Advocating for Abortion Access: Lessons and Challenges

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Ten years ago, I initiated a research and advocacy process to learn from the experiences of struggles for abortion access in different parts of the world, which became known as the 'Johannesburg Initiative'. This article traces some of the lessons and challenges that emerge from reflecting on what has stayed the same, and what new challenges present those concerned to mobilise for and maintain women's rights to sexual and reproductive autonomy.

Advocating for Abortion Access grew out of a realisation that while what was done in South Africa could not provide a blueprint for anywhere else, it could surface lessons of how to think about making change happen. It occurred to us that if we analysed the processes of achieving or not achieving change in more countries, we could develop a deeper understanding of strategies for change. Through the Johannesburg Initiative we brought together activists from 18 countries, both those engaged with longstanding struggles and those grappling with how to enhance their abortion activism.[1]

The impetus for the Johannesburg Initiative came from questions from activists elsewhere in the world. After the 1996 South Africa Termination of Pregnancy Act was passed, activists from all over the world were asking all of us in the South African movement, 'How did you do it? We need to replicate what you've done'; or stating that 'what happens in South Africa will shape what happens in the rest of the continent'. Both of these perspectives showed naiveté about what makes for policy change. Achieving this law was a product of both a moment in history and a well-prepared movement.

Most often, brilliant advocacy strategies are not plotted out from start to finish. Despite the increasing desire of donors to use logical frameworks that

would predict policy outcomes after one or two years of funding, this is seldom what makes for change. Usually, success is a product of the sustained involvement of a diversity of civil society organisations and interests undertaking a wide mix of strategies, which may or may not have been coordinated at all, but which intersect with a critical moment in time. However, when one looks retrospectively, as I did in the South African case, and as we did later during the Johannesburg Initiative, one could tease out a range of critical insights and interventions from different groups that, together, made the impact.

## 1 Policy analysis for strategic planning

During the first Johannesburg Initiative, workshop groups collectively identified factors that seemed to either facilitate or constrain change. These were then grouped in ways that illustrate the model below, developed to analyse the role of non-governmental organisations (NGOs) in influencing policy (Klugman 2000a,b).[2]

This framework was used in the research on abortion advocacy for identity in each case:

- Who defines the problem, how and why?
- What sort of solutions are put forward, by whom and why?
- What are the interests and motivations of politicians, bureaucrats and other implementers, such as health professionals?
- What activist strategies are used to link the three spheres of problem identification, solution development and bureaucratic/political process – both by those who would advance or obstruct abortion rights?

The two-way arrows around the framework are there to remind us that this is not a linear process.
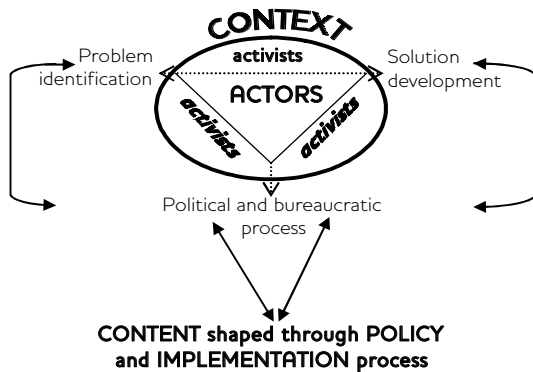
No sooner has a law been made, or a court case won, than new problems emerge about whether and how to implement change. Diverse solutions may be available, but what decides which, if any of these, are taken up? By unravelling strategy in this way, activists can ensure that their targets, messages and solutions are clear and realistic at any particular time, given the range of forces at work. The conceptual framework serves as a model to remind activists of the range of factors which influence change. It helps both in analysing what has happened and why and in preparing for future advocacy, strengthening the chances of its success.[3]

