Title: My womb, my private space: A domain of public contestation.

STRUCTURE

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1. Acknowledgements

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2. Introduction and Background

This lecture focuses on the wrongs and rights in the process of reproducing humanity. It also portrays paradigm shifts from the narrow confines of demographic targets to quality care and broader Sexual and Reproductive Health and Rights for improved Reproductive Outcomes. Some interesting questions on this lecture include the following:
Who has a right to determine the number of children I should have as an African woman?

Denying me my right to decide whether to have a child or not is denying me my status & choice as a woman and a human being. In the developing world including Africa, a woman's existence is bound to her womb. For example, if a woman produces a daughter or only daughters, her status is nil. She must try harder. Women are trapped, if you don't bear/produce a son, there is pressure from the in-laws, but governments continue telling us, through public policies, to stop having children. Women have no value in this world.
Their wombs are a subject of public contestation.

This lecture is a tribute to other women out there who are marginalised, disenfranchised and socially excluded. These women do not know that they have rights and therefore cannot

even claim such rights while they reproduce nations. Reproductive rights are human rights and represent unwavering principles of justice for all women. The South African Constitution binds the state to work towards progressive realisation of the right to health including the right to reproductive health (McIntyre & Gilson 2002 in Mmusi-Phetoe 2012).

The United Nations (UN) Sustainable Development Goal 3 (SDG 3) calls for countries to ensure healthy lives and promote well-being for all, at all ages, as this realisation is essential to Sustainable Development. Once we talk ‘’health’’ as a people, we talk prevention of disease, promotion of health and protecting individuals from premature deaths. Health issues are social issues and a function of development hence they should be addressed through development tools and integrated processes. The outcome should be a reduction of ill-health or morbidity and mortality/ death.

The lecture contributes specifically to realisation of SDG 3 target 1, 2 and 7 by 2030.
Target 1 calls for countries to reduce the global maternal mortality ratio to be less than 70 per 100,000 lb by 2030.
Target 7: seeks to ensure Universal Access to Sexual and Reproductive Health-care services, including access for family planning, information and education, and integration of reproductive health into national strategies and programmes by 2030.
Target 2 calls upon countries to reduce neonatal mortality to at least as low as 12 per 1000 live births. The health, illness or death of a mother and her new-born are intertwined…they are reproductive outcomes.

The realisation of the above-mentioned reproductive outcomes should take place along the continuum of care (COC) of adolescence, pregnancy, childbirth, the postnatal period and depicts a Reproductive Health Cycle. In this lecture, Reproductive Health Care refers to Continuity of Care (COC) that is necessary throughout the female lifecycle from adolescence to immediate postnatal period.
Demographically, women of reproductive age refer to all women aged 15–49 years. However, recent reports have put the age from 10 years onwards – as it will be indicated later in the lecture.

3. Current issues

Based on the preceding background, the question is: Where are the current gaps or current issues along the Continuum of Care in the delivery of reproductive health?
Figure 1 below, is used to respond to the above question.

Figure 1. "Continuum of Care" for reproductive health care delivery

In this context, the COC, should further embrace integrated service delivery from pre-pregnancy to delivery and the immediate postnatal period.

The problem is that linkages along the Continuum of Care (CoC) are inadequately pronounced or misunderstood hence failure of delivery of integrated services that meet women's reproductive needs.

In addition, a discussion on issues of reproduction of humanity and how it starts, that is sexuality, is often still sensitive, subversive and a matter of overcoming taboos, struggling to find appropriate words. Breaking such learned silences open a Pandora's box. Some problems that we currently encounter in the reproductive health system such as unplanned pregnancies or other ailments are attributable to such silences.

The Parents, guardians and or teachers fail to talk openly to the young ones and the latter learn through experimenting.

<u>Pre-Pregnancy including Teenage pregnancy and Access to contraception:</u>

Teenage pregnancy is one of the most concerning public health problems globally including South Africa (UNFPA 2020; Wall-Weiler, Roos & Nickel 2016). It (teenage

pregnancy) often results in maternal complications such as maternal anaemia, pre-term birth and caesarean section delivery or even a death of a mother. It could also lead to neonatal complications which includes low birth weight of babies and perinatal mortality (Mmusi-Phetoe 2019; Chandra-Mouli, Ferguson, Plesons, Paul, Chalasani, et al. 2019).

