women

MDPI

Communication

Family Care Relationships in Reproductive Justice

Eriko Miwa [1], Erika Shoji [1], Eisuke Nakazawa [1] and Akira Akabayashi [1,2,*]

[1] Department of Biomedical Ethics, Faculty of Medicine, University of Tokyo, Tokyo 113-0033, Japan
[2] Division of Medical Ethics, School of Medicine, New York University, New York, NY 10016, USA
* Correspondence: akira.akabayashi@gmail.com or akirasan-tky@umin.ac.jp; Fax: +81-35841-3319

Abstract: The *Roe* v. *Wade* case, which legally supported abortion in the U.S., was overturned in 2022, and the international conversation about reproductive justice gained momentum as a result. Reproductive justice is a concept that advocates reproductive freedom (the freedom to have/not have children and the freedom to raise children in a healthy environment) for all couples and individuals. This paper introduces the family care relationship in reproductive justice and presents a concept of reproductive justice. By incorporating family care relationships in the concept of reproduction, the complexity and uniqueness of the reproductive choice process are preserved. Family care relationships are well suited for focusing on family-centered societies and the processes leading to abortion care, and autonomous decision-making in reproductive choice can be strengthened. It is important to explore appropriate support methods from the dynamism of the caring network, advocate for positive freedom, and settle the decision-making power in a moderated position, even with some abandonment of individualism.

Keywords: abortion; reproductive justice; *Roe* v. *Wade*; caring network

Citation: Miwa, E.; Shoji, E.; Nakazawa, E.; Akabayashi, A. Family Care Relationships in Reproductive Justice. *Women* **2022**, *2*, 339–345. https://doi.org/10.3390/women2040031

Academic Editor: Mary V. Seeman

Received: 21 July 2022
Accepted: 30 September 2022
Published: 6 October 2022

1. Introduction

The issue of access to abortion care is one of the most traditional topics in bioethics, which has developed since the 1970s. Abortion, in particular, has been described as an antinomy of pro-life vs. pro-choice in bioethics. However, this simple dichotomy of pro-life vs. pro-choice may have been historically overemphasized. Awareness of the sanctity of life as a concept can be found worldwide at any point in time, but the concept varies from generation to generation and from place to place. Depending on the cultural aspects such as a woman's way of life, her view of family, and her sexual morality, the relationship between a woman's choice and the sanctity of life can vary. As an extreme example, the statement "she is pro-choice and believes in the sanctity of life" might be consistent with this fact.

The social context surrounding reproductive decision-making is undergoing significant change. Advances in reproductive technology including contraceptive measures, in vitro fertilization, preimplantation genetic diagnosis, prenatal screening, and improved intervention addressing infant dysfunctions have allowed for more technological possibilities. Anthropological research in Japan indicates that before the Meiji period newborns were understood to gradually become persons as their souls settled in their bodies [1]. Now that fertility treatments have become common, some people offer memorial services for discarded frozen embryos, considering them as their children. In a 1968 encyclical, the Catholic Church held that the personhood of the fetus begins at the moment of insemination [2]. Still, the theory of immediate animation has not always been the majority opinion in the Church. The view of delayed hominization also existed which suggested that the fetus attained personhood after a certain period of impregnation [3]. The family as a fostering environment has also changed over time. Many countries and regions have introduced civil partnerships and as the stigma of single parenthood wanes, women's right

to choose is increasing in most of the world. It is time to rethink and explain what we consider optimal in reproductive decision-making.

In this paper, we introduce a "three-layered approach" to complement the reproductive rights discussions. In particular, we highlight the role of the family care relationship as the second layer. By introducing this layer, the complicated decision-making process by families regarding women and children can be considered appropriately, and the discussion of reproductive rights can be advanced.

