive choices.

The second of these final three explored South African and New Zealand women's experiences of conversations with contraception providers about long-acting reversible contraceptives (LARCs)—such as Jadelle. The researchers noted three types of conversations: expert-led, patient-led, and collaborative. Women stated a clear preference for collaborative discussions as these weren't found to be authoritarian (expert-led) or responsibilising (patient-led); instead, they incorporated biomedical knowledge and education with the specific context of the woman. The authors noted that it is likely that reproductive justice is more possible in collaborative spaces.

Finally, the last chapter featured a collaboration of three authors exploring how pre-abortion counselling can make abortion *psychologically* unsafe in jurisdictions where it might be physically safe. In making this argument, they problematise the World Health Organisation's definition of safe abortion as only relating to physical provisions. By examining recordings of anti-abortion counselling sessions, they demonstrate that such sessions are harmful (and thus unsafe) as they draw on patriarchal discourses and position abortion seekers as ignorant and needing saving from themselves. They note that to be reproductively just, abortion counselling must therefore be "non-mandatory, client-centred [and] feminist" (p. 261).

Overall, this book is a welcome contribution to and expansion of literature centring reproductive and sexual justice concerns. It is difficult to narrow down an audience that this book would be *especially* useful for as that could indicate that sexual and reproductive justice can be neatly partitioned off into work that specifically centres reproductive and/or sexual health concerns. Clearly, it holds an appeal for any researcher interested in these fields. However, practitioners might ask, "How is it relevant to my work?" I would reply, how is sexual and reproductive justice *not* relevant to your work? Speaking specifically about social workers, other authors (Dodd, 2020) have noted that social work and social workers have not paid *enough* attention to how sexual and reproductive matters impact the lives of all of our clients and that we need to get much better at addressing this with our clients. Perhaps a book like this might encourage those social workers who read it—or even selected chapters—to consider how they might contribute to sexual and reproductive justice in work with *all* their clients.

(1) Pūrakau can be translated to mean Māori narrative and, in this context, is a research method.

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The Turnaway Study: Ten years, a thousand women and the consequences of having—or being denied—an abortion

Diana Greene Foster
Sribner, New York, 2020
ISBN 978-1-9821-4157-8, pp.367, Paperback, $NZD36

The Turnaway Study is a book that reports the results of a significant research study that aimed to answer the question: "what happens when a woman seeking an abortion is turned away?" A team of scientists including psychologists, epidemiologists, demographers, nurses, physicians, economists, sociologists, and public health researchers conducted a landmark 10-year study. They followed 1000 women from across the United States of America, some of whom had had an abortion and some who were turned away. The Turnaway Study was the first to investigate how abortion affects women by comparing those who get an abortion and those who want one but don't get one. The researchers sought to interview each woman in the study every six months over five years to understand how getting an abortion versus being denied an abortion affected their mental and physical health, their life aspirations, and their family well-being. From the study, the research team published almost 50 academic papers and it has been widely reported. To make an accessible text bringing together many of the findings, Foster Greene has gathered the stories of 10 women, reporting in their own words how they came to want an abortion and what happened to them after they were successful or were turned away. It is compelling reading.

The Turnaway Study found no evidence that abortion harms women. Women who got the abortion they wanted reported better physical health, employment and income than those denied an abortion. Their mental health was initially better and then eventually the same and their hopes for the future were better. They were more likely to be in a positive romantic relationship and have a wanted pregnancy. The others, denied an abortion, faced complications of pregnancy and birth, longer-term health conditions. Two women died. The social consequences were also significant—increased anxiety, difficulty leaving violent relationships, economic hardship and there were some impacts on the health of their existing children.

