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Articulating reproductive justice through reparative justice: case studies of abortion in Great Britain and South Africa

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ABSTRACT

Public health and rights-based approaches to abortion advocacy are well-established. Feminists are, however, increasingly using a broader framework of 'reproductive justice', which considers the intersecting conditions that serve to enhance or hinder women's reproductive freedoms, including their capacities to decide about the outcome of their pregnancies. Nonetheless, reproductive justice approaches to abortion are, conceptually, relatively under-developed. We introduce a reparative justice approach as a method of further articulating the concept of reproductive justice. We first explain how this approach can be used to conceptualise safe, accessible, and supportive abortion as a key element of reproductive justice in relation to the *injustice* of unwanted or unsupportable pregnancies. Using Ernesto Verdeja's critical theory of reparative justice and case studies of two countries (South Africa and Great Britain) where abortion is legal, we show how such an approach enables an analysis of reproductive justice within the specificities of particular contexts. We argue that both the rights-based legal framework adopted in South Africa and the medicalised approach of British law have, in practice, limited reparative justice in these contexts. We discuss the implications of reparative justice for abortion advocacy.

Keywords
abortion; reproductive justice; reparative justice; public health; human rights; gender

Public health and rights-based approaches have achieved significant successes in relation to the liberalisation of abortion legislation and the provision of abortion services in a number of countries across the globe (Hessini 2005). Within a public health approach, safe abortion provision is positioned as a means of improving women's health, in particular by reducing the morbidity and mortality associated with unsafe abortion. In contrast, mainstream Western feminist advocacy, which has been taken up by gender networks in the global South (Hessini 2005), has typically hinged on a liberal rights-based approach in which self-determination, choice and equality are foregrounded (Cook and Dickens 2003; Ferree 2003).

There are, however, also several long-standing feminist critiques of the abortion rights approach, whether deployed on its own or in tandem with a public health argument. The liberal framing of abortion rights rests on an assumption of unfettered agency on the part of women seeking abortions (Petchesky 1986) and fails to consider the gendered, raced and classed social conditions that, firstly, lead to unwanted or unsupportable pregnancies (Smyth 2002), and secondly, structure women's ability to exercise the right to 'choose' (Fried 2006).

In light of such critiques, various authors have argued for the notion of 'reproductive justice', which incorporates and goes beyond a 'reproductive rights' approach. Drawing on a social justice framework, a reproductive justice approach emphasises systemic or holistic analyses, seeking to illuminate the complex array of social, economic, cultural and healthcare possibilities and challenges that serve to either enhance or hinder women's reproductive freedoms (Gilliam, Neustadt, and Gordon 2009). The SisterSong Women of Color Reproductive Health collective in the USA has been credited with coining the term (Bailey 2011), and women of colour have been central in highlighting the marginalisation of intersecting dimensions - such as race and class - within feminist discourse concerning abortion rights (Fried 2006). Activists have drawn attention to the disproportionate difficulties that can prevent women living in poverty from exercising their 'rights' to safe abortion, as well as the ways in which eugenicist State policies construct particular, racialised, bodies as unfit to reproduce, making the 'choice' to continue a pregnancy and parent a child a reality for only certain groups of women (Ross 2006). Reproductive justice expands a rights-based discourse to address the social reality of inequality, specifically, the inequality of opportunity in controlling reproductive destiny. Reproductive issues are seen as intertwined with economic issues, welfare reform, housing, prisoners' rights, environmental justice, immigration policy, drug policies, violence, work and family (Bailey 2011). Through this framework, abortion is re-positioned as one important element of a much broader social project.

In this paper, we suggest that, although a reproductive justice approach adds crucial elements that are lacking from public health and rights-based discourses on abortion, it requires further articulation. In particular, there is a need to consider precisely how particular legislative and social contexts may facilitate or impede reproductive justice in relation to the specific injustices of an unwanted or unsupportable pregnancy. We introduce a *reparative justice* approach as a framework for conducting such analyses and illustrate its utility by applying it to case studies of two countries – South Africa and Great Britain (i.e. England, Scotland and Wales)[1] – with different regulatory frameworks for legal abortion provision.

[1] We use the term Great Britain deliberately, to distinguish our case study from the UK. In doing so, we acknowledge the very different and restrictive legal framework in Northern Ireland, where abortion is criminalised except in a very narrow range of circumstances.

Developing a reproductive justice framework for abortion: introducing the concept of reparative justice

Reparative justice is associated with restitution or recompense for an injustice: when a person's or community's rights, and his/her/their interests are harmed, then this injustice needs to be remedied (Thompson 2002). It has been invoked in a range of contexts, including criminal justice, historical injustices (slavery and colonialism), and post-conflict situations. While it often refers to reparative obligations in the case of a crime, obligations to make reparation need not imply criminal liability (Kelly 2011).

As Walker highlights, reparative justice is distinctive in centring on harmed individuals (or groups) and focusing on the provision of 'direct benefit and relief to victims' (Walker, 2016, 14). A key advantage of this framework as a basis for theorising justice in relation to unwanted and unsupportable pregnancies is that it foregrounds the needs of individual women, and the concrete ways in which these might be addressed.

Petchesky (1986) theorises abortion as essential to women's reproductive freedom on the basis of intertwined 'social' and 'individual/bodily' aspects of pregnancy. Although she does not draw on a reparative justice framework, it is possible to mobilise her analysis to conceptualise unwanted or unsupportable pregnancies in terms of gendered injustices, which require particular forms of reparation. First, social injustices generate many unwanted pregnancies and/or render them unsupportable (for example, gendered inequalities in relation to contraception and childcare, unsupportive working environments, racialised inequalities in State support for child-rearing). Second, a lack of social/material support for a woman's decision to end an unwanted or unsupportable pregnancy represents an injustice in terms of her bodily integrity. This is central to what it means to be a person (in many, albeit not all, societies), i.e. bodily integrity underpins 'the existence of women as moral agents and social beings' (Petchesky, 1986, 388). These social and bodily injustices require a range of forms of social repair, including transforming the unequal social conditions within which reproduction takes place, and the provision of safe, accessible, and supportive abortion.

