Moving from reproductive choice to reproductive justice

Why, despite the progress South Africa has made in the area of sexual and reproductive health rights are there still unacceptable rates of maternal mortality? Why have increases in contraceptive usage, a decline in teenage fertility, and improved access to skilled caregivers not translated into improvements in many women's SRH? ***Tracy Morison*** reviews the approach to SRH thus far.

South Africa has a long way to go to ensure that women can prevent unintended and unwanted pregnancies and carry out our fertility preferences safely and with dignity, as women. As it stands, the country is unlikely to meet its sexual and reproductive health (SRH) related development targets, which is not only a development imperative, but also a transformation goal, since SRH rights, enshrined in section 27 of the constitution, contribute directly to women's empowerment.

The limits of "choice"

To date, research and policy has generally focused on reproductive *rights*: protecting women's freedom to make reproductive choices, accessing contraception, as well as their legal rights to abortion.

Underlying this rights-based approach is the idea of individual *choice*. Researchers and policy makers often speak of reproductive *choice* or decision making, and rights are generally viewed as afforded to and exercised by independent, choice making individuals. However, it seems that possessing SRH rights does not always translate into women's ability to exercise them. It is not enough to grant women choices; we need to consider what prevents us from exercising our rights and making decisions that are in line with our fertility preferences and desires.

Real life obstacles stop women from exercising SRH rights. One example is the causes of avoidable "maternal" deaths[1]. Well over a third (38,4%) of reported maternal deaths (between 2005 and 2007) were avoidable, according to the DoH. The causes of these deaths point to systemic and socioeconomic factors, as well as lack of SRH information. Of these deaths, 27% (Figure 1) were attributable to one of the top five avoidable causes, namely, unsafe (illegal) termination of pregnancy (ToP). ToP has been legal for almost two decades, yet the DoH reports that mortalities associated with unsafe induced abortions have none the less risen.

Why is this? Besides the fact that most of the designated sites for ToP are not offering services, research shows that many people do not even know that ToP is legal. In addition to lack of information, stigma also plays a role. Women, those who are unable to afford private healthcare, turn to clandestine "backstreet" practitioners to avoid punitive treatment at designated facilities and public criticism. Thus, a combination of social, cultural, economic, and systemic factors makes it difficult for women to safely terminate *unsupportable pregnancies*[2].

Many women may not even be able to avoid unwanted/unintended pregnancies in the first place. Approximately 215 million women worldwide want to prevent pregnancy, but cannot access reliable, modern contraceptives. Violence and sexual coercion are significant barriers to women having the ability to exercise SRH choices.

Many young women are coerced or forced into their first sexual encounter. In a study in KwaZulu-Natal, for instance, 46% of the participants reported that their first sexual encounter was forced. These women were more likely to experience unintended pregnancies and sexually transmitted infections. Unintended pregnancies are also more common among victims of intimate partner violence.

Problems with the language of choice

There are, as mentioned, numerous socio-economic factors that differently shape the context of sexuality and reproduction for women: inadequate information, poverty, inaccessibility of medical care, sexism, and so on. Yet, when we think of SRH issues in terms of reproductive choice, these factors are obscured. The problem then is that individual women are held responsible for poor SRH outcomes; the results of their poor choices. For instance, the reproductive choices of HIV-positive people (especially women) have often come under scrutiny, without considering factors such as the importance of sociocultural meaning of motherhood for social status.

A further problem is that individual women may also be blamed for social problems, as is often the case with teenaged mothers. Though many young women do not have a real say about sex (as discussed), they are often blamed for entrenching poverty and the moral decline of society.

This was evident in the debate that followed the baseless assertion that the Child Support Grant acts as a perverse

[1] This is the official term, but we must realise that not all of these women are mothers, especially those who choose not to see a pregnancy to term.

[2] Pregnancy occurs where there is a lack of material or emotional resources to see it to term and/or to care for a child (Macleod et al., *Critical Studies in Sexualities and Reproduction*, Rhodes University).

incentive. In many ways this debate was a red herring, drawing attention away from the important concerns of how to make contraception available to young women or to reduce disruption of pregnant learners' schooling and livelihoods.