1.1. Access to Abortion

Access to abortion care is a global issue. In Europe, for example, all countries except Poland and Malta have legalized abortion on request or broad social or economic grounds. However, access barriers to abortion care, such as short time limits and mandatory waiting periods and counseling, remain [4]. In Latin America, the Caribbean, and Africa, more than 90% of women of reproductive age are severely legally restricted from having abortions, and even in countries where abortion is relatively widely accepted, it has been reported that there are still women without access to safe abortion care [5,6]. This indicates that liberal abortion laws alone do not improve women's access to abortion care. In Asia, the situation is more complicated [7]. Thailand and South Korea have succeeded in legalizing abortion. On the other hand, some countries, such as Bangladesh, Indonesia, Laos, Myanmar, and the Philippines, continue to have severe restrictions. Thus, in 2014, at least 6% of all maternal mortality in Asia was from unsafe abortion procedures [8]. In China and Japan, abortion freedom still depends on population policies and is poorly positioned as a rights issue. China, which had a one-child policy, announced a policy of reducing the number of "non-medically necessary abortions" due to concerns about its aging population. In India and Vietnam, where abortion is widely permitted, many abortions are for gender selection, leading to sex ratio imbalances and unsafe abortions. In Japan, where the birthrate has been declining for decades, an increasing number of doctors have applied the requirement of spousal consent to unmarried women in a distorted manner, and the abandonment of infants by young women who had no access to abortion care during the available period has appeared frequently in the news.

Meanwhile, for the Japanese legal system, the current Penal Code enacted in 1907 defines abortion as a "crime of abortion" (chapters 212–216), which not only prohibits self-abortion by the abortionist but also punishes the medical professionals who perform the abortion. To cope with postwar food shortages and population growth, the Eugenic Protection Law was enacted in 1948, legalizing abortion to the extent that it met the law's criteria. The Eugenic Protection Law was renamed the Maternal Protection Law in 1996. According to the Maternal Protection Law, a physician designated by a medical board is allowed to perform an abortion "with the consent of the woman and her spouse" if (1) the continuation of pregnancy or delivery is likely to seriously harm the mother's health for physical or economic reasons, or (2) the woman became pregnant by assault or threat or by being raped while unable to resist or refuse (Article 14) [9].

Therefore, in Japan, although abortion is prohibited in principle by the abortion law, about 140,000 abortions are performed annually, or about one in every six pregnancies, due to a broad interpretation of Article 14 of the Maternal Protection Law, "for economic reasons" [10,11]. Despite this gap between law and reality, abortion is not treated as a major religious or political issue in Japan as it is in the U.S. and other Western countries, although there is a debate over abortion in Japan.

The year 2022 will be remembered in history as a turning point in U.S. abortion policy. On 24 June 2022, the U.S. Supreme Court overturned the 1973 *Roe* v. *Wade* decision in the Mississippi case of *Dobbs* v. *Jackson* Women's Health Organization (hereafter "*Dobbs* case"). In *Roe v. Wade*, the Court ruled that the right to an abortion was constitutional as part of the right to privacy and guaranteed women's right to abortion for the past half-century. However, with this new ruling, this right to abortion is no longer guaranteed by the U.S. Constitution, and it will be left to each state to decide. Nine justices of the

U.S. Supreme Court ruled 6-3 in the *Dobbs* case that a Mississippi law banning abortion after 15 weeks of pregnancy was not unconstitutional [12,13]. Since *Roe* v. *Wade*, 13 states have passed so-called trigger laws that automatically ban abortion when the U.S. Supreme Court overturns a decision, but with the *Dobbs* decision, 13 more states are expected to make abortion illegal or severely restrict it [14,15]. Many criticisms of the Dobbs case were expressed in terms of public health concerns, increasing racial and socioeconomic disparity caused by unexpected pregnancies, and the right to privacy and liberty [16–22].