Petchesky (1986) argues that the social and individual/bodily aspects of pregnancy cannot be separated. She cautions against feminist discourse which treats abortion as a 'problem' that might disappear if social conditions were transformed, noting the way in which this denies 'the level of reality most immediate for individual women: that it is their bodies in which pregnancies occur' (Petchesky, 1986, 13). This position has resonances with Walker's (2016) critique of 'transformative' accounts of reparative justice, which emphasise large-scale structural change and neglect the concrete reparations which can address the harms that individual women experience. Similarly, in conceptualising reparative justice in relation to unwanted/unsupportable pregnancy, we emphasise the need to challenge the unjust social circumstances of reproduction while insisting that safe, legal and supportive abortion is an always necessary – if insufficient – repair for the harm that an unwanted or unsupportable pregnancy represents to the individual woman. In the analysis that follows we explain how a reparative justice framework can be used to illuminate the extent to which this form of repair is achieved in different country contexts.

It is important to acknowledge concerns about a conceptual framework that positions women seeking abortion as (potential) victims of injustice. Feminist theorists have long critiqued the use of 'victim-based' discourses in support of women's access to abortion,

highlighting the ways in which accounts of women's 'needs' can be used to construct pregnant women as vulnerable, unreliable reproductive decision-makers (Lee 2003; Boyle, 1997; Sheldon 1997). Groups opposed to abortion have repeatedly capitalised on constructions of women as lacking agency in order to argue for restrictions on the provision of the procedure in women's 'best interests'. However, reparative justice 'does not aim at restoring a deficient status, but rather at affirming the equal dignity and rights of those who have previously been denied this status' (Walker, 2016, 10). In other words, as a process, it is about recognising those who are harmed as *persons*, with agency, to whom society has an obligation to make just repairs. Within this framework it remains possible to conceptualise abortion in positive terms, i.e. as indicative of 'women's strength and resourcefulness in the face of unwanted pregnancy' (Boyle, 1997, 45) and as an 'enabling condition for full human participation in social and communal life' (Petchesky, 1986, 378).

A critical theory of reparative justice

As with all abstract constructs, there is considerable debate about how reparative justice' should be theorised and applied (Isaacs and Vernon, 2011). In this paper, in keeping with reproductive justice advocates' concerns to contextualise the possibilities of subjectivity, we draw on Ernesto Verdeja's (2008) critical theory of reparative justice because this moves beyond a liberal, rights-based approach to reparations.

Verdeja's (2008) framework for understanding the goals of reparation, drawing on Nancy Fraser's (2003) notion of 'status parity', points to the need for reparation around material/objective conditions *and* symbolic/subjective, identity-based conditions. Verdeja further differentiates between individual and collective reparations. The combination of types of reparation and the recipients of reparation allows for four reparative dimensions: individual material, collective material, individual symbolic and collective symbolic, each of which will be discussed below in relation to abortion. As with all such frameworks, the distinctions made are heuristic or, as Verdeja acknowledges, "ideal-typical" (208); in practice, the four are intertwined in complex ways.

Reparation within the individual material dimension provides individuals with greater autonomy, including "individual rehabilitation through access to medical, psychological and legal services" (Verdeja 2008, 215). In relation to abortion, we conceptualise this as the facilitation of autonomous decision-making regarding the outcome of a pregnancy via legislative enablement and a commitment to supportive healthcare provision. In analysing country case studies in relation to this dimension, then, we can ask: to what extent do legal and healthcare policies facilitate women's autonomous decision-making in a particular setting?

The collective material dimension of Verdeja's (2008, 215) framework refers to the provision of "resources to victimised groups as a way of obtaining the material basis and security required for them to participate fully in social political and economic life". It means "the redistribution of economic resources" (Verdeja, 2008, 215) so as to ensure those affected are able to access the resources they need. In relation to abortion we can thus ask about the extent to which the provision of legal state-sponsored healthcare resources make abortion both accessible and safe for all women.

The collective symbolic dimension of reparative justice implies highlighting repressions, recognising victims' experiences of these repressions, condemning narratives that legitimate the repression and that place responsibility for suffering on the victim

(Verdeja, 2008). In relation to abortion, this speaks to paying attention to public discourses about, and social attitudes towards, abortion, and the ways in which they constitute available subject positions for women who decide to end their pregnancies.

The individual symbolic dimension focuses on recognising those suffering from injustices as individuals rather than reducing them to "amorphous collective identities" and includes paying attention to how injustice affects "individuals as individuals" (Verdeja, 2008, 214). In relation to abortion, the individual symbolic dimension highlights the importance of understanding individual lived experiences of unwanted and unsupportable pregnancies and of abortion within the social and structural dynamics of particular contexts.

Reparative justice and abortion in context: case studies of South Africa and Britain

In the rest of this paper, we illustrate how the four dimensions of Verdeja's critical theory of reparative justice may be used to explore how reproductive justice is furthered or hampered in complex ways in different contexts. We have chosen South Africa and Great Britain as exemplars as they provide an interesting juxtaposition in terms of legislation and access to abortion. We have purposefully not concentrated on contexts (such as Northern Ireland) where abortion legislation is very restrictive. In these cases, the application of reparative justice is relatively clear: the initial 'repair' required is the liberalisation of abortion legislation. We wanted, instead, to explore the framework in spaces where more nuanced work is required.