While the data are compelling, and it is worth pursuing the many scientific articles published, the strength of this book is in the narratives of 10 women. These are sandwiched between the analysis-based chapters. These are first-person narratives constructed from the interview transcripts. Foster Greene starts with 'Amy' whose story is of an "ordinary abortion" and illustrates abortion as a normal part of "planning a family and living a meaningful life" (p. 24). Other stories relate the experiences of women who had major health problems that made pregnancy very dangerous or who were using alcohol and other drugs. These chapters also provide a window into everyday lives of girls and women who struggled with poor access to health care and contraception. As a social worker who worked in an abortion service, all these stories were familiar. From the simple but crucial need to have agency over when, and if, to have a child and in what circumstances, to the painful choices of women with chronic health conditions or living with intimate partner violence, to the

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unhelpful involvement of family members in private decisions, all had good reasons. Because all reasons are valid. And ultimately, the Turnaway Study is a rigorous report that confirms that whatever the reasons, having the right to make the choice, and living with the conditions to make that choice to parent or not sustainable (Ross, 2006; Ross & Solinger, 2017) is what is best for pregnant people. Any reason for freely choosing an abortion is valid (Jones et al., 2023).

This book is strongly recommended for the study of reproductive justice in social work education, not just for what it teaches us about abortion, but for what it also tells us about health care, access and the barriers and enablers of personal choices that are meaningful and supported. It will be helpful in dispelling mis/disinformation that plagues many students' (and sadly, some educators') approach to reproductive health in social work education.

Abortion continues to be a contested site across the globe and the fight for reproductive justice seems never-ending. The unseemly scrabbling for power over the bodies of pregnant people drags on and on. Grown men (and some women) grasp for the right to force a pregnant child to give birth as pregnancy is a consequence of sex. It's always about control. Never life. The architects of anti-abortion laws are rarely the same people as those who fight for benefits, for free high-quality health care, access to early childhood care/education, and decent housing. Rather, these are the people who want to control and punish women. They do not care about the children who are born, only preventing pregnant people from deciding when and if they want to parent and whether they have the resources to enable them to raise children with dignity.

This book provides tangible, compelling evidence of the importance of reproductive justice. Abortion rights are a social work issue and progressive social workers will always fight for reproductive justice (Beddoe 2021; Goldblatt et al., 2022, Lavalette et al, 2022; Poehling et al., 2023).

In the afterword to this book, author Diana Greene Foster wrote "the familiar clash between science and ideology that characterises the debate on abortion also defined the debate over the pandemic and hampered the response. At the same time, the pandemic deepens the conflict over abortion rights by giving politicians another opportunity to restrict abortion while making access to care more fraught and riskier" (p. 315). Sadly, since she wrote these words, the famous 1973 Supreme Court ruling known as *Roe v Wade* has been overturned. At the time of writing this review, medical professionals, social workers and counsellors across the US are scrambling to find ways to help people and avoid the consequences of some of the absurd and hasty legislation that puts so many at risk, including people whose medication for chronic conditions is teratogenic. The struggle continues. Green has provided us with another powerful resource.

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Reviewed by **Liz Beddoe**, the University of Auckland.

Social work histories of complicity and resistance: A tale of two professions

Vasilios Ioakimidis & Aaron Wyllie (Eds.)
Bristol University Press, Bristol, 2023
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Social work is not, de facto, a 'good' profession. That is the authors' central hypothesis. Rather, they, and the chapters' authors, argue that social work's presumed professional benevolence is not inherent in social work, but a fraught tension composed of awe-inspiring acts of resistance and alarming rates of complicity with State-sponsored and societal oppression. For the authors, this is not in question, and yet social work associations and governments are unwilling to admit to the harm they have perpetuated. This is what the authors seek to call out both local and international social work bodies for failing to address.

This tome is simply not an easy read. Whether recounting social workers partaking in illegal adoptions of people deemed enemies of the State in Spain (Chapter 7), acts of courage to the point of being 'disappeared' by State authorities in the Southern Cone (Chapter 8), or of social workers oppressing adopted peoples by unlawfully withholding information (Chapter 17), this volume challenges the very assumptions of social work's professional meaning. As told in each of the chapters, the distinction dividing this dichotomy of complicity or resistance contains no simple answer, but is contextually the result of, first and foremost, the State's influence on social work practice, closely followed by cultural elitism and other societal biases.

