CONGRESS PAPER

The Role of Home Economics in Advocating for Women's Reproductive Rights

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Abstract

In 2015, the United Nations outlined the 2030 Sustainable Development Goals (united Nations, 2015). Of the seventeen goals, goal five targets gender equality and the ability to "ensure universal access to sexual and reproductive health and reproductive rights…" (United Nations, n.d.-a). Within the United States, historically and at present, women's reproductive rights are often at the center of political, legislative, moral, and social debates. However, to achieve the goal of gender equality, an emphasis on equality within women's reproductive rights must be established. As the Family and Consumer Sciences (FCS) discipline is centered on meeting the basic human needs of individuals, families, and communities, those within the profession must understand and advocate for women's reproductive rights. A review of historical and current infringements upon women's reproductive rights provides the background from which FCS practitioners can develop and enact advocacy plans to address equitable access to reproductive rights. Through these advocacy efforts, FCS can position itself as a leader in the fight for gender equality and provide support in reaching sustainable development goal five.

KEYWORDS: GENDER EQUALITY, REPRODUCTIVE RIGHTS, FAMILY AND CONSUMER SCIENCES, ADVOCACY, SUSTAINABLE DEVELOPMENT GOALS

The Role of Home Economics in Advocating for Women's Reproductive Rights

Despite the historical progress of medical science and technology, the global application of women's reproductive rights continues to be at odds with actions taken by those in power. Contentious debates often surround discussions of women's reproductive rights. While often viewed as synonymous with abortion and abortive care, women's reproductive rights also include "…freedom from discrimination, contraceptive information and services, safe pregnancy and childbirth … comprehensive sexuality education, freedom from violence against women, and HIV/AIDS" (Center for Reproductive Rights, 2013, p. 2). Across the globe, women face varied inequities in access to reproductive health and continue to have their rights subjected to political ideology, legislative action, violence, and patriarchal views of a woman's

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place in society (Yuan et al., 2019). In addition, the impact of the COVID-19 pandemic delayed significant progress toward reproductive rights achievement.

With roots in social justice, the 1908 founding of the International Federation of Home Economics (IFHE) and the 1909 founding of Home Economics in the United States embedded a mission focused on challenging social constructs and improving the lives of women in the home (International Federation for Home Economics, n.d.; Nickols et al., 2009). In the following decades, the focus shifted from women in the home to serving the needs of all individuals, families, and communities. Those working within Home Economics and the United States subset of Family and Consumer Sciences (FCS) continue to rely on a sense of mission to improve the lives of those around them by focusing on meeting basic human needs (American Association of Family and Consumer Sciences, 2023a). Although historical practices of the fields have, at times, been misaligned with women's reproductive rights, the field has tried to address women's needs through public resolutions and research (Kennedy, 2023).

Through a historical review of women's reproductive rights and a snapshot of current reproductive rights violations, this white paper will highlight the deviations between women's reproductive rights and basic human needs. An effort will be made to connect the need for reproductive rights to the United Nations through a focus on Sustainable Development Goal Five. Coupled with a discussion on the importance of viewing women's reproductive rights through the FCS Body of Knowledge, the stage will be set for actionable steps to increase the understanding and awareness of equitable access to reproductive rights through professional advocacy.

A Brief History of Women's Reproductive Health

Throughout history, women have taken simple and drastic means to control reproduction. The earliest reports of contraceptive use can be traced to 1550 BC Egypt (Frank, 1975). Although a global review of reproductive health from BC to the present would be stimulating, it is beyond the scope of this paper. Instead, the following review will begin with the nineteenth century, as this period marks increased efforts to control reproductive health. In addition, although this brief review does not touch upon violence against women or HIV/AIDS, freedom from violence and HIV/AIDS are essential components of women's reproductive rights. It is understood that throughout time, women have suffered from violence in every region and that HIV/AIDS continues to impact marginalized women at significantly higher rates (U.S. Centers for Diease Control and Prevention, 2024).

The nineteenth century marked a time of increased focus on women's reproductive health worldwide. This focus initially coincided with a growing concern for maternal and infant mortality. In Britain, the Registrar General's office began recording the number of maternal deaths starting in 1837 (Chamberlain, 2006). Social concern for maternal and infant mortality in India led Queen Victoria to send European-trained female doctors to the region (Saraiya, 2020). Many countries were still under colonialism, leading to maternal healthcare as a function of the ruling government.

