A NARRATIVE-DISCURSIVE ANALYSIS OF ABORTION DECISION-MAKING IN ZIMBABWE.

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ABSTRACT

Most research on abortion decision-making has looked at the factors or influences that are seen to affect abortion decision-making and thus take a health determinants approach. However, this approach is rarely able to account for the complex, multi-faceted nature of abortion decision-making, and it is often not located within a framework that can unpick the complex array of power relations that underpins the process of abortion decision-making. Research on abortion decision-making has rarely examined how women who undergo a termination of pregnancy (TOP) construct micro-narratives of the decision to terminate the pregnancy and also how these women are positioned by the service providers who interact with them.

Using a Foucauldian postcolonial feminist approach and narrative-discursive analysis, this study explores abortion decision-making narratives in a Zimbabwean context where abortion laws are restrictive. In this study I elicited the narratives of women who had undergone an abortion about how they came to make the decision and proceeded to terminate the pregnancy. I highlight the discourses employed in constructing these narratives and how women position themselves in these narratives and discourses. These are then compared to the subject positions enabled in health service providers' narratives on the same topic. These narratives are then linked to the social discourses and power relations that work to enable or constrain reproductive justice.

The data were collected from three sites in Harare, Zimbabwe. The three sites were Harare Hospital, Epworth and Mufakose. An adapted version of Wengraf's (2001) narrative interview was used to elicit narratives from 18 women who had terminated pregnancies (six at each site). Semi-structured interviews were conducted with six service providers (two nurses at Harare Hospital, two village health workers in Epworth and two nurses in Mufakose). All the service providers interviewed have experience working with women who have terminated pregnancies.

In narrating their stories about their abortions, the women employed discursive resources around shame, stigma, religion, health and culture. These discursive resources were drawn upon in the construction of the women's micro-narratives. The women spoke in a socially sanctioned manner where stories were enabled and constrained by particular religious, cultural and gendered discursive resources. In these stories, cultural constructions, gendered

understandings of motherhood and femininity constrained reproductive justice for women who have terminated pregnancies.

Comparisons of the way women positioned themselves and how they were positioned by health service providers point to the existence of social discourses and power relations that work to constrain reproductive justice. While the women saw themselves as having 'unsupportable pregnancies', the service providers positioned them as being evil, selfish and irresponsible. The negative positions deployed by the service providers point to the vilification and blaming of women who have undergone a termination of pregnancy. In these positions, the woman is at fault and there is silence on the role of men in abortion decision-making.

In the women's narratives and the health service providers positioning of the women a 'reproductive rights' discourse was absent. This was significant as much of the activism around abortion has centred on the woman's rights to her body. Where rights were mentioned, it was in reference to foetal rights (using cultural, moralistic religious understandings of abortion as killing). The missing 'reproductive rights' discourse points to a need to move from a reproductive rights framework to a reproductive justice framework that can be applied through local understandings of *hunhu/ubuntu*. By doing this, abortion is not seen as a 'choice' that a woman makes but rather as involving broader social and environmental circumstances that make a pregnancy 'unsupportable'.

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A NOTE ON TERMINOLOGY AND THE LEGAL STATUS OF ABORTION

Gender terminology

In the thesis I use gender terminology that could be considered as problematic. For example, I use the term ‘women’ to refer to the participants of this study. This does not mean that I am claiming that all the women in this study are similar or that they are a homogenous group of people. Rather, I use it as a general description of the participants.

Abortion and unsafe abortion

‘Abortion’ has been defined as the ending of pregnancy by the removal or forcing out from the womb a foetus or embryo before it is able to survive on its own. Abortion can occur spontaneously or purposely which is known as induced abortion. The women in this study all had induced abortions. In addition, all of the abortions in this study except one at Mufakose (the woman got pills from a doctor at his office) were unsafe, meaning that the woman self-aborted or relied on another person who did not have adequate medical training or access to proper facilities. However, in writing I use the term ‘abortion’ generally to refer to the procedures carried out by the women in this study.

Legal status of abortion

The table in Appendix O has been inserted to show the different legal statuses of abortion in the different countries mentioned in this thesis. The research referred to in the thesis should be read in the context of the legality of abortion in the particular country.

GLOSSARY OF TERMS USED IN THE THESIS

Word	Meaning
Ha	Shona expression of surprise
Roora/lobola	Shona word for bride price.
N'anga	Shona word for a traditional healer who uses a combination of herbs, medical/religious advice and spiritual guidance for healing
Cytotec (patent name misoprostol)	A medication used to treat stomach ulcers and also to induce abortion.

LIST OF ACRONYMS

APA	American Psychological Association
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CTOP	Choice and Termination of Pregnancy Act
HHDC	Humanities Higher Degree Committee
HIV/AIDS	Human Immuno-deficiency Virus/Auto-Immune Deficiency Syndrome
MOHCW	Ministry of Health and Child Welfare
MRCZ	Medical Research Council of Zimbabwe
MVA	Manual vacuum aspiration
NGO	Non-governmental organisation
PSZ	Population Services Zimbabwe
RPERC	Research Proposal and Ethics Review Committee
SQUIN	Single question inducing narrative
SRH	Sexual and reproductive health
TOP	Termination of pregnancy
TQUIN	Topic question inducing narrative
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Chapter 1: Setting the scene

1.1 Introduction

The following is an extract from an editorial in the Zimbabwean *Daily News* newspaper:

> In response to the *Daily News on Sunday* article of October 20, 2013 about PSZ's [Population Services Zimbabwe] illicit illegal abortions, I would like to call the honourable Minister of Health to urgently act on this issue. Apart from abortions being illegal in Zimbabwe, they are of no public health value and exacerbate sexual immorality and moral and cultural decadence. We need to restore our societal and cultural values hence the need for the minister to stop Population Services Zimbabwe from clandestinely providing illegal abortion services by asking them to focus on life-saving public health interventions like HIV/AIDS, ART, SRH, malaria and TB (Chamacha, 2013).

The following is a news story from the Zimbabwean *Newsday* newspaper:

> A 26-year-old Seke woman who aborted her pregnancy and dumped the baby in a toilet was yesterday sentenced to 12 months in prison. Zvikomborero Mutandwa of Njuma village in Seke, who pleaded guilty to the offence, will, however, serve 280 hours of community service at Zhakata Clinic after magistrate Lazarus Murendo suspended her sentence. Mutandwa told the court that she committed the offence after her boyfriend denied paternity. Prosecutor Norman Koropi told the court that on February 18 this year at around midday; Mutandwa drank two litres of diluted detergent in a bid to terminate her five-month pregnancy. The following day at around 3am, she started bleeding and went outside her house behind the toilet where she gave birth to a premature baby. Mutandwa threw the baby in a pit latrine and did not tell anyone. The matter, however, came to light when people in her village noted that the accused person was no longer pregnant and they informed the police. After investigations, the body of the premature baby was removed from the pit latrine, leading to Mutandwa's arrest (Marufu, 2015).

The above quotes from the *Daily News* and *Newsday*, two widely-read daily newspapers in Zimbabwe, provide a context of how abortion is viewed in the country. The *Daily News* editor refuses to acknowledge abortion as a public health matter and argues that the accused organisation, Population Services Zimbabwe (PSZ), should focus on more effective life-saving interventions. The trivialising of abortion here points to a trend where abortion is seen only as a moral and cultural issue and nothing else. Using this framework, the editor ignores all the other

aspects of abortion (public health, medical, psychological, reproductive rights and justice). In this framework abortion is said to be at the centre of sexual immorality and is seen as destroying culture. The woman here has no say and is vilified and labelled as the problem. By stopping abortion, society is seen as reclaiming the values that it has lost. The editor homogenises culture and tasks the minister with restoring the values that are being lost by people who decide to undergo abortions. He indicates that abortion should be policed in the country. The continued operation of PSZ (providing 'illicit' abortions) shows, in the editor's eyes, the failure of the government to do its job. It is from this understanding of abortion as morally and culturally corrupting that my contextualising of the study begins.

The story in the *Newsday* gives a background to the legal context of abortion in Zimbabwe and, in contrast to the *Daily News* article offers, a supposedly neutral explanation. The way a woman goes through the process of terminating her pregnancy is shown in the story as well as how the woman acting alone is important. The role of the villagers in alerting the police might be linked to the negative attitudes shown by the editor above. The woman who is identified by name and village of residence is portrayed as a "villain" who "dumped" the "baby" after drinking detergent. This identification, given the prevailing attitudes, will almost certainly lead to her being stigmatised. The Magistrate in the case sentenced her to 12 months which was suspended, although no explanation was provided. The way the story is written points to how abortion is viewed. The foetus is referred to as a premature baby and this suggests that the woman's action does is actually "killing". Although the 'reason' for the termination of pregnancy (which is the man denying responsibility) is given, it is only afforded one line. No further socio-economic, cultural, familial context is provided — conditions that led to the pregnancy being 'unsupportable' (Macleod, 2015, see page 18 for further discussion of unsupportable pregnancies). The rest of the story focuses on putting blame on the woman and the act of having an abortion which is described in gruesome detail: the woman is seen as "killing" and dumping a "baby" in a pit latrine.

The two extracts above provide a contextual backdrop for the thesis, illustrating some of the ways in which abortion is represented publicly in a Zimbabwean context. The extracts provide a contrast in terms of attitudes regarding abortion, as the first is overt in its moralising stance, but the second takes a more neutral, balanced reporting tone. Nevertheless, as shown above, there are a number of taken-for-granted assumptions. In the following, I focus on the legal context of abortion in Zimbabwe before moving to the research that has been done on abortion

in the country. I provide my rationale for the research which is based on the current legal status of abortion and the dearth of research that takes power relations into account. I describe the three study sites so as to provide some background of the socio-economic conditions in which the women I interviewed live. In the next three sections of the chapter I turn my attention to brief discussions of three important theoretical concepts used in the thesis. Firstly, I conceptualise the abortion decision-making process using debates from psychology. I then introduce my theoretical framework which is a Foucauldian postcolonial feminist framework. I argue for a move from using the signifier 'unwanted' to 'unsupportable' in referring to pregnancy as it fits when used with a reproductive justice framework in this thesis. I conclude the chapter by providing a brief overview of the rest of the chapters in the thesis.

1.2 Legal context of abortion in Zimbabwe

The legal status of abortion is embedded in the general legal system in Zimbabwe, which is structured in such a way that it discriminates against women. The law is composed of statutory and customary law. Statutory law is the written law established by enactments expressing the will of the legislature. Customary law, on the other hand, consists of the written and unwritten rules that have developed from the customs and traditions of communities. The world report produced by Freedom House (2010) noted that the presence of these two systems with regards to marriage contributes to the vulnerability of women as customary marriages are not registered and women do not have the same rights granted in civil marriage. A UNICEF Report (2011) noted that some traditional views and customs which are part of customary law can be seen as perpetuating violence, abuse and discrimination against women. It is within this context that unsupportable pregnancies and abortions occur.

A new constitution (approved in 2013) has recently been signed into law. It states that the circumstances under which a pregnancy can be terminated in the wake of the new constitution are still to be determined. Within the old constitution of Zimbabwe, the right of the life of the unborn children was protected. This has not changed under the new constitution as the lives of unborn children are still protected (Constitution of Zimbabwe, 2013). The Termination of Pregnancy Act of 1977, which was passed before independence, stated that a legal abortion could be obtained if the continuation of a pregnancy endangered the life of the woman, or posed a serious threat of permanent impairment to her physical health. The law also allowed termination of pregnancies in which there was a reasonable possibility that the foetus had been conceived as a result of unlawful intercourse, including rape, incest or intercourse with a

‘mentally handicapped’ woman. Under the law anyone who aborted illegally faced a minimum of five years in prison.

The Zimbabwe Civil Society’s shadow report to the CEDAW Committee (2012) noted that most women who have been found guilty of abortion have been given community service or cases have gone unprosecuted. A group of non-governmental organisations (NGOs) complained that many women who had grounds for terminating a pregnancy could not do so as they did not have the means to go through the process of consulting two doctors as stipulated by the old law (The Zimbabwe Civil Society’s shadow report to the CEDAW Committee, 2012). Despite the constitution stipulating that abortion in the case of rape is allowed, a case that was heard in the Zimbabwean constitutional court in 2012 shows how difficult this is. A woman sued the state for failure through delays by police and courts to grant her an abortion after she was gang raped (Zimbabwean Women Lawyers Association, 2013). The woman was since awarded damages by the court.

Until recently, those seeking post-abortion care at hospitals after having unsafe abortions were supposed to be reported to the police. In response to the high number of maternal deaths, the Ministry of Health announced a new post-abortion policy in April 2012 which states that women can have access to post-abortion treatment without being reported to the police (Ministry of Health, 2013). This was done to encourage women to seek treatment for abortion complications without fear of being prosecuted.

1.3 Research on abortion in Zimbabwe

Abortion is an area that is under-researched in Zimbabwe due to the social stigma and legal aspects surrounding it (Ndarukwa, 2012). Most of the available published research stems from the mid-nineties and early 2000s. Of the available research, most studies have used public health and medical perspectives. These studies mostly examined how women, who were being seen for post-abortion complications due to unsafe abortions, understood their ‘predicaments’ (Fawcus, Mbizvo, Lindmark, & Nystrom, 1996; Rutgers, 2001), and their preference of either surgical or medical abortion treatment (Maternowska, Mashu, Moyo, Withers, & Chipato, 2014). Other studies have taken a gendered and contextual approach and these include the research of Chikovore, Lindmark, Nystrom, Mbizvo, and Ahlberg (2002) and Chikovore

(2004) which looked at gender dynamics and men's perspectives on abortion, and of Ndarukwa (2012) who studied reasons why women chose to terminate.

Chikovore et al.'s (2002) and Chikovore's (2004) studies, to my knowledge, are the only ones that have examined gender power dynamics in terms of studying abortion in Zimbabwe. The studies focused on the perceptions of men to induced abortion and contraceptive use within marriage in rural Zimbabwe. One of the main findings was that men viewed abortion not as a reproductive health issue for women but as a way for women to hide their unfaithfulness in marriage. The men in the study felt powerless in controlling the women who were said to perform these acts (abortion and contraception) in silence and secrecy. The studies also concluded that men and women in this context partake in a 'hide and seek' game with regard to abortion and contraceptive use. The silence and secrecy employed by women were seen by the researchers as a form of agency and resistance and showed that, despite women being under the control of 'patriarchal structures', women had ways to manoeuvre despite the control men tried to place on them.

What is clear from the studies cited in the first paragraph is that complications from unsafe abortions are a major public health concern in Zimbabwe. There are no reliable figures readily available on the prevalence of abortion in Zimbabwe. Despite the lack of figures, the government has expressed concern about the high level of induced abortion (Maternowska et al., 2014). According to a civil society shadow report presented at the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) in 2012, up to 20 000 Zimbabwean women are dying annually during illegal abortions (The Zimbabwe Civil Society's shadow report to the CEDAW Committee, 2012). Although this figure has been disputed by the Zimbabwean Ministry of Health, these numbers are placing a large burden on the healthcare system of the country. The World Health Organisation has estimated that over 70 000 abortions take place in Zimbabwe annually (IRIN, 2005). Records obtained from Harare Hospital show that the number of admissions for abortion complications has increased over time and has resulted in high rates of maternal mortality (Maternowska et al., 2014). The Ministry of Health and Child Welfare (MOHCW) reports that abortion complications resulted in 35 percent of maternal deaths in 2008 (MOHCW, 2009). The Ministry of Health and Child Welfare has long expressed concern about the high number of deaths, and as part of its support for reproductive healthcare, it has supported the development of post-abortion care services (MOHCW, 2009).

The lack of accurate figures has been attributed to a range of factors. Maternowska et al. (2014) found that not all women who reported having received post-abortion care directly disclosed this information. This failure to report was associated with fear of legal and social repercussions resulting from other people finding out about the abortion. Rutgers (2001) reported high morbidity and mortality as a result of abortions in rural Matabeleland North where women, fearing legal and social censure, present at the hospital either late or do not arrive at all. Fear of legal repercussions, which include imprisonment and community service, was also reported in Ndarukwa's (2012) study where women only presented to hospitals when they had to due to post-abortion complications. Fawcus et al. (1996) also showed how relatives were reluctant to give information for fear of being prosecuted as abortion is a criminal offence.

Women may also not report having an induced abortion owing to social repercussions. Meursing and Sibindi (1995) noted two decades ago that within the socio-cultural context of Zimbabwe abortion is seen as culturally wrong. Reporting an abortion hence means admitting to having done something wrong. Religion has also been implicated and Chigudu (2007) reported that many Zimbabwean Christians view abortion as an evil sin that should never be allowed. This is important to consider in light of the fact that it is estimated that about 70 to 80 percent of Zimbabweans claim to be practising Christians (International Religious Freedom Report, 2010).

Despite the threat of legal and social censure, high numbers of induced abortions continue to be reported. Research has tried to explain why there are such numbers (Matsheza, 2010; Maternowska et al., 2014). Different studies have attributed the high rates of induced abortion to the erosion of traditional cultural values in the wake of rural-urban migration, the increased need to limit family size, the delay in the age of marriage owing to increased educational opportunities for women, and the fact that contraceptives are not readily available to women under 18 years of age (Maternowska et al., 2014). In studies that looked at abortion decision-making, women reported the reasons for seeking an abortion as including restricting family size, financial reasons, age (being too young to have a baby), pursuing an education, personal reasons for not wanting a child (e.g fatherless children), physical reasons, problems with relationships, and medical reasons (Matsheza, 2010).

The Zimbabwean women who have formed part of studies mentioned above reported different ways of terminating the pregnancy including using herbs or traditional medicine, misoprostol (sourced from doctors and pharmacies illegally) and inserting objects into their womb or vagina. Maternowska et al. (2014) reported differences based on social status, with women from richer backgrounds being able to access medical doctors and drugs like misoprostol and women from poorer backgrounds using herbs and inserting objects. The researchers attributed these differences to the lack of financial means and knowledge associated with women in poorer or lower income communities. These differences might also explain why mostly poorer women report for post-abortion care at public hospitals.

The role of the medical staff has been seen to be important in post-abortion care. Maternowska et al. (2014) reported women being morally reproached by nurses. Ndarukwa (2012), who is a nurse himself, stated that abortion and post-abortion care are seen as adding a further burden onto nurses who are already overburdened with other duties and responsibilities. Thus, women who present for post-abortion care are treated badly and are usually humiliated for having harmed themselves.

Kasule, Mbizvo, and Gupta (1999) looked at the attitudes of professional health workers (doctors, nurses, matrons, social workers and hospital administrators) towards medically supervised abortion. They found that the majority of doctors were supportive of medically supervised abortion (61.2 percent) while the nurses were divided: 43.2 percent for and 42.0 percent against with 14.8 percent being undecided. This study, however, only looked at medical abortion and not unsafe abortion. There has not been a study, to my knowledge, that has focused on healthcare workers' interactions with, and attitudes towards, women who have undergone unsafe abortion.

From the above, it can be seen that the Zimbabwean context is characterised by restrictive laws and anti-abortion attitudes due to social, cultural and religious understandings, and women fearing to acknowledge that they had terminated a pregnancy. Given this context, it is surprising that very little research in Zimbabwe has looked specifically at how patriarchal power relations, social stigma, social and cultural attitudes to abortion, public discourses about abortion, and gendered issues impact on abortion decision-making.

1.6 The three data collection sites

The three data collection sites for this study, Epworth, Mufakose and Harare Central Hospital, are in the capital of Zimbabwe, Harare. Epworth is located about twelve kilometres out of the Harare city centre and is a high-density dormitory town with close to 160 000 residents (Zimstat, 2012a). It is serviced by only two clinics (Zimstat, 2012a). Msindo, Gutsa and Choguya (2013) state that Epworth was not planned as an urban residential area and that people settled in the area as informal dwellers without sanitation. Gandidzanwa (2003) noted that the suburb's residents are largely poor, informally employed people, with overcrowding being a common problem. The residents are largely engaged in menial jobs that include vending (selling fresh products from Mbare, pre-paid mobile phone airtime or dried fish). The harsh economic times in Zimbabwe has taken its toll in Epworth with crime and prostitution being on the increase (Gandidzanwa, 2003).

Mufakose is a high-density suburb approximately 14 kilometres west of the central business district of Harare. The suburb has a population of 100 292 (Parliament of Zimbabwe, 2013). The suburb is largely made up of full-generation families, most of whom are poor (Parliament of Zimbabwe, 2013). With regards to health, there is one public health centre which also offers maternity services with a bed capacity of 30 (Parliament of Zimbabwe, 2013).

Harare Central Hospital is a 1200-bed hospital that serves community clinics for the City of Harare. Harare Central Hospital is one of two referral public hospitals that provides medical care to two-thirds of the urban population in Harare. This includes patients who are referred from lower levels of healthcare services such as clinics around the country as well as district hospitals (Mudyarabikwa et al., 2005 cited in Masiiwa, 2013). Harare Central Hospital is situated in Southerton (surbuban area) and caters for people from Glen View, Glen Norah, Highfield, Budiriro, Sunningdale, Mbare, Mufakose, and Kambuzuma amongst others. The hospital typically caters for households from a poor socio-economic standing who cannot afford private health insurance (Dambaza, 2006 cited in Masiiwa, 2013). Reviews of Harare Hospital records have shown an increase in admissions for abortion complications (Maternowska et al., 2014).

1.4 Health and economic context in Zimbabwe

Abortion cannot be separated from the health and economic situation in Zimbabwe. With regard to health, the Women Action Group (2011) noted that the problem with Zimbabwe is that the right to health is not enshrined in the Constitution or the Public Health Act. This means

that the state has no obligation to ensure the realisation of access to health. Coupled with the lack of laws on guaranteeing health is the lack of money put towards healthcare. UNICEF (2011) reports that the economic deterioration witnessed between 2000 and 2009 led to diminished healthcare budgets that have affected provision of healthcare on all levels. The lack of money meant that the healthcare system faced several challenges including chronic shortages of skilled professionals, aging infrastructure, and lack of essential drugs and commodities (UNICEF, 2011). The humanitarian crises that included the cholera and measles epidemics between 2008 and 2010 have exacerbated the health crises. The introduction of service fees for healthcare also affected the system as many people could not afford to pay (UNICEF, 2011).

The problems in the Zimbabwean healthcare sector are gendered and classed. The rural areas are most affected and Kambarami (2006) already noted that the majority of Zimbabwean women who are not employed are found in rural areas. An example of the classed nature of the healthcare system is that is estimated that 95 percent of mothers with more than a secondary education have child birth delivered by health professionals in contrast to only 39 percent of uneducated mothers (UNICEF, 2012).

In addition to experiencing a weak and struggling healthcare system, women also seem to carry the burden of HIV/AIDS and poverty, and to suffer from gender discrimination and violence in Zimbabwe. A report from the Organisation of African Women's Rights in 2010 showed that the violation of women's rights in Zimbabwe is on-going and includes the persistence of discriminatory laws, discrimination within the family, violence against women, obstacles to accessing employment, and under-representation in political life coupled with inadequate access to healthcare services (African Women's Rights, 2010). All this leads to a situation where the life expectancy of Zimbabwean women was at one time 34 years (in 2008), one the shortest in the world, although it is currently estimated to be 55 years (WHO, 2013).

With regard to the economy, women in Zimbabwe have been shown to have incomes that are lower than that of their male counterparts, to have less job security, and to experience high risk of being sexually harassed at work (African Women's Rights, 2010). When women are employed it is usually in lower-paying industries like fisheries, agriculture, forestry and the domestic sector (African Women's Rights, 2010). Zimstat (2012b) reports that in 2011, about 31 percent of economically active men were in paid employment as compared to 14 percent of

females. In the same report, women constituted a greater proportion (14.5 percent) of the unemployed population as compared to men (6.6 percent). Due to the economic decline of the past two decades, families were choosing to pay school fees for male children instead of for girls and this added to the levels of poverty among women due a lack of skills and opportunities (UK Foreign & Commonwealth Office Report, 2011).

