voices from the front line

Abortion rights and Roe v Wade: implications for social work – voices from the social work academy

Michael Lavalette, lavalem@hope.ac.uk
Liverpool Hope University, UK

Liz Beddoe, e.beddoe@auckland.ac.uk
University of Auckland, New Zealand

Goretti Horgan, g.horgan@ulster.ac.uk
University of Ulster, UK

Vishanthie Sewpaul, SewpaulV@UKZN.ac.za
University of KwaZulu-Natal, South Africa and
University of Stavanger, Norway

This paper draws together the work of three leading social work academics to look at the question of abortion and a woman’s right to choose in the context of the recent Roe V Wade reversal in the United States.

Key words abortion rights • fertility rights • Roe V Wade • women’s rights

To cite this article: Lavalette, M., Beddoe, L., Horgan, G. and Sewpaul, V. (2022) Abortion rights and Roe v Wade: implications for social work – voices from the social work academy, Critical and Radical Social Work, 10(3): 491–498, DOI: 10.1332/204986021X16608280244818

Introduction (CRSW Editor-in-Chief Michael Lavalette, UK)

As we were preparing the current issue of CRSW, the dreadful decision of the US Supreme Court to overturn the historic ‘Roe v Wade’ judgment came into force. The decision is an attack on women’s rights everywhere. The original judgment (Roe v Wade) in 1973 represented a significant step forward in the demand to make abortions more freely available and safer.

The right to free abortion was a key demand of the women’s movement in the 1970s. It stemmed from the argument that women¹ should have control over their bodies, and this meant that in the case of unwanted pregnancy, they should be able to terminate the pregnancy if they wished to do so. The late 1960s and early 1970s saw a liberalisation of society – in Britain, the Abortion Act 1967 made it legal for the first time in certain circumstances. Before the Abortion Act, there were an estimated 100,000 illegal abortions a year in Britain, performed in dangerous conditions and often resulting in serious injury or death.
The Supreme Court decision is an event of international significance. It is the result of sustained attacks on abortion and fertility rights by right-wing conservatives who see abortion as a threat to ‘family values’. Where anti-abortionists have been successful – in the US and Poland, for example – the result is more unwanted pregnancies and dangerous abortions.

In this article, we have invited three social work writers from across the globe to write about abortion rights and the significance of the Supreme Court decision. Each of our contributors is a leading social work academic, and they write here about an issue that – too often – is marginalised within social work literature: the need to defend abortion rights and a woman’s right to choose.

The whole world is watching: social workers need to take action (Liz Beddoe, New Zealand)

On Saturday 25 June, the US Supreme Court ended constitutional protections for abortion that had been in place for nearly 50 years, known globally as ‘Roe v Wade’, the famous 1973 court ruling that legalised abortion across the US. What this ruling said was that every woman should have the right to decisions over her own body and no decision could have more consequences. As many have said, if having sex meant every time risking death, birth injuries and other continuing health challenges, social ostracism, poverty, life-changing interruption to education and career, and the immediate lifelong responsibility for another human being, then most men would want a choice. The reversal of Roe v Wade, feared by people across the world, has happened. In 2016, feminists all over the world warned about the risk to Roe v Wade and many other rights with a Trump administration empowering the worst bigotry and pandering to racism and misogyny. We were right. Toxic fundamentalist and white supremacist forces are pushing back hard-won rights, even those that by far the majority of citizens support.

The move is expected to lead to abortion bans in roughly half the states, affecting millions. There are reasonable fears that in many of the more extreme states of the US, this will lead not only to bans, but also to the strenuous, invasive policing of people’s bodies using surveillance technology.

On Twitter and other social media after the ruling, data justice activists were urging people to delete their period-tracking apps and ask for their data to be deleted. People were urged to take stringent measures to avoid googling abortion help topics for fear of being later accused of abortion if they miscarried. Therapists and other health professionals are giving their patients ‘the talk’ about not discussing abortion until after the fact. Under this reversal of abortion rights, in some states, healthcare professionals will face prosecution for helping with abortion. The prison sentence for having an abortion may be longer than that applied to the rapist that caused it.

Even before the reversal of Roe v Wade, miscarrying women have been interrogated, even arrested, on suspicion of having procured an abortion. Moreover, this criminalisation of pregnant people is not confined to the US. In an article earlier this month, Shanti Das reported that despite a common understanding that abortion access is safe in the UK, freedom of information requests revealed that dozens of women have been investigated by the police for suspected breaches of an 1861 law over the past 10 years.
The Offences Against the Person Act 1861 says that it is unlawful to procure a miscarriage using ‘poison’, ‘an instrument’ or ‘other means whatsoever’, and that those found guilty can be jailed for life. While the Abortion Act 1967 transformed women’s healthcare by legalising abortion in England, Wales and Scotland, termination is only lawful where two doctors agree that continuing the pregnancy would potentially harm physical or mental health.