While social movements of the 1800s increased the focus on women's access to healthcare, they also perpetuated several attacks on women's reproductive rights. In addition, the imposition of foreign practitioners often brought racial overtones and attacks on women's reproductive rights. Indigenous communities in Canada saw their reproductive practices

criminalized and replaced by European healthcare models (Ragganandan and Lawford, 2021). In the United States, reproduction was used as a population control method through the removal of native individuals from tribal lands and the sequestering of native women from traditional roles and rituals (Ross & Solinger, 2017).

While abortion and contraceptives were considered legal in England and the United States before the stage of quickening, the point at which a pregnant woman can first feel the movements of the growing embryo or fetus, the 1800s brought about abortion legislation (Peterson, 2019; Ross & Solinger, 2017). Laws banning abortions began in the early to mid-1800s, with British criminalization starting in 1803, followed by the United States passing its first anti-abortion law in 1821 (Peterson, 2019; Ross & Solinger, 2017). The founding of the American Medical Association in 1847 led to further criminalization of abortion, with all states in the United States enacting restrictions by 1880 (Beisel & Kay, 2004; Planned Parenthood, 2023). Similar laws took shape worldwide as Germany passed abortive legislation in 1871, and Canada passed legislation in 1892 (CBS News, 2017). In addition to legislative barriers, in 1869, Pope Pius IX declared anyone who had an abortion would be excommunicated from the Catholic church, thus imparting moral restrictions on abortion (Peterson, 2019).

In addition to laws centering on abortion, laws concerning contraception also began appearing in the 1800s. However, it is essential to note that not all women had equal access to contraception in the first place, and access was a function of social and economic status. In the United States, the Comstock Act, a federal law prohibiting the selling or distribution of contraception through mail or across state lines, was passed in 1873 (Kennedy, 2023, Ross & Solinger, 2017). Canada's 1892 abortive legislation also targeted the sale, advertisement, and distribution of contraceptives (CBS News, 2017).

In the twentieth century, a continued focus on women's reproductive rights took center stage due to medical advancements, industrialization, and changing social perceptions. In 1913, the Malthusian League, located in London, produced the first form of printed information on birth control methods (Olszynko-Gryn & Rusterholz, 2019). A few years later, in 1916, the United States witnessed the opening of the country's first birth control clinic, which was shut down nine days later (Kennedy, 2023). In 1933, the Swedish Association for Sexuality Education was founded with a central focus on education and providing sexual information to assist reproduction and fertility issues in Sweden (Kling, 2010). In 1936, an amendment to the Comstock Act ruled physicians could mail contraceptives nationwide (Kennedy, 2023).

However, while some women began to gain more control over reproduction, global increases in nationalism and the introduction of eugenics significantly impacted women's reproductive health. Russia enacted a policy in 1920 giving women access to terminate a pregnancy; this freedom was short-lived, however, as the passing of an anti-abortion law in 1936 returned to the criminalization of abortion (Felder, 2022). The 1936 law coincided with a focus on eugenics, in which abortions were available to perfect the race (Felder, 2022). Similar practices took place in Germany, Sweden, Denmark, Japan, the United States, and several other countries, many focusing on who had access to abortion and practices of forced sterilization (Felder, 2022; Patel, 2017). Women were often the subject of forced sterilization, as exemplified by the United States, where women considered promiscuous were labeled as socially inadequate and could be subject to sterilization (Ross & Solinger, 2017).

While the second half of the 1900s brought about significant advances in reproductive health, women worldwide faced disparities in access and choice. Brought about by overpopulation concerns, in 1951, India became the first country to establish a national family planning program (Population in India's first five-year plan, 1997). Between the 1960s and the 1990s, the first oral contraceptive was approved, along with the IUD. Abortion restrictions in the United States were loosened, and laws prohibiting married women from taking contraception were banned, as were laws that did not allow unmarried women to take contraception (Kennedy, 2023). In 1979, the Convention on the Elimination of All Forms of Discrimination was created (United Nations General Assembly, 1979). This convention aimed to establish a program to monitor women's status worldwide formally and promote women's rights (United Nations General Assembly, 1979). Although these advances and others were significant, the American Medical Association still maintained that doctors should be responsible for women's access to birth control (Ross & Solinger, 2017).

The 2000s brought increasing attention to women's rights around the globe through an onslaught of media attention and ever-expanding access to the internet. Archived reports from Amnesty International document the details of women's rights from sexual slavery in Paraguay, women's rights violations in Somalia, and abortion legislation in Peru (Amnesty International, 2023). When perceived gains were made, they were subsequently met with legislative counterattacks. For example, the 2010 Affordable Care Act in the United States mandated "…any FDA-approved birth control method be available to those with insurance with no copay or deductible" (Kennedy, 2023, p. 8). Though aimed at providing financial access to birth control, this act set off several legislative arguments in which companies fought for the right to deny women access to birth control based on religious beliefs. In 2014, the United States Supreme Court sided with a nationally known company, Hobby Lobby, stating certain corporations could deny birth control coverage through company health plans (Planned Parenthood, 2023).