Two case studies serve well as illustration (Klugman and Budlender 2001). In the Kenyan case (Nzau-Ombaka 2001), the overall political and health system context were not conducive to legal change or public health system provision, but there were highly motivated and well-positioned medical people who were the activists in the policy analysis model. They took up the issue as a public health issue, given the very high levels of maternal mortality. They established the Private Providers' Network of Western Kenya which trained first doctors and later nurses in post-abortion care, understanding that once health workers were trained, they would be able to use their skills to provide safe abortions; and that nurses would do so at cheaper prices, hence enabling greater access. In relation to problem definition, unwanted pregnancy was already recognised as a problem by communities and the solution of abortions was normalised as a women's

issue, handled quietly, over generations, by women at community level, mostly with herbal remedies. The intervention described in the paper built on this by providing local level abortions in a private manner. In terms of the bureaucratic or implementation side, on the one hand this effort avoided the public health system because of its weakness and the political dangers of openly motivating for access to abortion. But on the other hand, it did strategically engage the perspectives of health providers. The author suggests that 'The most notable motivation was among the mid-level health professionals who felt empowered and proud that they could perform procedures previously considered the sole domain of doctors' (Nzau-Ombaka 2001: 186), illustrating the point that one needs to understand the interests of implementers if one is to be successful. What is also interesting is that it was the success of this initiative that opened space to push the Ministry of Health and the Nursing Council to accept the need for training health workers elsewhere in the country in post-abortion care; all of this within a health rather than a reproductive rights framing. This reinforces that these are not linear processes; in this case an intervention in implementing services itself enabled policy change, rather than policy change being the prerequisite for implementation.

The South African example is rather different (Klugman and Varkey 2001). Here too, historically, private providers had enabled women who could afford to pay to get safe but illegal abortions. But some women had been accessing legal abortions within the limited framing of the law, and they were almost exclusively white. Activists used a number of different problem definitions; some, the traditional public health one of high levels of maternal mortality and high costs to the public health sector in addressing consequences of unsafe abortion. But they also took the dominant concern of that moment in history – the historical discrimination against black women under apartheid – as a cornerstone of their argument, since white women (however few) had accessed legal abortions while black women had not. Hence, they managed to sway some politicians who may not have been sympathetic to abortion, but could be swayed on the question of discrimination.

The involvement of a wide array of activists also brought subtlety to the proposed solutions – unlike in Kenya, some of the medical advocates in South Africa

argued strongly that only doctors should be able to perform abortions; but public health and women's rights groups, concerned about the limited numbers of doctors, especially in rural areas, argued and won agreement for midwife provision – illustrating how different interests will propose different solutions. Another interesting dimension of the South Africa case study was its exploration of the enormous barriers to access after the law was won. As in Kenya, abortions were common. They were also highly taboo, and a change in the law did not change the taboos. Nurses and those seeking abortions were stigmatised. Activists had to take on new challenges, beyond legal change, in addition to the technical training of health providers in how to perform abortions. The Reproductive Health Research Unit implemented a 'values clarification' intervention to help nurses reflect on their values and gain some perspective on their role (Dickson-Tetteh and Billings 2002); the Women's Health Project developed *Health Workers for Choice* to improve health service responsiveness to clients (Varkey *et al.* 2001) and a community-based intervention, *Communities for Choice* (Varkey and Ketlhapile 2001), to build men and women's acceptance of the need for and right to safe abortion services (Varkey *et al.* 2000).

As the focus shifted from changing the law to enabling implementation, the Reproductive Rights Alliance (RRA) that had facilitated coordination between the various players slowly lost focus and funding. As a result, in 2006 when Doctors for Life, the South African chapter of an international anti-abortion group, managed to secure a constitutional court case questioning aspects of the consultative process through which the abortion law was decided (IPAS 2007), the RRA was not functioning and no new constituencies had been developed to be able to jump into defence of the law at that moment. Many of the activists of the mid-90s remobilised and the court case was not won, but this serves as a warning that as laws are won they are also lost, and movements need to sustain themselves and create new allies over time.

2 Findings of the comparative analysis
The comparative analysis drew out lessons that remain pertinent today. It is worth quoting at some length from our conclusions:

> Where abortion is a site of political struggle and anti-choice perspectives hold sway in institutions

of power, pro-choice activism tends to be defensive. In this context, the options open to activists are very different from those where there is a window of opportunity for change – whether through a change in political leadership or through the opportunity to build a groundswell of public support for change. Likewise, if the bureaucracy of the health system has no entry points for public engagement, then gaining entry to persuade management to change policies or procedures, or to build capacity of health providers may not be possible.

Even in situations where there is limited scope, however, the papers show a variety of innovative approaches to increasing access, mostly operating outside of the system, be it the political system or the public health service delivery system. This points to an area of weakness in abortion activism – the lack of experience of activists in engaging with public health systems. Activists are more comfortable in the field of legal reform which usually requires targeted bursts of energy, rather than the very slow, incremental pace of change of health systems. Activists tend to avoid grappling with how to support health system reform to ensure that quality abortion services are available. They are more likely to resort to encouraging or providing abortion services in the private or NGO sector than finding ways to improve access within major health institutions.