South Africa's Basic Education Portfolio Committee meeting reported on 7th September 2021 in Parliament that 30% of teenage girls, between 10 and 19 years old, fell pregnant in South Africa. More than 65% of those pregnancies were unplanned. On the other hand, Stats SA (2022) and the Department of Social Development (2022) respectively reported that 34 587 teenagers gave birth in the financial year 2020/2021 in South Africa. Of that figure, 688 were between ages, 9 and 10. **The question is: Are we failing our girl children?**

The problem of teen pregnancy is accompanied by about 1300 of newly HIV infected adolescent girls and young women in South Africa per week as was reported in the City Press newspaper and News 24 in September 2021. Early pregnancy and motherhood force many girls to drop out of school and many are trapped in a cycle of poverty. Many of the adolescents who fall pregnant may be forced to assume adult roles prematurely to which they are not prepared for emotionally or physically. Some of these girls are even forced into early marriages. This could have devastating social and economic costs.

Access to contraception has become a de facto proxy indicator for access to Sexual and Reproductive Health services within the global SDG framework and therefore warrants special attention. Contraception to prevent unplanned or unwanted babies is at the heart of reproductive health and grounded in basic human rights.

All International Conferences on Population and Development' (ICPDs) including the latest held in 2019, the Nairobi Summit on ICPD 25, recognized "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of Family Planning of their choice". The theme for ICPD 25 was **"we transform the 1994 ICPD goals to a reality for all**". The 2019 ICPD was the 52nd session of the UN commission on Population and Development. The UN member states had adopted a Declaration which re-affirmed the importance of ICPD programme of Action for guiding Population and

Development policies including Reproductive Health and Reproductive Rights within the context of the 2030 Agenda for Sustainable Development (UNFPA 2021).

In the same vein, the Committee on the Rights of the Child has added a voice, calling on the member states to provide adolescents with access to Sexual and Reproductive information, family planning and contraceptives. The adolescents should be informed about the dangers of early pregnancy, prevention of HIV and sexually transmitted diseases (STDs) (UNFPA 2019). The above will empower them to make the right choices…This is also at the heart of reproductive health, rights and justice.

A research study conducted in SA in 2019 revealed a relatively high contraceptive prevalence rate of 64.6% which concealed problems with service delivery; equitable access and correct use of contraception especially among certain groups such as young or rural women (Harries, Constant, Wright, Morroni, Müller et al. 2019). Poor or absent communication and counselling provided by health care providers was the underlying factor to the problems which have just been cited (Harries et al 2019).

Pregnancy**:** Unplanned pregnancy remains a fundamental issue in reproductive health and happens mainly because of not using contraception or incorrect use thereof. Stats SA confirmed that an unmet need for family planning was high at 18% resulting in unplanned pregnancies in this country (Stats SA 2017).

In some of the studies that I conducted among pregnant women, it emerged that 90% pregnancies were unplanned. That was and still is a problem and a determinant of poor reproductive outcomes. Other determinants of poor reproductive outcomes in pregnancy were found to be nutritional inadequacies; women eating last in their families even when they are pregnant; neglect and abuse by their male partners; HIV or AIDS and pregnancy itself (Mmusi-Phetoe 2012; Mmusi-Phetoe 2016).

Ante-Natal Care/ ANC. It is often poorly attended, especially by teenagers. World Health Organization (WHO) recommends that ANC should be initiated within the first trimester of gestation with at least four follow-up visits, and optimally eight visits during pregnancy (Haddrill, Jones, Mitchell and Anumba 2014; Fraser, Cooper & Nolte 2014:109). Women with appropriate ANC attendance tend to have satisfactory birth outcomes. ANC clinics

should serve as key gateways and interventions that improve reproductive health outcomes (Gumede, Black, & Naidoo 2017).

In another research study that I conducted on the Social factors determining maternal mortality in SA, it emerged that 60% of the participants had not attended ANC when they were already in their third trimester of pregnancy. It was this risk group that was further associated with unintended pregnancies, late booking in pregnancy due to un-affordable access to health facilities and poorly managed obstetric complications. All these demographic factors presented a chain of events, demonstrating causal linkages between poverty at the level of the household and poor reproductive outcomes (Mmusi-Phetoe 2012).