The 1861 legislation means that anyone who has an unregulated abortion or tries to terminate their pregnancy without medical supervision is acting unlawfully. Das describes the surveillance of people investigated as including a ‘digital strip search’ and gives the example of a 15-year-old whose phone and laptop were seized. It was later found that the pregnancy ended through natural causes (Das, 2022).

Forcing pregnancy on an adult, young person or even a child as young as nine or ten is unconscionable, regardless of their reasons for wanting an abortion. Invasive investigation and surveillance of personal communications is cruel and offensive. How many times do we have to say it? The right to make this most significant decision should not be up for debate. I have always found it helpful to frame the body autonomy arguments by using the example of organ donation. No state can require an individual to give up an organ or bone marrow, even when doing so would save another’s life. Similarly, in the recent debates about vaccination, although we would want people to be vaccinated, we cannot physically force the vaccine onto them. Yet, restrictive abortion laws would force pregnant people, even when their lives are at risk, to bear children against their will. Sally Rooney (2018) captured the argument beautifully in this passage in a short essay in the London Review of Books:

No matter how much you need a kidney donation, the law will not force another person to give you one. Consent, in the form of a donor card, is required even to remove organs from a dead body. If the foetus is a person, it is a person with a vastly expanded set of legal rights, rights available to no other class of citizen: the foetus may make free, non-consensual use of another living person’s uterus and blood supply, and cause permanent, unwanted changes to another person’s body. In the relationship between foetus and woman, the woman is granted fewer rights than a corpse.

The thought of young girls forced to endure dangerous childbirth or adults facing the agony of going to the brink of death before sepsis takes their lives should be unbearable and unconscionable. However, for the zealots, it is not, as for all the weeping and wailing about the rights of embryos, essentially, the forced birth advocates do not care if pregnant people die. They do not care if children are left without their mothers because doctors were too scared to save their lives with a simple medical procedure. They do not care about the lifelong grief and loss of parties in what becomes essentially forced adoption. What forced birthers care about is controlling our bodies. When you peel away the hypocrisy and moralising, they do not want people to be in charge of their own lives. They will prove this time and time again by also putting barriers in place for people to access contraception and sex education. They will force pregnancies and try to force adoptions, but they will not fight for decent incomes, free childcare, high-quality free education and healthcare. No, they want the proof of sex punished.
Social work action is needed. I have written in this journal about the need for social work to take on board reproductive justice as a core social work issue (Beddoe et al, 2019; Beddoe, 2021). Reproductive healthcare is crucial in ending health inequalities. However, social work bodies are not very proactive in pushing this agenda forward. We will see statements of concern right now, but what will happen when the furore dies down and the social workers and activists close to the front line of this battle quietly get on with trying to ensure pregnant people find ways to access services? They will go on facing abuse, harassment and threats as they go to work in the morning. So, what can the social work profession do? I offer the following suggestions:

- Teach and promote feminist social work again. It has slipped off the curriculum so easily over the last 20 years, as social work education has been besieged by the neoliberal drive to focus on investigation and risk assessment (see Witt et al, 2021; Younes et al, 2021).
- Centre a feminist perspective in thinking about the women we work with in the profession, ‘moving away from seeing women as merely the object of the social work gaze, the focus of scrutiny and judgment’ (Beddoe, 2021: 9).
- Advocate for our professional bodies to include clear, strong statements about all aspects of reproductive justice in their policies. It is time to review national and international statements on health and well-being because these so often drive everyday situational ethics (Hyatt et al, 2022).
- Be more inclusive in thinking about social justice to ensure that the places we work in are safe, respectful and empowering for all people of all genders, sexualities, ethnicities and beliefs.
- Take a strong stand against the rampant misogyny, racism, homophobia, transphobia and class hatred we see every day.

We must challenge our colleagues and our students. We need to do better.

**Abortion: far from a 'settled issue' in the UK**

(Grace Horgan, Ireland)

Abortion is a ‘settled matter’ in the UK, according to outgoing Prime Minister Boris Johnson and his deputy, Dominic Raab. Johnson pointed out that ‘we recently took steps to ensure that those laws were enforced throughout the whole of the UK’ (Elgott, 2022).

Certainly, abortion is now legal under most circumstances across the UK, but it would be wrong to say that it is a settled matter. While the law in Northern Ireland is considerably better than that pertaining in England, Northern Irish women do not have access to abortion after ten weeks, unless the abortion is medically indicated. Meanwhile, in Scotland, England and Wales, abortion remains a matter for the criminal law and not for medical regulation – unlike every other form of healthcare.

