COVID-19 and Abortion: Making Structural Violence Visible

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COVID-19 has compromised and disrupted sexual and reproductive health (SRH) across multiple dimensions: individual-level access, health systems functioning, and at the policy and governance levels.[1] Disruptions to supply chains, lockdown measures and travel restrictions, and overburdened health systems have particularly affected abortion access and service provision. The pandemic, rather than causing new issues, has heightened and exposed existing fractures and fissures within abortion access and provision. In this viewpoint, we draw on the concept of "structural violence"[2,3] to make visible the contributing causes of these ruptures and their inequitable impact among different groups.

Rarely used in abortion research, the concept of structural violence shows how institutionalized and everyday forms of violence restrict and affect abortion access and quality of care. Drawing on relevant case studies, we demonstrate the additional analytical possibilities that structural violence offers for abortion researchers by complementing existing frameworks widely used in abortion research, including social determinants of health, intersectionality, health inequalities and reproductive justice. We conclude with a call for more research that grapples with structural and indirect forms of violence that surround and shape abortion trajectories.

Contending with an Epidemic of Exposed Fault Lines

Pandemic conditions affect the circumstances—such as increased intimate partner violence under lockdown or quarantine measures[4]—that make pregnancies supportable or unsupportable.[5] They also impact the accessibility, availability and provision of contraceptives and abortion-related care. Disruptions to and delays in contraceptive and medical abortion supply chains have potentially increased the number of unintended or unplanned pregnancies,[6] especially as lockdown or quarantine measures have reduced access to services.[7] Womxn's* concerns around risk exposure or perceptions of limited care provision may have led to their greater hesitancy in accessing services from formal providers;[8] this is particularly true in countries with overburdened health systems, where health care professionals are diverted to tackle the pandemic, in turn creating shortages in trained abortion providers and affecting availability of services.[9] Prepandemic, all of these experiences and factors were stratified and affected womxn differently across axes of race, ethnicity, age, marital status, class, gender and sexual identity, immigration status and others. This disproportionate distribution of inequities demonstrates how risks are structurally embedded, and differentially experienced, navigated and dealt with. Pandemic conditions magnify these inequities.

People seeking contraceptives and abortion have always dealt with a range of barriers: laws comprising a range of restrictions or conditionalities,[10] social and legal sanctions,[11] lack of resources,[12] poor quality of care[13] and refusal or unavailability of services.[14] Rather than creating new crisis conditions, COVID-19 lays bare existing fault lines and inequities embedded in the interlinked structures of health systems, social institutions (including the economy), and governance and law. These long-standing inequities—gendered, classed, racialized—are sustained and reproduced by the underlying historical, social, political and cultural contexts that shape access to SRH. Collectively, these entrenched inequities and fault lines are "structural violence."

Why Is Structural Violence Relevant for Abortion Research?

Structural violence—distinct from direct or interpersonal violence—is the violence of injustice and inequity. Shifting away from individual experiences, it focuses attention on the often unnoticeable systems (legal, political, economic and sociocultural) and social relations that are part of the fabric of society and that shape individuals' experiences, including health and wellbeing.[15,16] Structural violence is institutionalized, making it "everyday violence" that functions through "everyday internalization."[17,18] These intersecting structures exert violence in a systematic and indirect manner, functioning collectively as the "social machinery of oppression"[3] to cause pain and social suffering.[19] Experienced and accumulated by individuals over a lifetime, structural violence creates "unequal life chances,"[2] which affect womxn's health and wellbeing over their life course.[20] Racism is one example of an institutionalized social system, rendered invisible to those not experiencing it, which intersects with such other structures of inequality as ableism or sexism to create and reproduce structural violence.

Originating from the interdisciplinary field of peace studies,[2] structural violence has been used to interrogate HIV,[21] racism in health care,[22] health inequalities,[23] infectious diseases,[24,25] maternal health[26] and clinical medicine.[27] Structural violence has much in common with the social determinants of health: Both concepts center the influence of distal forces (social, economic, political) on

*We use the terms "womxn" or "pregnant persons" to include all individuals—transmen, nonbinary persons, cis-gender women, among others—who may want or need an abortion.

health outcomes, and hold that morbidity and mortality "are not inevitable, natural or equitable but instead are biological reflections of social inequality."[28] Possibly reflecting disciplinary divergences in the uptake and use of these allied but distinct concepts,[28] the concept of social determinants of health is far more common in abortion research than is structural violence.