1.5 Rationale for research

Given the situation of abortion in Zimbabwe, this research is important in order to understand how women construct their abortion decisions and also how health service providers construct and position women who terminate their pregnancies. As indicated, not much research is available on this matter in Zimbabwe and of the research that does exist none has taken a reproductive justice approach (although Chikovore's research attends to gender power relations). The majority of studies have framed abortion from a public health perspective. This is not unique to Zimbabwe. In a literature review of African abortion studies for the period 2007 to 2014 Macleod, Chiweshe, and Mavuso (in press) found that only one study (of the 39 studies reviewed) took a reproductive justice or rights approach. The effects of unsafe abortion are well documented and African research, in particular Zimbabwean research, needs to focus on studies that not only consider the public health implications of unsafe abortion but also the contextual social, cultural, and gendered understandings of abortion and their implications for reproductive justice. This study looks at the narratives of women who terminate pregnancies and the way these women are positioned by health service providers, linking these narratives to social discourses and power relations that work to enable or constrain reproductive justice. As such, it will be the first study that has taken such an approach in Zimbabwe.

Since I am interested in 'narratives', 'discourses', 'reproductive justice', 'power relations', and 'positioning', adopting a Foucauldian postcolonial feminist approach is appropriate. Foucault's analyses of power, discourses, governmentality and bio-power can help illuminate the way women narrate their decision to terminate a pregnancy and also how health service providers construct and position these women. Postcolonial feminist understandings can illuminate exploitative and discriminative discourses and also highlight and foreground (neo-)colonialist power relations that might exist in postcolonial Zimbabwe. Taylor and Littleton's (2006) narrative-discursive analysis is used as the analytical method as it speaks to the construction of narratives within a social and discursive environment.

Within the over-arching research aim stated above, the following main research question was formulated: How do women and service providers construct the process by which women come to decide on and proceed with a termination of pregnancy?
The following sub-research questions were also formulated:

- How do women who have elected to have an abortion narrate the process by which they came to the decision to terminate the pregnancy?
- How do service providers construct and position women who have elected to have an abortion?
- What social/cultural discourses/practices are deployed in these narratives?
- What power relations underpin a pregnancy becoming unsupportable?

1.7 The concept of decision-making

Having contextualised my study, I now move on to speaking to the concept of decision-making which is central to this thesis. In the following, I place abortion decision-making within a particular framework. I start by focusing briefly on how decision-making in general has been conceptualised. I move on to focusing on how abortion decision-making has been characterised in studies on abortion, with a particular focus on the debates around abortion decision-making which, especially in America, tend to centre on informed consent for minors. I finish by outlining how I conceptualise abortion decision-making.

In a general sense, decision-making has been defined as the process of making choices among possible alternatives on the basis of given criteria or strategies (Schacter, Gilbert, & Wegner, 2011). The "study on decision-making is interested in multiple disciplines such as cognitive informatics, cognitive science, computer science, psychology, management science, decision science, economics, sociology, political science, and statistics" (Wang & Ruhe, 2007, p.73). As such, many theories exist on what decision-making entails, ranging from mathematical models to psychological theories (see Kenji & Shadlen, 2012; Schacter et al., 2011; Wang & Rue, 2007 for further discussion). Theories of decision-making can be classified broadly into descriptive and normative theories where "the former is based on empirical observation and on experimental studies of choice behaviours; and the latter assumes a rational decision-maker who follows well-defined preferences that obey certain axioms of rational behaviours" (Wang & Ruhe, 2007, p.74). The two classifications both focus on choice. Normative theories look at how people *should* make decisions and descriptive theories at how people *do* make decisions.

Although decision-making theories have been broadly characterized into two categories, psychological theories fall somewhere in between the two and have been classed broadly as falling within a category of prescriptive theory (Schacter et al., 2011). This means that psychological theories try to predict people's choices. Psychological theories have largely seen the process of decision-making in the context of a set of needs, preferences and values that an individual has which influences their choices. The focus in psychology has been on the choice that an individual makes given their circumstances and the steps they took in making that decision. Psychological theories have, therefore, been interested in the various factors that influence decision-making. The factors include past experience (Juliusson, Karlsson & Gärling, 2005), cognitive biases (Stanovich & West, 2008), age and individual differences (De Bruin, Parker, & Fischoff, 2007), and belief in personal relevance (Acevedo & Krueger, 2004). The factors/influences framework is taken up in abortion decision-making studies, as shown below.

The literature on abortion decision-making has not clearly defined decision-making but it has been associated with internal cognitive processes where a woman uses her thought processes in selecting a logical choice from the available options (Harvey-Knowles, 2012; Khan & D'Costa, 2002; London, Orner, & Myer, 2007). This thought process is seen as happening in light of the factors/influences, (using a health determinants framework discussed in the review of literature chapter) which are believed to aid choosing the best option. Within this understanding in the literature, abortion decision-making is a process whereby a woman considers the pros and cons of terminating a pregnancy or taking it to full term based on various factors/influences. During this process, terminating the pregnancy or taking it to full term are the choices or alternatives available.

The different underlying factors/influences in abortion decision-making are closely linked to one's life circumstances. Sereno, Leal, and Maroco (2013, (p. 143) argue that "the decision is a meaningful experience that reflects personal characteristics, and is associated with relationships and social support, economic and educational circumstances, life contingencies and the social, cultural, and legal environment." Coast, Norris, Moore, and Freeman (2014) have tried to document the abortion decision-making process by using data from different countries and coming up with a framework that tries to cover the different aspects of abortion decision-making. The process they have started will help in better understanding what decision-making entails.

Within Coast et al.'s (2014) framework, abortion decision-making is influenced by the perceived and actual costs of the different options available. These costs are framed within the macro-environmental and micro-level contexts not only for abortion but also for post-abortion care. Abortion decision-making processes occur within "international, national and sub-national contexts; individual contexts and an individuals' pregnancy termination related experiences, ordered as a time-sequence from sex to abortion sequelae" (Coast et al., 2014, p. 4).

The international, national and sub-national context is concerned with the legality of abortion, socio-cultural structure, provision and availability of safe abortion and the flow of information with regard to abortion. The individual context focuses on the woman's socio-demographic characteristics, knowledge and beliefs, relationships and resources which interact with each other and with the international, national and sub-national context. The individual's pregnancy termination related experiences focus on an individual womens' "sexual behaviour, contraception (non-)use/failure, becoming aware of a pregnancy, (non-)disclosure and negotiation, emotions about pregnancy, having a child and TOP, attempts to terminate the pregnancy, and the sequelae of those attempts" (Coast et al., 2014, p. 12). These (TOP experiences) are seen as being embedded in the international, national and sub-national context and individual context. The individual's pregnancy termination related experiences focuses on the "personal decision steps and choices than any individual woman makes on the trajectory to terminate a pregnancy or to attempt to terminate a pregnancy" (Coast et al., 2014, p. 12).

In line with Coast et al.'s (2014, p. 12) "individual pregnancy termination related experiences" level which is discussed above, some literature has seen the abortion decision-making process as stages that a woman goes through. These are known as 'stage theories'. Stage theories try to understand a sequence of events that includes finding out about the pregnancy, asking for ideas, deciding to terminate, looking for methods and dealing with the consequences of an abortion. Bracken and Kasl (1975, cited in Rowlands, 2008) presented a model on decision-making processes. The stages are: i) acknowledgement of the pregnancy; ii) formulation of options to continue the pregnancy and keep the baby, to continue the pregnancy and offer the baby for adoption or to undergo abortion; iii) selection of abortion or continuation of the pregnancy by a balancing exercise; iv) commitment to the chosen outcome; v) adherence to the decision (Rowlands, 2008). The selection of abortion or continuation of the pregnancy is done

through a balancing exercise. In this framework, thus, various factors/influences are seen as being integral in the decision-making process.

Other researchers have put a timeline on what they consider to be the decision-making process. Kjelsvik and Gjengedal (2010) have stated that the time from when the woman realises she is pregnant until she has made the final decision to abort or to carry to term is termed the decision-making process. It is during this time that the various factors are considered. Research has looked at how this process is an active one, where the pregnant woman consciously makes decisions in light of the factors and influences mentioned earlier (Lie, Robson, & May, 2008).

Abortion decision-making, although borrowing concepts from some of the major theories on decision-making, has been largely seen as different to decision-making in other contexts. Manian (2009) has shown how American law sees abortion decision-making as different to decision-making in other areas of health. The argument here is that the pregnant woman in some American states is seen as being irrational and should therefore be helped in making the decision. Siegel (2007) spoke of what is known as the woman-protective rationale which states that for the sake of protecting women's mental health, abortion should be banned. The introduction of law on informed consent[1] in America with regards to abortion can be seen as reinforcing the idea that "competent adult women lack the capacity to determine for themselves what is best for their own health" (Manian, 2009, p. 225). In these cases, pregnant women are seen as being incompetent in making a decision and pregnancy is characterised as some sort of disability that affects their mental reasoning.

The issue of competence has also been taken up in the United States and South Africa around debates that have focused on the ability of minors to make the abortion decision alone without parental involvement. Those who call for parental involvement argue that teenagers are too young or immature and incapable of making such an important decision which leads to often serious and lasting medical, emotional, and psychological consequences of abortion (Joyce, 2010). Seen in this light, decision-making is not straightforward when it comes to minors as they need protection. The same arguments were brought forward by the Christian Lawyers Association in South Africa who argued that allowing minors to have abortions on their own

[1] The informed consent law requires that before an abortion, a woman seeking the abortion receives factual information from the abortion provider about her legal rights, alternatives to abortion, available public and private assistance, and "medical facts" which include disputed medical findings around foetal pain. In some states women have to view ultrasound images.

was reckless and wrong (Macleod, 2008). The Christian Lawyers Association argument is premised on how 'adolescence' is conceptualised as a transition period where a person has not fully developed into an adult and thus requires 'proper adults' to make the decision for them (Macleod, 2008). On the other hand, those who oppose parental laws have argued that abortion decision-making for minors is not different to that of adults and adolescents need to be given the right to choose so as to protect them from harm arising from medical issues and sometimes parental refusal to approve the abortion (Gold & Nash, 2007).

Understanding the abortion decision-making process simply as a woman considering two alternatives – termination or keeping the pregnancy to full-term – in light of certain factors, as is suggested in much of the literature, does not fit with this research. This research sees abortion decision-making as a process involving a series of negotiations back and forth between beliefs, social reality and desire (Petchesky, 1990). Just as was shown by Coast et al.'s (2014) framework, abortion decision-making is seen as happening across different levels that interact with each other. The abortion decision-making process involves a construction of narratives and the deployment of various discourses by the woman who has a pregnancy who also positions herself in these narratives and discourses. My use of the concept of abortion decision-making process here follows the work of Puri, Ingham, and Matthews (2007) who have argued that abortion decision-making is dynamic and situation-specific. This means that two women in the same circumstances (socio-economic, religious or age) will not necessarily go through the same process, and that abortion decision-making is intricately intertwined with social and cultural contexts.

Viewing the abortion decision-making process as dynamic and situation-specific allows one to listen to the narratives of individual women without putting them into clusters around the factors that influence their decision-making. Using this understanding, it is then redundant to try and impose a common abortion decision-making process across the board. A common framework, although seen as important in public health where predictions and estimations are important, is eschewed in a narrative/discursive understanding. Within common discursive resources and common narratives that women have, it is important to look at how individual women construct their own process without being lost in the group comparisons. This then allows for a move from looking for factors that influence women to have a TOP to an understanding of individual narratives and how they are constructed using particular discursive resources.

1.8 Fusing Foucault and postcolonial feminism

This study uses a Foucauldian and postcolonial feminism as the theoretical lenses to illuminate abortion decision-making. A Foucauldian feminist approach has been put to work in illuminating gendered conditions before. For example, Macleod (1999) adopted a Foucauldian feminist approach to show the constructions of teenage pregnancy in South Africa. McNay (1991) also incorporated Foucault's anti-essentialist theory of the body into feminist explanations of women's oppression. In understanding abortion decision-making in South Africa, Mavuso (2014) adopted a Foucauldian post-structural feminist lens. Inspired by these studies, I provide my own understanding of a postcolonial Foucauldian feminist framework using areas within abortion decision-making as a reference point concerning where the two theories intersect.

Foucault's rejection of metanarratives and universal norms and his anti-humanism which challenges to the notion of a unified subject paves the way for a politics of diversity and inclusion. Tamale (2011) has shown how Foucault's conceptualisations about the body, power and subjectivity provide insights for postcolonial feminism. She points to four convergences between Foucault and postcolonial feminisms which are: the body as the site of power, power as local, emphasis of discourse, and critiques western humanisms for the privileging of the masculine and universal proclamations. Using Foucault's conceptualisations of power, therefore, has great significance for postcolonial feminism.

The role of patriarchal power relations in Zimbabwe is still apparent (Kambarami, 2006) and since patriarchy is an important concept in postcolonial feminism (Bakare-Yusuf, 2003), a Foucauldian analysis of these power relations helps to illuminate these patriarchal relations. Patriarchy is no longer seen as a single overpowering force that controls women (the masculine is no longer privileged and universal), but rather as power relations that are constantly contested and reconstituted (see Chapter 3 for more discussion). Using a Foucauldian postcolonial feminist theoretical framework allows one to see how abortion decision-making revolves around the female body which is the site of power where individual needs (wanting to terminate an unsupportable pregnancy) are in contestation with the state (abortion being illegal due to moral and societal obligations).

Foucault's genealogical analysis of subjection carries significance for postcolonial feminism in that it shows how various forms of knowledge, as well as the truths within which we operate,

serve the need to control and normalise, because knowledge can be used as a means to measure, classify, examine and categorise people and their personal choices and lifestyles (Foucault, 1980). In Foucault's view, this is specifically true in the domain of sexuality (see further discussion in section 3.2.6 on power and sexuality).

The use of a Foucauldian postcolonial feminist approach here provides great insights in understanding abortion decision-making processes in a Zimbabwean context. Foucault's conceptualisations of power, bio-power, discourses and governance used together with postcolonial constructions of the African women, domesticity, sexual politics and patriarchal power relations can illuminate how an abortion decision is made in an Africa postcolonial context. My theoretical chapter will show how Foucault, as the overarching theorist, can enrich postcolonial feminist insights in understanding abortion decision-making.

1.9 Adopting a reproductive justice framework

Reproductive justice has been defined as:

> The complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives (Asian Communities for Reproductive Justice, 2005).

Macleod (2011) has argued that health psychology and abortion advocacy need to move away from the 'choice' rhetoric and rights framework which have arisen within mainstream Western feminist advocacy, and need to focus rather on reproductive justice. The reasoning behind the argument (which can be seen in the calling for reproductive justice among Black American women) is that abortion is not just about legal access but happens within a context of social, economic, gender, and colonial inequalities (Ross, 2006; Roth, 2012).

Macleod (2011) proposes a reproductive justice approach which means that the focus is not on the abortion itself but on the broader social and environmental circumstances that make a pregnancy 'unwanted'. Mavuso (2014) has shown how, in a South African context, gendered and generational power relations contribute to a denial of reproductive justice. By adopting a reproductive justice framework, Mavuso (2014) was able to locate the abortion decision within the economic, religious, social, political, and cultural aspects of women's lives. Adopting a

reproductive justice approach in Zimbabwe will allow for an appreciation of how women's low socio-economic status, inadequate reproductive health services and vulnerability to sexual exploitation and rape play a part in abortion decision-making. The adoption of a Foucauldian postcolonial feminist framework fits in well with illuminating the broader social and environmental circumstances that make a pregnancy unwanted/unsupportable.

1.10 Moving from unwanted to unsupportable/unsupported pregnancies

The adoption of a Foucauldian postcolonial feminism allows for an interrogation of the language used in abortion research. The research around abortion decision-making has focused on conditions that render a pregnancy 'unwanted' (Besculides & Laraque, 2004; Kjelsvik & Gjengedal, 2010; Tsui et al., 2011). The use of the term unwanted has been contested by Macleod (2015). She has proposed the use of the signifier 'unsupportable/unsupported' in preference to unwanted, as the former denotes a pregnancy that is difficult for a variety of reasons while the latter suggests a liberal subjectivity in which a range of desires and choices are possible. Macleod (2015) argues that the signifier 'unwanted pregnancy' (by focusing on the individual woman and her desires for or against pregnancy) does not take into account the interaction of micro- and macro-level power relations in which pregnancies occur. This is in line with Macleod's (2015) assertion that the signifier 'unwanted' just as other common signifiers 'unintended', 'mistimed', 'unplanned' are constrained discursively and do not take into account the inevitable complexities that make a pregnancy problematic. This critique gives room for a narrative that focuses on the conditions that make the pregnancy unsupportable/unsupported. This study takes into account the power relations that exist during women's abortion decision-making process and this is shown in one of the research questions noted earlier.

Studies in some African countries (Chikovore, et al., 2002; Schwandt et al., 2011) that used the term 'unwanted' would have been enhanced by using the term 'unsupportable' as a more appropriate term. These studies, by using the term 'unwanted', focused only on the individual women's desires and thus ignored the micro- and macro-level power relations that can make a pregnancy unsupportable. Macleod (2015) has stated that a pregnancy can become unsupportable due to a number of issues that include religious, biological, legal, and medical reasons. It is some of these conditions that are imbricated in abortion decision-making. This study will focus on why pregnancies become unsupportable/unsupported. The uses of the signifier 'unsupportable/unsupported' in this study allows the research to move from the view

of a woman having alternatives that she chooses from freely and to viewing a woman's pregnancy as being difficult due to any number of complications as argued by Macleod (2015). The signifier 'unsupportable/unsupported' fits well within a reproductive justice framework as it focuses on all the conditions of a women's life that makes a pregnancy problematic.

1.11 Thesis overview

The next chapter (**Chapter 2**) reviews the literature on abortion decision-making. Firstly, I discuss the role of the law in influencing abortion decision-making especially in settings where abortion laws are restrictive. I then move to pregnancy intent, where issues around the 'wantedness' of pregnancy are discussed. Following this, I examine what has been found with regards to the role of interpersonal relationships, especially the role of friends, family and partners in abortion decision-making. In this chapter, I also touch on how socio-economic factors and health considerations (abortion to save a woman's life, mental ill health and abortion, pre-natal screening and diagnosis, role of HIV/AIDS and the role of healthcare workers) have been shown to influence abortion decision-making. Next, I explore the literature on the influence of culture and religion, stigma and age. My attention then shifts to the role the media plays in influencing abortion decision-making and debates around competence in making decisions about abortion. I review some narrative/discursive studies that have been conducted as way of locating this study within a particular framework. There are not many narrative/discursive studies on abortion decision-making, and because of this the chapter looks at the so-called factors that have been found to influence abortion decision-making. Chapter 2 then concludes by looking at literature that speaks to healthcare service providers' views on abortion.

Chapter 3 forms the theoretical basis of the study. I begin by providing some background on Foucault and then move on to introduce some of his theoretical concepts (discourse, power, bio-power and governance). I link these to abortion decision-making by explicating how power has been used in understanding sexualities. Feminism is then discussed in a way that outlines how feminism has been taken up on the continent. I move on to examining the beginnings of postcolonial feminisms. I do this by providing an explanation of postcolonial feminist concepts that include domesticity, sexual politics and patriarchal power relations. I close off the chapter by discussing bio-power and resistance in African contexts.

Chapter 4 outlines the data collection and analysis procedures I used in the study. I begin the chapter by stating the aim of the study and the research questions. My focus then switches to

aspects of the overall qualitative narrative-discursive design, which includes the recruitment and inclusion criteria, interview procedure and the participants. I then describe the ethical considerations, potential consequences of the research and critical reflexivity which are important in this type of research where the subject matter is illegal and awakens a lot of emotions in people. I go on to introduce the analysis procedure for the women's narratives which is narrative-discursive analysis. Firstly, the term narrative is defined and then Taylor and Littleton's (2006) narrative-discursive method is expounded. The detailed analysis procedure is then discussed. I end the chapter by outlining the data analysis of the health service providers' interviews.

Chapter 5 is my first analytical chapter and focuses on the discursive resources that the women used in their narratives. It was interesting that a discourse of reproductive rights was missing from the women's talk. I start by exploring the discourse of shame and stigma which was seen as permeating other discourses as well. I turn my attention to the moralistic religious discourse which includes religiously-complicated pregnancies and how abortion is seen as 'bad' and 'evil'. I then discuss the cultural discourse which includes culturally-complicated pregnancies and abortion being culturally shameful. My focus then turns to the conjugalised fatherhood discourse, masculine provider discourse and the faithful female partner discourse which are discussed in that order. Finally, I discuss the health discourse.

In **Chapter 6**, the focus turns to the women's stories of their abortion experiences. I structured the chapter around three themes which include narratives of abortion being shameful, narratives that cohere around justifying the abortion and narratives that speak to the act of abortion. Under the 'abortion is shameful' narrative I discuss how women felt ashamed at having an abortion. The narratives that cohere around justifying the abortion include: abortion assisting in preventing shame and stigma, abortion assisting to protect children already born, continued pregnancy resulting in lost opportunities, having no choice because of poverty, having no choice because of the unreliability of the partner and partner's family, and abortion being justified under the circumstances in which the women found themselves. I end by exploring narratives that speak to the act of abortion which include: abortion invoking fear, abortion invoking regret, conflict and guilt, the importance of secrecy in carrying out an abortion, and how support to terminate a pregnancy can be found.

I then focus my lens in **Chapter 7** on comparing the positions enabled in the women's narratives with the way they were positioned by the health service providers. The health service providers' positioning includes viewing women who terminate their pregnancies as: immoral and going against cultural norms; irresponsible and reckless; killers and sinning against God; prostitutes who are protecting their jobs; manipulators of a lax legal system; having selfish reasons for deciding to do the abortion and thereby seeing no other options; oblivious to the harm and pain they will cause themselves; and foolish in wanting money from older men. I also examine the way the health service providers position themselves which includes being against abortion, protectors of cultural/religious norms and the law and also as helpers and advisors.

Chapter 8 provides a concluding discussion for the study. I begin the chapter by providing a summary of the findings and then pick up on certain aspects of these findings. These include how the women challenged the norms by speaking about their experiences, the missing reproductive rights discourse, and how a move to a reproductive justice framework could be beneficial. I problematize the reproductive rights framework and advocate for a move to the reproductive justice framework. In so doing, I ground the reproductive justice framework within the concept of *ubuntu/hunhu*. This follows my main thesis argument which is that abortion decision-making should be understood within the broader social and environmental circumstances that make a pregnancy unsupportable. I end the chapter by reflecting on the research and discussing the limitations of the study and possibilities for future research.

Chapter 2: Contextual backdrop: Understanding abortion decision-making

2.1 Introduction

As already mentioned in the introductory chapter, there is a dearth of literature that focuses on the complexity and multi-faceted nature of the abortion decision-making process. Most of the available research has used a health determinants approach which examines the factors or influences that are seen to affect abortion decision-making. However, this approach is often not located within a framework that can unpick the complex array of power relations that underpins the *process* of abortion decision-making. Since this comprises the majority of the literature, I thus turn my focus to discussing the various influences and factors that have been shown to play a part in abortion decision-making. These include pregnancy intent, interpersonal relationships, socio-economic factors, health considerations, culture, religion, stigma, age of the woman and the role of the media. Literature from Zimbabwe and other African and 'global south'[2] countries is given priority so as to contextualise the factors that have been shown to impact upon women in these contexts during abortion decision-making processes. The issue of context is particularly important in decision-making as different factors have been shown to be pertinent in different contexts.