The rounded argument Ioakimidis and Wyllie seek to conjure is that, while some localised social work organisations have sought to reckon with past complicity in injustice, the international social work community's silence on historic oppression of minority and vulnerable populations is untenable. They argue that, in order for healing to flourish where social work complicity has occurred, both local and international social work bodies must reckon with their past injustices against affected communities.

Dividing the book into five sections, the authors: (1) lay out their argument for facing social work's past; (2) consider the legacies of colonialism and racism within social work; (3) evaluate the ideologies which social work adopts out of complicity with the State; (4) examine social work complicity within State institutions and forms of detention; and (5) share the experiences of survivors subjected to current and historical social work injustices.

The book's five sections weave together a compelling, albeit incoherent at times, story of the ways in which the social work profession has been abused by the State or has abused those it claims to help. There is no shortage of powerful anecdotes. The strength of this approach highlights that, primarily, social work's complicity with injustice is not in question, rather the inaction of social work bodies in response to historic injustice is debated out of fear of undermining the professionalism of social work and uncertainty over who should be held responsible for historic injustice.

A key theme which highlights the complexity of identifying 'who' is responsible, is found

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in Chapter 11, where Rich Moth, writing about the history of England's mental health institutions, argues, "State social work is better understood as a highly context-dependent form of institutional activity, conditioned by the nature of the welfare regime from which it emerges and within which it is situated" (p. 165). Amplifying this issue, Michael Lavalette, writing about popular social work in Palestine (Chapter 10), comments, "Professional interpretations (and many academic histories) of social work often ignore the contested nature of the social work project" (p. 148). Put simply, if social workers, and associations alike, are to seek to challenge their own past injustices, this must evolve in each local context where people have been discriminated against by the profession.

Bringing the debate to the issue of pedagogy, Caroline Bald and Akudo Amadiegwu brilliantly argue in "Decolonisation and critical social work pedagogies" (Chapter 16) that many roots of the oppression discussed in this book stem from the dominance of Western thought over indigenous and other forms of knowledge within education. The authors take aim at Western ideas embedded in theories, such as attachment theory, which perpetuate certain social norms that are specific to Western societies and tend to exclude non-Western concepts of community and family. Situated near the end of the book, this chapter serves as a valuable penultimate chapter to summarise the core issues identified in the preceding chapters: that education and societal concepts (State-sponsored or other) influence social work practice to perpetuate social injustice.

Proclaiming the voices of the historically oppressed by hostile governments and, by clear extension, the social work profession, the book covers a broad range of issues and topics. For this reason, anyone seeking to read this material will undoubtedly be moved by the accounts told within, whether it be atrocities under Nazi Germany, illegal adoptions, mistreatment of refugees, ostracization of mental health patients, and anyone who finds themselves outside the expected norms of society.

For myself, having spent time working in child protection, I found myself equally moved and disturbed by the honest accounts by Guy Shennan in "We want social workers to hear our story": Learning from parents whose children were taken away" (Chapter 15). These accounts compelled me to stop, consider, and reflect. Anyone who chooses to read this volume will surely experience their own journey of reflection in one or more of the book's chapters.

The book's challenge can be summarised by Bob Pease's comments in "Facing the legacy of social work: Coming to terms with complicity in systemic inequality and social injustice" (Chapter 14), "As long as we see ourselves only as good people doing good work, we will remain defensive towards knowledge that challenges the premises of our work" (p. 227).

Reviewed by **Blake Gardiner**, Systems & Policies Developer, Open Home Foundation

When social workers impact policy and don’t just implement It: A framework for understanding policy engagement

John Gal & Idit Weiss-Gal
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The ANZASW Code of Ethics (2019) requires social workers to challenge oppression and injustice as part of the social work responsibility to achieve social change. The Social Workers Registration Board (2023) competencies deepen and extend this requirement and ask social workers to understand and advocate for social and economic justice to provide equity and fairness to all. Furthermore, social workers must contribute to the policy-making process to shape more responsive systems and structures for those people who use them. How do we go about that?