We contend that structural violence offers an additional set of analytical insights for abortion research—understandings of how "everyday violence" shapes abortion access—shifting away from individualized approaches to an interrogation of structural forces, and challenging passive understandings of "determinants" in favor of a more explicit focus on the causes of violence.[29] We build on the nascent abortion and structural violence literature,[20,30–36] and draw from other fields to make our case.

• *It exposes the cumulative violence of institutions.* SRH interventions tend to "individualize" responsibility for reproductive management, by focusing on individual behaviors and actions instead of the environments that shape, constrain or enable them.[5] Interventions aimed at individual behavioral change (e.g., uptake of a contraceptive method) double-burden womxn, who are already oppressed by heteropatriarchal hierarchies, while simultaneously held responsible for the attainment, access and exercising of their rights.[37] Abortion research largely locates violence at the micro level[38]—disrespectful care;[39] denial of services;[40] limiting choices, including postabortion contraception;[41] and interpersonal violence—as a determinant or outcome of seeking care.[42]

Located within broader neoliberal systems that determine the individual as responsible or irresponsible health care seekers, individualization builds on constructions of "good" reproductive citizens. A focus on individual responsibility draws on structures that privilege ableism, classism, sexism and racism in determining abortion trajectory acceptability.[43] As well as womxn's own abortion decision making, such constructions are re-enacted in interactions with health care workers, who utilize and reinforce gender norms, and burden womxn with the emotional and physical labor of (preventing) reproduction.[44] For example, Saunders' exploration of working-class mothers' reproductive experiences in Glasgow, Scotland, demonstrates how individualization is a defining feature of reproductive decision making.[43] Doctors—while expressing discomfort around later gestation abortions—justify them for younger pregnant people living in deprivation, treating them differently than older and more educated womxn who are considered "valued" reproductive citizens. This individualization and "responsibilization"[45] rhetoric is also evident in how "othered" persons (e.g., Indigenous and Two-Spirit persons,[46] sex workers,[47] trans and nonbinary persons,[48] migrants[49] and those living with HIV/AIDS[50]) are treated by structures that replicate violent institutions of reproductive discrimination. It contributes to an "inflexible tension between cultural ideals and women's lived realities,"[30] which perpetuates structural violence.

Where abortion research interrogates broader forms of violence (e.g., discrimination in abortion care[34]), it draws on complementary and critical frames like intersectionality.[51] Yet, the focus remains located within individual experiences of violence or on specific institutions and their failures. The individualization of responsibility can take on forms of "symbolic violence,"[52] manifesting as internalized shame and stigma, humiliation and guilt—all evidenced in womxn's abortion trajectories. Structural violence necessitates acknowledging the interconnected and compounding violence of social, health, legal, economic and political systems within which an individual navigates their abortion access and care.[31] Even though negative outcomes are felt and experienced individually, structural violence inequitably subjects people to oppression and social suffering.[15,19]

Luffy et al. show how, in Nicaragua, multiple entrenched political and sociocultural institutions—a total ban on legal abortion; *machismo*; and social stigma around womxn's sexual behavior, including their access to and use of contraceptives—act in concert to cause harm.[36] Harm is caused because these structural factors combine to produce violent conditions within which womxn attempt to make their decisions.

The persistence of structural violence does not mean that there are no acts of resistance challenging or confronting it. Rather, applying a structural violence lens means that we can also understand how people (as individuals, communities and solidarities) resist and contest structural conditions. From individual acts of resistance that refuse to internalize abortion stigma or shame,[53,54] to collective acts that operate outside of systems of structural violence through the provision of hotlines or web-based services for medication abortion,[55] to population-level overturning[56] or delaying[57] of structurally violent laws, the presence of these acts of resistance reveals the structural violence in operation. For example, young women in Kenya exercised agency and self-reliance to procure abortion, prioritizing their own health care needs above felt or perceived societal stigma.[54] In Argentina, activists conducted a direct-action campaign to make medical abortion information available to those seeking abortions.[55] And in the Republic of Ireland, a constitutional amendment that denied lawful access to abortion care in nearly all situations was repealed following widespread activist movements for a referendum on the issue.[56]

• *It interrogates "everyday violence" experienced across a trajectory.* Examining the ways in which structural violence operates across a single abortion trajectory helps to unpack how structural factors systematically cause everyday violence, meted out in ways that are inequitable and unjust. By applying the lens of structural violence at every point in an abortion trajectory, whatever the outcome,[58] we can unpack the factors at play and the ways in which they cause individual "humiliations, discriminations, recriminations and injustices."[59] We illustrate this with examples from points in trajectories of care, all drawn from pre-COVID-19 evidence; however, it can be reason-

ably assumed that these experiences will be magnified by COVID, given what we know about the impact of another health emergency—Zika—on abortion-related care.[60] The policy response of multiple governments to Zika was to recommend that womxn avoid or delay pregnancy; an individualized response that ignored inequalities of gender, class and race, and placed responsibility for managing risks on womxn.[60]