Research (Harvey-Knowles, 2012; Hess, 2007; Rausch & Lyaruu, 2005) has tended to show that the decision to terminate a pregnancy is done in light of the factors mentioned above and that abortion decision-making processes are not the same for every woman. However, despite the uniqueness of each woman's circumstances, findings have generally shown that differences exist between women in developed and developing countries, women in countries where abortion is legal or illegal, women in countries where levels of social stigma are high or low, married or unmarried women, and women with supportive or unsupportive partners. Kumar, Hessini and Mitchell (2009) argue that, despite abortion existing across time and geographic location, the experience of abortion for women, families, communities and societies differs drastically across the world. For the purposes of this chapter, the factors that have been shown to influence abortion decision-making are discussed in turn. This does not mean that a woman going through the abortion decision-making process is influenced by these 'so-called' factors the same way as other women or that women will be influenced by one particular factor. It is important to remember that my research is about the *process* of abortion decision-making and

[2] The term global south refers to countries from Africa, Latin America, and developing Asia including the Middle East which face serious problems and challenges. The term is however, problematic as it homogenises various countries.

how this is underpinned by certain social narratives/discourses/practices and power relations. Thus, to speak of factors influencing abortion decision-making is anathema in terms of the theoretical framework used in this research as this suggest direct causation (see Chapter 3 for further discussion).

I begin this chapter by looking at the role of the law in abortion decision-making. I then look at the different 'factors' that have been found to influence abortion decision-making. As a way of situating my study within a particular framework, I review some of the studies that have used a narrative and discursive framework when researching abortion. I end the chapter by reviewing research on the attitudes of healthcare providers who work with women who have terminated pregnancies.

2.2 The role of the law in abortion decision-making

Abortion decision-making has been shown to be difficult in situations where it is illegal and high levels of social stigma exist (Kambarami, 2006). MacCarthy, Rasanathan, Ferguson, and Gruskin (2012) have noted that for all women, the ability to safely terminate a pregnancy depends in part on the legal status of abortion where they live, as this influences whether services are clandestine and/or potentially unsafe. Furthermore, while post-abortion care can be life-saving for women who experience spontaneous abortion or for those whose only option is unsafe abortion, accessing post-abortion care, too, can pose significant problems in countries where abortion is restricted, banned or criminalised.

A look at the legality of abortion in Africa shows how it can be divided into six different categories. The categories include where abortion is severely prohibited to "partial permission based on reasons such as to save a woman's life, preserve her physical and mental health, and on abortion permitted on socioeconomic grounds, to abortion without any restrictions as pertains in South Africa" (Guttmacher Institute, 2012 cited in Oduro & Otsin, 2014, p. 920). Unsafe abortion is high in Africa due to "the lack of clarity and knowledge about the abortion laws in many African countries, coupled with poor access to health services, however, often result[ing] in many women using clandestine, risky, unorthodox, and unsafe means to induce abortion, thereby significantly increasing their risk of dying through complications" (Svanemyr & Sundby, 2007 cited in Oduro & Otsin, 2014, p. 920). Zimbabwe is an example of a country where all of the above are pertinent.

Abortion decision-making is also complicated in the context of sexual violence (rape/incest). In most countries where abortion is illegal, the constitution has provisions for abortion in cases of rape or incest (Rossier, 2007). However, in some cases access is denied due to structural failures (Chigudu, 2007). Some of these structural failures include the police and doctors not being available to assist the woman who has been raped accessing TOP services (the law in Zimbabwe used to require a police report of the rape and two doctors to confirm before a judge decides whether to grant the TOP). A recent example of the delays was noted in the previous chapter in Zimbabwe where a woman sued the state for failure through delays by the police and courts to grant her a legal abortion after she was gang-raped (Zimbabwean Women Lawyers Association, 2013). In the following sections, I review literature on the 'factors' that have been found to influence abortion decision-making. These are pregnancy intent, interpersonal relationships, socio-economic factors, health considerations, culture, religion, stigma, age of the woman and the role of the media.

2.3 Pregnancy intent

The decision whether to bring a pregnancy to full term or to terminate a pregnancy has been shown to be influenced pregnancy intent (Harvey-Knowles, 2012; Hess, 2007). Pregnancies have been differentiated on a number of levels as follows: i) intended pregnancy is when the pregnancy has been planned and is wanted; ii) unintended/unplanned pregnancy is a pregnancy that was either mistimed or unwanted; iii) mistimed pregnancy is when a woman did not want to become pregnant at the time of conception, but did want to become pregnant in the future; iv) unwanted pregnancy is when a woman did not want to become pregnant at conception or at any time in the future (Hess, 2007; Rausch & Lyaruu, 2005; Tsui et al., 2011). Tsui et al. (2011) note that most intended pregnancies (in this case desired) are carried to full term and that unintended, mistimed and unwanted pregnancies (undesired) often lead to termination of pregnancy. Finer and Zolna (2011) concluded, after reviewing literature on pregnancy in the United States of America, that 40 percent of women in all reproductive ages resort to abortion when faced with an unintended pregnancy. Despite this, it is important to remember that not all women with unintended pregnancy elect to terminate their pregnancies and not all women with wanted pregnancies elect to keep it to full term (Harvey-Knowles, 2012; Schuster, 2005).

Other research on types of pregnancies has looked at the desire of a woman to be pregnant (Rossi, Makuch, & Burgos, 2010). Research on desire has largely focused on the desires of HIV-positive women and this is covered under the health section (section 2.6) of this chapter.

Desire has been shown to be largely influenced by socio-economic, socio-cultural and religious contexts. Mavuso's (2014) work on examining micro-narratives of women's abortion decision-making processes in South Africa revealed that participants spoke of a desire not to have children or be pregnant because of their socio-economic conditions as playing a role in their decision to terminate the pregnancy. Some research has noted that the desire to not have children is linked to the conditions of the pregnancy that were viewed as shameful like being unmarried (Schuster, 2005).

The research on pregnancy intent tends to focus on the individual – her intentions, her wants, her plans and her desires (or at best her and her partner's). While the research is useful to some extent, and does show how women feel about their pregnancies, it is important to understand that the decision-making processes linked to these feelings/plans are located within the interpersonal and social/cultural power relations within which they are formed. These are discussed below.

2.4 Interpersonal relationships

One of the common factors that has been found to play a part in abortion decision-making processes is interpersonal relationships. Interpersonal relationships include the role of husbands, partners of women, boyfriends, family, friends and other relatives. Research has shown that in some cases more than one relationship has an influence on the process whilst in other cases there might not be a relationship that plays any part (Khan & D'Costa, 2002; Puri et al., 2007). The research on interpersonal relationships is useful in terms of understanding the micro-level power relations within which the decision to terminate a pregnancy is made. Research on the influence of the different relationships is discussed in the following sections.

2.4.1 The role of husbands/partners

Research on the role of husbands/partners has focused on male claims around being household heads and key decision-makers. Studies in India, Bangladesh and Nepal on abortion decision-making found that husbands played a significant and dominant role in making the final decision as to the outcome of the pregnancy (Khan & D'Costa, 2002; Puri et al., 2007; Sinha, Khan & Patel, 1998). In Chiredzi district, Zimbabwe, men were found to have the final say in matters of reproductive decision-making with regards to abortion (Chikovore et al., 2002). Tsui et al. (2011) similarly found that men in Peru and Nigeria drew on their position as household heads to make the decisions regarding reproductive health and abortion. Schwandt et al. (2011)

attributes the position of men in sub-Saharan African to their recognition by other family members as heads of households and principal decision-makers not only in relation to economic matters but also with regard to fertility including abortion decision-making.

In Southern Africa, Wojcicki, van der Straten, and Padian (2010) established that since men pay bride wealth which is also known as *lobola* or *roora*, they tend to have the final say in reproductive and sexual decisions including abortion. Drawing on the aforementioned research, it can be said that *lobola* or *roora* as a social practice influences the role that a man might play during abortion decision-making. African patriarchal systems, of which *lobola* or *roora* are a part, have been shown to create reproductive social systems in which men are dominant (Tamale, 2003). In such systems, men dictate the sexual and reproductive health matters of their families.

Despite these systems, women also have space to manoeuver and they can sometimes use other means to influence reproductive decisions, for example by not involving men when making these decisions (Chikovore, 2004). In Cameroon, Schuster (2005) found that women would avoid sharing their plans with their partners and only told other women they trusted as a way of avoiding pressure not to terminate a pregnancy. It is through some of these processes that women can make the decision whether terminate or bring a pregnancy to full term.

The way men partake in abortion decision-making is dependent on the type of relationship that the man has with the woman, for example whether the woman is his wife, mistress or girlfriend (Rausch & Lyaruu, 2005). The type of relationship most likely influences his involvement as well as his desires regarding how to manage the women's reproductive health. Rausch and Lyaruu (2005) concluded that a man might support his wife to carry a pregnancy to full term but encourage a girlfriend to abort since social sanctions might be brought to bear on them for having a child out of wedlock. Marital status was also implicated in how partners encourage the women in the decision-making process in a study in Sweden (Kero, Lalos, Hogberg, & Jacobsson, 1999). The men in this study felt that they would encourage women to have abortions if they were not married to them so as not to have children in dysfunctional family units.

Chingandu (2007, p. 3) has linked a practice in Zimbabwe known as 'small house' to unsafe abortions. 'Small house' is defined as, "...an informal, long term, secret sexual relationship

with another woman who is not a man's legal wife, carried on in a house that is a smaller version of the man's own home in another residential suburb." She argued that most of these girlfriends or 'small houses' are given money by the married men to have unsafe abortions as a way of them not bearing the man's offspring. Chingandu's (2007) research remains the only Zimbabwean study that has looked at the impact of 'small houses' and multiple relationships on abortion.

The nature of the relationship – that is, being a husband, partner or boyfriend – is supplemented by the current status of the relationship: whether the relationship is viewed as good or bad. In line with this, Zabin, Huggins, Emerson, and Cullins (2000), in a study involving 250 low-income women in America, found that pregnancies that are not wanted with a particular partner due to problems in the relationship were more than twice as likely to end in abortion as those that were wanted. Poor relationships between women and their partners was the most often mentioned factor in women terminating a pregnancy in a Swedish study (Sihvo, Bajos, Ducot, & Kaminski, 2003). Research in Cameroon and Ghana has found similar trends (Schuster, 2005; Schwandt et al., 2013).

Other research has shown that men's role in abortion decision-making is largely influenced by their attitude towards abortion. Moore, Jagwe-Wadda, and Bankole (2011) found that in Uganda, men's stated attitudes about abortion often prevented women from involving them in either the abortion or post-abortion care. Chikovore (2004) similarly found that men in Zimbabwe held negative attitudes to abortion. They believed that if a woman is having an abortion, it must be because she is pregnant with another man's child. These negative views meant that the men in Chikovore's (2004) study would not support their partners to have an abortion in any circumstances.

The role of men in abortion decision-making has also been inherently linked to the partner's ability to provide emotional and financial support. In Gabon, Hess (2007) found that the women in her study had requested their boyfriends' opinions when considering undergoing an abortion because the boyfriends were responsible for the financial upkeep of the pregnancy. Amongst married couples in Nepal, husbands noted financial considerations as their most important consideration in deciding whether to terminate a pregnancy (Puri et al., 2007). Final considerations were also influenced by the male partner in Uganda where men control most of the financial resources (Moore et al., 2011). In this setting men were also found to play a

critical part in determining whether women receive a safe abortion or appropriate treatment if they experience abortion complications (Moore et al., 2011).

The roles that men can play in abortion decision-making is different. In a study in Zambia, Dahlback et al. (2010, p. 256) found that some of the partners who were involved in the decision-making process "made the decisions, made the arrangements, accompanied their girlfriends and paid to have the unsafe abortion procedure done." In the same study Dahlback et al. (2010) found that other men's roles in the abortion decision-making process can also be indirect; that is, women terminate their pregnancy because of a lack of general support from their male partners.

Dahlback et al. (2010) found that other partner-related factors that played a decisive role in the final decision-making process included issues surrounding men denying paternity, refusing to provide financially, a lack of emotional responsibility and support for the mother and child. Whether or not a male partner decided to accept responsibility for a pregnancy was also seen to have a significant influence on a woman's subsequent decision to keep or terminate a pregnancy. This was noted in a study in Ghana (Schwandt et al., 2013), in which women indicated that by denying responsibility, male partners were not acknowledging paternity. This meant that they were not prepared to financially support the woman and the child once it was born. By the male partner not acknowledging paternity, the women then would have children outside of marriage which is against social norms (see section 2.7 on the influence of culture and religion on having children outside marriage).

Studies have also shown a link between the male partners' level of education and abortion decision-making. Hess (2007) found that among younger women in Gabon, high education levels of their partners were strongly associated with abortion. This was also true in a study among women in France which showed a positive association between the partner's level of education and the likelihood of abortion (Sihvo et al., 2003). It may be that higher education levels of the woman and her partner are markers of social class, and that it is more acceptable for them to plan their family and terminate a pregnancy when the time is not right to have children and the priority is to establish their careers (Sihvo et al., 2003). Another reason might also be that women with well-educated partners have better access to abortion facilities (Hess, 2007). It is not only access to facilities but also to information that influences abortion decision-making as Agrawal and Agrawal (2013) found in India where educated women were

more likely than uneducated women to have information about, and access to, abortion services.

The implications of the studies mentioned above are that men do inherently play a part in abortion decision-making whether actively or inactively. The type of relationship, attitudes, men's education level and payment of *lobola* or *roora* have been found to have an influence on the role men play in abortion decision-making. The literature has shown that in African countries the role of men as household heads allows them to have a say in abortion decision-making. Despite this, African women also resist this by excluding men from abortion decision-making. This study, in particular, will analyse how Zimbabwean women reconcile an unsupportable pregnancy, reveal their abortion decision-making and explain the role of the men responsible for the pregnancy.

2.4.2 Family and friends

The role family and friends play in women's decisions around either continuing or terminating a pregnancy has also been found to be important (Harries, Orner, Gabriel, & Mitchell, 2007; Schuster, 2005), although this varies from context to context. For example, research in India showed that amongst married couples who live with the husband's parents, the mothers-in-law participate in abortion decision-making by suggesting family planning and abortion decisions (Ganatra & Hirve, 2002). Conversely, in American settings where the culture is largely 'individualistic', family members' involvement in abortion decision-making was found to be minimal (Finer & Henshaw, 2006; Major et al., 2000). These two studies point to the differences in context.

In a Zimbabwean context, Fawcus et al. (1996) showed that, even though the country is traditionally 'collective', there was little or no input from family members during abortion decision-making. Thus women acted in isolation. Acting in isolation was also noted by Chikovore et al. (2002) who established that, although men tried to assert their control in Zimbabwe, women usually hid their pregnancies and terminated the pregnancy without the man's or their family's or friend's knowledge. The reasons for the women in the two studies from Zimbabwe acting in isolation were linked to the fear of stigma associated with having an abortion.

Where family and friends play a role, studies have shown differing levels of influences in abortion decision-making. For example, Harries et al. (2007) found in South Africa that involvement by other people ranged from family and friends being heavily involved to women being afraid to discuss their intention to terminate a pregnancy, leading to their acting in isolation. However, another South African study by Orner, Cooper, Harries, and De Bruyn (2010) revealed that family influence is highly important in abortion decision-making. The findings in South Africa are different to what has been found in Cameroon where Schuster (2005) found that young, unmarried women were heavily influenced by their girlfriends and mothers in the decision-making process but not by other family members. The women in this study also excluded their male partners from their decision-making because they feared the partner could insist on his rights as a father and husband. Regarding the role of parents, Dahlback et al. (2010), found that the parents played a dual role in the abortion decision-making process, with women choosing to terminate in secrecy due to fear of their parents' reaction or parents actively seeking to have the woman terminate the pregnancy as a way to hide the social shame and financial burden brought on by the pregnancy.

2.5 Socio-economic factors

Studies on socio-economic factors and abortion in Gabon, Malawi, Mozambique and South Africa have shown that women who have unsafe abortions usually come from poorer backgrounds (Harries et al. 2007; Hess, 2007; Jackson, Johnson, Gebreselassie, Kangaude, & Mhangoe, 2011; Mitchell, Kwizera, Usta, & Gebreselassie, 2010). American research also reveals that pregnancies are terminated more often in poorer communities compared to wealthier communities (Pugh Yi, 2011). Further evidence of poorer women accessing abortion was found in a USA study by Jones, Finer, and Singh (2010) who found that 69 percent of women having abortions in 2008 were living on incomes lower than the federal poverty line in comparison with 35 percent of women in the general population. Pugh Yi (2011) argues that the main reason for poorer women undergoing abortions is the financial costs of bringing a pregnancy to full-term and rearing children. Despite the differences between the American context and the African countries mentioned, results seem to show that poorer women tend to abort more pregnancies regardless of whether it is an unsafe or safe abortion.

Studies have constantly shown a relationship between unsafe abortion and socio-economic status. In Ghana, Sundaram, Juarez, Bankole, and Singh (2012) revealed that women who are most vulnerable to having unsafe abortions are younger, poorer, and lack partner support. This

is supported by a review of 32 studies from 27 countries where Bankole, Singh, and Hass (1999) found that socio-economic factors like disruption of education or employment, lack of financial support from the partner, desire to provide schooling for present children, failure to afford taking care of additional children, poverty and unemployment were some of the most important factors in abortion decision-making. Recently, the same results were found in a Nigerian study where women in Tunde's (2013) study reported that factors such as poverty, dropping out of school, level of education and inadequate access to medical personnel, facilities and equipment were predictors of unsafe abortion among adolescent girls. The three studies here also show the interaction of age and other socio-economic indicators.

The role of personal finances in influencing abortion decision-making has also been studied as noted earlier. Hess (2007), in a Gabonese study, concluded that financial difficulties played an important role. Studies in India (Ravindran & Balasubramanian, 2004) and South Africa (Harries et al., 2007) revealed that women felt abortion to be necessitated by the difficult financial conditions in which they found themselves. The difference between the two studies was that while in the South African study it was the women making the decision alone because of lack of financial resources, in India it was a family decision as they could not afford for the woman to be 'confined' and allow the pregnancy to hinder her from continuing, or becoming involved in, employment.

Socio-economic factors have been shown to not only be limited to the direct financial costs of bringing the pregnancy to full term and possibly taking care of the baby that is born but also include aspects such as the perceived costs of future financial gains. One of the costs of future financial gains is that of not finishing one's education and not being able to find attractive work opportunities. Harries et al. (2007), in their South African study, found high numbers of women being motivated by the need to finish school or studies as a way to access better job opportunities in the future. This was also true in Schuster's (2005) study in Cameroon where young, unmarried women overwhelmingly cited fear of losing their educational opportunities as reasons for terminating pregnancies. The same has also been found in different contexts in the USA. Finer, Frohwirth, Dauphinee, Singh, and Moore (2005) found that higher proportions of younger, childless and never-married women identified interference with education as a reason for their decision to terminate the pregnancy. In Zimbabwe the influence of socio-economic factors on abortion decision-making has not yet been systematically studied. Rather

than tackling this question, I try to understand the narratives of women from a range of socio-economic statuses in terms of their decision-making processes.

2.6 Health considerations

Health considerations have been shown to be important in abortion decision-making. These health considerations include saving a woman's life due to physical health issues, mental ill-health, foetal defects and HIV/AIDS status. They also include the attitudes of health service providers. Health considerations have been viewed as interacting with other factors such as availability of health resources and socio-cultural attitudes in influencing abortion decision-making. These will be discussed in turn below.

2.6.1 Abortion to save a woman's life due to physical health

Complicated pregnancies that put the life of the pregnant woman in danger are a factor that influence abortion decision-making in both resourced and under-resourced countries (Chigudu, 2007). Medical conditions that make it difficult or dangerous to give birth that have an impact on abortion decision-making include cancer, heart disease, diabetes, auto-immune disorders, HIV/AIDS and certain other sexually-transmitted diseases (Finer et al., 2005). It is important to note that even in countries with relatively restrictive abortion legislation, abortion is often allowed in order to save the life of the pregnant woman. Most African countries, including Zimbabwe, have laws that permit abortion when the health of the woman is threatened. In other words, in terms of what people see as a 'legitimate' reason to terminate a pregnancy, the life of the woman features prominently. This means that those who terminate a pregnancy for this reason will face less stigmatisation.

However, there are not many studies that have focused on the health of the woman in the abortion decision-making process. It is not clear, for example, how many women have had abortions in countries where it is permitted due to dangers to their physical health. In Zimbabwe, where the old constitution allowed for women to have an abortion to save a women's life, the Zimbabwean Women Lawyers Association (2013) stated that it was difficult for women to find two doctors to certify that she was in danger due to the pregnancy. They report that most women only received the required legal documents when it was too late to have the abortion. A lack of clear laws and policies was also found by Shepard and Becerra (2007) in Chile where there is no uniform policy regarding medically-indicated abortion resulting in individual doctors doing as they see fit.

2.6.2 Abortion decision-making in cases of mental ill-health

The relationship between induced abortion and mental health is an area of political controversy (Steinberg & Russo, 2008). There are two distinct areas that have been researched which include having an abortion because of mental ill-health (this is one of the stipulations in some of the restrictive abortion legislation which allows women to undergo abortion) and opting out of having an abortion because of fears of the mental health consequences of having an abortion. The two will be discussed separately below.

Much of the research has focused on whether having an induced abortion will lead to mental illness (Charles, Polis, Sridhara, & Blum, 2008). According to the American Psychology Association (Major et al., 2008), scientific and medical groups have found that induced abortions performed in safe circumstances in the first trimester do not cause mental health problems and that the risk of mental health problems in these circumstances is equal whether an unplanned pregnancy is carried to term or is terminated via abortion. Steinberg and Russo (2008) argue that pre-existing factors in a woman's life, such as emotional attachment to the pregnancy, lack of social support, pre-existing psychiatric illness and conservative views on abortion increase the likelihood of experiencing negative feelings after an abortion.

Despite the weight of medical opinion on the subject, pro-life advocacy groups have continued to allege a link between safe and legal abortion and mental health problems (Stotland, 2003). The term ‘post-abortion syndrome’ has been used to refer to negative psychological effects which are attributed to abortion. However, ‘post-abortion syndrome’ is not recognised as an actual syndrome by any medical or psychological organisation, and physicians and pro-choice advocates have argued that the effort to popularise the idea of a ‘post-abortion syndrome’ is a tactic used by pro-life advocates for political purposes (Grimes & Creinin, 2004). In the USA, some state legislatures, including Texas and New Mexico, have mandated that patients be told that abortion increases their risk of depression and suicide, despite the fact that such risks are not supported by the bulk of the scientific literature with well-designed research studies (Major et al., 2008). This inevitably has been linked to affecting abortion decision-making with women fearing mental illness after abortion and thereby choosing to carry a pregnancy to full-term (Grimes & Creinin, 2004).

In terms of abortion decision-making, when a woman has a mental illness, research has centred on whether they are competent enough to make a decision to terminate a pregnancy (Stotland,

2003). Even where legal systems allow therapeutic abortion to preserve women's mental health, practitioners often lack access to mental health professionals who would be qualified to make critical diagnoses or prognoses that pregnancy or childcare endangers patients' mental health (Cook, Ortega-Ortiz, Romans, & Ross, 2006). A review of laws from the 'developed' world (UK, USA, Germany) shows that in most cases mentally ill pregnant women have no say on whether to terminate or carry a pregnancy to full-term (Charles et al., 2008; Cook et al., 2006). An example is that in the USA a judge decides whether a woman is mentally competent to undergo an abortion and can understand the information provided by medical sources (Charles, et al., 2008). In many jurisdictions that have a mental health indication for abortion, it is often applied inconsistently and with a lack of transparency, causing unfair access to lawful services. In sub-Saharan Africa most countries do have laws allowing for mentally ill women to be granted access to abortion but it is not clear how many women are able to access it (Harvey-Knowles, 2012; Schuster, 2005).

2.6.3 Prenatal diagnosis and selective abortion

Prenatal tests, which have become a routine prenatal care procedure in developed countries, have been shown to give reproductive self-determination to families that are at high risk of serious diseases (Saxton, 2000). Boyd et al. (2008) state that approximately 150 000 women in the USA per year are faced with the diagnosis of a foetal anomaly and most women will terminate for that reason. Kerns et al. (2012) suggested that the type of defect correlates well with the pregnancy management decision. Some of the conditions that influence abortion decision-making if detected are Down's Syndrome, trisomy 18, muscular dystrophy, cystic fibrosis, sickle cell disease, and anencephaly (Blickstein, 2006). The decision whether or not to carry a pregnancy to term is considered in light of what type or quality of life the child will be able to lead as he or she grows up (Kerns et al., 2012).