Our starting point is a key element of the legislation governing abortion in the two countries, *viz*. the locus of decision-making. In South Africa, women may request an abortion up to 12 weeks of gestation. For this period, the locus of decision-making (at least legally) rests with the woman. In contrast, in Great Britain, the locus of decision-making rests with doctors who have to recommend an abortion on various grounds. At first glance, then, it appears that reproductive justice is better served in South Africa than it is in Britain: women are legally provided with the 'choice' regarding the outcome of their pregnancies. Nevertheless, as our analysis below shows, when the lenses afforded by the reparative justice perspective suggested by Verdeja (2008) are systematically applied across the two countries, a more complex picture emerges. The 'repair' of safe, accessible and supportive abortion is hindered and facilitated in these two contexts in uneven ways and we suggest that reproductive justice is not fully served in either setting.

Our analysis is, necessarily, restricted by the research that is available. In the sections that follow we draw on existing empirical and conceptual work concerning abortion in South Africa and Great Britain to provide an analysis of the key dimensions of reparation in each country.

Abortion in South Africa: A Case Study of Reparative Justice

Individual Material Dimension: Structural Facilitation of Autonomous Decision-making

The Choice on Termination of Pregnancy Act (Act No. 92 of 1996) as amended in the Choice on Termination of Pregnancy Amendment Act (Act No. 1 of 2008) (henceforth CTOP Act) replaced the restrictive Abortion and Sterilisation Act (Act No. 2 of 1975) that was promulgated during Apartheid. The CTOP Act, at least on paper, is strong on the individual material dimension of reparative justice as it recognises women as autonomous decision-

makers, who may request a termination of pregnancy within the first trimester of pregnancy. This stipulation is premised on a clear human rights basis in the Act, extending to every woman "the right to choose whether to have an early, safe and legal termination of pregnancy" (CTOP Preamble, 1996, 1).

The locus of decision-making shifts to the health service provider from the second trimester, with medical doctors making the decision based on the woman's mental or physical health, risk of physical or mental foetal abnormalities, rape or incest, and the social and economic status of the woman. Thus, the autonomy of decision-making accorded to the woman is circumscribed by gestation date.

The CTOP Act requires the state to promote the provision of non-mandatory and non-directive counselling before and after a termination of pregnancy. This provision seems to constitute pregnant women as autonomous decision-makers. However, Vincent (2012, 126) argues that abortion counselling can "easily be founded on problematic assumptions about women, their bodies, their sexuality and their choices". One of the mechanisms, she points out, of such normative counselling is to create a hierarchy of deserving candidates for abortion: differentiating appropriate and acceptable reasons for requesting abortion from inappropriate and unacceptable ones.

Indeed, research indicates that, in spite of the CTOP Act, women are often not, in practice, treated as autonomous abortion decision makers within general healthcare services. Staff at referral centres have been shown to put obstacles in the way of women seeking services, invoking metaphors of killing and making religious references (Harries et al. 2007). In addition, women living with HIV, in a country with a high incidence and prevalence of HIV, report being actively dissuaded from accessing abortions (de Bruyn 2006).

Collective Material Dimension: Provision of Resources

In the CTOP Act (1996, 1) it is indicated that "the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised". Up to 12 weeks of gestation, trained midwives can provide the service and abortion can be performed at primary health facilities. An amendment to the Act (Choice on Termination of Pregnancy Amendment Act, 2008 (Act No. 1 of 2008)) allowed any health facility with a 24-hour maternity service to offer first trimester abortion services without the ministerial permission that was previously required. The Act and its Amendment thus, on paper at least, specify that the State needs to make available the resources implicit in the collective material dimension of reparative justice.

The initial expansion of services in South Africa post the passing of the CTOP Act was achieved through the distribution of low cost technology and through training of personnel through the National Abortion Care Programme (NACP) (Benson, Andersen, and Samandari 2011). This had immediate positive effects, with a decrease in the incidence of unsafe abortions (Berer 2004), as well as lower rates of maternal morbidity and mortality as a result of incomplete abortion, particularly amongst young women (Jewkes Rees, Dickson, Brown, and Levin, 2005).

Nevertheless, many women still procure abortions outside of designated clinics, consulting traditional healers (Jewkes, Gumede, Westaway, Dickson, Brown and Rees, 2005) and health professionals performing abortions without licence (Moodley and Akinsooto 2003) or using a readily available herbal infusion (Constant et al. 2014). Advertisements for illegal abortion services abound in taxi ranks and city centres. Women presenting with

incomplete abortions, having procured an abortion outside of the designated facilities, cite lack of knowledge of their rights under the CTOP Act, or lack of information about a local facility as reasons for approaching an illegal service provider (Jewkes et al. 2005; Moodley and Akinsooto 2003). More broadly, there is a lack of knowledge in the general population concerning the legal status of abortion (Macleod, Seutlwadi, and Steele 2014; Morroni, Myer, and Tibazarwa 2006).

A major barrier to women accessing safe abortion in South Africa is that service provision is often extremely limited. Research shows that a significant number of women do not receive the abortion care that they requested (Gerdts et al. 2014). There are frequently delays in the delivery of services and long queues at facilities (Trueman and Magwentshu 2013). Only just over half of the designated clinics are functional (Bateman 2011), and fewer than one third of trained health service providers actually provide the service (Trueman and Magwentshu 2013). Services in functioning facilities are fragmented according to the willingness of the health service providers to be involved in the various aspects of abortion care (Harries, Stinson, and Orner 2009). Many health service providers and facility managers cite personal objections to abortion on the grounds of conscience (Trueman and Magwentshu 2013). Nurses who do volunteer report, stigmatisation, victimisation and intimidation in the communities where they live (Potgieter 2004; Sibuyi, 2004). Facility, departmental and government officials are viewed as lacking the political will to implement the CTOP Act (Trueman and Magwentshu 2013).