However, it is important to remember that prior to the Dobbs case, the U.S. was in the midst of a wave of states passing heartbeat bills between 2011 and 2020 [23]. These laws were designed to bring about a substantial ban on abortion by severely restricting access to abortion care, including setting short time limits, imposing severe penalties on doctors who perform the procedure, and introducing the statutory damage compensation system against anyone involved.

Barriers to abortion care are said to be caused by a cumulative effect of a combination of regulatory requirements [24]. In other words, the problems in the countries just described indicate that abortion must be viewed as an event that occurs to women as well as a pathway to abortion care and not rely on the single fact that abortion is not legally prohibited.

1.2. Reproductive Justice

The essential element of "positive freedom" in achieving Reproductive Justice (hereafter, RJ) was recognized from the early days of RJ advocacy. The Cairo Declaration and the Programme of Action (PoA) were adopted at the International Conference on Population and Development (ICPD) in Cairo, Egypt, in 1994 [25]. According to ICPD-PoA, reproductive health/rights is "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence [25]." ICPD-PoA was groundbreaking in rejecting the view that governments control reproduction for population control and instead established a policy of empowering women in developing countries through improving reproductive health. It focused on meeting individual needs and improving the quality of life rather than statistics and presented a plan of action emphasizing positive freedom rather than a negative one. This basic policy is still followed today.

While we positively evaluate the ICPD-PoA, it is important to highlight its limitations. The RJ concept in the ICPD-PoA is premised on an individualistic ontology of the relationship between the individual woman and the government, with the family and community having only the instrumental status of objects of intervention, although attention is given to their diversity. The individualistic interpretation of reproductive decision-making has been criticized. First, the individualistic approach focuses on the performance of acts with negative freedom, "can choose without the undue intervention of others," and second, by focusing on the individual, it oversimplifies the decision-making process by failing to take into account the situation and context in which the individual is surrounded [26].

This paper modestly and tentatively introduces a "three-layered approach" to RJ—the individual, the family care relationship, and the government—to incite a discussion with readers. This three-layered approach could be helpful as an analytical framework in family-oriented societies such as those in Asia, and countries that have legalized abortion but have problems with the path to abortion care. The distinctive feature of the three layers is the family care relationship layer. We clarify the characteristics of the second layer, the family care relationship layer below, and explain how this layer works in RJ in a way that brings about positive freedom. We argue that RJ must be extended by a caring network constructed between the couple or family and those close to them and that the caring network is essential to RJ. By focusing on "externalizability," we also show that it is possible to frame RJ so that the individual woman's right to self-determination is not threatened by introducing a layer of family care relationships.

2. Ethical Analysis

2.1. Ethical Analysis 1: Clarifying the Layers of the Family Care Relationship

Having/not having children is more than a matter of individual self-determination; it is a matter of resource and risk allocation in the caring network. The caring network is both the determining factor for the resources of care provision and the absorber of risk when a new child is welcomed into a close-knit group of people. The arrival of a baby in the home creates a need for constant care. Parents may be the primary providers, but grandparents, aunts and uncles, friends, cousins, and siblings who have preceded them are also involved in providing care. This includes not only direct care of the baby but also housework and care for those taking care of the child. Pregnancy is also a period of high risk for pregnant women, who can only have an uncertain prediction during the pregnancy period. Some expectant mothers can work until the very last minute before childbirth, while others must abandon work early due to complications or other reasons. The husband and surrounding family members take on these financial risks in a dispersed manner, even if there are shades of gray.

The impact of the decision to have/not have children must also be considered on the part of the caring network. Standing on the basic tenets of the ethics of care, all stakeholders must be considered without being separated from the relationship, and the families embedded in the network also have to be respected as decision makers. Here, the family is treated as a unit, not a set of individuals, to avoid inviting individualism. What would it mean to strengthen "autonomous family choice" instead of "autonomous individual choice"? If we view the family as a caring network rather than a set of individuals, then the basic premise is that the caring network of the family care relationship must not break down for the family to be respected as a decision maker. The strengthening of "autonomous family choice" means that the coordination of resources in the network is strengthened. Suppose there is a quantitative enhancement in the allocation of resources and risks in the network, in terms of an increase in the totality of resources and risk tolerance, or a functional enhancement in terms of a more efficient flow of resources and dispersion of risks. In this case, we can assume that there will be more choices, or the feasibility of the options they decided to take will increase.