Giving birth and Maternal deaths: Estimates of the maternal mortality ratios (MMRs), based on the reports of the National Committee's Confidential Enquiry into Maternal deaths (NCCEMD) that is, the Saving Mothers Reports, have stated the SA MMR to be low in the last two decades (Stats SA 2020; Rapid mortality surveillance report 2019 & 2020). However, these reports note uncertainties in the level of MMR and concur with the findings of the study that I conducted in 2016 on the Magnitude on Maternal Mortality in South Africa. The latter highlighted inconsistent, contradicting reporting of maternal deaths and a reflection of misunderstanding of MMR in SA because of the perceived underestimation of maternal deaths. The Saving Mothers Reports confirmed that there is currently no specific system for routinely identifying maternal deaths in the community (NCCEMD 2014:3). The non-inclusion of maternal deaths that is taking place in the community in the estimation of the MMR in South Africa, raises concerns regarding comprehensive, accurate and reliable data and a real picture of maternal deaths to inform policy and action.

Quality care in the labour wards and postnatally: The lives of mothers can be saved through provision of quality maternal health care services. However, provision of quality care in obstetric and labour wards remains a challenge and a thorn to the lives and dignity of women's health.

Women come across unsympathetic and insensitive health care providers in health care centres. The negative attitude is mainly experienced by the poor, rural and black women

in South Africa, while the elite black and white women are served with respect. Attitudes impact on quality health care. The problem is that services are target oriented, rather than quality care oriented. An account of how poor quality care in the labour wards determine reproductive outcomes is exhibited below:

I interviewed a mother of a teenager who had just passed away after giving birth as part of the verbal autopsies for a study that I conducted in KZN. The mother narrated the following words that deserve to be quoted. She was weeping:

> *"I paid my teenage daughter a visit at the labour ward; I was informed that her membranes had been ruptured to induce labour. She was also told that she must walk around after the membranes were ruptured. No explanation was given for this intervention. By evening she had not delivered then a caesarian section was performed.*
>
> *When I called my daughter, she reported that she was awake and had delivered a healthy baby boy.*
>
> *Then I do not know what happened sisi, (crying). These nurses neglect them, especially if the girl is young … the nurses killed my child.*
>
> *I've never heard that after the water has been broken, a woman is still expected to walk. What they did is unfair because the matron told us straight on our faces that the nurses were sleeping after my daughter's caesarian section. The sister in charge went on lunch for two hours;*
>
> *We asked how many times they checked on her after the operation. The sister in charge said they should have checked her every hour but that was not done.*
>
> *The nurses never checked my daughter throughout the night. She died alone, in difficulties. No one knows what happened and yet she was brought to the hospital to receive professional help (crying). If the patient was cared for, she would not have died. I reached the conclusion that my daughter was neglected deliberately".*

Why should women die giving birth? Is it because they have wombs?

Another verbal autopsy from a young woman whose neonate had died claimed to have delivered the baby on her own in her hospital bed and to have sustained vaginal tearing. She reported that the hospital staff was cruel, unsympathetic, inhuman and insensitive and reported as follows:

> *"When the black stuff started coming out of the baby' nose I could feel fear overwhelming me. I think the nurses had not sucked the baby properly (meaning clearing the baby's airway) after it was born. Before I was discharged, I realised that I had sustained a tear. I reported it to the nurse. The nurse examined me and confirmed that I had sustained a tear. She said she cannot suture me as it was already late for suturing. She advised me to wash with salt at home. I was discharged. After two days at home, the baby developed fast breathing. The chest began to be hard. Then the baby started frothing a black stuff from the nose. I hired a taxi and took the baby back to the hospital. The baby was sucked to clear the nose and given oxygen. We were re-admitted but the baby died a day later at the hospital. I am very hurt (crying).*

The two incidents above recounts a loss of trust in the quality of care and technical competence at the hospital. At the heart of program performance are the skills, attitudes and competencies of staff.

How can I talk reproductive rights without talking about Abortions/Safe abortion or termination of pregnancy in SA: Abortion or pregnancy termination, means the removal of a foetus from the womb/uterus before it is mature enough to live on its own. It is one of the reproductive outcomes. This is often a challenge and a predicament between faith and reproductive choice as these are often seen as opposing paths.

Unsafe and illegal abortions are claiming a toll on women's lives, especially in developing countries where the rates of unsafe abortions seemingly do not change (IPPF 2008). In South Africa clandestine abortions continues to be a serious problem. Although the Population Review 2022 recorded 4,5%, the SA government news agency notes that 58% of the estimated 260 000 abortions that take place in South Africa every year are illegal.