In 2019, the world shifted with the impact of the COVID-19 pandemic. Access to healthcare was limited due to social distancing practices, and along with supply shortages and the closing of facilities, concerns for maternal health rose (Polis et al., 2022). Many women, especially those in lower-income and historically marginalized countries, faced additional barriers to accessing contraceptive devices and healthcare (Polis et al., 2022). In discussing maternal health during the COVID-19 pandemic, Wangamati and Sundby (2020) noted Kenyan women turned to alternative delivery methods for fear of or lack of hospital access. Research by Bittleston et al. (2022) found the impact of COVID-19 caused several young Australians to miss or reschedule sexual health appointments, including cervical screenings and sexual health testing. Though few examples have been provided on the impact of COVID-19 on women's reproductive health, these examples provide a lens for a more significant discussion of women's reproductive health during times of crisis.

This brief review highlights how much of the conversation surrounding women's reproductive rights has typically centered on abortion. However, the fact remains women's reproductive rights include several issues, each relating to basic needs and human rights. Yuan et al. (2019) state, "even though the universal human rights declarations admit that couples have the right of family planning, such right has rarely been accepted as the right of women as individuals" (p. 2). The continued discrimination against women's reproductive rights is a global issue. When women are unable to choose whom they have relations with, are barred from accessing sexual

health education and contraceptives, and when others dictate their reproductive care, women suffer. As of 2023, the United States is one of two countries that has signed but yet to ratify the Convention on the Elimination of All Forms of Discrimination against Women (United Nations Human Rights Treaty Bodies, n.d.). An additional six countries, including Iran, Somalia, and Sudan, have taken no action toward contributing to the Convention on the Elimination of All Forms of Discrimination against Women (United Nations, 2023).

The Current State of Reproductive Rights – A U.S. Focus

Often linked with abortion rights, the term *reproductive rights* frequently evokes value-laden positions associated with politics, religion, and moral judgment, as many consider the discussion of sexual health taboo (Health Poverty Action, 2018). From 1994 to 2023, several countries worked to increase access to abortion in collaboration with family planning efforts and a focus on maternal health (Council on Foreign Relations, 2023). However, in 2022, the most significant blow to women's reproductive rights in the United States came from a federal ruling by the U.S. Supreme Court. The Dobbs v. Jackson Women's Health Organization ruling of 2022 overturned the 1973 ruling, Roe v. Wade, which determined the right to an abortion was protected by the U.S. Constitution (Center for Reproductive Rights, 2022). The 2022 ruling sent abortion laws back to the states and removed the constitutional right to obtain an abortion. According to the Guttmacher Institute (2023), 24 of the 50 states have either banned abortion or are likely to do so in the future, and only 38% of women aged 13-44 currently live in states that support abortion rights.

In addition to a lack of access, women seeking abortive procedures in countries where the procedure is illegal often face a variety of perceived, internalized, enacted, and structural stigmas (Biggs et al., 2020). In 2022, the Centers for Disease Control (2022a) reported that induced legal abortions in the United States contributed to a maternal mortality rate of 0.43 deaths per 100,000 women in 2019. In comparison, Hoyert (2021) reported the maternal mortality rate for live births in 2019 to be 20.1 deaths per 100,000. In addition, in the United States, maternal mortality rates significantly impact Black women who have higher instances of their complaints and pain being overlooked and ignored (Janevic et al., 2020). Communication between patients and providers and provider bias have also been identified as avenues for discriminatory reproductive health practices (Janevic et al., 2020).

These discriminatory practices extend beyond public healthcare settings. As an example, a 2020 U.S. investigation found women in the state of Georgia immigration and customs enforcement (ICE) facility had undergone gynecological procedures deemed unnecessary and invasive (Vásquez, 2022). Without consent, more than 40 women in the facility underwent procedures, rendering them unable to have children (O'Toole, 2020). Although complaints were initially logged in 2018, it was not until 2020, during the COVID-19 pandemic, the claims were addressed (O'Toole, 2020). Just as the discriminatory practices of the twentieth century targeted minorities, these recent cases show a continuation of racially biased reproductive care.