Finer et al. (2005) noted that medical reasons for choosing abortion present much more difficult choices for the pregnant woman as sometimes they are forced to terminate a pregnancy despite their pregnancy desires. Finer et al. (2005) state that women who are opposed to abortion find it difficult to go along with medically-indicated abortion. This is because, for many of these women, the decision to oppose abortion is a religious one where abortion is not permitted under any circumstances.

Research has shown that in 'developing' countries the identification of foetal defects is lower compared to 'developed' countries (Chigudu, 2007). This is mainly because of the lack of resources to identify foetal defects. In one of the few African studies investigating foetal defects conducted in Cameroon, parents with children suffering from sickle-cell disease indicated that they would choose to abort if the foetuses were found to be affected (Wonkam, de Vries, Royal, Ramesar, & Angwafo, 2014). Patients with sickle-cell disease in the same study were also generally supportive of prenatal diagnosis and termination of pregnancy if there were defects that would affect the future well-being of the child. Chigudu (2007) has noted that Zimbabwean women mostly in rural and poorer areas will not have any knowledge of the defects until a child is born.

There are social and ethical debates surrounding prenatal diagnosis and selective abortion. Disability rights activists are critical of the intent to abort if the foetus is destined to become a disabled person (Saxton, 2000). This is because they worry that selective abortion will perpetuate the view that any disabled child would necessarily be a burden to the family and society and therefore would be better off not being born (Saxton, 2000). On the other hand, medical professions justify prenatal diagnosis and selective abortion on the grounds of the costs of childhood disability: the costs to the child, to the family, and to the society (Asch, 1999).

Sex selective abortion has been also found to be an influence in abortion decision-making and is widespread in certain countries, especially those in East and South Asia, where an inordinately high social value is placed on having male over female children (Li, 2007). Here there is a gendered valuing of children which has implications in terms of abortion decision-making. The sex of the child is established using antenatal screening techniques, and some pregnancies are terminated if the foetus is female. Barot (2012) has found that in India and China factors that include inheritance and land rights which pass through male heirs has meant sons are preferred over daughters. This is supported by Li (2007), who adds that women are regarded as an unproductive investment due to the fact that women require dowries and leave the natal family upon marriage. Due to the preference for sons, women tend to abort if they know they are going to have a daughter through prenatal tests (Barrot, 2012; Li, 2007; WHO, 2010).

Debates on sex selective abortion are growing in European countries with a particular focus on migrant women (Ticktin, 2005). Saharso (2005) has shown that the debates around sex

selective abortion in the Netherlands are complex. She argues that prenatal diagnosis and sex selective abortion are intricately linked and having laws banning sex selective abortion might lead to oppression of migrant women. Saharso (2005) argues that a feminism that does not have a priori moral positions and pays attention to different contextual factors needed when dealing with sex selective abortion is needed. The approach taken by Saharso (2005) suggests that access to abortion (including sex selective abortion and PND) in the Netherlands should be available for all women. Saharso (2005) argues that limiting access for Muslim women as a way of protecting them from their culture places these women in a position where they are seen as mere prisoners of their culture yet they do possess agency.

2.6.4 Role of HIV/AIDS

Reproductive decision-making is a particularly problematic situation for women living with HIV as they attempt to balance their own needs against both social childbearing expectations and judgmental attitudes against HIV-positive persons who choose to reproduce (London et al., 2007; Orner et al., 2010). It is within this context that an HIV-positive woman's desire to become pregnant, carry a pregnancy to full-term or terminate a pregnancy is played out.

In relation to the abortion decision-making and other reproductive choices for HIV-positive women, research has tended to focus on pregnancy desires. Cooper, Harries, Myer, Orner, and Bracken (2007) found that unintended pregnancies constitute a major problem with HIV-positive women in South Africa and, using data from the 1998 South African Demographic and Health Survey, showed that approximately 53 percent of these pregnancies are either unplanned or unwanted. Cooper et al. (2007) concluded that this showed that pregnancy desire is affected by HIV status. However, MacCarthy et al. (2012) have reviewed research from Brazil, Uganda and Zimbabwe which has suggested that pregnancy desires may not vary by HIV status. The difference in the findings might be linked to contextual differences and the data Cooper et al. (2007) used which was from 1998 when treatment for HIV/AIDS was not as advanced as currently.

MacCarthy et al.'s (2012) review is supported by other studies from other countries which have tended to suggest that pregnancy desire might be the same for HIV-positive women and those who are negative. In India, for example, the desire for a male child, deaths of previous children, family size norms and cultural barriers to pregnancy termination were found to be motivating factors for having a child amongst both HIV-positive women and HIV-negative women,

suggesting that pregnancy desires are the same (Jadhav et al., 2010). Furthermore, amongst women in Fiji, Papua New Guinea and Botswana, it has been found that the cultural obligation to fulfil the duty of motherhood was a driver of pregnancy intent for all women in spite of their HIV status (Gorman, 2010; Upton & Dolan, 2011). Finally, having a child with one's current partner was an important reason for pregnancy desire in Brazil in spite of HIV status (Rossi et al., 2010).

Despite research showing that pregnancy desires are the same in most contexts between HIV-positive and HIV-negative women, the debate has been on-going as to whether abortion decision-making is the same. Research has revealed contrasting results. Two studies in Vietnam concluded that awareness of HIV-positive status was related to an increased likelihood of having an induced abortion (Bui et al., 2010; Chi et al., 2010). In contrast, a study in Italy identified a range of factors contributing to HIV-positive women's decision to terminate a pregnancy such as unplanned pregnancy, previous pregnancies and disease progression, but found no association between pregnancy termination and HIV status (Floridia et al., 2010). Some studies in South Africa found that socio-economic hardship and poor living conditions at the time of pregnancy were considered more important reasons to choose to abort than HIV status (Orner, De Bruyn, & Cooper, 2011; Orner et al., 2010). De Bruyn (2003) has also concluded that, despite the differences that might exist between HIV-positive women and those who are negative, some HIV-positive women have the same reasons for wanting to avoid pregnancy and abort as other women. In one Zimbabwean study, Moyo and Mbizvo (2004) actually found an increased desire for pregnancy from HIV-positive women so that they could replace childhood deaths and spontaneous abortions that may result from HIV infection. Other research has shown that HIV status is important in abortion decision-making. Women in India, Sweden, the USA, Thailand and Zimbabwe have cited concerns which are connected to abortion decision-making such as worries about possible negative effects of pregnancy and childbirth on their own health, and worries about infecting the child and their ability to care for the child as time goes on (Feldman, Manchester, Maposhere, 2002; Ishida et al., 2009; Keegan, Lambert, & Petrak, 2002; Kuyoh & Best, 2001; Lindgren, Ottenblad, Bengtsson, & Bohlin, 1998; Yadav, 2001).

Despite the conflicting research studies mentioned above linked to HIV/AIDS' impact on abortion decision-making, which can be attributed to the different areas where the research took place and also the methodological differences in the studies, HIV-positive women seem

to be subject to greater stigma in terms of reproductive decision-making. London et al. (2007) noted that in South Africa, stigmatisation was far worse for pregnant HIV-positive women than for HIV-negative women as societies had judgmental attitudes towards HIV-positive persons reproducing. Respondents in their study generally acknowledged that there was little community support for pregnant women living with HIV and they concluded that this was largely due to a perception that they risk infirmity or death by becoming pregnant.

In other research in South Africa, women and men living with HIV reported judgmental and/or discriminatory attitudes by healthcare workers regarding their reproductive intentions (Cooper et al., 2007; Harries et al., 2007; Orner et al., 2010). Negative experiences for women living with HIV seeking safe legal abortions may be compounded when HIV/AIDS healthcare/support services do not address abortion issues (Harries et al., 2007). Harries et al. (2007) argued that abortion services are separate from both sexual and reproductive health (SRH) and HIV care services and counselling specifically on abortion is not included in in-service training for healthcare providers of SRH and HIV care. This, in turn, renders them ill-equipped to counsel women on abortion.

2.6.5 Influence of healthcare providers

It has also been shown that health service providers can play a key role in the abortion decision-making process (Harries et al., 2007; Harvey-Knowles, 2012). Healthcare providers such as gynaecologists, trained medical doctors and staff nurses, as well as auxiliary health workers, auxiliary nurse midwives, medicine sellers, traditional birth attendants and traditional faith healers may play a role in abortion decision-making (Puri et al., 2007). Healthcare providers influence women's abortion decision-making by either encouraging or discouraging terminating a pregnancy in various ways. These will be examined below.

Harvey-Knowles (2012) found that healthcare workers in America usually influenced women towards having abortions by not informing them of all the necessary options. This is different to what Harries et al. (2007) found in South Africa where women spoke about the negative and judgmental attitudes displayed by staff at public health facilities and related instances where staff were not only rude and hostile but attempted to dissuade them from having an abortion.

In other cases in South Africa, health workers influenced the decision-making process by turning women away from the clinic for no apparent reason (Jewkes et al., 2005). Gresh and

Maharaj (2011) found that South African healthcare workers were a deterrent for women seeking abortion because of their negative attitudes. Nurses in this study were seen to be judgmental and imposed their own views on women who sought an abortion. According to the researchers in a study in Ghana, family planning nurses also often had strong religious views and negative attitudes toward abortion, and the nurses themselves came across as barriers to abortion by discouraging patients from having one (Schwandt et al., 2013).

2.7 The influence of culture and religion

Abortion decision-making has been shown to be largely influenced by cultural and religious factors in different societies. Puri et al. (2007) have argued that the influence of culture and religion transcend all the other factors that might have an influence on abortion decision-making. Here culture refers to the set of shared attitudes, values, goals, and practices that characterizes a society. In some literature culture is synonymous with traditional beliefs due to the fact that it is accumulated over time (Kebede, Hilden & Middelthon, 2012; Puri et al., 2007). Cultural norms and religious beliefs (religious beliefs can also be part of culture) have been seen to operate as regulatory discourses which provide scripts on how people should behave and act (Adamczyk, 2013; Hess & Reub, 2005; Frohwirth, Coleman, & Moore, 2014). Studies on the influence of culture and religion on abortion have focused on how women negotiate cultural and religious understandings when deciding to have an abortion and after the abortion (Adamczyk, 2013; Frohwirth et al., 2014; Hess & Reub, 2005; Kebede, Hilden & Middelthon, 2012; Settergren, Mhlanga, Mpofu, Ncube, & Woodsong, 2000).

Culture and religion have been shown to intersect. Thus, some of the studies have looked at the two together. Kebede et al. (2012) showed how women in Ethiopia viewed abortion as being morally and socially hazardous due to the cultural and religious norms regarding abortion. This led the women in the study to be stigmatised and isolated for having an abortion. Hill, Tawiah-Agyeman and Kirkwood (2009) also found similar results in Ghana. Abortion was seen by women who had terminated a pregnancy to be sinful in terms of religion and culturally shameful. In their study, Hill et al. (2009) found that women needed privacy or secrecy so that they would not face the public shame that came from disregarding cultural and religious norms.

On a cultural level, abortion has been seen to go against social values and most African studies have shown how abortion is perceived as going against ‘our culture’ with understandings about

children and life beginning at conception (Macleod, Sigcau, & Luwaca, 2011). Izugbara, Otsola, and Ezeh (2009, p. 397) showed how Kenyan men "were generally condemnatory toward abortion, viewing it as women's strategy for concealing their deviation from culturally acceptable gender and motherhood standards." In the same study, women only considered having an abortion because it "shields … against the shame of mistimed or socially unviable entry into recognized motherhood" (p. 397). This means that although abortion is culturally shameful, it is also used to hide a culturally-complicated pregnancy. Johnson-Hanks (2002) found among Cameroonian women who had terminated a pregnancy that although abortion and the pregnancy conditions were both shameful (the pregnancy conditions are discussed below) abortion was seen as the lesser shame.

The conditions that have been found to make a pregnancy culturally-complicated and abortion culturally unacceptable are linked to traditional beliefs surrounding sexual practices (Izugbara et al., 2009; Orisaremi, 2012). In Nigeria, Orisaremi (2012) found that women chose to terminate pregnancies that were conceived outside marriage as this was against the cultural norms (conception outside marriage can also be considered to be against religious beliefs). Keeping the pregnancy would lead to social stigma and censure. The importance of traditional beliefs, even in areas where abortion is legal, was found by Macleod et al. (2011, p. 237) in a rural area in South Africa where "abortion was constructed as killing and inevitably destructive of cultural values and traditions" and therefore should be opposed so that 'our' culture should be preserved. Cultural understandings are, therefore, seen as influencing abortion in two ways: denouncing abortion for being against cultural values and women choosing to abort due to the pregnancy going against cultural values.

Religion has also been seen to influence women during abortion decision-making owing to religious understandings of abortion as sinful, wrong and an act of killing (Adamczyk, 2009). In Nigeria, Pakistan and Mexico, abortion was seen by many women as raising ethical concerns due to the fact that it went against religious norms (Tsui et al., 2011). Using abortion patients at an American clinic as their sample, Greene Foster, Kimport, Gould, Roberts and Weitz (2012) found that the some women chose not to terminate their pregnancies because of their religious beliefs. The women had spiritual concerns about going through with the abortion due to the guilt they felt. Frothwirth et al. (2014) found that despite religion influencing abortion attitudes and behaviour for women (the study was on Catholic women), they were willing to face the consequences. The women in the study, although accepting the wrongness

of abortion, “cited a willingness to face any religious consequences of their decision to terminate their pregnancy” (p. 4).

Two studies in Zimbabwe have shown how religious attitudes influence abortion decision-making. In a study by Settergren et al. (2000) in Bulawayo most of the participants mentioned having to confront their religious beliefs when faced with a decision of whether to terminate or bring the pregnancy to full term. Ndarukwa (2012) also found similar results in a study in Chitungwiza with most participants in the study claiming that they felt guilty soon after having an abortion due to their religious beliefs. Religion has therefore been implicated in three ways: i) women deciding against a TOP for religious reasons; ii) women making a decision to terminate a pregnancy against their religious beliefs which condemn abortion; iii) women living with the consequences of having an abortion in light of their religious beliefs.

2.8 Stigma

Stigma is a fairly subtle, but important, ‘factor’ that may play itself out in a range of ways. Norris, Bessett, Steinberg, Kavanaugh, De Zordo, and Becker (2011, p. 1) have described stigmatisation as “a deeply contextual, dynamic social process” with stigma from abortion being the “discrediting of individuals as a result of their association with abortion.” These associations are already shown to include cultural and religious understandings of abortion. Kumar et al. (2009, p. 628) have also defined abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood.”

In addition to Kumar et al.’s (2009) notion of stigma resulting from the violation of female ideals of sexuality and motherhood, Norris et al. (2011) add four other causes of abortion stigma. These are: attributing personhood to the foetus, legal restrictions, the idea that abortion is dirty or unhealthy, and the use of stigma as a tool for anti-abortion efforts. With regard to the attribution of personhood to the foetus, research in some African countries has shown that the generally-accepted view is that life begins at conception (Bowes, 2009; D’Souza, 2014; Senah, 2003; Sigcau, 2009). Thus, abortion is seen as killing or murder. As already shown, legal restrictions mean that abortion is seen as breaking the law and thus wrong. Norris et al. (2011, p. 7) have shown how, in the USA, abortion has been made to seem “dirty, illicit, and harmful to women” by anti-abortion activists (see health considerations section 2.6 for physical and psychological threats to women attributed to abortion). The ‘harm’ to women is seen especially

in areas where abortion is illegal and unsafe. The stigma that comes from viewing abortion as killing, harmful to women, against cultural and religious beliefs is then used by those opposed to abortion to keep it illegal as shown by the Editorial from *The Daily News* in Chapter 1. Lithur (2004) has argued that the combination of social perceptions, traditional and cultural values, religious teachings, and the laws governing abortions have reinforced people's negative attitudes toward abortion and this has an influence on the women's desire to keep their abortions secret. For example, participants in a study on abortion in Cameroon identified the social stigma attached to abortions as hindering their ability to seek medical care in the event of abortion complications (Johnson-Hanks, 2002; Kumar et al., 2009; Schuster, 2005).

Religious norms and cultural norms often lead to stigma. Settergren et al. (2000), in a community project in Bulawayo, Zimbabwe, found that people viewed abortion as a sign of promiscuity which is considered a sin. They also found that people blamed women who chose to terminate a pregnancy for having had sex before marriage. Participants indicated that in the event of getting pregnant they should accept it as a gift from God. The woman who terminates a pregnancy against such norms is vilified.

In situations where abortion is legal the stigma implicit in cultural and religious understandings is important in influencing women's reluctance to visit healthcare providers or clinics within their communities for fear of being recognised and ostracised, consequently impacting on their right to choose (Harries et al. 2007). In Burkina Faso, where abortion is illegal, Rossier (2007) found that women kept their pregnancies secret when considering abortion for fear of being stigmatised by other community members. This is also true for Zimbabwe, where studies have shown that the stigma placed on abortion means that women act alone in their decisions by either keeping a pregnancy secret or choosing unsafe abortion options that are located some distance away from their communities (Kambarami, 2006; Kasule et al., 1999). In a study conducted in Zimbabwe, Chigudu (2007) concluded that fundamentalist religious attitudes make it difficult to even introduce a discussion of the prevalence of abortion in communities.

Jackson et al. (2011) have argued that a large number of African women resort to unsafe abortion in order to respect the values of their community. Their argument is that the reasons that render a pregnancy 'unwanted' usually include avoiding the social stigma of pre-marital sex and pregnancy. They state that even in areas where the law permits abortion, women may still resort to unsafe abortion in order to keep their transgression of social values secret. In

Mozambique, for example, where the permissibility of safe abortion is determined at the hospital level on a case-by-case basis, many women turned to unsafe abortion. This is due to lack of privacy at the hospital where they may be recognised and compelled (by community members) to disclose their health-seeking motives (Mitchell et al., 2010). Kumar et al. (2009) have proposed that stigma about women having abortions causes shame, guilt, denial, and fear that may result in the choice of unsafe/illegal providers even in places where abortion is legal. An example of this is women in South Africa who continue to abort outside of designated facilities due to their fear of being stigmatised (Jewkes et al., 2005).

2.9 Influence of age

The influence of age on abortion decision-making has focused largely on the 'dangers' of teenage pregnancies. The debates have been polarised, with some researchers viewing teenage pregnancy as unwanted due to the social undesirability of teenage parenthood, and the moral undesirability of teenage abortion (Hoggart, 2012). Other researchers have challenged this risk framework, which categorises teenage pregnancy as a social problem and an adverse event, and questioned many of the values underpinning the strategy (Arai, 2009; Duncan, 2007; Macleod 2011). The debates surrounding 'teenage pregnancy' have been discussed elsewhere (see Macleod, 2011) and are not the main focus of this study, except to indicate that the research on abortion decision-making occurs within the contested terrain of understandings of 'teenage pregnancy'.

Research on abortion decision-making has indicated that the reasons behind abortion are not quite the same for young women as for older women (Harvey-Knowles, 2012; Olukoya, Kaya, Ferguson, & AbouZahr, 2001; Tsui et al., 2011). Issues that have been said to specifically influence younger women are their economic situation, the desire to pursue their studies and the problems they have in going ahead with a pregnancy that is sometimes not accepted by their partner or their parents (Olukoya et al., 2001). For older women, abortion has been seen to be more to do with choosing the number of births they will have or with spreading out these births, with facing up to financial problems or with managing their professional lives. These differences have been attributed to the fact that women face different life circumstances and reproductive health-related issues at different ages (Harvey-Knowles, 2012; Tsui et al., 2011). However, these differences are not absolute as they do not take into consideration women who are married at a young age.

Despite the debates around teenage pregnancy and the construction of the concept of 'adolescents', research on abortion has shown that teenagers are treated differently in certain contexts. The viewing of teenage pregnancy as a public health problem because of its association with socio-economic difficulties and health-related problems for both mother and child complicates the abortion decision-making processes of teenagers. Ekstrand, Tyden, Darj and Larsson (2009) have shown that Swedish teenagers' basic right to decide whether or not to have an abortion may be limited by societal norms and the disapproval of teenage childbearing. Teenagers here were driven to terminate their pregnancies due to their being considered too young to have children. Teenagers' relative youth might also explain findings around teenagers' roles in the abortion decision-making process. Ganatra and Hirve (2002) found that adolescents in India had a lesser role in the decision-making process on abortion than did older women. There has been a major debate on this in the USA, for example, with some states requiring parental consent for a minor to obtain an abortion (Adler, Ozer, & Tschann, 2003). The question of whether these young women are cognitively competent to make these decisions has led to some research in this area.

The idea that teenagers are immature and cannot make an abortion decision has led to the construction of laws on parental consent. Adler et al. (2003) have also shown that in the USA many states require parental consent or notification for teenage abortions. Legislation mandating parental consent has been justified by several assumptions, including high risk of psychological harm resulting from abortion, the inability of adolescents to make an adequately informed decision and the benefits of parental involvement (Adler et al., 2003). However, as already shown, studies have suggested a relatively low risk associated with abortion, and adolescents seeking abortion appear to make an informed choice (Macleod, 2011).

2.10 The role of the media

The media (including newspapers, internet sources, radio and television) has been noted to play a role in abortion decision-making. Rohlinger (2006) indicated that in an effort to persuade an audience, groups who support or oppose abortion provide the public with information in order to deliberately misinform or selectively inform the public with 'knowledge' to support their own opinions or beliefs. This is a serious problem for individuals trying to seek information on abortion.

A study of teens and young adults (18–29 years old) in America showed high levels of Internet use and of those using the Internet, 72 percent had gone online to obtain health or medical information (Fox & Jones, 2009). In South Africa, Macleod and Feltham-King (2012) showed how newspapers play a role in the constructions of abortion. They found a link between the names used by the newspapers (woman, girl/teenager/child, mother, patient and minor) and abortion and stated that, "the subject positionings enabled by these names were dynamic and complex and were interwoven with the localised, historical politics of abortion" (Macleod & Feltham-King, 2012, p. 737).

Although no research exists at the moment in Zimbabwe on the link between media and abortion decision-making, a review of websites, especially news sites, paints a picture of how the media can influence abortion decision-making. A review of the stories found in the *Zimbabwean Herald* and *The Sunday Mail,* which are the country's leading government controlled newspapers, shows a bias against abortion. The stories equate abortion to murder. In a recent story about a model who aborted with the help of her boyfriend, *The Herald* portrayed the model as a woman who is 'bad' for society (*The Herald Online*, March, 2013). The comments from the public that followed underneath the story provide some of the views held by Zimbabweans, with the woman in question being classified as a 'fool', 'prostitute' and 'murderer' who deserved to go to jail.

2.11 Narrative/discursive approaches to abortion

Narrative/discursive studies on abortion have focused on the woman's experiences of abortion and public discourses about abortion and in so doing have shown how the 'choice' to seek an abortion is not only an individual decision due to personal circumstances but is located within both socio-cultural and socio-economic power relations (Lie et al., 2008). While other studies mentioned above use the health determinants approach which, although looking at micro- and macro-level 'factors' (as shown by the discussion on culture, religion and stigma before), how these are then intertwined is under theorised. Other than indicating that the one 'influences' the other, there is little indication of how social and cultural issues are imbedded in women's decision-making with regards to abortion. Narrative/discursive approaches focus on unpicking the complex power relations that underpin a pregnancy. Narrative/discursive studies have shown that "such decisions [abortion decisions] are moderated by the value systems and social norms of the society or community in question" (Lie et al., 2008, p. 153). Narrative/discursive approaches allows us to view the social in terms of dynamic and multiple power relationships

rather than as static ‘determinants’ or factors. This approach also allows for contradictions to be highlighted, as well as the fluidity and complexity of the power relations that cohere around reproductive issues, including abortion. This section, firstly, examines studies that have focused on public discourses on abortion from a narrative/discursive approach and then shows how these discourses have been taken up the in women’s stories on termination of pregnancy.

