

Why aren't women getting safe abortions?



Many women in South Africa (SA) risk their lives to end an unwanted pregnancy. Despite the liberalisation of laws and formalisation of services dedicated to abortions, women continue to resort to illegal and unsafe solutions that render them vulnerable to

health and social risks, serious morbidity and even death.

For many women in SA, access to safe reproductive health services remains a challenge. Even where formal services are available, women prefer and seek quick, private responses to their problem and often avoid seeking help at designated healthcare facilities. Various reasons are offered in explanation, ranging from a fear of ill treatment by facility staff and lack of confidentiality to long waiting lists and ambiguity surrounding rights to, access to and availability of services (particularly restricted in rural areas).

At a social as well as a structural level, the role of stigma requires underscoring. Women express a need for secrecy out of fear of a social aftermath, while healthcare practitioners can be influenced by their right to conscientious objection to being designated as an abortion service provider and the covert peer social sanctions experienced by those who do choose to provide these services. Conscientious objection has been identified as an important issue in understanding the obstacles associated with implementation of and access to legal abortion services. It is a particularly complex matter in both the local and the global contexts, and needs comprehensive engagement and appropriate response at the broader policy and institutional levels as well as at community and individual levels. Conscientious objection gives healthcare professionals the constitutional right^[1,2] to freedom of moral belief, religion, and conscience with regard to rendering services to women seeking to access legal abortions. Stated more simply, a trained healthcare provider may object to offering legal abortions on moral or religious grounds even where designated facilities for these services exist. SA legislation^[2,3] further states that when a practitioner refuses to provide services, based on their constitutional right of freedom of thought, belief, and religion, they are obligated to inform the woman and refer her to an alternative service facility. This in itself could prove problematic if the practitioner believes that the offering of this information and referral may be interpreted as an endorsement of abortion: effectively, the practice of referral also becomes subject to conscientious objection. As result, the pool of designated services that are actually operational is extremely small in relation to the need for these services, and despair drives women of all ages to conceal and terminate their pregnancies under dangerous and often life-threatening conditions.

It is evident that challenges to accessible and acceptable reproductive healthcare services are driven by an array of sociopolitical and historical factors that create barriers to effective service delivery. Structural and social pathologies deter women from accessing formal, safer abortion services and expose them to harm by preventing them from exercising a basic human right to safe reproductive healthcare. These 'pathologies' represent *structural violence*^[4] whereby the social structures or institutions surrounding reproductive healthcare needs harm women by preventing them from meeting their basic need for effective and efficient care. The status of women seeking abortion services (both socially and structurally) denies them access to the utility of these services, rendering them susceptible to premature death, distress, and feelings of guilt and shame. This form of structural violence against women is often legitimised and maintained through cultural processes in SA. Cultural ideologies and religious beliefs in society, as well as in professional healthcare

circles, play a key role in denying women access to abortion services via processes of stigmatisation, judgement, isolation and alienation. These prejudices and discriminatory practices at a cultural level not only support structural violence against women, but also make the denial of abortion-related services culturally and socially acceptable.

Aside from these social and structural pathologies, we need to ask ourselves why women are finding themselves in a position where they deem their pregnancies unwanted. Although many women legitimately choose not to have children, or not to have additional children, many others' choices are influenced by external factors such as poverty, ineffective support structures, fear of rejection by a partner, and abandonment by partner and/or family, to name just a few. In other words, a pregnancy being 'unwanted' has much to do with the circumstances surrounding a woman and her unborn child. We should therefore really be asking ourselves who or what is failing this woman that she feels she has *no choice* but to deem her pregnancy unwanted and abort – or worse, give birth and then dump her baby.^[5] What does this woman need in order for her to believe that she has a choice and may have her child instead of feeling obligated to terminate? Are we satisfied that the acceptable response rests in a discourse that advocates a 'solution' to 'fix' her by terminating her pregnancy, instead of addressing the needs that drive her to believe she has no other choice?

We believe that the answer lies somewhere between including men as partners who share responsibility in reproductive choices and practices, and structural support that includes effective, accessible prevention and intervention initiatives for women. In the reproductive healthcare environment, the right of practitioners to refuse to perform abortion-related services, based on their democratic right to conscientiously object, inadvertently places women at risk of harm, injury and death. Simply put, one individual's democratic right to choose impairs another's human right to determine the status of her future. The state's responsibility to resolve this conflict between this almost immutable juxtaposition of the constitutional right of the practitioner to refuse abortion services v. that of the woman wishing to access legal abortion is complicated by the heterogeneity of these populations. In some instances, research has shown that practitioners who have previously objected on moral or religious grounds agree to perform these services when offered monetary rewards such as overtime or special rates. Without disputing earnest objections, conscientious objection in this situation becomes highly questionable and demands closer examination of this constitutional right. It would be easy to propose rigorous regulation of these rights at policy level, but much empirical research has shown that policy does not necessarily translate to action and that implementation of policy at grassroots level is one of the greatest challenges our country faces.

Too often men are excluded from reproductive health initiatives, with devastating effects, especially considering the patriarchal nature of SA society.^[6] Empowering women about their rights and choices is simply not enough when women in our society are subjugated by power imbalances between men and women. Progress in shifting these gender imbalances in accepting responsibility for reproductive health has been slow and unequal, while the clandestine nature of abortions and unplanned pregnancies confounds scientific progress in understanding the true nature of these phenomena. Although accessibility to and acceptability of abortion services in SA requires serious attention as a public health priority, we should also be critical in our approach when we propose to prevent and intervene. The need for abortion among women in SA is such a

convoluted issue that its outcome is as much a choice *for* women as it is *against* women. We need to be cognisant of the complexities outlined above when proposing and implementing prevention and/or intervention strategies if we hope to confront this formidable public health concern. State initiatives should therefore not only be redressing the effects of stigma, both socially and structurally; the state should also invest in supporting the non-profit sector that provides specialised reproductive healthcare services outside of conventional state structures and clinics. While maintaining existing structures, supporting the specialisation of reproductive health and abortion services outside state community clinics would improve privacy and confidentiality for women approaching and utilising service providers. It would also maximise commitment of staff specially recruited to provide these services, while minimising structural pathologies such as the effects of stigma in the immediate work environment. The National Health Insurance (NHI) Fund, with the Green Paper launched in 2011^[7,8] and the White Paper launched in 2014 and due to be tabled in Cabinet in the near future,^[9] would offer a further avenue for broadening of specialised services outside existing governmental facilities, such as specialised reproductive health services including family planning and abortion services.

With NHI, which is being phased in over a 14-year period, all private healthcare providers will be bound to provide services to a quota of state-subsidised patients from low-income settings. Its formalisation should increase access to improved healthcare services as a whole; however, it does not guarantee effective and efficient abortion and preventive reproductive health services. Specialising service provision in the reproductive healthcare spectrum may be critical in promoting services tailored to the needs of women and

their partners. Multisector, multidisciplinary support in this regard is crucial if the needs of women, and their partners, are to be met holistically, comprehensively and equally – it is worth exploring.

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