The United Nations Fund for Population Activities (UNFPA), an agency of UN for Population and Reproductive health, warns that it has never promoted and does not promote abortion as a method of family planning (UNFPA 2005; UNFPA 2022). The UNFPA (2005; UNFPA 2022) further highlighted that the UN's position has always been that every attempt should be made to eliminate the need for abortion. The 1994 ICPD reaffirmed by 2019 ICPD 25 holds that:

- An unsafe abortion is a serious public health concern hence prevention of unwanted pregnancies must always be given the highest priority
- However, the status of a country's population policy, including the legal status of abortions, is the sovereign right of each nation.

The UNFPA (2022) is committed to supporting governments to strengthen their national health systems so as to prevent abortions and to ensure that the management of complications from the abortions are part of reproductive health, family planning and sexual health programmes, thereby saving women's lives.

South Africa's Choice on Termination of Pregnancy (CTOP) Act 92 of 1996 as amended by the Choice on Termination of Pregnancy Amendment Act 38 of 2004 and re-amended by the Choice on Termination of Pregnancy Amendment Act 1 of 2008 (www.gov.za) expanded access to abortions by allowing registered nurses and registered midwives, to perform abortions up to the twelfth week of pregnancy. This Act suggest that a woman of any age who is eligible for an abortion can be provided with a service upon request, even without giving reasons (SA DoH 1996). According to the SA DoH (1996 and 2005), exceptions include: women who are more than 20 weeks pregnant and their lives or those of the fetuses are at stake or likely to have serious birth defects.

The COTP follows the Abortion and Sterilisation Act 2 of 1975 which was implemented to women on racial grounds during the Apartheid system. This act reserved access to abortion exclusively for white women, while increasing control over the black women's bodies, their sexuality and reproduction. It is noted that under this act, approximately 1,000 white women accessed abortion every year, while the number of black women seeking abortions was not even recorded (Sullivan, Harrison, Harries, Sicwebu &

Galarrag. 2018: 424-431). Every year, about 430 black women died and thousands harmed because of backstreet abortion. This reveals the ugly face of the regulation of women's reproductive bodies. The above happened within a population control framework during Apartheid (Sullivan et al; 2018: 424-431).

Apartheid South Africa's laws against abortion have hurt poor Africans and often the youngest women the most. Black women endangered their lives by falling pregnant unintentionally. Their desperation of committing backstreet abortions turned them into criminals. This was viewed as unnecessary carnage of women that resulted from criminalization of abortions and brutal form of women torture (as Susanne Klausen, a historian of abortion under apartheid writes in 2018). *Only because these African women had wombs!*

To ensure that reproductive rights are acted upon requires more than accessing safe abortion. It requires ending poverty, racism and all other structural barriers to living a fulfilling life of dignity and empowerment so that these laws are not just on paper but in practice. This is a struggle to reproductive rights which must be linked to the broader struggle for social justice and human rights.

Sterilizations**:** The Sterilization Act, 1998 (No. 44 of 1998) provides for the right to sterilization and determine the circumstances under which it may be performed. This provision affirms individuals' constitutional rights to decide on their respective reproductive goals.

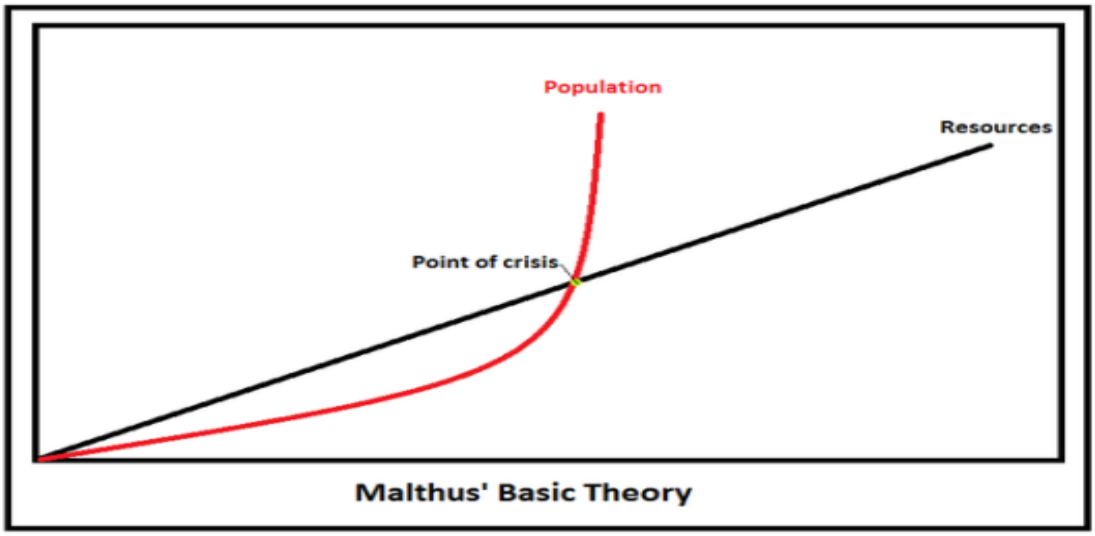
Some South African women have experienced forced or unconsented sterilizations in the recent past. A woman shared on South Africa's eNCA television channel in 2020 that she was sterilised without her consent after giving birth in a state hospital in 2006. She was 17. Her womb had been removed. She learned about it 11 years later when she tried to have another child. She was one of the 48 women in the group who were sterilised without consent at state hospitals. Most of the latter were sterilized because they were HIV positive.