When Social Workers Impact Policy and Don’t Just Implement it: A Framework for Understanding Policy Engagement helps us to answer how we can contribute to the policy-making process. Reading this book reminded me of Heywood’s (2021) contention that political ideologies surround us, shape our thinking, we use them in our practice, but we often are not able to understand them in any coherent way to make sense of the world we encounter. Given social policies are practical (and pragmatic) expressions of such ideologies, I found those observations comfortably apply to social workers’ encounters with social policy. How do we make sense of the social policies that surround us? To what extent do policy approaches influence our social worker positioning? How do we resolve our conflicted positions when implementing social policies we might not wholly agree with?

Gal and Weiss-Gal offer the reader an accessible explanation of the motivation, enablers, and barriers to engaging in the policy decision making process. This ethical requirement of ours is set out in seven digestible chapters with a constant focus on the authors’ “policy engagement conceptual framework” and aided by the liberal use of real examples of policy engagement around the world (including from Aotearoa New Zealand).

It has been my experience that frameworks can be difficult to understand, even when explained in accompanying narrative. This book succeeds in overcoming that issue. The authors explain the framework by discussing one aspect per chapter, walking the reader through the social worker–social policy nexus, then discussing the environments that constrain or permit policy engagement, the following chapters then consider the opportunities, facilitation, and motivation social workers have to influence the policy-making process. In doing so, the authors gradually (and necessarily) move from the macro to micro considerations.

The chapter on the environmental factor discusses the encounter with policy at a macro level. It sets out the four environments (the welfare regime, policies and problems, the profession, and people) using examples in social work to describe how these environments shape social workers and their actions. There are interesting examples which the authors skilfully use to bring an abstract discussion into focus, and they demonstrate the grand accomplishments that social workers have achieved through history. I did wonder if their discussion on neoliberalism deserved greater consideration and weight than what is currently present.

With the environment identified as the context in which social workers can (must) influence policy, the rest of the book sets out the three factors (opportunity, facilitation, and motivation) which shape if and how social workers engage in this ethical requirement. I would suggest that opportunity is the crux of the matter—how can social workers reach into the decision-making institutions? The authors discuss that thorny issue and provide plenty of quite inspirational examples for this humble street-level social worker. But that might be the issue for me, rather than amplifying the many tireless examples from street level social work, the authors do tend to amplify "not your average" social workers here with the examples. This chapter left me frustrated, not at the book, but at the opportunities most social workers struggle to find or grasp through no fault of their own. It did also leave me (fleetingly) wondering whether this book was for me, or those working in transnational social advocacy groups.

The chapter on facilitation helpfully calls out that social workers' place of employment will have a significant impact on their ability to engage in policy decision-making. The recognition of barriers to engagement moves the theoretical/conceptual preceding chapters into the practical world. Here the authors discuss the varying types of social work organisations: from central and local government social work organisations, large advocacy agencies, and non-profit social service providers. Following the style set out in preceding chapters, Gal and Weiss-Gal present the reader with more examples of social workers manoeuvring past barriers or where their workplaces enable policy-making engagement. Two main points around enablers stood out for me: increased professional accountability, and the role of management in community social services. I am reminded (indulge me here) of the narratives told to me by tireless (and tired) social workers in my master's research into street-level advocacy, with one participant's observations of social work colleagues standing out in particular: "some get absorbed in fighting against and advocating within the organisation … some give up, some get acculturated into the organisational and systemic values and principles" (Renau, p. 60, 2021).

The book rounds off the framework with a discussion around individual motivation. As expected with this aspect, this chapter contains many individual-level examples of social workers, but also draws on interdisciplinary (public administration, psychology, and political science) theory and evidence to unpack the influence of personal values, attitudes, skills, and so on. In a chapter that focused on the micro level, it was slightly frustrating that a number of theoretical considerations frame these discussions. However, this chapter is an essential read in that it makes sense of the other aspects of the framework and offers the reader… motivation.

Is this book worth reading? The authors conclude by revealing the goal of this book: "to enlighten scholars and professionals who care about social work and about what it can contribute to people, communities and societies" (p. 130). It does (and it is). Let's get ethical.

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