The case studies suggest, too, that while struggles for legal reform may more easily attract the interest of activists, the interests of poor and marginalised women will only be served when abortion activism takes on questions of service accessibility. The papers illustrate how activist fatigue can set in once legal struggles are won. Yet the need for advocacy only begins with the legal victory. From this point, strategies both to retain legal victories and to move from law to implementation need tenacious and sustained efforts.

What all papers have in common is the lessons learnt about the need to link strategies to a sophisticated analysis of the factors supporting and constraining abortion access. So, for example, a public march will not be effective when one cannot mobilise larger numbers than the anti-choice movement or where the police response

will demoralise participants. Similarly, where service providers are reticent to perform abortions, failure to address this barrier will undermine any other advocacy efforts. The original research framework for these studies provides a template for activists to analyse their changing contexts and continually revisit their problem definitions and solutions. It also reminds them to continually assess how the political and bureaucratic system will respond to these and should be targeted. The country studies provide a wealth of ideas of what to try and where to take care. (Klugman and Hlatshwayo 2001: 38–9)

This kind of model of policy analysis remains useful to guide activists on how to build up a coherent strategy. It is a reminder not to focus on only one dimension of the problem, and not to assume there is only one solution; and to test options against the experiences and needs of those most affected and the perspectives of activists who have most experience in engaging on the ground dynamics. It points to the need to analyse political space and the political process in order to assess whether or not legal change or policy change or litigation are the best options at a particular time or whether movement building should continue while waiting for a more appropriate moment. Activists also need to remain prepared to challenge any legal or policy losses at any moment, having secured the legal arguments, the data and the personal experiences of the impacts of the laws and policies necessary to shift public, political or juridical opinion.

In order to do this successfully, activists need to fully understand the workings of the bureaucracy and the opportunities and barriers to implementation of services for the majority of the population. A longstanding feminist in Colombia commented that activists there have been very conscious in lesson learning from elsewhere, finding allies within the Department of Health 'serious, hardworking technical people' (Anonymous Colombian 2008). Finally, activists need to continually analyse and identify the myriad ways in which the public and private sectors can manage to ignore national policy – sometimes in women's favour, and sometimes against – and build working relationships with health system managers, nurses and medical school teachers, and community organisations that monitor and advocate for quality services. Without doubt, the more that supportive individuals are positioned

within the system, whether the legal, judicial or health system, the greater the opportunities for impact. At the same time, the more diverse the range of groups mobilising support from the outside of these structures, and the greater the extent to which they collaborate with each other and with those on the inside, the greater the possibility of winning, maintaining and implementing change. Most critically, as these struggles go on from decade to decade in many countries, it is essential to woo a new generation of activists. The same Colombian describes how they brought in a younger generation of professionals – doctors, psychologists, social workers, including young men – 'sometimes the subject of tough debate among the older guard of feminists activists' but essential to regenerate energy and bring in a new and broader base for taking on future challenges.

3 The continuing challenge of conservative movements and discourses

What has changed since the Johannesburg Initiative? The context has changed in some key ways, as have the actors, the problems and the potential solutions.

Conservative forces across the world have consolidated, focusing on women's bodies and the bodies of any persons whose desires and behaviour transgress societal norms as the cause of moral and economic decline. Coordinated cross-country anti-abortion activism has increased using a wide range of entry points to whittle away at gains made, and in many cases using human rights language and ethical arguments – such as the need to protect women's health – as the basis for their positions. While this problem is not new – the Johannesburg Initiative discussed the challenges of framing the message in ways that would resonate with wider publics – the anti-choice movement appears to have greater funding and stronger synergy of arguments and strategies across the many issues it is taking on (whether abortion, sex education or sex work) in tandem all over the world. They are using the traditional methods of the progressive movement for mobilising their own conservative mass base in this effort – such as a web-based petition for US citizens urging their government not to ratify the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) on the grounds that, among other things 'CEDAW is silent on abortion yet many countries have been ordered by the CEDAW Committee to legalise abortion' (C-FAM 2008).