Human life is not something that can just be born and left to die, but it must be protected and nurtured by someone. The obligation to keep this *zoe* as a *bios* is an obligation specifically imposed on the layers of family care relationships, and the "abortion advocacy" by J. Thomson [27] may be extendable to the decision of whether or not to welcome a child into the caring network. In the following section, we will clarify the demarcation line of who can enforce what and to what extent and the relationship between advocating for positive liberty and the right to self-determination.

2.2. Ethical Analysis 2: Positive Freedom Advocates and the Scope of Self-Determination in Caring Networks

Second, let us examine reproductive decision-making in the family care relationship layer. Caring networks are dynamic when it comes to reproductive decision-making. For instance, when grandparents say, "We want to see our grandchild" to their daughters and daughters-in-law, they are proposing a transaction: "Let us see our grandchild, and in exchange, we will channel some form of resources to them for their care." The transaction involves bargaining over the allocation of resources and risks within the network. Women need to decide to have/not to have children based on the transaction of resources and risks with grandparents.

Of course, grandparents cannot force women to have children, no matter how generous their expressed willingness to provide resources for the care of their grandchildren. This is because the physical risks associated with pregnancy and childbirth, as well as the social risks such as career opportunities and time, can never be externalized. Thus, a structure in which the final decision is left to the woman, and she bears the risk, is ultimately unavoidable. However, the decision is not an independent individual decision but a

complex decision that is subject to diverse influences depending on the state of the caring network. This has implications for possible social support for women's decision making in light of their caring network.

Possible support for the caring network includes reducing constraints on decision-making due to the dynamism of the caring network by encouraging greater network coordination. This can positively increase the freedom of individual and family care relationships. The placement of universal access to medical facilities, childcare support such as nursery schools, and various assisting agencies can also be interpreted as strengthening the coordinating power of the network.

The advantage of considering the caring network as a unit is that the complex elements within the family care relationship can be visualized as influencing the decision-making process, and appropriate assistance can be provided for elements that, while not being the subject matter themselves, are important for strengthening the coordinating power of the caring network. To focus on the dynamism of the network, childcare, caregiving, and reproductive labor, in general, cannot be considered in isolation here. For instance, it may be the case that, to support childcare of a given family, providing housekeeping assistance or caregiving assistance would strengthen the coordinating power of that network more in terms of the efficiency of resource allocation than providing childcare assistance.

However, it should be noted that social support for the caring network has its limitations. A variety of maternity and parenting supports is provided by the government and non-governmental organizations. However, just as there are risks and costs that cannot be externalized from individuals to the caring network, there are elements of the caring network that cannot be externalized. For instance, elements attributed to genus value include the affection and attention children seek from their parents, the intimate interactions between couples, and the legal rights and obligations of kinship. Other elements that are attributed to the difficulty of marketization include nursing care, care for sick children, and care for the physically challenged. These are situations where it is difficult to find providers, requiring the involvement of a certain number of fixed people, which makes full externalization difficult. Such elements that cannot be externalized are easily associated with the breakdown of the caring network. Therefore, changes in family members' lifestyles and life plans due to the arrival or non-arrival of children are risks that should not be ignored. It is unacceptable for society to make decisions about non-externalizable risks and costs outside the network. That is, society can provide support from the outer edges of the network, but it is not acceptable for society to control family decisions by reducing an individual's or family's access to the option of not having children.