For example, crisis pregnancy centers seek to persuade pregnant people considering or seeking abortion to instead choose parenting or adoption, using legal structures that permit the impression of regulation and objective advice about abortion.[61] Denial of care (or nonreferral for care), often conducted under a guise of conscientious objection, is possible in systems where professional power is privileged or unconstrained. The provision of low quality or disrespectful abortion care reflects power structures and relationships allowing a provider to act with impunity.[62,63] Abortion care that is conditional upon—explicitly or implicitly—"accepting" postabortion contraception reveals coercive practices that deny individual rights.[64] At each point, irrespective of context, structural violence means that individual-level harm can occur at multiple times in a single abortion trajectory and accumulate over the life course.

• *Structural violence in national and transnational policies.* Institutions operate within and across nation states, and locate structural violence in the design and application of their policy and legal frameworks, which are often rooted in longstanding historical injustices. Many formerly colonized nations retain colonial-era laws that criminalize or penalize abortion—notwithstanding the "irony" that many of the colonizing nations have largely liberalized their own laws.[65] In Malawi, the current colonial-origin law precludes adolescents from accessing a safe procedure, (re-)enacting structural violence through a denial of services and the lack of recognition of adolescents' specific abortion needs.[66] Restrictive abortion laws are experienced as direct forms of violence, but all abortion laws—even more liberal ones—enact barriers to full reproductive freedom.[67] These laws overlap with and are enacted alongside other punitive laws—criminalization of HIV nondisclosure,[68] "defilement laws"[69] or mandatory reporting requirements[70]—that create and legitimize conditions of violence and inequity.

Institutions do not operate in isolation to enact and maintain structural violence. Legal and health systems can work in concert to punish and oppress some, such as people living with HIV, while protecting others.[68,69] In South Africa, for example, despite liberalization of the abortion law, a convergence of multiple institutions (legal, cultural, medical, social and religious) means that structural violence is "legitimised and maintained,"[32] and access to safe abortions is constrained (e.g., through the convergence of a lack of abortion facilities, abortion stigma, conscientious objection, dearth of accurate information sources, and the need for secrecy). Eklund and Purewal, exploring sex-selective abortion in China and India, reveal how criminalization of the practice ignores the structural dimensions of son preference that contribute to gender inequity, while showcasing government efforts to tackle the issue through awareness, deterrence and incentivization.[33] Purewal demonstrates how neoliberal state policies in India reproduce and reinforce sex-selective abortion as a reproductive strategy—permeating the state, family and individual domains.[35]

Structural violence for abortion also operates transnationally. The U.S. government's Mexico City policy (also referred to as the "Global Gag Rule"; GGR), as well as its multiple amendments and recasting (e.g., "Protecting Life in Global Health Assistance"), provides a good example. By determining—through the lever of aid conditionalities—which services can and cannot be provided by whom and to whom, the GGR imposes one state's moral discourse on abortion on others, particularly low-and-middle income countries receiving aid. The impacts of the policy are experienced inequitably and globally;[71,72] it can also be argued that aid dependency is itself a form of structural violence. Other development programs—even when couched in the language of rights and empowerment—can further forms of structural violence.

Antiabortion groups work locally, nationally and transnationally, to create, contribute to and reinforce conditions of structural violence. Antiabortion rhetoric is intimately tied to anti-LGBTQI discourse, part of a broader antifeminist and antigender ideology.[73,74] These are also linked to conservative[75] and authoritarian regimes,[76] as witnessed in India[77] and Poland.[78] Recent reports detail funding flows from antiabortion conservative groups in the United States to far-right groups in Europe.[79] These transnational antifeminist and antiabortion efforts have been ongoing since the 1980s,[74,80] drawing on essentialist notions of motherhood and femininity in their campaigning.[81]

Antiabortion lobbies work transnationally, funding local groups and affecting health care provision. In Ukraine, for example, US-funded antiabortion groups have set up so-called "pro-family" forums and purportedly lobbied Members of Parliament. They are linked with antiabortion pregnancy centers that attempt to deter abortion-seekers with misinformation.[82] This global network of antiabortion "crisis pregnancy centers" are active in a number of countries, including Argentina, Ecuador, Mexico, South Africa and the United Kingdom.[83,84]

Too Vague to Be of Analytical Use?