Arguably, those promoting the right to access abortion have not reflected on how to frame their claim in the current context. Much of the language of the west, particularly the language of 'pro-choice' has not resonated across class and race even in the USA for a good while (see Gerber Fried, this *IDS Bulletin*). There is debate under way about ways in which those promoting access to abortion might make more explicit their recognition of the complexity of the issues at stake. There are those who argue that the right to abortion should stand without caveats; others would argue that the aim of reducing recourse to abortion is legitimate for health and cost reasons. Arguments are made that the urgency of enabling women to have early abortions goes beyond health and cost to address the emotional challenges health workers may encounter in having to conduct late abortions – something that has gained considerable prominence in media reporting in the USA and UK in recent times. Frances Kissling and Kate Michelman suggest that for the USA, there is a need to revisit the basis on which these arguments are made:

> Those who are pro-choice have not convinced America that we support a public discussion of the moral dimensions of abortion. Likewise, we haven't convinced people that we are the ones actually doing things to make it possible for women to avoid needing abortions … If pro-choice values are to regain the moral high ground, genuine discussion about these challenges needs to take place within the movement … Our vigorous defense of the right to choose needs to be accompanied by greater openness regarding the real conflict between life and choice, between rights and responsibility.
> (Kissling and Michelman 2008)

This poses a classic dilemma for the feminist movement. Just as the debate on the acceptability of sex work and whether sex work can be distinguished from trafficking has split the feminist movement and provided allies for those who are fundamentally against women's equality and rights; so we may find increasing dissent on the nuances of the question of abortion access, further weakening clarity of solutions and messages put forward by the movement for abortion access. This issue plays out in a particularly complex way in relation to HIV/AIDS. Much still has to be done to bring issues of the sexual and reproductive health and rights of HIV-positive women into the mainstream of HIV/AIDS activism, and with it to broaden the alliances for improving access to abortion (ICW 2007). Similarly, the use of sex-selective abortions as a means of securing boy children in India and China is giving rise to calls against sex-selection that slide easily into arguments for controlling access to abortion (as in India), and into the vilification of women who have such sex-selective abortions, rather than into arguments for improving the status of girls and women such that they would be prized in the family and community. This too is proving deeply divisive within the reproductive rights movement. A comment on a report on sex-selection captures this complexity, 'How do pro-choice feminists feel about this form of femicide? What's more important: that a woman has a right to an abortion, or that a female has a right to life?' (Two Rivers 2007).

4 Reflection for a change

What is needed are spaces for constructive reflection on the current context globally and in diverse countries. This will enable activists to shape arguments and strategies in ways that explore questions of values and the contours of the debate in their specific circumstances in greater depth, taking into account the diversity of framings – legal, rights, health-related or religious – that are available in different countries. By doing so, activists will be better placed to advocate for abortion rights and argue effectively against those who are promoting a fantasy that ending abortion will achieve happy families, women's health and economic wellbeing. In particular, they need to engage the broader development community which continues to ignore the ways in which lack of access to safe abortion makes it impossible to achieve most development goals.

The Millennium Development Project has shown how unsafe abortion both reflects and undermines any possibility of achieving gender equity and preventing maternal mortality and morbidity (Grown *et al.* 2005). It is legal in almost all countries of the world to save a woman's life and in more than three-fifths of countries to preserve women's physical and mental health (Grown *et al.* 2005: 61). Hence, one is not necessarily asking development agencies to take on the vexed question of improving the law; but for making sure that safe abortions, or at minimum quality post-abortion care, are available as part of the comprehensive primary healthcare

system to which the development community is ostensibly committed.

Despite the fact that we know that lack of sexual and reproductive rights undermine women's dignity, their right to control their own futures, and to participate in community and national development, addressing the desperate need for safe abortion remains off-limits for most mainstream development practitioners. This is the area in which much greater effort needs to be put into identifying potential allies and together reframing global development problems to put questions of sexuality and reproduction at front and centre – whether in relation to girls' education, to economic development, or to the rights of children to be wanted and loved. Broader recognition that addressing unsafe abortion is an essential contribution towards achieving the Millennium Development Goals needs to be won.