Provision of abortion services in South Africa is uneven across socio-economic status and location. Poor women and women in rural areas are more likely to die from abortion related complications than their counterparts (Orner et al. 2011). Notably, women in urban centres and wealthier women can access services through private providers (in particular Marie Stopes). Indeed, it has been argued that poor women are no better off in terms of abortion service provision than they were before the CTOP Act (Trueman and Magwentshu 2013).

Collective Symbolic Dimension: Public Discourses and Attitudes

There is a reasonably strong anti-abortion lobby in South Africa. Three legal challenges have been mounted against the CTOP Act or portions thereof by religious pro-life organisations. This is counterbalanced by the women's movement that continues to motivate for the provision of accessible and safe abortion and the de-stigmatisation of abortion (Trueman and Magwentshu 2013).

Overall public support for abortion in South Africa is reportedly low, with few people approving of abortion on request or for social and economic reasons. There is, however, some support for abortion in the case of rape, incest and danger to women's health (Harrison et al. 2000). A survey amongst university students found that women students had more positive attitudes to the autonomy of women in abortion decision-making and in making abortion accessible than male students (Patel and Kooverjee 2009).

The gendered aspect of public talk about abortion has been highlighted in a number of studies. Feltham-King and Macleod (2015), for example, show how the bifurcated positions (pro-choice versus pro-life) stated in the South African newsprint media (1978 to 2005) about abortion were distinctly gendered, with the majority of female commentators consistently taking a pro-choice position, and male commentators taking a neutral/unstated position or a pro-life position. Macleod and Hansjee (2013) show how men may deploy

discourses of equality, support and rights (e.g. paternal rights) to subtly undermine women's reproductive right to 'choose' an abortion.

Individual Symbolic Dimension: Individual Narratives in Context

To our knowledge, no research in South Africa has focussed specifically on women's experiences of unwanted and unsupportable pregnancies and the circumstances surrounding them. Studies on experiences of abortion in relation to public attitudes and discourses have mostly concentrated on young women, with findings showing that young women struggle to trust anybody in relation to abortion, feel that their decision was judged, indicate that attitudes to abortion enforce secrecy (de Lange and Geldenhuys 2001), and experience shame, embarrassment, guilt and sadness (Mojapelo-Batka and Schoeman 2003). The interpellation of pro-life religious framings of abortion in women's experiences of deciding upon and undergoing an abortion in South Africa is highlighted in Harries et al. (2007), where women reported knowing that abortion is a legal right in South Africa, but questioned whether it is 'right' on religious grounds. In the same study, women reported fears of being ostracised from their communities, which often led to them seeking care outside of their residential area. This stigma is exacerbated when the women are also HIV+ (Orner et al. 2011).

Abortion in Great Britain: A Case Study of Reparative Justice

Individual Material Dimension: Structural Facilitation of Autonomous Decision-making

In contrast with the South African CTOP Act, the framework that regulates abortion in Great Britain does not recognise women as abortion decision-makers at *any* gestation of pregnancy. Abortion is a crime under the Offences Against the Person Act 1861 in England and Wales, and a common law offence in Scotland (Sheldon, 2016). However, the Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, (henceforth referred to as 'the Abortion Act') makes abortion in Great Britain legal if two medical doctors are of the opinion that it is necessary on one of several grounds. These concern the risks of continuing the pregnancy for the health of the pregnant woman, or the future health of her foetus.

The medicalised framework of the Abortion Act reflects the historical context in which it was produced. Parliamentary support for legal medical grounds for abortion in the 1960s primarily reflected concerns about female morbidity and mortality caused by unsafe illegal abortion. The Abortion Act aimed explicitly to address this (Sheldon 2016). Although feminist scholarship remains critical of the law's paternalism (Boyle 1997; Sheldon 1997; Jackson 2001; Lee 2003, 2004; Sheldon 2016), it is broadly agreed that the Abortion Act has facilitated liberal abortion *practice* in Great Britain. A doctor can agree in good faith that *any* abortion requested by a pregnant woman is necessary, because (when performed in safe settings) abortion is always statistically less risky than continuing a pregnancy to term (Sheldon 2016). Moreover, contemporary abortion counselling policy and practice position women as competent, autonomous decision-makers who require support, but not guidance, regarding their decisions to end their pregnancies (Lee 2003). Lee (2004) argues that, in addition to the norms of medical practice increasingly prioritising patient autonomy,

abortion practice has evolved on the basis of experience, namely, that women make their own decisions about abortion prior to contact with healthcare services.

Nonetheless, research also illustrates that women continue to experience judgemental encounters with some health professionals (Astbury-Ward, Parry and Carnwell 2012; Kumar et al. 2004; Lee 2004). Moreover, while health professionals typically describe abortion as a decision that 'belongs' to pregnant women (Beynon-Jones 2012; Lee 2003), a study of professional accounts of abortion practice in Scotland illustrates that particular requests for abortion (for example, those that are 'late' or 're-occurring', or which are made by women who fit normative ideals of motherhood) are routinely positioned as problematic and in need of regulation through forms of professional intervention (Beynon-Jones 2012, 2013a, 2013b). Collectively, this body of research indicates that women are unevenly constructed as legitimate reproductive decision-makers by health professionals.