The continued criminalisation of those who self-manage abortions with pills obtained via the Internet means that women in Britain could still end up in prison for taking control over their own bodies. Indeed, a 24-year-old woman is due in court in Oxford on 15 July charged, under the Offences Against the Person Act 1861, with causing an illegal abortion using pills she imported through the post.
Therefore, the issue of abortion is far from settled even in Britain. In Northern Ireland, it is a fragile mess, where some women still have to travel to access this basic healthcare and the access that is available is thanks to a small band of conscientiously committed doctors who have been providing an early medical abortion (EMA) service on top of their other work, without any resources.

Since abortion was decriminalised in 2019, women needing abortions have been able to legally access abortion pills by the Internet. The precariousness of this position became obvious in March 2020, when lockdown happened. India, from where the abortion medication provided by feminist websites is sent, closed its borders and shut down its postal service. At the same time, the new regulations covering abortion within Northern Ireland came into effect.

This meant that British Pregnancy Advisory Service (BPAS), which had been able to provide a telemedicine service for Northern Ireland since October 2019, was no longer able to do so legally. For two or three weeks, it seemed that anyone needing an abortion would have no choice but to travel to England, despite the pandemic. Unfortunately, most flights to England had been cancelled because of lockdown. Two young women who had been booked into English clinics had their flights cancelled at the last moment and, within a few days of each other, tried to take their own lives. This compelled the region’s sexual and reproductive health (SRH) doctors, who had been preparing for the commissioning of services, to act, and in the absence of any guidance from Stormont’s Department of Health, they set up an ad hoc EMA service.

The EMA service established by these doctors in April 2020 is the only abortion service available in Northern Ireland over two years on. For 18 months of that time, access to the EMA service was provided by a sexual health charity, Informing Choices NI (formerly, the Family Planning Association NI). Informing Choices provided the central access point for those seeking abortions from within its own reserves, which was clearly not sustainable, so the charity sought funding from the Department of Health. When this funding was not forthcoming, Informing Choices was unable to continue the service, so access to the EMA service in Northern Ireland is now organised through the BPAS.

This ridiculous state of affairs is due to the Minister for Health and the Department of Health refusing to commission abortion services despite this essential healthcare being legal and despite doctors and midwives being willing to provide the service. If you google NHS abortion services in Northern Ireland, you will not find any information on the Department of Health website. Instead, the top results will be for Marie Stopes and BPAS in England.

This lack of information provided by statutory bodies must impact on social work practitioners. While abortion was illegal in Northern Ireland, social workers adopted a proactive approach to the issue for those looked-after young people they supported. Throughout the 1990s, court cases were taken by health and social care trusts to ensure that young people in their care who needed abortions were able to leave the jurisdiction and travel to England. After devolution, however, the ‘chilling effect’ of a politics that was almost universally anti-abortion meant that such cases ceased. Residential social workers reported they were told that because abortion was illegal, they should not discuss it as an option with pregnant looked-after young people.

Almost three years after abortion was decriminalised in Northern Ireland, an unscientific poll of residential social workers found that no guidance had been provided to them in relation to the newly legal abortion services. While this is no surprise
given the department’s refusal to provide the general public with information, social workers need to be more proactive. As Beddoe (2021: 17) argued in this journal, social workers must end their ambivalence about reproductive justice and ‘situate the ongoing struggle for abortion rights within a broad health-disparities approach, based on the right to good healthcare for all’. In Northern Ireland, this means that social workers, with their trade unions and professional bodies, should be leading demands that the Department of Health honour its commitment to the United Nations Convention on the Rights of the Child (UNCRC) by providing full information about abortion services to the young people in the care of the state, as well as honour its commitment to ending health inequalities by commissioning services to ensure full access to abortion for all who need it.

**Radical social work supports life: beyond the pro-life–pro-choice dichotomy (Vishanthie Sewpaul, South Africa)**

The hurt, pain, anger and disappointment at the US Supreme Court overturning Roe v Wade saw massive outcries in the US and across the world, with the United Nations denouncing the decision as a ‘shocking and dangerous rollback of human rights that will jeopardize women’s health and lives’ (United Nations, 2022). The 24th of June 2022 is one of several of the bleakest days in the history of the ‘United States’, which should more fittingly be called the ‘Divided States’. The Roe v Wade ruling followed hot on the heels of the US Supreme Court’s judgment to expand gun rights, despite the frequency of gun violence and mass shootings, which disproportionately kill Black people. People’s right to bear arms stands in contradistinction with other people’s right to life, liberty and the pursuit of happiness, which is sacrosanct in the US Constitution.