Clearly, the largest strategic challenge in this period is to reinvigorate the values associated with promoting women's ability to control their reproductive lives – in relation to if, when and with whom they have sex; if and when they have children; and the existence of safe and accessible services to enable them to do so. This raises questions about the degree of coordination and the spaces – and donor support or lack thereof – for serious talking, thinking and planning by groups across the globe who are committed to enabling women's access to abortion. The opposition is globally coordinated; those concerned to promote abortion access are much less so. The consolidation of the International Consortium for Medical Abortion (2008) from region to region is a significant step forward in this regard. In addition to the value of this campaign for increasing access to abortion, it is providing one focused and ongoing international space to grapple with these global challenges, but more is needed.

At the time of the Johannesburg Initiative, in addition to widespread national activism, which has expanded today, there were regional sexual and reproductive health and rights networks. The possibilities of influencing global thinking through the major conferences of the 1990s served as very helpful focal points for bringing together progressive national and regional activists for reproductive rights and health. Some of this momentum has been lost in the 2000s, a trend across a number of movements

where the interactive synergy between national and global spaces for policy activism of the 1990s is no longer available (Pianta 2003). Many of the key reproductive health and rights donors that supported movement building in developing countries, and regional networks, particularly in Latin America, have shifted geographic and topic focus, and the major force and funds mobilising civil society in this field at present is the HIV/AIDS pandemic. There remain clear spaces for influencing global policy in relation to HIV/AIDS and reproductive health and rights activists have shifted substantial attention in this direction, frequently in new collaborations with movements for sexual and gender diversity, women's rights, sex worker rights and HIV/AIDS itself.

Even though most mobilisation for reproductive rights and health within international law and UN bodies is focused on defending gains made in the 1990s rather than making new gains, we are nevertheless seeing a 'normalisation' of these issues all over the world. The participation of hundreds of people in the Fourth Asia Pacific Conference on Reproductive and Sexual Health and Rights held in October 2007 in Hyderabad, India, serves as some indication of the extent to which the mainstream reproductive health movement has indeed taken on the discourse and practice of the Platform of Action of the International Conference on Population and Development. Sessions abounded on issues of abortion, and of sexuality, both of which remained taboo in the mid-1990s. Similarly, the October 2007 Women Deliver Conference initiated by Family Care International, with a number of other mainstream reproductive health organisations based in the north, incorporated abortion as a central dimension of maternal mortality and morbidity – the focus of the conference. Women Deliver was followed by the Global Safe Abortion Conference hosted by Marie Stopes International, which brought together 800 public health experts, government representatives and activists from over 60 countries in the first-ever global conference of its kind; surely a significant marker of the widespread work on the issues. While a conference is not a movement and does not signify the necessary levels of participation from people working at community level in different parts of the world, nor the degree of consensus on concept and strategy that would be required to turn around many of the gains being made by the global conservative movement, it is nevertheless a significant marker of opportunities that could be realised should sexual

and reproductive health and rights movements reinvigorate themselves organisationally and strategically.

5 Conclusion

A key lesson in this process is that even while an issue may stay the same – the need for women to access safe abortions with dignity – as times move on, new groups get involved and new leadership emerges. In 1996, the focus of learning was South Africa, and something striking about the current period has been the renewed interest in the lessons from the Johannesburg Initiative, and in some of the tools developed by South African activists to promote health worker and community buy-in to abortion service delivery (Varkey *et al.* 2001; Varkey and Ketlhapile 2001). But now it is the activists in Colombia and Mexico City who are being asked by activists in Central America, 'How did you do it?'; and 'If you could do it, we can too!' (Consuelo 2008). Again the questions of moments in history arise – will the same process that brought victory to Mexico City and Colombia lead to victories elsewhere? Probably not. But can lessons be learnt about organisation and strategy? Certainly.

Notes

* The opinions expressed in this article are those of the author and do not necessarily reflect those of the Ford Foundation.
1 *Advocating for Abortion Access – Eleven Country Studies* (Klugman and Budlender 2001) and *Strengthening Strategic Planning for Advocacy – A Workshop Manual* (Hlatshwayo and Klugman 2004) grew out of this, and was used to support activists in conducting their own analysis and in strengthening their own strategies from country to country.
2 The idea of three separate streams of problems, solutions and politics is adapted from Kingdon

(1995). My addition is the realm of the bureaucratic, without which policy analysis fails to address the world of informal policies that determine implementation, and the dynamics of the implementation process as well. The idea of understanding policy processes in relation to the broader context and the role of actors in that context is drawn from Walt and Gilson (1994). The model is fully elaborated in Klugman (2001).
3 These points are drawn directly from Klugman (2001: 2–4).

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