Collective Material Dimension: Provision of Resources

In the introduction to its current Clinical Guideline on *The Care of Women Requesting Induced Abortion*, the Royal College of Obstetricians and Gynaecologists (RCOG) – the body that regulates training within this medical specialty in Great Britain – locates abortion provision as part of the professional responsibility of gynaecologists. It also identifies abortion firmly as a 'healthcare need' which the State has an obligation to address (Royal College of Obstetricians and Gynaecologists, 2011, 1). Resonating with this framing of abortion, the National Health Service (NHS) funds the vast majority of procedures performed on women resident in England, Scotland and Wales (e.g. 98 per cent of abortions in England and Wales were funded by the NHS in 2014 (Department of Health 2015)). In stark contrast to South Africa, then, abortion is undoubtedly 'entrenched as a normal part of routine healthcare' (Sheldon, 2016, 344) in Great Britain.

However, the RCOG Clinical Guideline suggests problems with NHS Commissioning in some areas mean that 'access to both early and late abortion services varies significantly across the country and some women continue to face difficulties' (Royal College of Obstetricians and Gynaecologists 2011, 28 - for additional evidence of uneven access see Lee et. al. 2004; Heller, et al. 2016; Purcell et al. 2014). Additionally, although the RCOG frames abortion as a positive 'healthcare need', this status has long been contested within both Parliament and the British medical profession (Boyle 1997; Davis & Davidson, 2006; Sheldon, 1997). Following the 1967 Abortion Act, major inequalities in abortion provision in particular areas of the country were generated by NHS doctors' objections to abortion, which led to the establishment of independent sector providers in England and Wales (Abortion Law Reform Association 1997). In recent decades, the NHS has increasingly commissioned abortion services from (non-profit making) independent sector providers (these accounted for 67% of NHS-funded abortions performed on women resident in England and Wales in 2014 – Department of Health 2015). This has implications for the sustainability of abortion services because, as the number of abortions performed in the independent sector increases, 'the opportunities for training in NHS facilities decrease' (Royal College of Obstetricians and Gynaecologists 2011, 27).

Collective Symbolic Dimension: Public Discourses and Attitudes

Feminist scholarship has long highlighted the problematic symbolic repercussions of the Abortion Act. Drawing on this literature, it is possible to identify two key ways in which the collective symbolic dimension of reparative justice in relation to unwanted/unsupportable pregnancy is hindered in contemporary Great Britain.

Although the construction of abortion as a public health issue played a key role in the passing of the Abortion Act, the law's depiction of abortion as a medical matter continues to limit opportunities to acknowledge unwanted/unsupportable pregnancy as an issue of gendered injustice (Sheldon, 1997). In the decades following the Abortion Act, opponents of abortion have repeatedly capitalised on the authority granted to medical knowledge claims within public discourse about abortion in Great Britain. Specifically, they have used medical arguments to construct the foetus as an independent person, and to claim that women are physically and emotionally damaged by ending their pregnancies (Amery, 2014; Hopkins, Reicher and Saleem,1996; Hopkins, Zeedyk and Raitt, 2005). Operating within the confines of a medicalised legal discourse on abortion, supporters of the procedure typically counter these challenges with alternative medical knowledge claims, reproducing the dominant medicalised framing of abortion and further marginalising discussion of gender inequalities (Amery, 2014; Science and Technology Subgroup 1991; Sheldon 1997).

As well as silencing questions of reproductive justice, the Abortion Act positions women as unreliable reproductive decision-makers (Boyle 1997; Sheldon 1997). It also stigmatises women who seek to end their pregnancies by insisting that women need health grounds to render abortion a non-criminal act (Sheldon 2016). Contemporary media representations likewise depict abortion as a controversial and deviant course of action that requires special justification (Purcell, Hilton and McDaid (2014).

However, as Purcell, Hilton and McDaid (2014) point out, negative media depictions contrast sharply with regular British public attitudinal surveys (see also Sheldon 2016), which show majority support for women being able to terminate a pregnancy without interference from the government (Ipsos MORI 2011). This indicates that, in spite of its narrow framing in Parliament and the media, the discursive framing of abortion as an issue of women's autonomy is routinely available within British society.

Individual Symbolic Dimension: Individual Narratives in Context

Research concerning women's experiences of abortion in Great Britain demonstrates that, although women often report feeling supported through their interactions with health professionals and services, some also describe feeling judged (Astbury-Ward et al. 2012; Kumar et al. 2004; Lee 2004; Purcell et al. 2014). Lattimer (1998) suggests that, far from being able to articulate the meaning of unwanted/unsupportable pregnancies in the contexts of their own lives, women negotiate their identities during healthcare encounters in relation to dominant discourses concerning motherhood and abortion. More recently, Astbury-Ward et al. (2012) highlight how concerns about stigma limit women's ability to share their experiences beyond the context of the clinic, leaving them unable to seek help and support. Collectively this research suggests that, while an 'abortion rights' discourse may be available in Great Britain, women's experiences of abortion are nonetheless shaped by stigmatising narratives of its meaning.

Conclusion

Reproductive justice extends public health and rights-based approaches to abortion advocacy by emphasising the intersection of power relations through which women's reproductive actions in the world are delimited. However, despite the potential of a reproductive justice approach, we have argued that it lacks specificity as a means of addressing the particular, gendered injustices of unwanted or unsupportable pregnancies. In contrast, a reparative justice framework, which foregrounds the individuals harmed by injustices, points to the need for particular forms of 'reparation' in relation to unwanted/unsupportable pregnancies and provides a means to assess whether these are accomplished in practice.