Another problem with seeing SRH issues solely in terms of choice is that it overlooks fundamental societal inequities. Most obvious is the public-private divide in healthcare. Though the majority of South Africans (85%) accesses public healthcare, the bulk of the private sector enjoys the core of the financial and human resources (Figures 2 and 3). Choice is clearly a luxury for those able to afford it: those who can pay for quality health services, fertility treatment, or discreet ToP services. Social inequities undermine women's SRH outcomes and decision making at the personal, familial and community levels, with very real health implications.

The concept of reproductive choice clearly has limitations and problems. In contrast, the concept of reproductive justice extends beyond "choice" to include inequities and disempowerment as significant factors in SRH outcomes.

Reproductive justice: an alternative guiding concept

The concept of reproductive justice foregrounds the inter-connection of reproductive and social justice concerns. This concept illuminates the real-life connections between SRH and interrelated socioeconomic and political issues, like poverty, access to care and insurance, gender-based/intimate partner violence, and stigma. Thus, when we look through the lens of reproductive justice, we see the crisscrossing of race, class, and gender that creates different issues for different women according to their particular context. Inequities are seen as linked to discrimination on the basis of several identity markers (e.g., age, religion, sexuality, race, socioeconomic status, culture, gender, immigrant status).

Adopting a reproductive justice framework in South Africa would require researchers and practitioners to address fundamental inequities so that all people are able to reproduce, or not, and to manage their fertility safely and with dignity. In order to ensure that people are able to access information, resources and services, the reproductive justice agenda charges us to:

- Advocate for policies and practices that allow marginalised populations to access SRH care, including the reduction of linguistic and cultural barriers;
- Promote policies that expand coverage to people without medical aid – such as the new proposed National Health Insurance;
- Address the role of stigma and shame in accessing ToP services
- Address the intersection of violence and SRH;
- Remove the barriers that limit contraceptive and reproductive care/access to women with disabilities;
- Promote increased investment in comprehensive SRH education that includes HIV and STI prevention, contraception, pregnancy planning, fertility, ToP, and intimate partner violence.

Reproductive justice, unlike "choice or decision-making", provides a complex understanding, suitable to our multifaceted country, of ways that women's SRH experiences and needs are differently shaped by their circumstances, as well as the obstacles and challenges that they face in exercising their SRH rights. ■

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Figure 1: Causes of avoidable maternal deaths

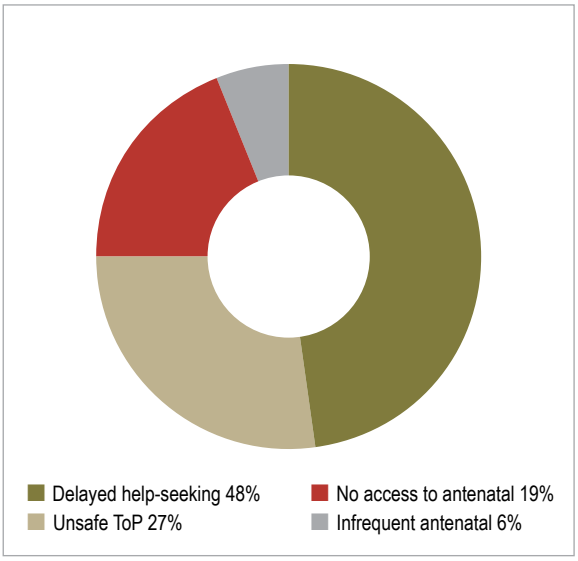

Figure 2: Distribution of funds

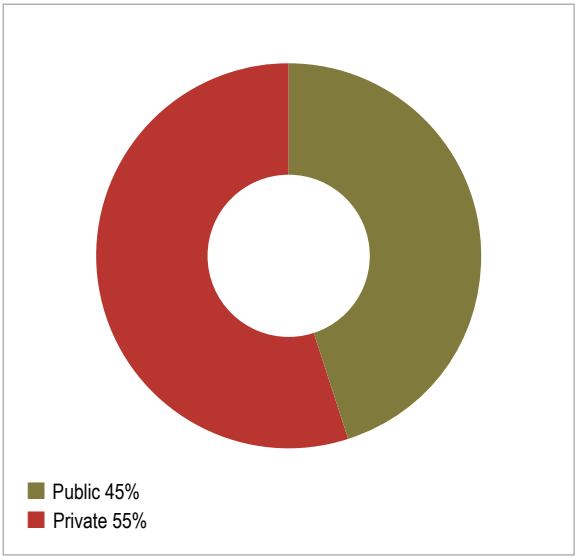

Figure 3: Distribution of GPs