Some research on public discourses on abortion has been taken up in South Africa, where, despite having one of the most liberal abortion laws in the world, the public seem to have remained negative (Bowes, 2009; Hansjee, 2011; Macleod et al., 2011; Sigcau, 2009). In one of the studies, Hansjee (2011) looked at the discourses employed by men when discussing abortion in focus groups. In their talk, the men undermined women’s reproductive rights by employing discourses which seem, at the base, to be supportive of women and which include discourses of equality, support and rights (Hansjee, 2011). An example is how they found men using a rights discourse to claim their paternity rights in any decision to terminate a pregnancy.

In other research, Sigcau (2009) found, in a rural community in South Africa, how public discourses were largely pro-life: not only defending rights of the foetus but also protecting the traditional family. In the study, abortion was accepted in some instances only when the man was involved in the decision. Protection of the traditional family also extends to the wider community: Macleod et al. (2011), in a study in South Africa, highlighted how abortion is seen as destroying cultural values and traditions. This cultural discourse was enabled by the construction of abortion as killing. The construction of abortion as killing was also seen in a study in Western Cape, South Africa by Bowes (2009, p. 89) who found abortion being constructed as “murder and therefore a sin, resulting in the woman being positioned as a murderer and sinner.”

Although focused on university students who did not have abortions, Ronco (2013) found that when talking against abortion, students drew from certain discourses that include ‘foetal personhood discourse’, ‘religion discourse’, ‘moral discourse’, ‘motherhood discourse’ and ‘social discourse’. These discourses were premised on the ideas around abortion being murder as the foetus was a human being from conception. Since abortion was murder, it was wrong and went against social and religious norms. Students who reasoned in this way spoke of their complete disagreement with abortion. Ronco’s (2013) study, conducted in South Africa,

complements the above-mentioned studies which show how public discourses on abortion are at times negative.

These kinds of public discourses have been found to dovetail with women's micro-narratives about their abortion decision-making. Women are seen as drawing from these larger societal discourses in constructing their stories. Ndunyu (2013), in a Kenyan study, showed that women's stories drew on societal norms around motherhood and femininity. The women in the study made sense of societal norms in terms of religion and culture. These women saw abortion as both shameful, as it meant denying motherhood, but also as necessary, as it hid circumstances of a pregnancy that went against societal norms (for example pregnancy outside of marriage). The same use of public discourses was found by Izugbara et al. (2009), in a Kenyan context, where abortion was seen as shielding not merely against the shame of mistimed or socially unviable entry into recognised motherhood, but more importantly against the negative socioeconomic consequences of mistimed or unnecessary childbearing and inconvenient entry into motherhood.

Mavuso (2014) conducted a narrative-discursive study in South Africa that tried to locate the decision to have an abortion within the economic, religious, social, political, and cultural aspects of women's lives. Her findings showed how women saw abortion as being forced by their circumstances. The women in the study "constructed marriage as the legitimate space for reproduction to occur, invoked mothering practices and reproductive decision-making which centre on children's needs, and drew on constructions of non-marital gender relations as unfair and unstable" (p. 80). They also drew on a religious discourse that sees abortion as sinful. In telling their stories, the women in Mavuso's (2014) study were drawing on the same public discourses on abortion that have been seen in other work in South Africa.

2.12 The views of healthcare providers on working with women who have had abortions

In section 2.6.5 I discussed how healthcare providers who work with women who have terminated pregnancies have been found to influence the women's decision-making process. In this section I look at the views and knowledge that healthcare providers have about termination of pregnancy. Research has shown that in most countries where abortion laws are restrictive, healthcare workers tend to have negative attitudes against abortion due to their own personal, cultural and religious beliefs (Lipp, 2008; Silva, Billings, Garcia, & Lara, 2009). These

attitudes tend to vary, however, in relation to the reasons that women provide for needing an abortion. In most of these restrictive contexts, healthcare providers are usually uncertain about the legal status of abortion in their countries (Castaeda, Billings, & Blanco 2003).

Where abortion is legal, research has tended to focus on conscientious objection which is when healthcare professionals or institutions exempt themselves from providing or participating in abortion care on religious and/or moral or philosophical grounds (Harries, Stinson, & Orner 2009). An example is in South Africa where the CTOP Act makes allowance for a healthcare provider's right to conscientious objection. Harries et al. (2009, p. 296) state that "a healthcare provider may refuse to perform an abortion, however, they are obliged to inform a woman of her reproductive right to choose an abortion according to the Act, and to refer her to another provider or facility." The CTOP Act legalised abortion on request in South Africa in 1996 up until to 12 weeks of gestation and thereafter under specified conditions (Harries et al., 2009).

In contexts where abortion is restrictive, healthcare workers may interact with women who have had unsafe abortions and are in need of post-abortion care. Research has shown that in these cases where abortion is illegal, healthcare workers become important in helping or perpetuating the stigma that may exist in such contexts. An example is in Mexico where abortion is illegal except when related to cases of rape. Midwives who are responsible for helping women who have unsafe abortions referred to the women as murderers and thus perpetuated stigma (Castaeda et al., 2003). To further strengthen the findings in Mexico, a recent literature review of 36 studies in sub-Saharan Africa and Southeast Asia by Loi, Gemzell-Danielsson, Faxelid, and Klingberg-Allvin (2015) found that induced abortion was seen as ending a human life and being a mortal sin and thus was considered unacceptable by healthcare providers offering post-abortion care.

In addition to the labelling of women, nurses in Ghana have been shown to be opposed to abortion and have sent women away for seeking abortions (Payne et al. 2013; Schwandt et al., 2011). In Schwandt et al.'s (2011) study, family planning nurses who interacted with women who have sought abortions and have been involved in tragic cases felt affected by the process and saw abortion as wrong. The nurses in this study already had strong religious views and negative attitudes towards abortion and due to a combination of the tragic cases they saw and their negative attitudes, they themselves became barriers to women accessing abortion. These negative attitudes can also influence the way healthcare providers view abortion laws. A study in Pakistan by Rehan (2003) found that most of the 114 healthcare providers in their study

thought the abortion law which allowed abortion to save a woman's life was too liberal. Rehan (2003) attributed their stance to their religious beliefs.

The attitudes of healthcare providers appear to be affected by the reasons for the abortion. Healthcare providers are more likely to be supportive of abortion and have positive attitudes towards women who abort due to rape or incest, severe foetal genetic disorders, when it was necessary to save the life of the woman or in the case of HIV/AIDS (Aniteye & Mayhew, 2013; Belton, Whittaker, Fonseca, Wells-Brown, & Pais, 2009; Harries, Lince, Constant, Hargey, & Grossman, 2012, Orner et al. 2010). The reasons for this are more acceptable and the woman who is terminating a pregnancy is not blamed as she might be were she terminating due to socio-economic or personal reasons.

A study in Zimbabwe by Kasule et al. (1999), which looked at the attitudes of professional health workers, (doctors, nurses, matrons, social workers and hospital administrators) to medically-supervised abortion, found that most nurses (57 percent of their sample) were against any type of abortion and would not consider helping women who had undergone an unsafe abortion. The study by Kasule et al. (1999) appears to be the only Zimbabwean study that has looked at the role healthcare workers play in abortion decision-making. In my study, by including the narratives of healthcare providers in the three sites, will partially fill the gap that exists in this area of research.

2.13 Conclusion

Abortion decision-making has been understood from different frameworks of which two were highlighted in this chapter. The first is the health determinants model where reasons/factors are identified that influence women when they are faced with a pregnancy they want to terminate. This has been the most used framework in abortion decision-making research. The other framework, which I adopted, is the narrative/discursive one, which tries to understand how social and cultural issues are imbedded in women's decision-making with regards to abortion. The review literature showed that although the health determinants is able to show micro- and macro-level 'factors' it gives little indication of how social and cultural issues are imbedded in women's decision-making with regards to abortion.

In this chapter, I firstly reviewed how the law plays a role in abortion decision-making. The section showed how abortion decision-making is complicated in places where the law is restrictive and how this also affects post-abortion care as women are fearful of reporting to hospitals or clinics that cater for post-abortion complications. Having looked at the role of the law, my focus was then on discussing the different factors that have been shown to influence abortion decision-making. Here, I explored how unintended pregnancy increases the chances of women having abortions. The interpersonal relationships section that followed included the role relationships play in the abortion decision-making processes. The different types of relationships implicated in the studies were relationships with partners, husbands, mothers, friends and siblings. In some cases, however, women opted to act alone both in deciding and going ahead with the abortion. In looking at the socio-economic factors that have been found to influence abortion decision-making, I found that studies have constantly linked abortion to women from poorer backgrounds, whether safe or unsafe. Some of the findings showed that women from poorer backgrounds are more unlikely to plan their pregnancies and have no financial means to bring pregnancies to full term.

My review then moved to health considerations that have been noted as a very important factor in abortion decision-making. It was found that although undergoing abortion to save a woman's life due to physical problems was legal in many countries, the statistics on this were unclear given the different bureaucratic policies in some of these countries. The issue of structural constraints also came up when I discussed mental ill-health and abortion where women who were, by law, allowed to terminate pregnancies due to mental ill-health could not access mental health professionals. I also mentioned the controversy surrounding post-abortion syndrome which has been suggested by some researchers as being a consequence of abortion, although this has been disputed due to lack of evidence. I moved to discussing the added dimension that HIV/AIDS brings to women who want to terminate pregnancies. Here I showed how debates have centred on whether reproductive desire is the same for HIV-positive and HIV-negative women. Despite inconclusive findings, it was clear that HIV-positive women are at a greater risk of experiencing stigma when it comes to decisions relating to their pregnancies because of their status. I ended the section by exploring how negative attitudes by healthcare service providers influence women when deciding to have an abortion. The providers were seen as judgemental and trying to influence women not to go ahead with terminating pregnancy.

In terms of culture and religion, research shows that the two intersect in providing certain norms that either make a pregnancy something to be ashamed of or abortion to be seen as a shameful act. Cultural and religious norms play a part in much of the stigma that women face during the abortion decision-making process. Stigma influences women in deciding to terminate pregnancies and also in hiding the act of an abortion to such an extent that women do not report for post-abortion care when they have complications. I then explored debates on the influence of age which centre around the dangers of teenage pregnancies and whether 'adolescents' are able to consent to have an abortion. Despite the on-going debates, I showed how research has focused on the different needs of teenagers and older women when it comes to abortion decision-making. Moving on to the role of the media, I explored how the media representations of abortion have been shown to have an effect on women who are faced with an abortion decision.

After examining the different factors that have been found to influence abortion decision-making, I then discussed studies that speak to my approach. These studies used a narrative/discursive approach and showed how public discourses on abortion are taken up in women's stories. Here the public discourses were largely seen as negative and painted abortion as wrong, immoral and unacceptable. The women's stories then showed how they understood their abortion decision-making in light of the public discourses.

Lastly, in this chapter, I looked at the views and knowledge healthcare providers have on abortion. The studies portrayed healthcare workers as having negative attitudes that mirror some of the public discourses of abortion found in the narrative/discursive section. Healthcare workers were seen as persuading women not to go ahead with their termination of pregnancy because abortion is, in their view, wrong. This was seen in areas where abortion was legal. I explored the views of healthcare workers who interact with women for post-abortion care in countries with restrictive laws and these were seen to be perpetuating the stigma surrounding abortion, through healthcare workers judging and shaming women who presented for post-abortion care. In the next chapter (Chapter 3) I lay out the theoretical lens used for this study which is a Foucauldian postcolonial feminist approach.

Chapter 3: A Foucauldian postcolonial feminist framework

3.1 Introduction

Foucault's theorising has increasingly been used in sexuality and reproductive studies especially as a means to analyse the power dynamics inherent in the field (Sawicki, 1988). Feminist and postcolonial theorists have also utilised Foucault's ideas (e.g. Boyle, 1997; Macleod, 1999). In this chapter, I outline my theoretical framework: Foucauldian postcolonial feminism. It draws from Foucault as the overarching theory and also postcolonial feminists' insights. Foucauldian theory has been taken up by scholars in Africa and other postcolonial contexts (Mohanty, 1988; Tamale, 2003). In this chapter I use Foucault's work on discourses, power relations, bio-power, discipline, punishment and self-surveillance and postcolonial feminist theories on domesticity, sexual politics and patriarchal power relations in understanding abortion decision-making.

Postcolonial feminisms have arisen as a way of re-evaluating the constructions of gender and sexuality in colonial and anti-colonial discourses by drawing from postcolonial theory and feminism (Mohanty, 1988). It arose as a response amongst women from the 'Third World'[3] who engaged in the feminist movement as well as postcolonial studies. Postcolonial feminists have criticised 'western feminism'[4] on the grounds that it is ethnocentric and does not take into account the unique experiences of women from 'Third World' countries or the existence of feminisms indigenous to 'Third World' countries. Postcolonial feminisms also critique the lack of gender engagement in postcolonial theory. The focus in postcolonial feminisms is "on racism, ethnic issues, and the long-lasting economic, political, and cultural effects of colonialism, inextricably bound up with the unique gendered realities of non-white non-Western women[5] (Weedon, 2002, p. 85). It sees the parallels between recently decolonised nations and the state of women within patriarchy and takes the "perspective of a socially

[3]The use of the term '''Third World''' is potentially problematic and I use it here to denote the countries of the so-called 'global south'. I use these terms with caution for a number of theoretical and political reasons. Both terms imply a particular value judgment, by using an ordinal schematic for organising nations according to a hierarchical denomination.

[4]Western feminism is also a potentially problematic term and to avoid any misconceptions its use here refers to feminism from the first world countries or the so-called Western world. When I use the term 'Western feminists' I am not trying to imply that the view from this part of the world is monolithic by any means but rather I am following in the footsteps of Mohanty (1991) who states that, "I am attempting to draw attention to the similar effects of various textual strategies used by writers which codify Others as non-western and hence themselves as (implicitly) Western" (p. 52) in reference to Western feminists.

[5] Non-white and non-Western are also problematic in that they define race from a white or European perspective.

marginalized subgroup in their relationship to the dominant culture" (Kramarae & Spender, 2000, p. 746).

I have chosen to use the plural postcolonial feminisms in line with Tamale (2004) who argues that those who identify as postcolonial feminists are varied in their standpoints and understandings. For example, there are debates on the effect that colonisation has had on Africa with regards to patriarchy. On one side, postcolonial feminists such as McFadden (1992, 2000, 2002) and Oyewumi (1997) have argued that patriarchy was brought by the colonising powers. On the other side, theorists such as Mama (1997) argue that patriarchy already existed and colonisation only entrenched it. The discussions surrounding these debates cannot be covered here but have been covered elsewhere (see Bakari-Yusuf, 1999). My use of postcolonial feminisms is to show that it is not a monothetic concept but it includes multiple voices and locations (Schutte, 2000). I have done this carefully, keeping in mind Tamale's (2004) and Spivak's (1999) warning that labelling can be difficult as more often than not it becomes a process of oversimplification that glosses over differences and controversies. The label postcolonialism, just like poststructuralism, is a broad brush label that, although useful in some ways, hides a lot of differences and does not provide sufficient clarity regarding the exact nature of the theoretical space that one wants to occupy. The theoretical space I occupy in regards to postcolonial feminist issues is Foucauldian.

When discussing postcolonial feminisms my interest lies in feminism in an African context. Much of the material labelled under postcolonial feminism has been done by researchers who have worked on the continent and are aware of the conditions that are inherently African (there are also a lot of contributions to the topic from India). This is not to say that Africa is the same and that postcolonial African feminists are the same, but the umbrella term is applied to define those who, despite major differences, can be identified as African postcolonial feminists.

In the following, I expand on a Foucauldian approach that illuminates the social/cultural discourses/practices that may be deployed in narratives on abortion and how power relations underpin these narratives. I look at how Foucauldian theory can be applied to abortion decision-making, basing my arguments in concepts such as discourses, power relations, bio-power, discipline, punishment and self-surveillance. I also look at narrative theory and positioning before moving to feminism and Africa so as to ground myself in the history of feminist interpretations on the continent. I then move to a brief history of postcolonial

feminism starting from its beginnings, specifically on the relations between postcolonial feminism, Western feminism and postcolonial theory and its applicability to abortion decision-making. The chapter then turns to exploring the interaction between Foucault and postcolonial feminists' concepts which, I argue, are relevant to abortion decision-making and can be used to illuminate a Foucauldian theory on sexualities and reproduction.

3.2 Foucault

The following section focuses on Foucauldian theory and how it relates to abortion decision-making. The section starts by providing a brief background as a way of grounding Foucauldian concepts. I move to discuss some of his theoretical concepts that include discourses, power, bi-power and governance. I end the section by examining how Foucault's work on power has been applied to sexuality.

3.2.1 A brief background

Rabinow and Rose (2003) state that Foucault's writings can be divided into three phases: archaeological (*Birth of the Clinic: The Order of Things* and *The Archaeology of Things*), genealogical (*Discipline and Punish* and *the History of Sexuality, Vol. I*) and ethical (*The History of Sexuality, Vol. II and Vol. III; The Use of Pleasure, The Care of the Self*). The premise of the archaeological method is that systems of thought and knowledge "are governed by rules, beyond those of grammar and logic, that operate beneath the consciousness of individual subjects and define a system of conceptual possibilities that determines the boundaries of thought in a given domain and period" (Gutting, 2014, para. 26). Here Foucault is interested in examining the discursive traces and orders left by the past in order to understand the processes that have led to what we are today. Although the methods Foucault uses for archaeology and genealogy are the same, the two are inherently different.

Foucault's genealogy of the subject accounts "for the constitution of knowledges, discourses, domains of objects, and so on, without having to make reference to a subject which is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of history" (Foucault, 1980, p. 117). Genealogy, therefore, becomes a method of seeking to show how the plural, and sometimes contradictory, past reveals traces of the influence that power has had on truth. As one of the important theories of Foucault, genealogy deconstructs truth, arguing that truth is, more often than not, discovered by chance and backed by the operation of power or the consideration of interest (Foucault, 1972).

The ethical works deal with subjectivity or, as Foucault (1985) calls them the 'self's work on the self'. The essential condition for the practice of ethics is freedom: the ability to choose one action and not another. Foucault makes a distinction between moral codes (which are simply collections of rules and precepts) and ethics. He suggests that there are four aspects to how the individual constitutes him/herself as the moral subject of his or her own actions. The first aspect relates to the part of the individual which acts as the focus of moral conduct. The second aspect concerns what makes an individual recognise their moral obligations. The third aspect relates to the means by which individuals transform and work on themselves and the fourth aspect concerns what sort of person an individual might want to be. Throughout his life, Foucault relentlessly reworked his own ideas, by constantly re-reading, re-situating, and re-interpreting his early work (Rabinow & Rose, 2003). Rabinow and Rose (2003) have found that Foucault's thinking is sometimes contradictory, sometimes re-interpreting texts of the past, sometimes suggesting new and untried investigations, and sometimes jumping in completely unexpected ways.

However, the debates around changes in Foucault's thinking are not part of this study. Instead, my focus is on applying pertinent parts of Foucault's work to abortion decision-making. In particular I am interested in showing how Foucault's conceptualisations around power and its relationship to knowledge and discourse can be utilised in explaining the social discourses women draw on and positionings they take up in explaining their abortion decision. Using Foucault's work on bio-power, discipline and punishment, we can start to unpick the micro- and macro-level power relations underpinning abortion decision-making.

3.2.2 Discourses

Foucault (1972, p.26) sees discourses as "practices that systematically form the objects of which they speak... [discourses] are not about objects; they do not identify objects, they constitute them." According to Foucault, such things as madness, sexuality or discipline or, for that matter, abortion can only exist meaningfully through the discourses that surround them. Discourse contains subjects and objects and Foucault (1972) notes that the rules of discourse allow certain people to be subjects of statements and others to be objects. Foucault also spoke about the notion of subject positioning where his concern was to explore the ways in which discourses privilege certain subject positions whilst marginalising others (see later section 3.15 on narrative positioning).

A Foucauldian conceptualisation of power (see later section 3.4 on power) is fundamentally anchored to discourse and knowledge insofar as discourse produces systems of truth and knowledge that enable forms of power to operate (Foucault, 1969). This, therefore, means that the link between knowledge and power is discourse. Foucault (1980, p. 131) states that "truth is not outside power, or lacking in power, truth is a thing of this world: it is produced only by virtue of multiple forms of constraint and it induces regular effects of power." Thus, power relations are pervasive in the broader pattern of discourse, and knowledge claims are part of both the pattern of discourse and the relations of power. The reproduction of power relations and dominance depends, then, also on the "structures of discourse: who is allowed (or obliged) to speak or listen to whom, how, about what, when and where and with what consequences" (van Dijk 1993a, p. 110). Foucault (1980) adds to this argument by saying that knowing is not discovering truth but is making truth and in every society and period, there are different 'regimes of truth'.

Discourse is created within a historical context and displayed in a number of multifaceted ways which include the law, media, church, medicine and the government (Foucault, 1969). For example, abortion, which can be understood as a combination of discourses, discursive practices, discursive events, material practices and embodied practices in any given context will be constructed through laws, media, religion, medicine and government policies.

According to Foucault (1972), discourse is an argued dialogue within a culture, a procedure that formulates beforehand what our knowledge can discuss, what our knowledge can say and do. As such it becomes hegemonic in character, thereby placing boundaries on what can be said. This then means that there is neither any sort of underlying meaning or truth within things, nor any transcendental meaning or truth to be imposed upon things. Knowledge, in this instance, becomes a 'product' produced through human communication and practices which occurs only inside the validating, material framework of a larger pattern of discourse (Schneck, 1987, p. 18).

Weedon (1987) has referred to Foucault's understanding of discourse as:

> ...ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them. Discourses are more than ways of thinking and producing meaning.

> They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern (p. 108).

This definition of discourse shows that discourse goes further than just creating meaning and existing as a way of thinking within a society but constitutes all historically-, socially-, and institutionally-specific structures of statements, terms, categories, emotions and beliefs, whether the subject, who is sought to be governed by discourse, is aware of these or not (Scott, 1988). The definition also shows the imbrication of embodiment with discourse. Using abortion as an example in this way of thinking, it cannot be understood as simply a tangible action. Abortion is a discursive event where a woman's body (which is transformed by certain social relations) is the central character in the experience of abortion. The intervention of abortion shows the materiality of the body, thereby making abortion not merely a physiological given but a bodily process immersed in multiple social relations including sex and gender relations (Amuchastegui, 2013). Abortion, and the discourses deployed regarding abortion, are immersed in the reproductive capacities of women's bodies and happen within particular historical conditions that include legal regulation (Amuchastegui, 2013). This then means that "the social conditions, the relationships, the emotions, and the meanings that women experience during sexual intercourse, pregnancy, and abortion are as central as the bodily intervention itself" (Amuchastegui, 2013, p. 2). Therefore, when looking at abortion, we are looking at a process of embodiment, that is "an experience of the body that is historical and social but not altogether signifiable nor simply discursive" (Parrini, 2008, p. 15).

Discourse is also productive, as Foucault (1984) described discourses as "polymorphous techniques of power" (p. 60) that "produce" (p. 298) effects of truth. This means that the power that comes from discourses shapes paradigms and social rules which frame the limits of human behaviour and reality. Such discourses need not be explicit, however, as silences too hold power: "Silence itself – the things one declines to say or is forbidden to name … is no less the absolute limit of discourse … than … an integral part of the strategies that underlie and permeate discourses" (Foucault, 1984, p. 300). In this case the silence around abortion in Zimbabwe is integral to the construction of 'truth' regarding abortion.