Two key forms of repair are required: Transformation of the social conditions which generate unwanted pregnancies and render them unsupportable and the provision of social and material support for women to end pregnancies which they do not want, or decide that they are unable to, continue. In recognition of its significance to individual women who are pregnant, but who do not want to be, our analysis has focussed on the latter form of repair. Using two countries with contrasting legislative frameworks we have illustrated how Verdeja's (2008) critical theory of reparative justice can be employed to analyse the extent to which the provision of legal, safe, accessible and supportive abortion as a form of repair is hindered or facilitated in particular social contexts.

Abortion is legally available in both South Africa and Great Britain, although the legal locus of decision-making differs, with South African law recognising women as autonomous decision-makers up to 12 weeks of gestation and British law delegating decision-making to medical doctors. While, on paper, reproductive justice appears to be better served in South Africa than in Great Britain, our application of the reparative justice framework indicates that the situation is substantially more complex than this initial gloss suggests. A multi-dimensional analysis reveals that reproductive justice is served neither in South Africa, with its rights-based legal framework, nor in Great Britain with its public health approach to legal abortion.

In South Africa, although women are legally positioned as autonomous decision-makers within the first trimester of pregnancy, this is frequently undermined through differentiation in abortion counselling regarding deserving and non-deserving cases, and significant barriers to access. While the state is legally required to make resources available, in reality service provision is severely hampered, and access is uneven across women's socio-economic status and location. Moreover, there is substantial opposition to abortion in South Africa, in relation to which women who end their pregnancies experience stigma, shame and the need for secrecy.

In contrast, in Great Britain, abortion provision is framed as a healthcare need, is funded by the NHS, and is widely available despite some variation across the country and at later gestations of pregnancy. Moreover, research suggests that women are typically treated as decision-makers in practice, and survey respondents generally agree that women should have decision-making power over the outcome of a pregnancy. However, the legal framing of abortion as a decision that belongs to the medical profession creates ongoing ambiguities about women's autonomy in this process. Perhaps more significantly, it shapes the symbolic terrain of public discourse on abortion in Great Britain (Sheldon 2016) in ways that both limit the articulation of abortion as a gender justice issue and reinforce negative positionings of women who decide to end their pregnancies.

It is important to acknowledge the recursive relations between different dimensions of reparative justice, as Verdeja (2008) does. In particular, public discourses concerning the meaning of abortion (collective symbolic dimension) have implications for how service providers are viewed both by themselves and by others. Research suggests (Gallagher, Porock and Edgley 2010; O'Donnell, Weitz and Freedman 2011) that this will impact both the individual material dimension (the extent to which providers position women as legitimate decision-makers) and the collective material dimension (availability of provision) of reparative justice. In addition, reparative justice regarding abortion is deeply entwined with other health justice issues, including the general functioning of the healthcare system. While Great Britain's National Health Service is well established, South Africa's public health sector faces a number of challenges.

Applying reparative justice advocacy to South Africa implies, firstly, working with health service systems and providers to ensure supportive provision and that safe abortion is accessible to all women, and, secondly, undermining social processes that foster public negativity regarding abortion while supporting those that affirm women in their decision. In Great Britain, reparative justice would imply, firstly, legislative recognition of women as autonomous decision-makers, secondly, extension of abortion services and equality of access, and, thirdly, undermining negative depictions of women who have terminated their pregnancies.

Our analysis of the limitations of the medical approach and rights-based framework embedded in legislation in Great Britain and in South Africa respectively illustrates the need to rethink abortion advocacy. If reparative justice implies, in relation to abortion, the material facilitation of autonomous decision-making, the provision of legal and healthcare resources that make abortion accessible and safe, public discourses that affirm women as decision-makers regarding the outcome of a pregnancy, and the provision of spaces for women to construct and tell their own stories of their pregnancies, then these issues need to be central to advocacy for reform.

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References

Abortion Law Reform Association. 1997. *A report on NHS abortion services*. London: Abortion Law Reform Association.

Amery, F. 2014. "Solving the 'woman problem' in British abortion politics: A contextualised account." *The British Journal of Politics and International Relations* 17(4):551-567.

Astbury-Ward, E., Odette P., and R. Carnwell. 2012. "Stigma, abortion, and disclosure: Findings from a qualitative study." *The Journal of Sexual Medicine*:3137-3147.

Bailey, A. 2011. "Reconceiving Surrogacy: Toward a Reproductive Justice Account of Indian Surrogacy." *Hypatia* 26 (4): 715–41.

Bateman, C. 2011. "Abortion Practices Undermining Reformist Laws - Experts." *South African*