The Institute of Medicine has identified women's reproductive care as a critical gap in the U.S. healthcare system (Cottrell et al., 2019). "Women who are poor and from racial and ethnic minorities are the least likely patient population to receive needed reproductive healthcare services," and "…low-income women are disproportionately vulnerable to gaps in coverage" (Cottrell et al., 2019, p. 2). These statements convey the intersectionality of reproductive issues as women's reproductive rights are constrained not only by gender, race, and socio-economic status but also by "…limited economic circumstances, lack of access to education, limited employment opportunities, poor living conditions, disability, ethnicity, as well as the challenging political and legal environments where they live" (Hartmann et al., 2016, p. 2).

An often-overlooked subset of women's reproductive rights involves the intersection of gender, age, and location. In 2022, Sex Ed for Social Change reported access to sexual education was a function of the state in which young people live. For example, 16 states within the United States provide abstinence-only education, while only 29 states require sex education (Sex Ed for Social Change, 2022). Even more alarming, Sex Ed for Social Change (2022) notes, "13 states do not require sex ed or HIV/STI testing instruction to be any of the following: age-appropriate, medically accurate, culturally responsive, or evidence-based/evidence-informed" (p. 3). These exclusions violate both reproductive rights and individuals' ability to meet their basic human needs.

On the opposite end of the spectrum, women past reproductive age often receive limited focus on their reproductive rights and sexual health. This lack of focus may be due to the taboo nature of sexual and reproductive health but may also be a feature of the societal portrayal of womanhood as a function of motherhood (Huang et al., 2016). Banke-Thomas et al. (2020) reported although "…65% of women will remain sexually active in old age…they do not tend to use contraception during sexual activity…" (p. 2). From 2007 to 2017, the Centers for Disease Control and Prevention reported the number of sexually transmitted diseases in adults 65 and older has more than doubled (Smith et al., 2020). Unfortunately, sexual education efforts have primarily targeted individuals of reproductive age, leading to a neglect of the needs of older adult women. The abandonment of a focus on reproductive rights for women past reproductive age infringes upon basic human needs and reproductive rights.

Connecting Reproductive Rights to the United Nations Sustainable Development Goals

In 2015, the United Nations (UN) created 17 sustainable development goals centered on global issues impacting individuals worldwide (United Nations, 2015). Of the 17 goals, goal five targets the issue of gender equality and proposes a mission to "achieve gender equality and empower all women and girls" by 2030 (United Nations, n.d-a). In alignment with the UN, the IFHE adopted six of the UN sustainable development goals, including goal five. With six targets, three sub-targets, and goal indicators, goal five is central to the global achievement of women's reproductive rights (United Nations, n.d.-a). Within the targets, sub-targets, and indicators, five of the nine targets/sub-targets can be seen as intrinsically linked with women's reproductive rights (See Table 1).

Table 1 UN Sustainable Development Goal 5: Gender Equity

Target	Indicator
5.1: End all forms of discrimination against all women and girls everywhere.	5.1.1: Whether or not legal frameworks are in place to promote, enforce and monitor equality and non discrimination on the basis of sex – Lack of equal rights amendment, intermediate level of scrutiny that supreme court has assigned to gender equality cases.
5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.	5.2.1: Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age. 5.2.2: Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence.
5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.	5.3.1: Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18. 5.3.2: Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age.
5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.	5.6.1: Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. 5.6.2: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.
5c: Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.	5.c.1: Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment.

Adapted from: United Nations, n.d.-a

A 2007-2021 longitudinal data collection set by the United Nations (UN) indicated less than 60% of married or partnered women between the ages of 15 and 49 can make their own choices concerning specific reproductive issues (United Nations, 2022). In addition to education and choice barriers, maternal mortality rates remain a global issue. Although improvements have been made in European and Asian regions, 87% of maternal deaths worldwide are still attributed to Sub-Saharan Africa and Southern Asian regions (World Health Organization, 2023). The Universal Declaration of Human Rights comprises 30 articles, including the right to freedom from discrimination, access to justice, the right to marry and establish a family, and the right to work (United Nations, n.d.-b). In particular, article 30 states, "No one, institution nor individual, should act in any way to destroy the rights enshrined in the UDHR" (United Nations, n.d.-c). Put simply, reproductive rights are "… human rights related to reproductive health and choice" (Virginia Commonwealth University School of Social Work, 2023).

Reproductive Rights and the Body of Knowledge

As a profession, FCS has identified itself as the people-centered science. However, the field has only sometimes positioned itself to support the diverse needs of all people. As a collection of issues, when reproductive rights are not realized, they have the potential to impact the family, which is central to the work of the FCS profession. As women's rights are a global issue, the totality of the profession should be concerned with how inequality and access to reproductive rights impact the family and Home Economics at large.