Hereunder follows a discussion of the lecture's theoretical perspectives.

4. Theoretical Perspectives

In this section, the theoretical perspectives on which this lecture is based is presented.

1. Malthus's theory of population growth. Comparing population increases according to birth rates and in relation to food production, Malthus held that the population size increases geometrically (2,4,6,8) while food production increases arithmetically (1, 2, 3, 4). To Malthus, geometric growth of population will eventually exceed the arithmetic growth of resources if left unchecked. His preventive checks included marriage, abstinence and celibacy (MAC). His positive checks included famine, war or pestilence (on the people). As an Anglican church elder, Malthus was not in favour of contraception, but that good morals and religious duties should be promoted. To Malthus, fertility added to population size and not national wealth.



2. The Social Determinants of Health framework notes that medical-technical solutions are important but not sufficient to improve the health status of women (CSDH 2007). Therefore, a broader approach based on integrating social interventions into true primary health care (PHC) system could be a more effective approach to improving reproductive outcomes.

3. Empowerment of Women developed by Stein was found to be relevant to the lecture as it highlights the relationship between health, empowerment and self-determination of women. It holds that interventions for reproductive health care

should aim at directing resources towards increasing education, skills, job opportunities, autonomy and self-esteem of women. Provided with these capabilities, women may achieve a strong sense for recognition of their reproductive decisions, responsibilities and rights that they are entitled to. This should however be followed by accessible and quality reproductive health care to all.

Power relations determine women's access to both material and non-material resources including health care, their ability to control their lives, and their decision-making capability. The empowerment process within the gender and development context seeks to address the powerlessness of women and has the greatest potential of reducing vulnerability associated with being a woman as well as poor reproductive outcomes.

4. Quality of Care Framework that was developed by Bruce (1990) to achieve reproductive goals still holds and form an important theoretical pillar for this lecture. It assesses quality of care in reproductive health units and has the following 6 elements:

- Choice of treatment;
- Information given or shared;
- Technical competence;
- Interpersonal relations;
- Follow-up and continuity of care;
- Appropriate constellation of services which also incorporates integration of services.

These should be achieved through a primary health care (PHC) system.

The above-mentioned theories collectively constitute the theoretical framework for this lecture. A presentation of literature insights follows.

5. Literature Insights on Women's Health including Reproductive Health.

I wish to share several myths on the subject before I discuss reviewed literature for this lecture.

Myth Conceptions

The third world's worst problem is overpopulation. Women of the 3rd world breed like rabbits…They have only themselves to blame for their poverty. Therefore, the solution should always begin with family planning programs.

These myths are Informed by eugenics theories which talk to ("racial improvement" and "planned breeding").

Myth 1: Exponential Growth: Malthusianism. Birth rates are rising in the developing world and population growth is getting out of control.

Myth 2: Pressure on Resources**:** The World can't support all those hungry mouths: There are simply not enough resources to provide for them.

Myth 3: Big families are poorer**:** Poor people would be much better off if they had fewer children to feed and clothe.

Myth 4. Lack of Control**:** Without contraception, people have as many children as possible.

Having cited the preceding myths, I now present what literature says on this topic.

The international and national policies addressed population, focusing on controlling fertility which was understood entirely as women' fertility. It was argued that strengthening family-planning services was crucial to slowing population growth (United Nations 2018). Such services should be designed by governments to ensure a balance between population and resources (Ahlburg, Kelley & Mason 1996; United Nations 2018).