Critiques of structural violence have largely focused on its lack of conceptual clarity, using the limitations of its operational use as examples. Criticism is concerned with the "atheoretical" presentation of structural violence, in which it is separated problematically from a background and theory that explains its emergence.[29] Uses of structural violence have pointed out existing structural factors, such as the role of imperialism and colonialism in disease patterns. These structures, however, are not critically engaged with in relation to specific contexts, which leads to

"moral judgements" of structures rather than contextualized analyses, which in turn obfuscates the very structures perpetrating violence.[3] As such, structural violence risks becoming an "apolitical" concept, in which "structure is called out but never defined" meaning "'the perpetrators' of violence remain obscured."[29]

These critiques are important in relation to abortion research. Abortions are deeply political, and pregnant people's access is defined by myriad structural values that are contextually specific. Abortion policies are embedded in historic,[65] colonial,[85] supremacist and eugenicist structures,[86] which have sought to control some womxn's reproduction more than others.[43,87,88] For structural violence to be a useful concept, it must be able to move beyond description and make these structures visible.

One way of achieving this is to use structural violence as a complementary lens to other theoretical frameworks (e.g., Critical Race Theory, Feminist Theory,[29] Reproductive Justice,[89] Abortion Trajectories Framework[58]). Such frameworks situate individuals in larger structures, within which violence is not only embedded, but a normalized reality.[29] Complementing broader theories with structural violence allows research on abortion to engage with the intersecting structures that impact reproductive justice, such as education or labor markets.[59]

The Power of Structural Violence

Structural violence is powerful because it is entrenched, systematic and omnipresent in everyday lives. We argue that it is the linkage between the systemic macro and the everyday micro that makes structural violence a compelling lens for abortion research. Health emergencies, such as COVID-19 and Zika, amplify and illuminate how structural violence is produced, reproduced and maintained. Farmer suggests that structural violence takes new forms in every era;[3] we disagree to an extent. COVID-19, rather than creating new forms of injustice, has rendered visible existing structural violence and inequities. Whether abortion is considered part of essential health care—and if it is, the availability and quality of that abortion care—is an expression of structural violence. Abortion telemedicine—largely unavailable before—has been made more available during the COVID-19 pandemic as a result of public and professional activism.[90] COVID-19 has made visible the structural violence of not providing medical abortion by telemedicine in nonpandemic times, and the continued criminalization of self-management.[8]

Abortion access and provision largely occurs under conditions of structural violence. Stigmatizing and anti-abortion policies and laws that directly or indirectly limit access[91,92] operate in concert with under resourced and overburdened health systems[93,94] that do not provide womxn-centric care and further entrench the medicalization of abortion.[95] These function under long-standing systems of classism, racism, (neo)colonialism, cis-hetero patriarchies and neoliberalism. Alongside forms of cultural violence—e.g., abortion stigma or the sustained lack of knowledge and information channels—these systems enforce and reproduce symbolic violence that is felt and enacted in womxn's abortion experiences.

Our viewpoint has focused on abortion, but we suggest that structural violence is a useful lens for all aspects of sexual and reproductive health. For example, understanding how policy and programmatic privileging of postpartum long-acting reversible contraceptives as a "one stop shop"[96] is an expression of professional institutional power potentially operating against womxn's reproductive autonomy.[97] Structural violence helps make sense of the ways in which implicit Neo-Malthusian population control framings of family planning programs[98] are linked to reproductive governance.[99] The Family Planning 2020 (FP2020) and Implant Access Program, for instance, needs to be understood in the historical context of population control programs and the proliferation of neoliberal market ideology in the Global South.[98] Senderowicz details how contraceptive coercion is structurally produced as part of global family planning efforts, instrumentalizing womxn's bodies.[100] As Senderowicz and Higgins state emphatically, "reproductive autonomy is non-negotiable, even in times of COVID-19."[101] Challenging contraceptive coercion requires not just an understanding of the interpersonal threats that shape it, but also of the deep, interconnected structural and embedded forms of threats and violence that surround such interventions.

Analytically, structural violence enables the interrogation of the interconnected systems of oppression that surround abortion access and provision. Particularly in pandemic times, it reveals how local, national and transnational systems link and influence each other, as well as demonstrates how such acts of resistance as self-management or hotlines can be understood as both highlighting structural violence and simultaneously usurping it. We conclude with a call for more research that grapples with structural and indirect forms of violence that surround and shape abortion trajectories.

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