In 1971, the Journal of Home Economics created a resolution addressing women's access to abortion and supported repealing restrictive abortive laws and promoting abortive care. In 1972, the profession further outlined its role in the discussion of family planning, stating, "life is enriched for the individual, the family, and the community when children are born to parents who want and can care adequately for their young" (Journal of Home Economics, 1972, p. 19). From 1968 through 1994, the American Home Economics Association, now the American Association of Family and Consumer Sciences (AAFCS), released resolutions aligning the field with issues centering on reproductive rights (American Association of Family and Consumer Sciences, 2023b). These resolutions included family life education, the status of women, gender equity, adolescent pregnancy, abortion, human sexual behavior research, and eliminating all forms of discrimination against women (American Association of Family and Consumer Sciences, 2023b). While these resolutions were powerful, there has been a lack of effort to continue focusing on women's reproductive rights from within the profession. In the 2009 publication of the Family and Consumer Sciences Body of Knowledge, Nickols et al. addressed the historical failings of the discipline, noting:

> …it behooves those in the profession to constantly conduct internal examinations to ensure that as a field we are developing and using a body of knowledge that is relevant to contemporary society, is future oriented to encompass emerging conditions, and has the broadest possible applications, including research and practice. (p. 267).

With these statements in mind, the profession should work to link the body of knowledge to advocacy for women's reproductive rights.

Advocacy as Policy

As seen within the historical context, women's reproductive rights are a perennial problem. The question of why the profession should advocate for women's reproductive rights lies within the core elements of historical and professional practice. Braun and Williams (2002) addressed civic engagement within the profession, noting, "engaging in public work, and especially public policy, is an element of our professional heritage" (p. 13). The FCS profession calls on practitioners to address the basic humanity of individuals, families, and communities.

The reproductive rights violated within the historical and current state of women's reproductive rights disrupt the attainment of basic human needs. Using the systems of action developed by Brown and Paolucci (1979), applying a critical science perspective to women's reproductive rights can help practitioners transfer theory to practice.

Gather Information

Through technical action and questioning, practitioners can explore reproductive rights within their community, state, and country. For example, taking the time to review city dashboards and websites, such as the status of women in the states and the Center for Reproductive Rights, can help practitioners examine technical questions such as:

- What are my community's reproductive rights rules, laws, and regulations?
- What facts support my community's decision(s) for reproductive legislation?

Explore Personal Assumptions

Using the FCS BOK and self-reflection, professionals should define a lens to focus on women's reproductive rights. As women's reproductive rights comprise several issues, finding a

connection between well-being and reproductive rights can be facilitated by interpretive and reflective questioning. Questions to consider should include:

- What personal factors affect my views and opinions on reproductive rights, and where did these factors originate?
- What do I believe constitutes well-being, and how will I know if well-being is unmet?

Choose an Advocacy Path

Once the information has been gathered and personal assumptions have been addressed, it is crucial to determine how to advocate for women's reproductive rights. It is also important to remember advocacy can take on many shapes and forms, and not every individual feels comfortable participating in public advocacy. In whatever way you feel leads to advocacy, one's voice is needed in the fight for women's reproductive rights. When considering an advocacy contribution, comfort level can be determined through the following questions:

- Is my contribution best met through social media, news outlets, and letter writing, or through calling local, state, and national representatives?
- Is my contribution best met through research aimed at informing the FCS community and my larger community on women's reproductive rights issues?

Collaborate

In addition to individual advocacy, building capacity through collaborative advocacy projects is essential. First, consider whether to lead or contribute to established projects. For example, many local and national organizations currently have advocacy platforms that could benefit from an FCS professional's expertise. In addition to organizational collaboration, consider the following questions:

- Are any of my colleagues able to be collaborative partners?
- Are there disciplines outside of FCS I could partner with to increase awareness of women's reproductive rights?

Conclusion

As noted, significant missteps in addressing basic human needs occur in understanding and championing women's reproductive rights. Based on the history of the discipline and the BOK framework, FCS is uniquely positioned to address the interrelationships between women's reproductive rights and the well-being of individuals, families, and communities. Through advocacy, FCS professionals can begin to address the gap between women's reproductive rights and gender equality, thus facilitating the achievement of the UN Sustainable Development goal of ensuring "universal access to sexual and reproductive health and reproductive rights…" (United Nations, n.d.-a). In closing, practitioners should consider the following question when advocating for women's reproductive rights, "…what will happen if we take an active role, and what will happen if we do not" (Journal of Home Economics, 1972, p. 20).

Biographies

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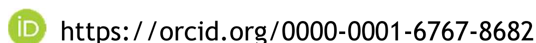
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