As such the fertility of women in the developing world, especially that of African women, became a domain open for public policy making. The fertility management strategies were developed which were either ante or pro natal depending on a particular society's needs, however mostly ante-natalist for women in the South.

For example, births were prevented with the aim of influencing reproductive behavior of women, reducing family sizes and promotion of a small family norm. The apartheid South African government propagated a population policy which prescribed TFR of 2.1 children per family. That was despite the cultural and or family decisions.

Some feminists disagreed with this notion, citing poverty, underdevelopment, and unequal distribution of resources between the North and the South as key causes of high fertility rather than seeing high fertility as a major cause of poverty and economic backwardness. They viewed population control as a philosophy without a heart. It was designed to manipulate and objectify women; a philosophy of domination where people of different sex, race, and class are viewed as inferior to its architects (Hartmann 2016). In her classic book on Reproductive Rights and Wrongs: The Global Politics of Population Control, Hartman (2016) argues that a focus on population control through women fertility jeopardises both women's reproductive health and economic and social justice.

Population control negatively affects people in their most private and intimate areas of their lives. Instead of promoting ethics, empathy and true contraceptive choice, population control policies encourage and condone coercion and they are no solution to the serious problems faced by the developing world. Such policies will not resolve the problem of increasing women's ill-health, reproductive morbidity and mortality (Hartmann 2016). Many characteristics of poverty contribute to high fertility, lack of education for women, too little family income to "invest" in children or even accessing family planning. ….

It was against this background that at the UN 1994 International Conference on Population and Development (ICPD), 179 countries agreed on developing a broad framework on Population and Development that addressed a set of Population & Development goals and objectives which were to be achieved through a universal provision of a range of reproductive services. Prior to 1994, the policies that were implemented were informed by the following World Population Conferences (WPC):

The first World Population Conference held in 1954 in Rome which resolved that more and comprehensive information was required on the demographic situation of the developing countries in order to address population issues.

The second one was held in 1965 at Belgrade. It focused on the analysis of fertility as part of development planning. On the question of population growth, the conference resolved that human needs and wishes in respect of family size should be for individuals and couples to decide and should be a private matter and not a matter of public debate and policies.

The third was held in Bucharest in 1974 was the first to discuss a highly sensitive question of population and its relationship to development.

The conference resolved that population problems are symptoms of inequity and imbalances in the development process. Therefore, population variables and development are interdependent and should be treated as such. The conference concluded that the population problem can be resolved by socio-economic transformation; that is, through implementation of population and social welfare policies. Implied in this was that population policies and plans should be integrated into development efforts.

The fourth conference, the International Conference on Population, was held in Mexico City in 1984. The focus was the importance of improving the quality of life of the people. The conference endorsed most of resolutions of the Bucharest conference and emphasised the necessity to combat all forms of racial discrimination, including apartheid.

The fifth conference, the International Conference on Population and Development (ICPD), was held in Cairo in 1994. It was dubbed the turning point and paradigm shift in international discussions on population, and emphasised ‘integral linkages between population and development’. The conference’s focus was on the importance of meeting the needs of individual women and men rather than meeting demographic targets (Population Reference Bureau 2004 in United Nations Population Fund (UNFPA) 2020).

The latter was regarded as profoundly important because it laid out a completely different approach to the population problem, stating that population concerns should not be

separated from ecological and socio-economic development agendas. Emphasis was put on women empowerment, ensuring that sexual and reproductive health are realised across countries and that women participate in making decisions that concern them.

It was resolved that women must be part of the development efforts by ensuring that they have equal access to education, their health is protected, be encouraged to participate in the economy and be rewarded equally as their male counterparts. The conference resolved that:

- every pregnancy should be intended, and every child wanted
- women must be protected from unsafe abortion
  the health of adolescents must be protected and encouraged

Understanding Reproductive Health, reproductive rights and improved reproductive outcomes

The International Conference on Population and Development Programme of Action (ICPD PofA) has defined reproductive health is “a state of complete physical, mental and social well-being in all matters relating to the reproductive system, its functions and processes”. This means that people should have a satisfying sex life and that they are capable of reproducing children, and free to decide if, when and how often to do so, in their private spaces…it should not be something dictated to by public population policies.