Foucault's theory of discourse illustrates how language gathers itself together according to socially-constructed rules and regularities that allow certain statements to be made and not others: ''It enables us to understand how what is said fits into a network that has its own

history and conditions of existence'' (Barrett, 1991, p. 126). Foucault (1980) notes, however, that discourse can never be just linguistic since it organises a way of thinking into a way of acting in the world. Discourses define the boundaries of what can be thought of and communicated at a given time in a given society and how people undertake certain practices (Rabinow & Rose, 2003). The practices include those of the government and the government of the self which shape the subjectivity of the people or as Foucault (1980) puts it, they shape the individual's relations to him/herself (see later discussion on section 3.5 and 3.6 on self-surveillance).

Once discourse becomes 'normal' and 'natural', it is difficult to think and act outside it (Barret, 1991). Normalisation is a process that happens over time. Fegan (1999) states that discourses construct women as gendered subjects and other feminine categories such as 'mother'. So, for example, motherhood can be viewed as 'normal' and 'natural'. For instance, statements exist about how motherhood is good and as a consequence abortion is evil and wrong. This, then, becomes the way things are: motherhood can be understood as a regulative discourse as it may place upon the individual particular assumptions of what is acceptable or forbidden in a particular society. This happens through repeated constructions. So, for example, when desiring motherhood, or when the selflessness of motherhood becomes entrenched as normal and natural, going against this seems unnatural and abnormal. A way of resisting this discourse can be by seeking unsafe abortions from sources away from one's community and taking the decision without discussing it with family or societal members.

These types of discourses shown above perpetuate the idea that abortion is bad and evil. A woman who chooses to terminate a pregnancy is aware of these discourses, as they constitute the norms she knows as a member of a particular society. She has 'absorbed' the discourses because she has grown up around them and has learned that they are acceptable and the norm. However, despite their existence, this does not mean that these discourses are accepted by everyone without any resistance or action.

Even though discourse is productive, and works in a very material way through social institutions to construct realities that control both the actions and bodies of people (see later discussion on bio-power in section 3.5) it can be contested (Rabinow, 1984). Resistance is possible because of the dynamic nature of discourse. One of the major critiques of Foucault is that he fails to fully theorise resistance, and instead provides a theory of the docile body.

However, other theorists have seen the potential for resistance in Foucault's theories. Hekman (1990, p. 187) points out that ''the silences and ambiguities of discourse provide the possibilities of refashioning them, the discovery of other conceptualizations, the revision of accepted truths." Also, re-fashioning occurs in the ways in which people combine/shift discourses in their personal narratives. Therefore, although discourses seek to govern, they can also be used in resistance. This is explained by Diamond and Quinby (1988, p.185) when they refer to discourse as, "...a form of power that circulates in the social field and can attach to strategies of domination as well as those of resistance."

Resistance in Foucault's theorising cannot be separated from power (power is discussed next in detail). Foucault (1978, p. 95) contended that "where there is power there is resistance" and his theories of self-fashioning (1984) show how power is productive and not wholly oppressive. This provides a method of analysis that focuses around sites of resistance, contestation and conflict. Foucault (2003, p.15) states that "rather than analysing it [power] in terms of surrender, contract, and alienation, or rather than analysing it in terms as the reproduction of the relations of production, shouldn't we be analysing it first and foremost in terms of conflict, confrontation and war" in "local, regional, and material institutions." This, then, means that resistance becomes the point of departure where identities are contested, and battled for and against. Resistance can then be understood as a search for alternative 'truths'. Using the motherhood example from earlier, this, then, means that other contested discourses around singleness and femininity can counter the 'normal' and 'natural' discourse of motherhood.

3.2.3 Power

Foucault's conceptualisation of power was a shift away from the traditional view of power as an overpowering single entity. Foucault (1984) theorised that power exists in relations and due to this he speaks of 'power relations' or 'relations of power' instead of power. For Foucault (1978), power is not something that can be

> ..acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of non-egalitarian and mobile relations... [power] comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled as the root of power relations…no such duality extending from the top down (p. 94).

In the quote here Foucault moves from the traditional understanding of power being a single entity that is possessed by a few people who then use it to oppress others.

Foucault (1978, p. 93) also differentiates between power and power relations by stating that power "…insofar as it is permanent, repetitious, inert, and self-reproducing, is simply the over-all effect that emerges from all these mobilities…power is not an institution, and not a structure; neither is it a certain strength we are all endowed with; it is the name that one attributes to a complex strategical situation in a particular society." In relation to this, Halperin (1995) notes that when we identify and confront someone who seems to have power, our traditional understanding of power does not work given this understanding of power, since the relationship itself is imbued with and characterised by power. He adds that "power is thus a dynamic situation, whether personal, social, or institutional" (p. 17). This understanding of power as being dynamic and not being an institution has consequences for my use of patriarchal power relations in the following sections.

It is also important to note that even though power relations are multiplicities that are not fixed once and for all but are ''unbalanced, heterogeneous, unstable, and tense'' (Foucault, 1978, p. 93), they can be coded in ways that integrate them, thus producing strategies such as politics or war. Particular "homogenizations, serial arrangements and convergences" (Foucault, 1978, p. 94) of practices can produce states of domination by obstructing relations of power. This means that even though power does not exist inherently in the state or the law or a ruler, these formations may be "the terminal forms power takes" and these structures could be perceived as the manifestations of power (Foucault, 1978, p. 92). Relations of power may be blocked at the personal as well as the institutional level, meaning that Foucault not only rethinks the location of power but also its nature. He suggests that power is neither inherently evil nor a negative, repressive force (Foucault, 1978). He states that "we must cease once and for all to describe the effects of power in negative terms: it 'excludes,' it 'represses,' it 'censors,' it 'abstracts,' it 'masks, ' it 'conceals' but in fact power produces and it produces reality" (Foucault, 1977, p. 194). Foucault (1984) then adds that we must analyse relations of power in order to learn what is being produced. The implications of this Foucauldian understanding of power for postcolonial feminist interpretations are far-reaching especially since colonial power and patriarchal power relations are recurring themes.

3.2.4 Bio-power

In *Society Must Be Defended*, Foucault (1976) coined the term "bio-power", a new form of power that emerged in the 18th and 19th centuries (along with liberalism, democracy, and capitalism) through which the state (Foucault's work was concentrated on Europe) began to

both regulate populations and discipline individual bodies. Foucault (1976) argues that bio-power comes into being as the state begins using new technologies and discourses of health, birth, mortality, and demography as mechanisms of regulatory power to exercise control over populations. He argues that instead of replacing the disciplinary power[6] that precedes it, bio-power "dovetails into it, integrates it, modifies it to some extent and above all, uses it by infiltrating it…" (Foucault, 1976, p. 242).

Foucault (1976, p. 241) links the emergence of bio-power to a new 'political right' which is the right "to make live and let die." The political right entails the state's increasing ability to regulate and control living populations and individuals, as well as the expectation that the state will protect certain populations and bodies provided that they fit within social norms, adhere to standards, and obey laws (Foucault, 1976). In Zimbabwe, this then means that the state's regulations concerning abortion (e.g. legislation and policy) seeks to control the bodies of the population and this creates certain social norms which are taken up in everyday subjectification.

The body is seen as a privileged site within which bio-power operates; it (bio-power) is "dependent upon bodies and what they do" (Foucault 1980, p. 104). The body is a "projection of the dominant discourses" (Foucault, 2003, p. 56). Bio-power functions on the micro (individual) and macro context (population) (Foucault, 2003). On the individual level bio-power is seen in the form of daily practices. On the macro level it is seen in dominant discourses around what is considered healthy for the whole population. For example, when we eat healthily we do not, at a population level, want to have a health crisis, and over-burden the healthcare system; at an individual level this promotes our own wellbeing as being healthy enables higher levels of productivity.

As shown above, bio-power is seen in the ways in which power manifests itself in the form of daily practices and routines, through which individuals engage in self-surveillance and self-discipline, and thereby subjugate themselves (Foucault, 2003). Bio-power focuses on the body as the site of subjugation. It highlights how individuals are implicated in their own oppression as they participate in habitual daily practices such as the self-regulation of hygiene, health and

[6]Disciplinary power is a type of power whose main function is to train. It links forces together to enhance and use them: it creates individual units from a mass of bodies. Disciplinary power is discussed in more depth in the next section.

sexuality. Its force derives from its ability to function through knowledge and desire – the production of scientific knowledge which results in a discourse of norms and normality, to which individuals desire to conform (Foucault, 2003).

Foucault (1976) also adds that the political right is undoubtedly problematic as it marks some populations and bodies as normal, superior, and worthy of protection and other (racialised, classed, gendered, sexualised) populations and bodies as inferior, deviant, or threatening. This 'otherness' is then used as justification for violence against, or neglect of, certain populations and individuals. In colonial times, the African 'other' was seen as threatening and thus required regulation (Tamale, 2003). With regards to abortion decision-making, only 'certain bodies' are more likely to have unsupportable pregnancies and these include poorer women, women not in long-term heterosexual relationships and rural women. This is in contrast to those 'bodies' with money (higher classes) who are able to attain safe abortions away from the public eye, even in countries where it is illegal (Hess, 2007). These 'certain bodies' are thus seen as threatening as they go against the regulations and expectations placed upon them.

Foucault (1977, 1990), through his discussion of bio-power, demonstrated how the human body is a central component in the operation of power. He theorised the body as "an inscribed surface from which the prints of history can be read" (Rabinow, 1984, p. 83). The arena where bio-power plays out has been named 'bio-politics' (Rabinow & Rose, 2003). Rabinow and Rose have argued that the aim of bio-politics is to supposedly improve life through regulating, managing and isolating those elements that are seen as threatening optimum existence in any given society. The purpose of bio-politics is not to modify any given phenomenon as such but to modify a given individual insofar as she or he is an individual (Foucault, 2003). Bio-politics does this by "encouraging what ought to be; it seeks to lower or modify the mortality rate, increase life expectancy, and stimulate the birth rate by establishing regulatory mechanisms in order to achieve some sort of equilibrium for each biological process" (Foucault, 2003, p. 35).

Foucault (1976) identified medicine as the hinge between the level of the private body of individuals and the body of the population or the species, both of which are policed, supervised and examined for their condition, improvement and protection. Thus, medicine polices private bodies at the same time as it regulates populations (Prainsack, 2004). Foucault (1976) sees medicine as perpetuating discourses about sex and sexuality which are the main channels through which bio-power achieves its aim. Policing sexuality and the body becomes a major

avenue of population control through the process of truth-making. Bio-power operates through regulation and discipline, with negative and violent consequences for some populations and individuals (Rabinow & Rose, 2003).

Bio-power can be seen as operating in African contexts through the two aspects of bio-politics: that is, control of the population and of the body of the individual. Tamale (2003) has argued that secrecy and taboos concerning sexuality are some of the tools that allow patriarchal power relations to create and sustain gender hierarchy in African societies thus showing the operation of bio-power. Tamale points to the use of laws that prohibit all 'sex outlaws', which include those who choose to terminate a pregnancy, 'prostitutes', homosexuals, bisexuals and transgendered individuals which is an example of 'othering'. Tamale (2003) concludes that bio-power in patriarchal power relations operates by maintaining a tight grip on certain activities, leading to the silencing of the voices of those individuals and groups who engage in them. Tamale (2003) cites attacks on homosexuals in Kenya, Uganda and Zimbabwe by police who act as the agents not only of the patriarchal state but also cultural and social norms which makes it extremely difficult for homosexuals to live peacefully. These actions are visited on the bodies of the 'other' as they are seen as engaging in unacceptable bodily practices. The attacks by the police are meant to highlight the limits of acceptable bodily practices (viz. partriachial heterosexual bifurcated gendered sexual interactions).

The law, the media, societal members and educational systems, both formal and informal, may act as reinforcing bio-politics by constructing African women's sexuality and desire (McFadden, 2003; Tamale, 2003, 2004). This is done through the creation of common sense truths about men and women that must be accepted in order for the discourse of patriarchy to function. Discourses operate by engraving inscriptions on their bodies. The subordination of African women's bodies is done through the control of their reproductive and sexual health. Several socio-cultural norms and religious norms such as virginity testing, female genital mutilation, female chastity, occult sexuality and taboos around polyandry have been implicated in keeping sexual repression firmly in place. These represent the exercise of patriarchal bio-power on women's bodies as defined by Foucault.

Abortion is regulated through a range of bio-political mechanisms of which one is the legislation surrounding abortion. Abortion regulation is an example of how state power influences and disciplines the bodies of its subjects: how it regulates the population and shapes

it according to the state's needs (Prainsack, 2004). Through the regulation of abortion, the state in most African countries not only attempts to restrict a woman's control over decisions about her own body, but also defines which of its citizens should or should not become a parent (e.g. able-bodied vs. disabled). Bio-power therefore explains how the state, buttressed by scientific discourses, "brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of the transformation of human life" (Foucault, 1984, p. 17).

3.2.5 Governance

In *Discipline and Punish*, Foucault (1975, 1977) describes disciplinary power using Jeremy Bentham's architectural figure of the Panopticon to illustrate how it functions. The prisoners in Bentham's Panopticon believed that they were always under surveillance by the guards whom they could not see. Thus, the prisoners began to discipline themselves, even when the guard was not present. This type of power, which disciplines when it is invisible, can be compared to the way societal discourses place certain injunctions on the woman who is faced with a pregnancy decision. The rule/norms that are inherent in social discourses can be considered as the guards in the Panopticon. The woman who is faced with a pregnancy decision does so with the knowledge that she is under surveillance by the guards/norms.

Foucault (1977) argues that the Panopticon can be viewed as a disciplinary mechanism that aims to arrange and control specific and identifiable groups of people. He adds that the forces that are used to arrange and classify groups of people also render those people as individual units. The individual, he argued, is thus a construction of power created only when that individual is recognised as part of a larger identifiable group. Thus, a group is not created by a mass of individuals, but vice versa (Foucault, 1977).

According to Foucault, it is only through discipline that modern individuals are created out of a mass. Disciplinary power, he claims, differs from pre-existing power mechanisms in that it is applied primarily to bodies and what they do. The benefits of disciplinary power, Foucault explains, lie in its precise manipulation of the body so as to render bodies both useful and docile (Foucault 2003, p. 249). Therefore, disciplinary power "dissociates power from the body; on the one hand, it turns it into an aptitude, a capacity, which it seeks to increase; on the other hand, it reverses the course of the energy, the power that might result from it, and turns it into a relation of strict subjection" (Foucault 1977, p.138). All of this takes place, Foucault

maintains, through the meticulous regulation of the body's movement and the time and space in which it moves.

Foucault (1977) claims that bodies of individuals are trained to be useful and docile through three techniques of control which are hierarchical observation, normalising judgment and examination. In the technique of hierarchical observation, the exercise of discipline assumes a mechanism that coerces by means of observation. Hierarchical observation involves the act of seeing without being seen or observing without being observed (as in the Panopticon). This observation maintains discipline not by force but by a calculated gaze. The second element of discipline, normalising judgement, states that for punishment to be effective it needs to be corrective and be regulated for the sake of reform (Foucault, 1977). Normalizing judgment creates a system of normalization where the actions of individuals are not judged by social status but by standards set for all. By having punishment define an individual's actions as virtuous/non-virtuous, a double system of gratification is created where the individual has positive actions reinforced and unwanted behaviours disciplined. The last element, examination, involves both hierarchical observation and normalizing judgment and makes it possible to qualify, classify and punish. Examination is an example of what Foucault calls power/knowledge, since it combines into a unified whole "the deployment of force and the establishment of truth" (Foucault, 1975, p. 184). This is because it elicits both the truth about those who undergo the examination (regarding the state of their health) and controls their behaviour (by directing them to a course of treatment). Health service providers are implicated in this type of discipline through the use of hospital records. In these instances the individual is turned into a case that is used as a scientific example and becomes an object of care (Gutting, 2014).

Individuals voluntarily control themselves by self-imposing conformity to cultural norms through self-surveillance and self-disciplinary practices, especially those of the body such as the self-regulation of hygiene, health and sexuality. Foucault (1976) sees the production of 'docile bodies' (passive, subjugated and productive individuals) as being used in maintaining the political order. Through its many institutions that include schools, hospitals, prisons and the family, the state brings all aspects of life under its controlling gaze. The institutional disciplining, surveillance, and punishment of the body creates bodies that are habituated to external regulation, working "to discipline the body, optimize its capabilities, extort its forces,

increase its usefulness and docility, integrate it into systems of efficient and economic controls" (Foucault 1980, p.139) and thus produces the types of bodies that society requires.

A woman faced with an abortion decision in a country like Zimbabwe can be seen as going through the same process where disciplinary power has her in check. She is aware of the laws, cultural and societal practices which act as the institution of power that keeps watch over her. Through her interactions with her community and the law she is aware of the observations placed upon her and the punishments that will follow if she chooses to do what is illegal both in the eyes of the law as well as her community. She has internalised the social control that monitors society and maintains the disciplined efficiency of the social system. All this might point to why some research (Chikovore, 2004) in Zimbabwe has shown that those who choose to terminate a pregnancy act in isolation.

The internalisation of social control is a form of self-surveillance which is usually understood as the "attention one pays to one's behaviour when facing the actuality or virtuality of an immediate or mediated observation by others whose opinion he or she deems as relevant – usually, observers of the same or superior social position" (Vaz & Bruno, 2003, p. 273). Rabinow and Rose (2003) argue that the concept can be expanded to include individuals' attention to their actions and thoughts when constituting themselves as subjects of their conduct. Self-surveillance is also based on the cultural postulation that certain thoughts and actions are dangerous or unwholesome to the constitution of the individual as a subject. This expansion can give insights into abortion decision-making. The woman who is faced with an abortion decision is faced with acting in accordance with her observers (members of the same or superior social position) her own ethical substance (keeping in mind her history in terms of beliefs) and caring for herself (unsupportable pregnancy).

Foucault's approach has been taken up in health studies. Healthism is a part of health studies which links the "public objectives for the good health and good order of the social body with the desire of individuals for health and well-being" (Rose, 1999, p.74). In healthism, the state no longer seeks to discipline, instruct, moralise or threaten people into compliance (to have healthy bodies and hygienic homes) but "individuals are addressed on the assumption that they want to be healthy and enjoined to freely seek out the ways of living most likely to promote their own health" (Rose, 1999, p. 86–87). As a technology of the self, healthism assigns a key role to experts. Rose states that by aspiring to be healthy and being shown the joys of a healthy

body, people's personal goals become aligned with political goals thus rendering the person governable. Healthism, however, has limited applicability in a Zimbabwean context where the health system does not function due to lack of resources (see Chapter 1 section 1.4) but is pertinent in European liberal democracies where there are considerable economic and health resources. Despite this, health service provider interactions are sites where healthism may be implemented, with healthcare workers providing people with injunctions concerning healthy and correct living.

3.2.6 Power and sexuality

With regard to sexuality, Foucault (1990, p. 17) explains that "sex became a crucial target of power" (p. 147), a topic at the center of a "discursive explosion." Foucault indicates that bio-power arose as a result of the necessity of policing and regulating sex with the well-being of humanity in mind. Foucault (1990) states that through the confessional technique and the disciplinary power inherent in it we are compelled to speak the 'truth' about ourselves and this is how we come to believe there is a 'truth' about our sexuality in the first place. The confessional technique is based on the religious confession and is central to Foucault's understanding of the workings of power. Foucault (1978, p. 56) describes how "Western societies have established the confession as one of the main rituals we rely on for the production of truth" and how we have created a "…continuous incitement to discourse and to truth." The functioning of the confessional technique can be seen through how health service providers interact with the people that they serve. We have to tell the truth to health service providers so that we are given the appropriate treatment. The installation of the confessional serves in ensuring the operation of power by acting as surveillance agents for regulative discourses.

Foucault (2010) also showed how, through discourses of the body, power relations arrange sexuality in order to control sexual practices. He pointed out four main discourses of how this is possible which are: i) a hysterisation of women's body; iii) a pedagogisation of children sex; iii) a socialisation of procreative behaviour; iv) a psychiatrisation of perverse pleasure (Foucault, 2010, p. 79–80). For the purpose of this research I will only expand the first discourse of hysterisation of woman's body. Foucault (2010) states that the women's body is viewed as a sexually overwhelmed body that is inserted into the family space where women have a biologic-moral responsibility for children. The woman's body is responsible for the welfare and morality of the society and she has to give birth regularly. The hysterisation of the

woman's body also refers to the location of problematic sexuality within the woman's body. Nedesan (2008, p. 113) adds that "hysterisation of women's sexuality and normalization of heterosexuality are elements of the government strategies seeking to combat the nation's alleged descent into moral decay." This means, then, that discourses around motherhood as being natural, and patriarchal power relations the normal way of life form the social backdrop within which abortion decision-making takes place. Foucault's conception of sexuality not as an innate or natural aspect of the body but rather the effect of historically-specific power relations provides a useful analytical framework for explaining how women's experience is diminished and controlled within certain culturally-shaped notions of female sexuality.

3.3 Feminism and Africa

It is important to consider the relationship between feminism and Africa before delving into postcolonial feminism informed by Foucauldian theory. This allows for an informative grounding about feminist interpretations on the continent. Tamale (2014) has warned of homogenising Africa and calls for attention to be paid to the pluralities within. These pluralities can be found in the way feminist scholarship has developed on the continent. Feminism has been understood differently amongst African scholars and this has created different varieties of African feminisms (Goredema, 2010; Tamale, 2007). Toure, Barry, and Diallo (2003) have argued that feminism in Africa can be divided into intellectual feminism and popular feminism. Intellectual feminism, usually promoted by urban and educated African women has a "tendency to export the debate on women's rights outside Africa" (Toure et al., 2003, p. 2). As an antithesis to African intellectual feminism, popular feminism "is rooted in the culture and lived experience of African women and traditional African society in terms of food production as well women's role in the liberation movements against colonialism" (Toure et al., 2003, p. 3). Debates on African feminisms can also be seen elsewhere (see Atanga, Ellece, Litosseliti, & Sunderland, 2013). My interest here lies in providing a background to how feminism has been taken up in Africa.

Tamale (2004) has located feminism in Africa in the continent's historical realities of marginalisation, oppression and domination brought about by slavery, colonialism, racism, neo-colonialism and globalisation. McFadden (2002) has argued that due to these historical realities, African feminisms have tended to place importance on the inter-connectedness of gender, women's oppression, race, ethnicity, poverty and class. Due to this history, African feminisms have also tended to be postcolonial in nature (Mama, 2005; Njambi, 2004; Tamale,

2004). African feminisms try to understand the different experiences and realities for African women and those in the diaspora in three political eras: pre-colonial, colonial and postcolonial (Goredema, 2010). These three eras, according to Goredema (2010), vary across the different African regions, leading to different experiences and definitions of feminism.

In being postcolonial, African feminisms have tried to set their own agenda by resisting other 'feminisms'. Goredema (2010) argues that debates have being raging in rejecting Western feminism because European and American feminists want to control the agenda and perceive African women as being problems that require solutions. The debates around rejecting mainstream feminism can be found in detail elsewhere (see Goredema, 2010; Reed, 2001) and are not repeated here except by noting that the agenda that African feminism sets is one that recognises the multiplicity of, and differences due to, the "complex realities of African women's everyday experiences" (Bakare-Yusuf, 2003, p. 1).

With regard to the female body, feminism in Africa has explored colonial constructions, with Tamale (2003) suggesting that the African woman during colonialism was viewed as profligate and hypersexual. This, in turn, led to intensified surveillance and repression especially of African women's sexuality. The construction of the hyper-sexed female body made it easy to justify the strict regulation and control of African women's sexuality. This regulation and control was achieved through various legal and policy strategies (examples of these are the Native Land Act of 1951 in Zimbabwe where women could not own land thereby meaning they were reliant on males) and discourses in the areas of medical health and hygiene (Gilman, 1986). The regulation and control was made on two levels: the colonial powers and the patriarchal family set-up that both 'policed' the African females' body (McFadden, 2002).