The family care relationship layer brings a powerful perspective to the complex decision-making process and visualization of care relationships, but it requires caution when decisions involve eugenic ideology and gender selection. In Vietnam and India, as mentioned in the first chapter, the practice of male-dominant inheritance and dowry makes the birth of a girl an unexternalizable risk for the family. Therefore, even though doctors are prohibited from telling the family the sex of the baby before birth and from performing abortions based on gender selection, people do not follow these rules and instead engage in medical tourism and unsafe abortions. The "externalizability" here is a useful explanation for the phenomenon, but it is not powerful enough to overturn the legitimacy of the family's decision. How the child's gender-dependent risk is embedded in the family care relationship layer in an unexternalizable form and how it can be erased requires further examination.

3. Conclusions

In this paper, we proposed the introduction of a three-layered approach with respect to RJ: individual, family care relationship, and government; by incorporating a family care relationship layer in RJ, we attempted to portray how reinforcing the autonomy of the reproductive choice could be interpreted without loss of complexity and uniqueness of the process. The results showed that one way to advocate for positive freedom in individual

cases is to explore appropriate methods of support from the dynamism of the caring network, and that one way is to incorporate the perspective of "non-externalizability" as a justification to prevent unjustified intervention, as indicated by the negative freedom perspective. We believe that the three-layered approach has the potential to improve RJ for highly cohesive family societies and for countries where access to abortion care is a challenge. However, issues of discrimination, such as eugenics and gender selection in reproduction, require further consideration. These issues may be one of the limitations of this paper. However, we also demonstrated that each country has the potential to explore its own measures for RJ based on its own culture and history, even without assuming individualism.

Author Contributions: Conceptualization, E.M., E.N. and A.A.; writing—original draft preparation, E.M., E.S., E.N. and A.A.; writing—review and editing, E.N. and A.A.; project administration, A.A.; All authors have read and agreed to the published version of the manuscript.

Funding: This work was supported by JSPS KAKENHI Grant Number JP20J12581.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: Not applicable.

Conflicts of Interest: The authors declare no conflict of interest.

References

1. Suzuki, Y. *Sentaku Sareru Inochi: Kodomo no Tanjo wo Meguru Minzoku [A Life of Choice: Ethnography on the Birth of a Child]*; Rinsen Book Co.: Tokyo, Japan, 2021.
2. Pope Paul, VI. *Of Human Life = Humanae Vitae*, Annotated ed.; Alvaré, H., Trouvé, M.L., National Catholic News Service, Eds.; Pauline Books & Media: Boston, MA, USA, 2018.
3. Donceel, J.F. Immediate animation and delayed hominization. *Theol. Stud.* **1970**, *31*(1), 76–105. [CrossRef]
4. European Abortion Laws: A Comparative Overview. Center for Reproductive Rights. 2022. Available online: https://reproductiverights.org/wp-content/uploads/2020/12/European-abortion-law-a-comparative-review.pdf (accessed on 8 September 2022).
5. Abortion in Latin America and the Caribbean. Guttmacher Institute. 2018. Available online: https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-latin-america.pdf (accessed on 8 September 2022).
6. Abortion in Africa. Guttmacher Institute. 2018. Available online: https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-africa.pdf (accessed on 8 September 2022).
7. Damayanti, I.; Sharma, K.; Kamei, A. Abortion in Asia: The Limits of Choice. Nikkei Asia. 2022. Available online: https://asia.nikkei.com/Spotlight/The-Big-Story/Abortion-in-Asia-The-limits-of-choice (accessed on 8 September 2022).
8. Abortion in Asia. Guttmacher Institute. 2018. Available online: https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-asia.pdf (accessed on 8 September 2022).
9. Maternal Health Act, Japan (Act No. 156 of July 13, 1948). Available online: https://www.japaneselawtranslation.go.jp/ja/laws/view/2603 (accessed on 20 July 2022).
10. Ministry of Health, Labour and Welfare, Japan. Summary of Reports on Health Administration in FY 2020. 2022. Available online: https://www.mhlw.go.jp/toukei/saikin/hw/eisei_houkoku/20/ (accessed on 20 July 2022).
11. Ministry of Health, Labour and Welfare, Japan. 040421 Pregnancy Notification Press Release (Revised). 2021. Available online: https://www.mhlw.go.jp/content/11920000/000784662.pdf (accessed on 20 July 2022).
12. Dobbs v Jackson Women's Health Organization, 142 S. Ct. 2228 (2022). Available online: https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf (accessed on 20 July 2022).
13. The Dobbs v. Jackson Decision, Annotated. The New York Times. Available online: https://www.nytimes.com/interactive/2022/06/24/us/politics/supreme-court-dobbs-jackson-analysis-roe-wade.html (accessed on 20 July 2022).
14. Witherspoon, A.; Glenza, J.; Yachot, N.; Chang, A. Tracking Where Abortion Laws Stand in Every State. The Guardian. Available online: https://www.theguardian.com/us-news/ng-interactive/2022/jun/28/tracking-where-abortion-laws-stand-in-every-state (accessed on 20 July 2022).
15. Nash, E.; Guarnieri, I. 13 States Have Abortion Trigger Bans—Here's What Happens When Roe Is Overturned. The Guttmacher Institute. Available online: https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned (accessed on 20 July 2022).