Can one imagine some men in conferences somewhere in this world e.g. USA or Europe dictating to me the number of children I should have as an African woman; Indeed, those are issues of my womb and my private space…

In line with the above definition of reproductive health, reproductive health care was further referred to as the constellation of methods, techniques and services that contribute to reproductive health and well-being, by preventing and solving reproductive health problems for improved reproductive outcomes. Reproductive health care services must meet women’s reproductive health needs of all ages regardless of race, class or any other social category. Reproductive and sexual health and rights goes beyond simply preventing or treating diseases and should thus be viewed as part of equity–oriented human development.

Violations of women's reproductive rights are universal though tactics vary from country to country with different justifications. For example, compulsory monthly gynaecological examinations instituted in workplaces in Rumania to control women's reproduction; the sterilization of female gypsies which are said to be involuntary in Eastern Europe; China's one-child policy; India's economic incentives to encourage women to undergo sterilization; abortions under coercion in Tibet and China; child-bearing after rape in Bosnia; or the ruling by American judges that as condition for probation, women convicted of child-abuse must be implanted with NORPLANT (a long term hormonal contraception that is inserted in a woman's body).

Other examples in Africa include rape; battery; genital mutilation or female circumcision. Often clitoridectomies are performed without anaesthesia with dirty cutting instruments leading to infection, tetanus and sometimes death.

Literature reveals harmful procedures such as vesico-vaginal fistula (VVF) which affect many child-brides in Northern Nigeria…this is a hole between the vagina and usually the bladder, leading to continuous leakage of urine from the bladder into the vagina and urinary incontinence (Amodu, Salami & Richter 2018).

In the apartheid SA, African women were coerced into being injected with a long acting hormonal contraception (depo-provera) immediately after the delivery of a baby. The justification was that no woman should be discharged from the labour ward "unprotected from pregnancy". This was dubbed the fourth stage of labour when I was training as a midwife. Many complained unsuccessfully that they did not want the injectable hormonal contraception because it dried up breast milk. Women could not make a choice on the suitable contraceptive method as there was limited range from which they could choose. The long acting hormonal contraception was promoted method hence mostly available.

I have seen young girls who worked on the farms and never had children before, or have proven their fertility, being injected with long acting hormonal contraception. That was in one of my previous jobs as a young Population and Development Program (PDP) officer in North West province (previous Bophuthatswana). That created infertility problems while infertility services were not offered to black women (Klugman 2000).

This lecture does not intend to argue that discussions about population, family planning, and access to health care are topics that shouldn't held. However, they must be discussed within the context of past family-planning programs that were implemented in the Global South and promoted and funded by outside countries for hidden agendas either than in the interest of women's health.

An example is the Ministry of Health in Peru, which changed health care laws and policies to accommodate the family planning movement and programs which was initially introduced in the 20th century in Peru. Although the mission statement was to provide health care to poor people, it covertly propagated population control and reduction of poor people (Gribble, Sharma & Menotti 2017). Some of the funders included the USAID which has a history of propagating population control especially in poor and developing countries in the name of alleviating poverty yet dominating those countries (Horner 2020).

6. Research Studies I conducted in the recent past on the subject.

Study 1	**Study 2**	**Study 3**	**Study 4**
What public policy can reduce reproductive morbidity and mortality in SA.	A model for integrating social interventions into PHC in order to reduce maternal and child mortality in South Africa.	Reproductive health outcomes: insights from experts and verbal autopsies.	The magnitude of maternal mortality in South Africa: views from South African experts.
Focus was on addressing reproductive health needs in SA. **Analysed** national MC&WH and Population Policies in South Africa to find out how reproductive health care was delivered. **Observed** delivery of reproductive health services in FP, ANC and identifying differences between real reproductive health needs and the present situation.	**Focus** on the root of ill-health and mortality of women in South Africa, The study explored factors which render women vulnerable to ill health and impact on their reproductive health status.	**F**ocus on the women and neonates who died because of birth-related circumstances in KZN. **T**he article argues that maternal mortality ratio received favourable attention compared to ensuring universal access to reproductive health whereas the latter is a necessary pre-condition to improved reproductive outcomes.	**F**ocus on the current system of identifying and estimating magnitude of maternal mortality ratio in South Africa
It emerged that: **M**C&WH package for poor women in South Africa reduces reproductive health to services for prenatal care	The study found that: **At policy level**, structural poverty, and unequal distribution of resources are the root to persistent	The study found that: **W**omen, Maternal and Child health policies are disempowering, despite the country's constitution	It emerged: **T**he system of identifying and estimating maternal deaths in South Africa was found to be inadequate in estimating the