Tamale (2004) has argued that these legal policy strategies and discourses reinforced traditional customs leading to the creation of a new order of novel sexual mores, taboos and stigmas. Thus, according to Musisi (2002) and Vaughan (1991), the subsequent suppression of women's sexuality, erotic culture and sexual expression through the medicalisation of sexuality in turn perpetuated the new set of sexual mores, taboos and stigmas. An example is taboos around women having several partners, something only permitted for their male counterparts, as it supposedly shows their maleness (Tamale, 2004). The Ugandan Penal Code is an example where a woman is guilty of adultery if she sleeps with any man outside of her marriage and a man is only guilty if he sleeps with a married woman (Tamale, 2004). Therefore, colonialism,

in tandem with African patriarchy, created an obstinate system of customary and statutory laws that evolved into new structures and forms of domination (Mama, 1997; Schmidt, 1991). The collusion of colonial administration and African patriarchy was made possible by the need of both parties to control the position of African women (McClintock, 1995).

3.4 Postcolonial feminisms

Having conceptualised Foucault and provided a grounding of feminism in Africa, I now move to postcolonial feminism. I begin by introducing the postcolonial feminisms and how it arose from both postcolonial theory and feminist theory. I discuss the postcolonial feminist concepts of patriarchal power relations, domesticity, sexual politics and how they can be informed by Foucauldian theory.

3.4.1 The beginnings

Postcolonial feminism has become a flourishing method of analysis to address key issues within feminism and postcolonial theory (it grew as a critique to both fields) (Bulbeck, 1998). As a critique of feminism and postcolonial theory, postcolonial feminism attempts to account for perceived weaknesses within both (Shital & Udgir, 2012). Postcolonial feminism shares with postcolonial theory the challenging of any exploitative and discriminative practices, regardless of time and space and also highlighting/foregrounding (neo-)colonialist power relations that are frequently neglected in other theories. However, postcolonial feminists have also criticised postcolonial theory for its silence about women's struggles (Mohanty, 1988; Shital & Udgir, 2012). Postcolonial feminism emanates from a standpoint where theorists view the position of women in many societies as being relegated to the position of the 'other' and they compare this position to the one colonised subjects used to hold: that is, experiencing the politics of oppression and repression (Azim, Menon, & Siddiqi, 2009; Mohanty, 1988).

As a critique of feminism, postcolonial feminism illuminates the tendency of Western feminist thought to apply its claims to all women around the world, when in reality the scope of feminist theory is limited (Shital & Udgir, 2012). Postcolonial feminists have argued that differences exist between so-called 'Western women' and those from the 'Third World'. Western feminism[7] has been viewed by postcolonial feminists as having a white women middle-class

[7] There are various forms of western feminism - radical, liberal, Marxist, queer. The point of commonality is their general failure to include power relations that cohere around the legacy of colonialism and current forms of subtle imperialism.

agenda. Mohanty (1988) asserts that Western feminists write about 'Third World' women as a composite, singular construction that is arbitrary and limiting. This creates a dynamic where Western feminism functions as the norm against which the situation in the 'developing world' is evaluated (Mohanty, 1988).

The postcolonial feminists' primary initiative, therefore, becomes theorising that focuses on 'Third World' women's resistance, agency and voice within the feminist movement. This agenda for postcolonial feminists is put forward by Mohanty (1988) as involving the empowerment of marginalised 'Third World' women' and their struggles of resistance against the patriarchal society in which they exist. This agenda is made possible by using deconstruction, critique, and agency as possibilities for conceptualising difference as tools in postcolonial feminist theory. By using some of these tools, postcolonial feminism has managed to create a position within which is a set of methodologies and concerns that can help to map out 'alternative subjectivities' (Mills, 1998). The alternative subjectivities concept has included challenging the public/private sphere conundrum which is discussed in the next section on domesticity.

3.4.2 Patriarchal power relations

Patriarchy is central in African cultures, especially in relation to sexuality and reproduction (Mama, 2005; Tamale, 2003) and in particular abortion. Patriarchal power relations are seen as creating and sustaining gender hierarchies in African societies by controlling sexuality and reproductive decision-making (Tamale, 2003). Before embarking on a discussion of patriarchal power relations, it is critical to provide definitions of patriarchy. In its literal sense, patriarchy means the rule of the father in a male-dominated family: a social and ideological construct which considers men as superior to women. Walby (1986) showed how patriarchy could be extended to understand power relations between men and women in a broader sense such as within communities. What is interesting about the initial theorisation of patriarchy is that it also suggested that elder men oppressed younger men (Walby, 1986).

Debates have been raging on how to conceptualise patriarchy. Bakare-Yusuf (2003, p. 2) notes that "many theorists have used the term 'patriarchy' in African contexts to refer to the organisation of social life and institutional structures in which men have ultimate control over most aspects of women's lives and actions." In these contexts, patriarchy is seen as a monothetic overpowering structure which may lead to "a danger of ontologising male power,

and assuming that human relationships are inevitably moulded by tyrannical power relations" (Bakare-Yusuf, 2003, p. 2). Using the example of viewing patriarchy as male domination over women (sexual differentiation), Bakare-Yusuf (2003, p. 2) argued that "equating sexual difference with male dominance can also obscure the ways in which both men and women help to reproduce and maintain oppressive gendered institutions." Examples here can be seen in the role aunts or *tetes* play in Shona culture where they hold a highly-esteemed position and are implicated in the oppression of other women (Mester, 2008). Bakare-Yusuf (2003, p. 3) suggests that "rather than viewing patriarchy as a fixed and monolithic system, it would be more helpful to show how patriarchy is constantly contested and reconstituted." Patriarchy here is then seen from a viewpoint where women are not mere victims of male oppression but are actively involved in challenging, contesting and in some situations perpetuating patriarchal power relations. This then leads to viewing patriarchy as an ever "changing and unstable system of power, [meaning that] we can move towards an account of African gendered experience that does not assume fixed positions in inevitable hierarchies, but stresses transformation and productive forms of contestation" (Bakare-Yusuf, 2003, p. 3).

I use the phrase 'patriarchal power relations' to show that I am not identifying one single cause for women's oppression but rather I am looking at how relations based on a patriarchal system work to oppress women. In this context patriarchal power relations are specific, regional (in this case Shona, Zimbabwe) "interlinked discursive and practical relations that, as a whole, effect a general polarisation of a broad spectrum of corporeal capacities, social experiences and multiple identities and result in the production of bodies that are sexed and identities that are gendered" (Kesby, 1999, p. 28). I suggest that a Foucauldian understanding of patriarchal power relations can aid in feminists' interpretations of patriarchy and how it functions to control women. Since patriarchy seems inherent in most African women's lives, it is easy to see it as an overarching, all-dominant power structure that controls women. However, a look at how Foucault speaks about the power/knowledge nexus can shed light on the micro and macro power relations that create and sustain patriarchy. Patriarchy can be seen as a knowledge/power system perpetuated through certain societal practices, discourses and beliefs which are perpetuated by all members of a certain society in uneven and complex ways.

Patriarchal power relations have also been seen to vary across different cultures or in the same culture in the way they control and subjugate women due to differences in class, caste, religion, region, ethnicity and the socio-cultural practices (Tamale, 2014). These differences are an

important backdrop to consider when examining abortion decision-making processes. Although two countries can be considered as being patriarchal in nature, it does not mean that the same conditions will exist for the woman faced with an unsupportable pregnancy. Western countries are still viewed as patriarchal societies even though access to abortion is high, unlike some African countries where it is outlawed. So in these cases, the patriarchal power relations that exist, for example, in Sweden are different from the ones in Zimbabwe. Stigma and social sanctions that have been noted in the two contexts are also different.

I now turn my focus to examining how patriarchal power relations impact on the lives of women with respect to issues surrounding sexuality, reproduction and mothering. Patriarchal societies tend to propagate ideas surrounding motherhood which restrict women's mobility and burden them with the responsibility of nurturing and rearing children. The African woman is then socialised into sustaining the very power relations which will continue to oppress her throughout her lifecycle (Tamale, 2004). Within the context of an African culture, as defined by men and not by herself, she is a second-class citizen (Tamale, 2004). In many contexts, her labour is unremunerated, available and disposable, her rights are subject to validation and her daughters will share her fate. Tamale (2004) has argued that the biological fact of bearing children is interrelated with the social position of women's responsibilities of motherhood which include nurturing, educating and raising children by devoting themselves to family. These interrelations often mean that distinctions are not easy to make. Heywood (2003, p. 248) has noted that "patriarchal ideas blur the distinction between sex and gender and assume that all socio-economic and political distinctions between men and women are rooted in biology or anatomy."

In relation to this understanding/debate, I borrow from Macleod and Durrheim (2002) who provide an understanding of patriarchy which shows its operation in the micro and macro levels of power. These authors state that patriarchy cannot be understood as the only site of domination or resistance but as being produced from a multiplicity and interplay of power relations. Macleod and Durrheim (2002, p. 44) also point out that Foucauldian feminism stresses "...the variety of ways in which effects of male domination are produced and gendered identities are constituted." Applying this to abortion decision-making sheds light on how the woman who is faced with this decision is positioned by the different levels of power in her everyday life (micro) and the larger society or nation social, cultural, material discourses and practices (macro).

3.4.3 Domesticity

The concept of domesticity covers the debates about what has been termed the public/private sphere conundrum that can be found in African societies (McFadden, 2000a). Tamale (2003) has theorised that capitalist patriarchal societies are characterised by a separation of the 'public' sphere from the 'private' sphere as a way of oppressing women. She states that these two spheres are, "highly gendered, with the former inhabited by men and the locus of socially valued activities, such as politics and waged labour, while the latter constitutes the mainly unremunerated and undervalued domestic activities performed by women" (Tamale, 2003, p. 11). Tamale (2003) has also argued that this division has necessitated the domestication of women's bodies and their relegation to the 'private' sphere, where women provide gratuitously the necessities of productive and reproductive social life while remaining economically dependent on their male partners. Therefore, in terms of abortion decision-making, the woman who decides to terminate a pregnancy challenges this division by rejecting the domestic reproductive life she ought to be carrying out. By rejecting reproduction she denies those in the public sphere; for example, she denies her husband the social capital that children bring.

The process of separating the public/private spheres has been shown to have preceded colonisation, with colonisation reaffirming it by consolidating and reinforcing it through colonial policies and practices (McFadden, 2002). Colonial structures, through legal and religious practices, guided by an ideology that perceived men as public actors and women as private performers, clarified and hardened the distinction between the public and private spheres. The nature of the public/private divide changed with the introduction of money as a method of exchange as well as such things as industries and shops. Whereas previously labour and production was mostly centred around the home and *kraal*, paid labour took place away from the home, and labour within and around the home took on less value. In addition, money was generally paid to men, giving them more power over women. Mama (1997) has likened the colonial containment of women in the private sphere as a process of systematised violence, one that restricted women to increasingly limited spheres through legislation and the policing of public space. This also means that men have 'power' over women because these isolated spaces allow for women to be abused out of the public eye without others easily being aware of it.

Postcolonial African feminists have argued that womanhood in Africa continues to be framed by narratives of domesticity (McFadden, 2000a; Tamale, 2002, 2008, 2011) which entails that

women should stay in the private sector. One of the ways these narratives are reinforced is through proverbs as Horn (2006) shows. Horn (2006, p. 11) states that the proverbs in most African cultures, along with contemporary cultural norms and laws, reinforce the idea that the 'proper' or 'real' African woman is a woman, "who is heterosexual, married, bears children, and more often than not, pleases her husband sexually." An example of how African women are seen can be found in the Shona proverb that I grew up hearing, *Mukadzi mwana anoda kuchengetwa* (The woman is like a child, she must be guided at all times). Horn (2006) has suggested that the construct of the "woman-mother" has also coloured policy and programming concerning women's health in Africa, where reproductive health and family planning services for married women have been prioritised over services for sexual well-being and health, or the sexual and reproductive health needs of non-heterosexual or unmarried women. This is similar to what Foucault suggests concerning the operation of bio-power in terms of separating bodies into different spheres of operating.

Domesticity is also perpetuated in legal frameworks that deal with women's rights, including the African Charter for Human and People's Rights. The charter according to Horn (2006, p. 9) "favours the heterosexual family as the primary unit of society, thereby extending rights to women according to the degree to which they participate in it." She notes that "what is problematic about this narrative of domesticity is not so much that it supports and reifies motherhood, a status and identity which is desired and enjoyed by many women" but rather, "the limitation of recognition of women's bodily and other rights to those concerns that support the patriarchal family alone" (p. 10). This understanding of domesticity is supported by McFadden (2000b, p. 23) who argues that "domesticity has become a controlling ideology [discourse] that interfaces male/female relationships in the private domain." She argues that this discourse of domesticity feeds into the heterosexual family unit where men are allowed to reproduce themselves socially, culturally and sexually. It is against the bedrock of the ideology of the heterosexual family unit, with the women occupying the domestic sphere, where abortion decision-making takes place (although not all women make decisions within a heterosexual family unit, of course).

Using Foucault's conceptualisation of bio-power can illuminate the theoretical insights of domesticity. Bio-power acts by separating bodies into different spheres of operating, (public vs. private) through surveillance (family planning, control of the population through policy, law, health systems, health services provision, proper management of the domestic space, proper

child care) and through the clinical gaze[8] (through service providers and self-surveillance: control of the individual body) that is exercised on women's bodies through reproductive health. The surveillance is not simply about reproductive health but also about being the good wife, maintaining a good household, tending to the children and the garden and ensuring the house is clean. All of these activities within the supposedly private mode of the domestic is closely surveyed and monitored, specifically along gendered lines.

3.4.4 Sexual politics

Sexuality is a key site through which women's subordination is maintained and enforced in postcolonial Africa (McFadden, 2003; Pereira, 2003). 'Sexual politics' as a concept arose from a 1970 book (by the same name) by Kate Millett. It has become an important concept that has been adopted by some postcolonial African feminists in relation to the field of sexual and reproductive rights (McFadden, 2003; Oloka-Onyango & Tamale, 1995; Tamale, 2004). Tamale (2004) defines sexual politics as the notion that women's bodies, both in and outside of intimate relationships, are sites of patriarchal power. McFadden (2003) echoes Tamale as she states that control over women's bodies by intimate partners, family, community, society and the state is on-going.

Discussions surrounding sexual politics have led to a deeper analysis on the intersection between the human body, gender and politics among most postcolonial African feminists (Diallo, 2003; Imam, 2000; McFadden, 1992; Tamale, 2003). This intersection between the human body, gender and politics has been seen as creating spaces in which sexuality acts as a powerful constraint for women in Africa. It also, however, provides empowering possibilities (Diallo, 2003).

Tamale (2004) has argued that although pre-colonial African societies manipulated culture to oppress women, the Judaeo-Christian and Arabic cultures also imposed a particular sexuality on African women which saw them as hyper-developed and in need of control. McClintock (1995) has argued that the cultural construction of women brought by Christian and Arabic cultures facilitated the consolidation of the patriarchal colonial state. Tamale (2007) has also added that in a postcolonial context, the two legacies of these socio-political formations

[8] The concept of the clinical gaze is associated with Foucault. It is part of a specific discourse on the body in which the body is perceived as a physical object capable of being observed, measured and treated with little or no reference to the person.

(Christian and Arabic) impose a variety of gendered constructs on the African woman. An example is the Christian construction of women in the New Testament where they are seen as submissive recipients of the husband's decisions. A woman deciding on her own to terminate a pregnancy, then, is a rejection of that construction. The abortion decision is thus complicated for women living in countries like in Zimbabwe where, as mentioned in the Literature section, Christianity has played a large role in the gendered construction of women.

3.4.5 Resistance

Using a Foucauldian understanding of power relations, African women can be seen as not just recipients of male control and decisions with regards to terminating pregnancies. The African female body is also equally a site of resistance, negotiation, identity, self-desire, pleasure and silence (Mama, 2005; McFadden, 2002; Tamale, 2003). Adopting a Foucauldian understanding of resistance as a search for alternative 'truths', African women can be seen as challenging the gendered, restrictive and discriminatory practices that exist in their contexts (see section 3.3 on discourse for discussion on Foucault's conceptualisation of resistance). The inclusion of silence as a tool of resistance is not without problems as it can work to reinforce oppression by making it seem as if the person agrees with oppression or discrimination. However, it can also be a tool of resistance and struggle, especially for the marginalised (Tamale, 2004). This legitimate silence surrounding African women's sexuality is a "silence that is safe, unengageable and ambiguous" (Tamale, 2004, p. 1).

Tamale (2004, p. 1) also adds that this conceptualisation of silence is "different from the Western feminist approach that normally condemns it and describes it as a total blank while valorising voice." The argument put forward is that even though speech with regard to sexuality is necessary and empowering, silence can be equally, or even in some instances, more powerful (Mama, 2005; Tamale, 2004). Bennett (2003) has highlighted the right to keep secrets about one's sexuality as an example of where silence may serve as a powerful tool of rejection of externally-imposed projections of African women's sexuality. Another example of silence being powerful as a tool of resistance is seen in women who choose to undergo a termination of pregnancy secretively – or in silence. This is particularly an act of resistance and agency where there are macro- and micro-level sanctions against her doing so as previously discussed.

Resistance also works together with agency when it comes to making decisions surrounding abortions. The woman who chooses to terminate a pregnancy, by resisting the dominant

discourse of motherhood that is inherent in patriarchal power relations, challenges the partriachial order and therefore acts with agency to define her own future. Fegan (1999, p. 258–259), in discussing how the law constructs women, argues that "despite law's discursive construction of 'Woman', and social (i.e. society's and the individual subject's) ideological consumption of these ideas and images, there remains a space for inner subjective knowledge – I'll call it 'agency' – from which resistance to their oppressive usage may be developed." This, then, means that women are not just victims who are dominated through patriarchal power relations but are active agents who may be empowered to act in particular ways as discussed earlier.

3.5 Narrative positioning

As my research focuses on analysing narratives, I now move to discussing narrative positioning. It is important to first discuss what narrative entails. Narrative involves the idea that people use the form of contextualised stories in order to largely make sense of their experience. Narratives help us examine how experience – in this study, abortion decision-making – is assigned meaning, and is linked to social structures and culture. Bruner (1990, 1996) has stated that narrative is the telling of stories by people about their experiences, drawing from a social world that is known to them. Narrative is therefore an important part of who people are. Barthes (1982, cited in Riessman, 2008, p. 4) stresses the universality of the narrative and notes that under almost an "infinite diversity of forms" (e.g. myth, fable, tale, epic, history, tragedy, drama, conversation, life stories), it is present in every age, in every place and in every society.

Narrative, however, has been used differently in the wider area of social constructionism (Taylor, 2007). My use of narrative follows from Taylor (2007, p. 3) who discusses narrative as part of her work on identities and defines a narrative as, "a construction, in talk, of sequence or consequence." This definition, which I take up, is important as it shows that narrative is not only made up of sequence, as is traditionally held, but also consequence. The concept of sequence can be manifested in expressions like 'then', 'next' and consequences from expressions like 'so' (Taylor, 2007). This means that when we tell stories we do not just talk about events as they happened but we also focus on the effects these events had on our lives. Taylor (2006) has also argued that a speaker may present an extended account of experiences which makes explicit reference to sequence. Speakers may also invoke temporality by making reference to a past or potential ordering (Taylor, 2006). In my research I am also interested in

micro-narratives which have been defined as “short bursts of narrative interactionally embedded in question-answer sequences: several stories produced often in intricate relations to one another” (Blommaert, 2006, p. 181).

The concept of narrative positioning is a poststructuralist version of positioning that is seen as being engrained in Foucault’s conception of discourse (Morrison, 2011). The concept “acknowledges both the constitutive force of discourse as well as the capacity of individuals to actively engage with, negotiate and potentially transform existing discourses” (Morrison, 2011, p. 93). When we construct narratives, we have to draw on culturally-available discourses in order to tell our story. Reynolds, Wetherell and Taylor (2007) noted that in so doing, the subject, though still bound to the accepted discourses, is active and able to negotiate positioning by means of the discursive resources available to them. Subjects are, thus, seen as “complex composites of, on the one hand, who they create themselves as and present to the world, as a way of acting upon it and on the other hand, who that world makes them and constrains them to be” (Taylor & Littleton, 2006, p. 23). In this light, narrative positioning reconciles the tension between being positioned and positioning oneself. The woman who is engaged in abortion decision-making is, therefore, positioned by the particular acceptable discourses in her society, for example, motherhood, but also positions herself depending on her personal situation. Butler (1990, cited in Bamberg, 2005, p. 445) draws the line between the “being-positioned orientation with its relatively strong, determining underpinning and a more agentive notion of the subject as positioning itself.” This view of subject positioning is similar to narrative positioning in that “the discursive resources or repertoires are not always and already given but rather are constructed in a more bottom-up and performative fashion, and they can generate counter narratives” (Bamberg, 2005, p. 445).

3.6 Conclusion

In this chapter, I put forward a Foucauldian postcolonial feminist framework. I firstly discussed Foucault’s conceptualisation of power, discourse, bio-power and governance. Foucault argued that discourses play a part in constructing certain ‘truths’ that maintain power relations. Thus, discourses are interrelated to knowledge and power. Foucault’s theory of discourse illustrates how language gathers itself together according to socially constructed rules and regularities that allow certain statements to be made and not others. Discourse, according to Foucault (1977, 1980, 2003), is related to power as it operates by rules of exclusion. In the chapter I

examined how once a discourse is accepted as ‘normal’ and ‘natural’, it becomes difficult to think and act outside it. However, this does not mean that a discourse cannot be resisted and individuals cannot act outside it.

With regard to power, I looked at how Foucault understands power as not one single overpowering entity but as existing in power relations or relations of power. This understanding proved useful for theorising partriachial power relations as discussed below. Foucault sees power as no longer belonging to an individual or as being only negative or oppressive, but as being productive as well. This understanding allows room for resistance which Foucault argues cannot be separated from power. It has also been taken up in postcolonial feminisms where resistance is seen as being important especially in postcolonial African contexts. The African woman’s body is a site for resistance as women challenge the gendered, discriminatory practices that exist within their settings.

Foucault describes a different form of power which is disciplinary power where self-surveillance becomes important as individuals mediate their actions based on perceived observations by others. This type of power disciplines when it is invisible and trains individuals to be useful and docile. Self-surveillance is also based on the cultural postulation that certain thoughts and actions are dangerous or unwholesome to the constitution of the individual as a subject. I discussed Foucault’s (1960; 1977; 1990) ideas on bio-power which demonstrated how the human body is a central component in the operation of power. Bio-power speaks to sexual surveillance which refers to the contestations and control between the individual and society over the woman’s body. I also explored power and sexuality where discourses of the body and power relations arrange sexuality in order to control sexual practices. Foucault’s conception of sexuality not as an innate or natural aspect of the body but rather the effect of historically specific power relations provides a useful analytical framework for explaining how women’s experience is diminished and controlled within certain culturally shaped notions of female sexuality.

Feminism has been taken up in Africa in a multiplicity of ways and due to this I termed my approach postcolonial feminisms as it is difficult to identify a one unified approach. The multiplicity adds to a richness of positions as shown in the chapter. The postcolonial feminisms I explored start from a point of rejecting the homogenising nature of ‘Western feminism’. I discussed how Foucault’s conceptualisations can inform postcolonial feminism. An analysis of

power relations is central to the feminist project of understanding the nature and causes of women's subordination (Boyle, 1997). Mohanty (2004) argues that the oversimplified traditional conception of power relations is problematic as it sees women as being simply the passive, powerless victims of male power. On the basis of Foucault's understanding of power as "exercised rather than possessed, as circulating throughout the social body rather than emanating from the top down, and as productive rather than repressive", feminists can start challenging accounts of gender relations that focus on domination and victimisation so as to "move towards a more textured understanding of the role of power in women's lives" (Sawicki 1988, p. 164).