Medical Journal 101 (5): 302–4.
Benson, J., K. Andersen, and G. Samandari. 2011. "Reductions in Abortion-Related Mortality Following Policy Reform: Evidence from Romania, South Africa and Bangladesh." *Reproductive Health* 8 (1) doi:10.1186/1742-4755-8-39.
Berer, M. 2004. "National Laws and Unsafe Abortion: The Parameters of Change." *Reproductive Health Matters* 12 (24): 1–8..
Beynon-Jones, S. M. 2012. "Timing is everything: The demarcation of 'later' abortions in Scotland." *Social Studies of Science* 42(1):53-74.
Beynon-Jones, S. M. 2013a. "Expecting motherhood? Stratifying reproduction in 21st-century Scottish abortion practice." *Sociology* 47(3):509-525.
Beynon-Jones, S. M. 2013b. "'We view that as contraceptive failure': Containing the 'multiplicity' of contraception and abortion within Scottish reproductive healthcare." *Social Science and Medicine* 80:105-112.
Boyle, M. 1997. *Rethinking abortion: Psychology, gender, power and the law*. London: Routledge.
Constant, D., D. Grossman, N. Lince, and J. Harries. 2014. "Self-Induction of Abortion among Women Accessing Secondtrimester Abortion Services in the Public Sector, Western Cape Province, South Africa: An Exploratory Study." *South African Medical Journal* 104 (4): 302–4.
Cook, R. J., and B. M. Dickens. 2003. "Human Rights Dynamics of Abortion Law Reform." *Human Rights Quarterly* 25 (1): 1–59.
Davis, G., and R. Davidson. 2006. "'A fifth freedom' or 'hideous atheistic expediency'? The medical community and abortion law reform in Scotland, c.1960-1975." *Medical History* 50(1):29-48.
de Bruyn, M. 2006. "Women, Reproductive Rights, and HIV/AIDS: Issues on Which Research and Interventions Are Still Needed." *Journal of Health, Population and Nutrition* 24 (4): 413–25.
de Lange, N., and J. L. Geldenhuys. 2001. "A Systemic Approach to Adolescents' Experiences of Terminating Their Pregnancies." *Society in Transition* 32 (2): 246–59.
Department of Health. 2015. *Abortion statistics, England and Wales: 2014*: Available at https://www.gov.uk/government/statistics/report-on-abortion-statistics-in-england-and-wales-for-2014.
Feltham-King, T., and C. Macleod. 2015. "Gender, Abortion and Substantive Representation in the South African Newsprint Media." *Women's Studies International Forum* 51: 10–18. .
Ferree, M. M. 2003. "Resonance and Radicalism: Feminist Framing in the Abortion Debates of the United States and Germany." *American Journal of Sociology* 109 (2): 304–44.
Fraser, N. 2003. "Social justice in the age of identity politics: Recognition, redistribution, and participation." In *Redistribution or recognition?: A political-philosophical exchange*, edited by Nancy Fraser and Honneth, 7-93. New York: Verso.
Fried, M. 2006. "The Politics of Abortion: A Note." *Indian Journal of Gender Studies* 13 (2): 229–45.
Gallagher, K., D. Porock, and A. Edgley. 2010. "The concept of 'nursing' in the abortion services." *Journal of Advanced Nursing* 66(4):849-857.
Gerdts, C., T. DePiñeres, S. Hajri, J. Harries, A. Hossain, M. Puri, D. Vohra, and D. Green Foster. 2014. "Denial of Abortion in Legal Settings." *Journal of Family Planning and Reproductive Health Care* 0: 1–3 doi:10.1136/jfprhc – 2014–100999.

doi:10.1136/jfprhc-2014-100999.
Gilliam, M. L., A. Neustadt, and R. Gordon. 2009. "A Call to Incorporate a Reproductive Justice Agenda into Reproductive Health Clinical Practice and Policy." *Contraception* 79 (4): 243–46.
Harries, J., P. Orner, M. Gabriel, and E. Mitchell. 2007. "Delays in Seeking an Abortion until the Second Trimester: A Qualitative Study in South Africa." *Reproductive Health* 4 (January): 7. doi:10.1186/1742-4755-4-7.
Harries, J., K. Stinson, and P. Orner. 2009. "Health Care Providers' Attitudes towards Termination of Pregnancy: A Qualitative Study in South Africa." *BMC Public Health* 9 (January): 296. doi:10.1186/1471-2458-9-296.
Harrison, A., E. T. Montgomery, M. Lurie, and D. Wilkinson. 2000. "Barriers to Implementing South Africa's Termination of Pregnancy Act in Rural KwaZulu / Natal." *Health Policy and Planning* 15 (4): 424–31.
Heller, R., Purcell, C., Mackay, L., Caird, L., and Cameron, S. T. 2016. "Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study." *BJOG : An International Journal of Obstetrics and Gynaecology*. doi: 10.1111/1471-0528.14117
Hessini, L. 2005. "Global Progress in Abortion Advocacy and Policy: An Assessment of the Decade since ICPD." *Reproductive Health Matters* 13 (25): 88–100.
Hopkins, N., S. Reicher, and J. Saleem. 1996. "Constructing women's psychological health in anti-abortion rhetoric." *The Sociological Review* 44(3):539-564.
Hopkins, N., S. Zeedyk, and F. Raitt. 2005. "Visualising abortion: Emotion discourse and fetal imagery in a contemporary abortion debate." *Social Science and Medicine* 61:393-403.
Ipsos MORI. 2011. "Public attitudes towards abortion." Available at: https://www.ipsos-mori.com/researchpublications/researcharchive/2854/Public-Attitudes-towards-Abortion.aspx (Accessed 08/03/2016).
Isaacs, T. and R. Vernon. 2011. *Accountability for collective wrongdoing*. Cambridge, UK: Cambridge University Press
Jackson, E. 2001. *Regulating reproduction: Law, technology and autonomy*. Oxford: Hart Publishing.
Jewkes, R. K., T. Gumede, M. S. Westaway, K. Dickson, H. Brown, and H. Rees. 2005. "Why Are Women Still Aborting Outside Designated Facilities in Metropolitan South Africa?"*BJOG : An International Journal of Obstetrics and Gynaecology* 112 (9): 1236–42.
Jewkes, R., H. Rees, K. Dickson, H. Brown, and J. Levin. 2005. The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa after Legislative Change. *BJOG : An International Journal of Obstetrics and Gynaecology* 112 (3): 355–59.
Kelly, E. 2011. "Reparative Justice." In *Accountability for collective wrongdoing*, edited by T. Isaacs and R. Vernon, 193-209. Cambridge, UK: Cambridge University Press.
Kumar, U., P. Baraitser, S. Morton, and H. Massil. 2004. "Decision-making and referral prior to abortion: A qualitative study of women's experiences." *Journal of Family Planning and Reproductive Healthcare* 30(1):51-54.
Lattimer, M. 1998. "Dominant ideas versus women's reality: Hegemonic discourse in British abortion law." In *Abortion law and politics today*, edited by E. Lee, 59-75. London: Macmillan
Lee, E. 2003. "Tensions in the regulation of abortion in Britain." *Journal of Law and Society* 30(4):532-553.