and childbirth, showing that women are valued only for their reproductive role. Children are the beneficiaries of this package & not women. **U**nhealthy birth control technologies were distributed to poor African women in public family planning units. **I**nternational funders of programs and those in power, rather than women themselves, chose birth control methods for poor women, an evidence of unequal power relations and vulnerability of poor rural African women. Reproductive health care was still provided through narrow vertical programs rather than integrated reproductive services.	female reproductive ill health and premature mortality, pointing to the need for a broader approach which would move beyond addressing individual health complications in health facilities. **T**he realm of women's reproductive health is medically dominated. **S**trategies and policies to improving women's health are rooted in the curative approaches whereas poverty among women is the key socio-economic determinant of women's health. **At service delivery level**: Non-compliance with the hospital procedures can lead to loss of life and dire consequences for families.	and policies that appear relevant. "**R**eproductive health services for adolescents are concentrated in towns. This leads to disempowerment of adolescents in rural areas". **L**ack of accurate education to women, adolescent or parents keeps them uninformed or ill-informed on sexual matters hence they make choices that impede their reproductive health. **A**bsence of a system to compel teachers to give reproductive health education for boys and girls.' **T**he culture of silence which surrounds women about their reproductive ailments exposes them to inaccessibility of reproductive health services.	magnitude of maternal mortality ratio to an extent that it: **E**xcluded community maternal deaths leading to underestimation of maternal mortality, thus obscuring the magnitude of the South African MRR. **I**ncomplete data and information is the main problem. .
Any Strategy to reduce reproductive morbidity and mortality must address the underlying issues.	**A**ccessible, equitable, quality reproductive health care services from the PHC Centres & hospitals remain one of the core pillars in successfully delivering such services.	Reduce vulnerability of women to the risks of poor reproductive outcomes through appropriate policies and services.	**V**alid, accurate and reliable data and information should form the backbone of decision making and women's health programme improvement

7. WHAT SHOULD BE DONE AND CONCLUSION:

Political commitment at the highest international and national levels is needed to institute policies and allocate the resources necessary to achieve a world where women are healthy, safe and empowered to control their own destinies for achieving equality and reproductive rights (International Centre for Research on Women [UNFPA 2020]).

Promotion of responsible exercise of reproductive rights and programmes which should be made accessible through the PHC system.

Contextualisation of women's health in terms of poverty and quality of life was and remains crucial. Women should be involved in the planning, implementation and evaluation of reproductive health care programmes.

Intersectoral collaboration help government, especially DOH, to work together and with other sectors for integration of women's empowerment, development and health.

Reproductive health needs of adolescents have been largely ignored by the existing services…. This point to the need for involvement of adolescents in planning their reproductive health.

As academics, we cannot afford to suffocate other women, to be self-righteous, and pretend to be private owners of the truth and the knowers of what is best for women because these women also exist, they must be involved in the interventions meant to ensure universal access to overall women's health and reproductive rights for improved reproductive outcomes….

This lecture would have reached its goal if it succeeds in cautioning policy makers to consider that reproductive health and reproductive outcomes as products of complicated power relations. Women need to be protected from policies of the parties that have other interests either than caring for their health and well-being in every aspect of health provision. The insights arrived at in this lecture will hopefully add value in the design and implementation of public policies and models which create conditions conducive to reducing the risks to overall women's health. Moreover, this lecture should assist the Government of South Africa to:

- be responsive to women's needs, including their right to reproductive health;
- strengthen advocacy programmes for the adolescents' reproductive health and responsible sexual behaviour; and
- strengthen training programmes for the providers of health care; however, this should be preceded by recruiting the right people who have a passion for the profession.

I conclude by a quoting from: **'**Ain't I a woman' authored by a feminist and a woman-rights activist, Sojourner Truth.

“If the first woman God ever made was strong enough to turn the world upside down all alone, these women together ought to be able to turn it back and get it right side up again”.

What can be learnt from this quote is that women must stand as a collective, fight for their wombs, their private spaces and their reproductive rights so that they turn this world right side up again.

Why should women suffer, just because they re-produce nations?

I thank you.

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Acts, Statutes and Laws referred to in this lecture

1. Abortion and Sterilisation Act (Act 2 of 1975) as amended by Sterilization Act, 1998 (No. 44 of 1998)
2. Choice on Termination of Pregnancy (CTOP) Act (Act 92 of 1996) as amended by CTOP Act 38 of 2004 and re-amended by the CTOP Act 1 of 2008
3. Constitution of the Republic of South Africa (Act 108 of 1996).