Following the Roe v Wade judgment, which denies women a federal constitutional right to abortion, social media posts showed the Statue of Liberty in tears and her walking away from the US, symbolic of the depth of betrayal felt by the majority of Americans who do support women’s right to abortion, as was endorsed in the landmark 1973 Roe v Wade ruling. The US is not a democracy of the people, by the people and for the people, but an autocracy, run mainly by patriarchal white men who deem it fit to control women’s bodies and lives. Unsurprisingly, six of the nine Supreme Court justices are men, with two of the men and one of the women being Trump appointees. The stymieing of gun control legislation and the overturning of Roe v Wade represents the worse of US politics. In a schizophrenic US, split between ultra-liberalism and ultra-conservatism, one can hardly blame the Statue of Liberty for turning its back!

The 1973 Roe v Wade decision was momentous regarding women’s sexual and reproductive rights, not only in the US, but also across the globe. It saw women as agentic individuals with the right to control their sexuality, their bodies and their destinies. It is mainly poor Black and Latino women, who are already denied quality health services, who will suffer the greatest from overturning Roe v Wade. There is also the concern that it will encroach on other rights, such as the right to contraceptives and to gay marriages, and that it will encourage other conservative countries to follow suit. According to the Guttmacher Institute, which supports women’s right to abortion, 26 states are likely to ban abortions. This means that women who need abortions have to travel from one state to another, which poor women can ill afford.
Overturning Roe v Wade is not going to reduce the demand for abortions; rather, it
denies women the legal right to safe abortions, which will result in women seeking
unsafe, backstreet abortions that threaten health and life.

The framing of abortion into a dichotomous pro-life–pro-choice debate is
erroneous, as it presents the issue within moralising – and, all too often, within religious
on the narratives of 15 South African women who opted for abortions, reflected that
while women were pushed into making the choice for abortion, they were decidedly
pro-life. The women talked about the unborn in endearing and humanising terms
like ‘my baby’ or ‘my child’, and one talked about ‘bonding with the baby that you
don’t even know, you don’t ever see’ (Gilbert and Sewpaul, 2015: 89). The women
did not choose abortions simply because they had a right to such a choice; rather,
there were dire life circumstances that pushed them into making the decision. Yet, the
condemning voices of society were such that the women internalised them and saw
themselves as sinners and murderers, and bore the burden of guilt and responsibility.
The women made decisions informed by an ethic of care and responsibility towards
others, including responsibility towards the unborn who they did not want to bring
into a world of suffering, neglect, deprivation and hardship.

In 1997, the Choice on Termination of Pregnancy Act No. 92 1996 was
promulgated, which allows South African women access to abortion: on demand
up to 12 weeks of pregnancy; on the recommendation of a medical practitioner
from 13 to 20 weeks; and on the recommendation of two medical practitioners
beyond 20 weeks. Despite the legality of abortion, when women make the choice
on account of various structural conditions – including: the fear, stigma and shame of
being pregnant and unmarried because of societal condemnation of out-of-wedlock
pregnancies; rejection and abandonment by partners; unemployment; poverty; and
ill-health – it remains stigmatised and their suffering is silenced. Illegality, will further
stigmatise women who have abortions and deprive them of required medical and
psychosocial services.

While access to reproductive health, including access to safe, legal abortion, is
a fundamental human right, the abortion discourse needs to go beyond a liberal
rights-based approach. Having to choose an abortion is an indictment of societies
and a reflection of the collective failure of societies in their obligations and
responsibilities towards women. The answer to women’s reproductive struggles
does not lie in banning abortions. As the world’s most developed economy, the US
exemplifies the negative consequences of ultra-neoliberal, racialised capitalism, as
it is in the unenviable position of being the most unequal among rich countries.
Rather than banning abortions, the US would do better to prevent women from
needing abortions by focusing on policies that minimise poverty and inequality.
This means expanding access to: quality, free education; decent employment and
wages; contraceptives; universal healthcare; affordable housing; paid parental leave;
and increased welfare spending.

Reducing women’s need to revert to abortion also means that we must challenge
and mobilise communities to confront the double standards of a society that reveres
motherhood and children but condemns women for becoming pregnant in less than
socially determined ideal circumstances, as well as to challenge societies that ostracise
and label children as ‘unwanted bastards’. The most felicitous start to life, after all, is
being born a wanted and loved child.

Abortion rights and Roe v Wade

497
Note
1 The terms ‘woman’ and ‘women’ are used throughout to include anyone who can become pregnant.

Conflict of interest
The authors declare that there is no conflict of interest.

References