16. Remarks by President Biden on the Supreme Court Decision to Overturn Roe v. Wade. The White House. 24 June 2022. Available online: https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/24/remarks-by-president-biden-on-the-supreme-court-decision-to-overturn-roe-v-wade/ (accessed on 20 July 2022).
17. The Editors. Lawmakers v. The Scientific Realities of Human Reproduction. *N. Engl. J. Med.* **2022**, *387*(4), 367–368. [CrossRef] [PubMed]
18. Shahawy, S.; Rattani, A. The fall of Roe v Wade: A call to action for religious medical providers. *Lancet* **2022**, *400*(10346), 93. [CrossRef]
19. Lewandowska, M. The fall of Roe v Wade: The fight for abortion rights is universal. *BMJ* **2022**, *377*, o1608. [CrossRef] [PubMed]
20. Lenharo, M. After Roe v. Wade: US researchers warn of what's to come. *Nature* **2022**, *607*, 15–16. [CrossRef] [PubMed]
21. Foster, D.G.; Biggs, M.A.; Ralph, L.; Gerdts, C.; Roberts, S.; Glymour, M.M. Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. *Am. J. Public Health* **2018**, *108*(3), 407–413. [PubMed]
22. Myers, C.; Jones, R.; Upadhyay, U. Predicted changes in abortion access and incidence in a post-Roe world. *Contraception* **2019**, *100*(5), 367–373. [CrossRef] [PubMed]
23. Evans, D.P.; Narasimhan, S. A narrative analysis of anti-abortion testimony and legislative debate related to Georgia's fetal "heartbeat" abortion ban. *Sex Reprod. Health Matters* **2020**, *28*, 1686201. [CrossRef] [PubMed]
24. Lavelanet, A.F.; Johnson, B.R., Jr.; Ganatra, B. Global Abortion Policies Database: A descriptive analysis of the regulatory and policy environment related to abortion. *Best Pract. Res. Clin. Obstet. Gynaecol.* **2020**, *62*, 25–35. [CrossRef] [PubMed]
25. United Nations Population Fund (UNFPA). Programme of Action—Adopted at the International Conference on Population and Development (ICPD). Available online: https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf (accessed on 20 July 2022).
26. Lanphier, E. A. Problem of Self-Ownership for Reproductive Justice. *Camb Q Healthc Ethics* **2021**, *30*(2), 312–327. [CrossRef] [PubMed]
27. Thomson, J.J. A Defense of Abortion. In *Biomedical Ethics and the Law*; Humber, J.M., Almeder, R.F., Eds.; Springer: Boston, MA, USA, 1976; pp. 39–54.