Lee, E. 2004. "Young women, pregnancy and abortion in Britain: A discussion of law 'in practice'." *International Journal of Law, Policy and the Family* 18(3):283-304.

Lee, E., S. Clements, R. Inghan, and N. Stone. 2004. *A matter of choice? Explaining national variation in teenage abortion and motherhood*. York: Joseph Rowntree Foundation.

Macleod, C., and T. Feltham-King. 2012. "Representations of the Subject 'woman' and the Politics of Abortion: An Analysis of South African Newspaper Articles from 1978 to 2005." *Culture, Health & Sexuality* 14 (7): 737–52.

Macleod, C. I., and J. Hansjee. 2013. "Men and Talk about Legal Abortion in South Africa: Equality, Support and Rights Discourses Undermining Reproductive 'Choice.'" *Culture, Health & Sexuality* 15(8): 37–41.

Macleod, C., L. Seutlwadi, and G. Steele. 2014. "Cracks in Reproductive Health Rights: Buffalo City Learners' Knowledge of Abortion Legislation." *Health SA Gesondheid* 19 (92): 1–10.

Mojapelo-Batka, E., and J. B. Schoeman. 2003. "Voluntary Termination of Pregnancy: Moral Concerns and Emotional Experiences among Black South African Adolescents." *South African Journal of Psychology* 33 (3): 144–53.

Moodley, J., and V. S. Akinsooto. 2003. "Unsafe Abortions in a Developing Country: Has Liberalisation of Laws on Abortions Made a Difference?" *African Journal of Reproductive Health* 7 (2): 34–38.

Morroni, C., L. Myer, and K. Tibazarwa. 2006. "Knowledge of the Abortion Legislation among South African Women: A Cross-Sectional Study." *Reproductive Health* 3 (January): 7. doi:10.1186/1742-4755-3-7.

O'Donnell, Jenny O., T. A. Weitz, and L. R. Freedman. 2011. "Resistance and vulnerability to stigmatization in abortion work." *Social Science & Medicine* 73:1357-1364.

Orner, P. J., M. de Bruyn, R. M. Barbosa, H. Boonstra, J. Gatsi-Mallet, and D. D. Cooper. 2011. "Access to Safe Abortion: Building Choices for Women Living with HIV and AIDS." *Journal of the International AIDS Society* 14 (January): 54. doi:10.1186/1758-2652-14-54.

Patel, C. J., and T. Kooverjee. 2009. "Abortion and Contraception: Attitudes of South African University Students." *Health Care for Women International* 30 (6): 550–68.

Petchesky, R. P. 1986. *Abortion and woman's choice: The state, sexuality and reproductive freedom*. London: Verso.

Potgieter, C.A. (2004). "Stigmatisation of termination-of-pregnancy providers in state hospitals." *HSRC Review* 2(3): 6.

Purcell, C., S. Cameron, L. Caird, G. Flett, G. Laird, C. Melville, and L. M. McDaid. 2014. "Access to and experience of later abortion: Accounts from women in Scotland." *Perspectives on Sexual and Reproductive Health* 46(2):101-108.

Purcell, C., S. Hilton, and L. M. McDaid. 2014. "The stigmatisation of abortion: A qualitative analysis of print media in Great Britain in 2010." *Culture, Health & Sexuality* 16(9):1141-1155.

Ross, L.. 2006. "Understanding Reproductive Justice : Transforming the pro-Choice Movement." *Off Our Backs* 36 (4): 14–19.

Royal College of Obstetricians and Gynaecologists. 2011. *The care of women requesting induced abortion*. London: RCOG Press.

Science and Technology Subgroup. 1991. "In the wake of the Alton Bill: Science, technology and reproductive politics." In *Off-centre: Feminism and cultural studies*, edited by S. Franklin, C. Lury and J. Stacey, 147-214. London: HarperCollins Academic.

Sheldon, S.. 1997. *Beyond Control: Medical Power and Abortion Law*. London: Pluto Press.
Sheldon, S. 2016. "The decriminalisation of abortion: An argument for modernisation." *Oxford Journal of Legal Studies* 36 (2): 334-365. doi: 10.1093/ojls/gqv026.
Sibuyi, M. C. 2004. "Provision of Abortion Services by Midwives in Limpopo Province of South Africa." *African Journal of Reproductive Health* 8 (1): 75–78.
Smyth, L. 2002. "Feminism and Abortion Politics : Choice, Rights and Reproductive Freedom." *Women's Studies International Forum*, 25 (3): 335–45.
Thompson, J. 2002. *Taking responsibility for the past: reparation and historical injustice*. Cambridge, UK: Polity Press.
Trueman, K. and M. Magwentshu. 2013. "Abortion in a Progressive Legal Environment." *American Journal of Public Health* 103 (3): 397–99.
Verdeja, E. 2008. "A Critical Theory of Reparative Justice." *Constellations* 15 (2): 208–22.
Vincent, L. 2012. "Shaking a Hornets' Nest: Pitfalls of Abortion Counselling in a Secular Constitutional Order – a View from South Africa." *Culture, Health & Sexuality* 14 (2): 125–38.
Walker, M. U. 2016. "Transformative Reparations? A Critical Look at a Current Trend in Thinking about Gender-Just Reparations." *International Journal of Transitional Justice* 10 (1): 108-125.