Foucault's concept of bio-power has provided insights for postcolonial feminisms and is linked to concepts like sexual politics and domesticity. Using Foucault's theory, we can understand the control of the population in postcolonial settings like Africa, is made possible by certain cultural practices/norms which define what is acceptable and what is taboo. These cultural practices and norms are the ones that inscribe rules, images, symbols and even hierarchies that give shape and character to the individual body (Tamale, 2003). Others have argued that these 'texts' that culture inscribes on African women's bodies remain invisible to the uncritical eye although it is a crucial medium for effecting social control (Mama, 1997). Having reviewed my literature in Chapter 2 and discussed my theoretical lens in this chapter, I now move to discussing the methodology employed in the study in the next chapter.

Chapter 4: Data collection and analysis procedures

4.1 Introduction

Abortion decision-making, as stated in Chapter 2, is a process that a woman goes through when deciding to terminate a pregnancy, drawing from her personal, social, economic and political circumstances. In this study my focus is on the personal narratives Zimbabwean women who have terminated a pregnancy share in relation to the abortion decision-making process. I was interested to see how these women position themselves and are positioned within these narratives. I employed a narrative-discursive approach to analyse the narratives of these women, which will be outlined later in the chapter. The analysis entails examining the details of talk rather than the structuring of the overall story. I also considered the discursive resources (the term will be explained later) that enable or limit such talk as well as the various subject positionings that appear within talk (Taylor & Littleton, 2006). Narrative-discursive analysis is interested in showing how, when constructing narratives, individuals draw upon recognisable micro-narratives and discursive resources in order to give an account of "the unique circumstances of a particular life" (Taylor, 2005a, p.49). Employing a narrative-discursive approach in understanding abortion decision-making allows an analysis of how women explain the circumstances that make a pregnancy unsupportable. The method also provides room to focus on how, in narrating these circumstances of a particular life, women employ certain discursive resources, and whether different women draw from different discursive resources. The narrative-discursive approach enables an analysis of fluid, complex power relations.

In addition, I was interested to see how the health service providers, who interact with women who have had an abortion, construct and position these women, as well as the positions the health services providers themselves take on the issue. An analysis of these constructions and positions shows the power dynamics at play. The health service providers' interviews were analysed using thematic analysis, which will be discussed later in the chapter. I begin this chapter by restating my research questions. I then move on to focusing on the overall study design, discussing the recruitment and description of participants, interviewing strategies employed, the ethical considerations, potential consequences of the research, critical reflexivity, the narrative-discursive analysis, analytical method and, finally, thematic and positioning analysis.

4.2 Research questions

The main research question of the study is as follows: How do women and service providers construct the process by which women come to decide on and proceed with a termination of pregnancy?

The study has the following sub-questions:

- How do women who have elected to have an abortion narrate the process by which they came to the decision to terminate the pregnancy?
- How do service providers construct and position women who have elected to have an abortion?
- What social/cultural discourses/practices are deployed in these narratives?
- What power relations underpin a pregnancy becoming unsupportable?

4.3 Qualitative narrative-discursive study design

In this section I discuss the overall research design which is a qualitative cross–sectional interview design. I shall begin by discussing the recruitment and inclusion criteria. I then explain my interview procedure and describe the women who were participants in this study.

4.3.1 Recruitment and inclusion criteria

The participants were chosen through purposive sampling. This sampling procedure involved the researcher actively selecting the most appropriate sample in order to answer the research question. The researcher decided on what needed to be known and set out to find people who could, and were willing to, provide the information by virtue of knowledge or experience (Bernard, 2002; Lewis & Sheppard, 2006). A purposive sampling procedure was appropriate and fits the purpose of this research. The women who took part in the study can be seen as a hard-to-reach research population who would have been difficult to reach using other sampling techniques.

In this case, 24 participants, 18 women and six service providers, were chosen from three sites in Harare (six women and two service providers per site). The rationale behind selecting the three sites was to sample for diversity as the sites differ in socio-economic status (see later explanation of the sites in this section). The inclusion criteria were women who had terminated a pregnancy in the past year and who were over the age of 18. The reason for these criteria was that I needed women who still had recent memories of the termination of their pregnancy and the age limit made it easy in obtaining ethical clearance. Interviewing those below 18 years of

age would have brought additional ethical complications, including the potential for re-traumatisation being possibly higher owing to minors' increased vulnerability due to age. For the health service providers the inclusion criteria were that they had to have worked at least two years with women who elected to terminate their pregnancies. The reason for this was to ensure that the health service provider could draw on experience dealing with women who had a TOP in the interviews.

The first site was Harare Hospital (see description of the site in Chapter 1) which has a ward (Room 20) that caters for women who have had post-abortion complications. It, therefore, provided access to participants who had already undergone an abortion. Women are usually hospitalised for less than four days while they are having medical procedures like Manual Vacuum Aspiration (MVA). However, the hospital does not differentiate between those who have had an induced unsafe abortion and those who have had spontaneous abortion. This meant that I had to approach several women before reaching my desired number of six women (see section 4.4 on ethical clearance for how the women were approached). The two health workers from Harare Hospital were chosen from Room 20 and the Obstetrics and Gynaecology ward (Ward A).

The second site was Mufakose, which is a working class suburb in Harare. Permission to approach clients was granted through the Heartfelt Crisis Centre which works with women in Mufakose who have had a TOP. The Heartfelt Pregnancy Crisis Centre caters for women who have had an induced abortion or are in the process of deciding to have an abortion. The nurse conducts follow-up consultations with women who have had abortions in the community and is in the process of establishing a support group for these women. The health service providers interviewed were nurses at the local maternity clinic who provide post-abortion care for women who have had a TOP.

The third site was in Epworth, outside of Harare, which is made up primarily of informal settlements. The Psychiatric Department at the University of Zimbabwe Medical School runs a Family Health and Pregnancy programme for first-year students where they interview pregnant women. I used this programme as the entry point in gaining access to participants. The women who had TOP were identified through the community health workers who interact with women who have terminated pregnancy. The health service providers interviewed in Epworth were community health workers who work with women in the community who have had a TOP.

4.3.2 Interview procedure

Narrative interviews were conducted with the women who had undergone an abortion and semi-structured interviews with the health service providers. The type of narrative interviews conducted with the women who had had a TOP was based on the one suggested by Wengraf (2001). The method of interviewing involves what he calls a single question inducing narrative (SQUIN) followed by a topic question inducing narrative (TQUIN). In each interview, there were two sub-sessions (I conducted all the interviews except one – see later discussion). In the first sub-session, I offered a carefully constructed single narrative question: "Please tell me the story of your decision to have an abortion, all the events and experiences that have been important to you personally; begin wherever you like, I won't interrupt, and I'll just take some notes for afterwards." Together with the co-researcher (see later explanation) we then analysed the narrative using the notes that the co-researcher was taking during the first sub-session. We then created follow-up questions. In the second sub-session, which followed 15 minutes later, the follow up questions were asked. Unlike with Wengraf, no third session was held due to time and logistical constraints.

All narrative interviews were conducted with a co-researcher taking notes which were discussed, by me and the co-researcher, after each interview to identify the emergence of topics and discursive resources. Due to the limited time involved between the two sessions, we did not listen to the recording but discussed what we thought were important questions stemming from the interview. Three of the participants at Harare Hospital and Mufakose, were not comfortable with being recorded so the co-researcher wrote down their narratives as accurately as possible due to the difficult inherent in doing micro-narrative analysis with only written notes. The interviews were all conducted in Shona as this was the language with which the participants were comfortable.

Since abortion is a sensitive topic, the women in the study were given the option of either a male or female interviewer during the recruitment phase. Only one participant objected to being interviewed by me as a male researcher, so in that case the female co-researcher conducted the interview and I took notes. The participant did not object to my taking notes. The female co-researcher took notes in all the other interviews. The female interviewer is a registered psychologist in Zimbabwe (her qualification was necessary to provide containment during interviews or debriefing if necessary) and she has experience working with women who have had a TOP at the Parirenyatwa Crisis Centre.

The semi-structured interviews with the health service providers were conducted after the narrative interviews with the women who had undergone a TOP. I conducted these interviews without the co-researcher. The interviews with the nurses at Harare Hospital were conducted in a private room provided in the hospital. In Mufakose, the interviews with the nurses were conducted at the local clinic in a private room. The community health workers' interviews in Epworth were conducted in their homes in a private room. The interview schedule was similar for all the health service providers interviewed (see Appendix M for a template). The interviews were all audio recorded except for the ones in Mufakose where the nurses objected to being recorded. In these two interviews, I had to write down their responses. The reason semi-structured interviews were conducted instead of narrative interviews (as with the women who had terminated pregnancy) was that the research questions for the health service providers were different. I was interested in their construction and positioning of women who had terminated pregnancy and not in their narratives about their experience of working with women who had undergone an abortion. Thus, semi-structured interviews were more appropriate.

4.3.3 Participants

The participants were 18 women from Harare who had undergone a TOP and six service providers: two nurses from Mufakose Clinic, two nurses from Harare Hospital and two community health workers from Epworth. All participants were female except for one community health worker from Epworth. Table 1 below shows the characteristics of the women who had undergone a TOP.

Table 1: Characteristics of participants

Pseudonym	**Age**	**Occupation**	**Highest level of education***	**Marital Status**	**Number of children at time of termination**
E1 (Sheila)	35	Unemployed	Grade 7	Married	2
E2 (Idi)	31	Unemployed	Grade 7	Married	2
E3 (Rose)	28	Unemployed	Form 2	Married	4
E4 (Ruth)	29	Church counsellor	Form 6	Single	None
E5 (Esther)	27	Unemployed	Grade 5	Single	2
E6 (Mary)	19	Unemployed	Form 2	Separated	2
H1 (Bell)	20	Student	Form 4	Single**	None
H2 (Tecla)	20	Unemployed	Form 3	Married	None

H3 (Eli)	22	Unemployed	Form 6	Divorced	None
H4 (Tina)	33	Unemployed	Form 2	Single	1
H5 (Tanya)	24	Unemployed	Grade 7	Single	None
H6 (Toni)	25	Sex worker	Form 1	Single	1
M1 (Abbie)	43	Unemployed	Form 4	Married	3
M2 (Doris)	31	Domestic worker	Form 2	Single	None
M3 (Clara)	20	Student	Form 5	Single	None
M4 (Fiona)	21	Domestic worker	Form 4	Single	None
M5 (Lucy)	19	Domestic worker	Grade 7	Single	None
M6 (Angie)	38	Vendor	Grade 7	Married	4

Key
E= Epworth
H= Harare Hospital
M= Mufakose
1–6= Number of interview

*Highest level of education – The Zimbabwean education system is made up of primary education which is from Grade 1 to 7 and secondary education which is from Form 1 to 6.
**Single – The woman identified herself as 'single' because she was being forced into a marriage that she did not want.

In the above table the average age of the women is 26.7 years and the ages range from 19 to 43. Ten of these women were unemployed, two were students, two were employed as domestic workers, one worked as a sex worker, one was a church counsellor and one was a vendor; ten women were single, six were married, one was divorced and one was separated; the average educational attainment was Form 2 and educational attainment ranged from Grade 5 to Form 6; the average number of children was 1.16, nine women had no children at the time of TOP, four had two children, two women had four children, another two women had one child and one woman had three children.

The following table shows the characteristics of the health service providers.

Table 2: Characteristics of service providers

Pseudonym	Age	Occupation	Experience
ES1 (Mimi)	52	Community health worker	16 years
ES2* (Terry)	32	Community health	10 years

		worker	
MS1 (Tasha)	46	Maternity nurse	20 years
MS2 (Vovo)	48	Maternity nurse	28 years
HS1 (Joan)	28	Midwife (nurse)	2 years
HS2 (Sife)	28	Midwife (nurse)	2 years

Key
E= Epworth
H= Harare Hospital
M= Mufakose
S=Health service provider
1–2=Number of interview

*Only male participant amongst the health service providers

The table above shows that the health service providers had an average age of 39 and ages ranged from 28 to 52; the average years of experience was 13 and the years of experience ranged from two to 20 years.

The women who had had TOP differed with regards to time since termination of pregnancy, method of termination and the need for follow-up medical treatment. By way of background to the narratives told by the women, these are summarised in the table below:

Table 3: Women's abortion decision-making characteristics

Pseudonym	**Gestation at time of TOP**	**Time since termination**	**Method/Instrument used**	**TOP performed by**	**Actions after termination**
E1 (Sheila)	4 months	10 months	Baboon tree leaves	Self	No doctor/clinic treatment
E2 (Idi)	2 months	7 months	Psychic nut tree	Self	Visited clinic
E3 (Rose)	2 months	7 months	Chili plant roots	Self	Visited clinic
E4 (Ruth)	4 months	8 months	Herbs	Herbalist	Visited private doctor 3 weeks later

E5 (Esther)	4 months	6 months	Psychic nut tree branch	Friend	Visited pharmacy and clinic
E6 (Mary)	3 months	8 months	Psychic nut tree branch	Self	No doctor/clinic treatment
H1 (Bell)	3 months	1 week	Cytotec pills	Colleague	Admitted in hospital
H2 (Tecla)	6 months	1 week	Family planning pills	Alone	Admitted to hospital
H3 (Eli)	3 months	2 weeks	Sugar plum tree branch	Woman next door	Admitted to hospital
H4 (Tina)	3 months	1 week	Psychic nut tree branch	Friends	Admitted to hospital
H5 (Tanya)	3 months	1 week	Soda	Alone	Admitted to hospital
H6 (Toni)	4 months	1 week	Crotchet hook	Alone	Admitted to hospital
M1 (Abbie)	3 months	11 months	Herbs	Traditional herbalist	Visited doctor
M2 (Doris)	5 months	6 months	Cytotec pills	Friend and Doctor	No doctor/clinic treatment
M3 (Clara)	2 months	10 months	Crotchet hook	Alone	Visited clinic
M4 (Fiona)	3 months	10 months	Herbs	Friend and aunt	Visited clinic
M5 (Lucy)	4 months	7 months	Herbs	Friend and woman next door	No doctor/clinic treatment
M6 (Angie)	4 months	8 months	Herbs	Woman from the area	No doctor/clinic treatment

The table above shows that the average gestation at the time of TOP was 3.4 months, with a range from two months to six months; average time since TOP was 5.5 months, with a range from one week to 11 months. It is worth noting from the table above that: 13 out of 18 had to have medical treatment following the TOP; 10 out of 18 had some assistance in performing the abortion; 16 out of 18 injected substances to induce the abortion, while only two used mechanical means.

4.3.4 Narrative summaries

As a way of orienting the reader to the individual stories, the following section focuses on narrative summaries for each of the women who took part in the study. They are included here to show how the individual stories of the women developed and how each of the women had their own unique narrative.

Sheila (E1) constructed a narrative around using the termination of a pregnancy to cover up infidelity. Her pregnancy brought about great shame due to the infidelity and presented a risk of social sanctions and being chased away from the matrimonial home. The termination itself was concealed so as to avoid shame surrounding having an abortion. The narrative also centres around the shame, pain, guilt and regret arising as a result of the termination, failure to conceive again and the eventual break-up of the marriage. Staying with the man responsible for the aborted pregnancy has led to these feelings being perpetuated.

Idi (E2) shared a story of how her bravery played a major part in making a decision to terminate a pregnancy. Despite having fears surrounding arrest, physical complications and social stigma due to undergoing a TOP, the situation she found herself in led her to being left with no choice but to terminate. She spoke of how her financial struggles and the presence of another child she was still breastfeeding presented a situation where a TOP was a justifiable option. Stigma surrounding being pregnant whilst breastfeeding and the TOP led to concealment from every one of the pregnancy as well as of the TOP. Culture and religion were seen to play significant roles in what is or what is not acceptable behaviour.

Rose (E3) shared a narrative concerning how her pregnancy was viewed as shameful due to her husband being dead and, therefore, not responsible for the pregnancy. She also had a very young child whom she was still breastfeeding. The man responsible for the pregnancy denied it; this, coupled with financial constraints, led her to undergo a TOP. She was placed in a

situation where there was no other option. Her story also shows the role played by close, trusted friends in finding the best method for a TOP. Fear of arrest, stigma and isolation from community members led to her concealing the TOP from the public. Her story also shows how believing in a forgiving God, despite hiding the TOP from church members, helped her in dealing with guilt and regret that might have arisen from the TOP.

Ruth (E4) constructed a story about how the disappearance of the man responsible for her pregnancy, the stigma associated with a 'fatherless' pregnancy, her home and financial situation led her, even as a Christian who is against TOP, to see it as the only available option. She talked of guilt and regret, which were fuelled by comments from family and church members who all have strong personal and religious beliefs which view a TOP as being an 'evil' event that should never happen. Fear of arrest led to her failure to seek medical treatment for complications arising from the TOP. Her belief in a forgiving God provided room to deal with guilt, regret and self-loathing.

Esther (E5) shared a story of how her 'fatherless pregnancy', her pregnancy threatening future employment and the lack of financial capacity to look after existing children led to her undergoing a TOP. The role of her close friends in making the decision and in finding the method to use for termination of her pregnancy was strongly highlighted. The fear of arrest and social stigma led her to conceal the TOP from community members and family members. The suspicions of those close to her were met by her strong denial and her offering other explanations like having had a miscarriage.

Mary (E6) constructed a story about how the disappearance of the man responsible for the pregnancy, the stigma associated with her 'fatherless' pregnancy, the stigma of having another child whilst still breastfeeding and with limited financial resources all overpowered her cultural and religious beliefs and health fears in deciding to terminate a pregnancy. The role of her close friends in finding the most appropriate method was also highlighted. Feeling stigmatised in her community was implicated in why her TOP is concealed.

Bell (H1) shared a story of her strong will to go through with a termination of pregnancy, despite pressure for marriage and the consequences that result from a TOP. She talked about how her pregnancy became complicated because the relationship between the man responsible and herself was not stable and also because the pregnancy implied losing her future educational

opportunities. She hides her TOP because of the perceived stigma she feared will come from family and community members. She justified her TOP because she realised that there were no other options.

Tecla (H2) constructed a narrative concerning how her bad marital relationship played a part in her decision to have a TOP. The situation at home forced her to act because continuing the pregnancy meant being stuck in an abusive marriage. Despite personal feelings, perceived stigma about TOP and the high risk involved with regards to health, the existence of a violent and controlling partner made the TOP the only viable option to safeguard her future and start afresh. Hiding the TOP from community members was a matter of importance as social standing was important.

Eli (H3) constructed a story of how the shame of having a child without a father led her to have a TOP. She saw her pregnancy as a threat to her social standing, and future opportunities. The pregnancy had to be terminated due to the stigma associated with being a single mother. Hiding the TOP as well as the pregnancy was important in her avoiding the stigma involved in both (especially from the church community). Despite the stigma and apparent 'evilness' of a TOP, she indicated that believed that God forgives, and this helped her deal with the regret and guilt that may arise from a TOP.

Tina (H4) shared a narrative about how the shame of being pregnant without a supportive partner coupled with her unemployment and having another child who is still being breastfed led to her having a TOP. The fear of being stigmatised led to her hiding both her TOP and pregnancy as a way of maintaining her social standing. An association with sex workers who are already marginalised helped her to gain information around how to perform a TOP.

Tanya (H5) shared her story about bravery in the face of adversity. The narrative showed how the disappearance of the man responsible for the pregnancy and poverty in the home led her to decide to terminate her pregnancy. Fear of being stigmatised led to her seeking information about TOP from people who are not a part of her community. Pain, shame and embarrassment followed the discovery of her TOP (by her family and other community members) and local nurses from clinics perpetuated the stigma by not keeping her information confidential. Her story showed how bravery is needed to make the decision to terminate a pregnancy and to deal with the sequelae that follow a TOP.

Toni (H6) constructed a narrative about how her pregnancy was complicated as the man responsible was not present, which led to the stigma associated with a 'fatherless child'. The presence of another child, being HIV-positive and a pregnancy threatening her employment opportunities added to her decision to have a TOP. Secrecy was seen as important as the discovery of a TOP could lead to stigmatisation and the loss of social standing. As a member of the church, maintaining her social standing within the church community was seen as important. Thus, concealing the TOP from them was a high priority for her. She felt that God is important in helping deal with her guilt as he is forgiving.

Abbie (M1) conveyed a story about being placed in a tough situation due to having an unplanned pregnancy during a personal phase of financial hardship, with her having no financial capacity to look after the pregnancy and later the child. A clash between personal circumstances and personal beliefs led to her having feelings of guilt, which were negotiated by the idea of a forgiving God. The importance of social standing and her position in the church led her to hide the TOP. Her husband wanting another child and the sequelae of failing to conceive again has led to the perpetuation of guilt feelings.

Doris (M2) constructed a narrative in which she indicated that the stigma resulting from a TOP is easier to cope with than the stigma that arises from a pregnancy without a father, without financial means to look after the pregnancy and being an HIV-positive woman. The help of her friends was important as they provided information on TOP such as the options for the methods to undergo a TOP. She talked about how bravery is required to go through with the TOP as advice from others and personal beliefs can act as deterrents to go through with it.

Clara (M3) shared a story about bravery in deciding how to deal with her pregnancy that threatened future educational opportunities. Faced with a pregnancy where the father denied responsibility, and the fear of potential retribution from parents who have invested in her education also added to the solution of having a TOP. Information on how to perform one was sourced from someone who was less likely to tell others. The stigma felt in the community, especially due to members who find out about her TOP, led to further stigmatisation and her living in fear that she might be arrested. She drew comfort from knowing that she did the right thing and she has protected her future. She showed how bravery is important in dealing with the sequelae of having a TOP.

Fiona (M4) shared a narrative showing how her pregnancy was complicated when the man responsible disappeared and the pregnancy threatened her job. This was coupled with her not having family support and her fearing the stigma associated with having a fatherless child, which led to a situation where she saw a TOP as the only viable option. Friends encouraged her to terminate and also provided suggestions about the method for the TOP. Although she felt justified in terminating at the time, feelings of guilt arose from the sequelae that followed which include her failure to conceive with a new husband. Failure to conceive was seen by her as possible punishment from God.

Lucy (M5) constructed a story about how her pregnancy was complicated by the absence of the man responsible and by severe financial problems, leading to a TOP being the only viable option. Her friends encouraged her to have a TOP and provided her with information about the method to be used. Hiding her TOP was important to her as she feared being stigmatised, arrested and losing her social standing. For her, the complications brought about by a fatherless pregnancy far outweighed the sequelae of a TOP.

Angie (M6) constructed a narrative around financial difficulties and the presence of other children who needed to be taken care of, making her pregnancy unsupportable, and leading to TOP. Her husband's inaction in stopping her from undergoing a TOP or inaction in helping her decide, provided her with the abortion decision-making autonomy. The inaction as in his lack of support/comfort/taking care of her also continued into the sequelae from the TOP. Guilt and regret arose from the physical and emotional trauma resulting from the TOP and also personal religious beliefs. However, these were solved by the acknowledgement of the toughness of the situation and the presence of a forgiving God.

4.4 Ethical considerations

This research was approved by the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department at Rhodes University before recruitment or interviewing commenced. Approval was also granted by the individual sites. Overall approval for data collection in Zimbabwe was given by the Medical Research Council of Zimbabwe (MRCZ). In adherence to the RPERC and MRCZ guidelines, potential participants were supplied with a letter requesting their participation, outlining the details of the research and explaining the purpose of the study (see later discussion regarding procedure). I also supplied them with a copy of the consent form which summarised the expectations and rights of a research

participant. These potential participants were assured that their inquiry about the study would not oblige them to participate. I discussed the documentation with each participant and invited questions before asking them to sign the consent form once they were satisfied with the conditions of their involvement in the research. (See Appendix G for request for participation letter and Appendix A for the consent form).

4.4.1 Privacy, anonymity, and confidentiality of data

As the topic being studied is highly stigmatised and illegal, privacy, anonymity, and confidentiality of data were thus of huge concern. Participants from Room 20, Harare Hospital were approached after consent had been obtained from the hospital. At the start of the recruitment and interviewing, the ward had three women who were having post-abortion care and I had discussions with them in the doctors' consultation room to ensure privacy. The three women agreed to participate after the discussions and also because they met the criteria for the research. The remaining three participants required from Harare Hospital were identified through the same process. To ensure that other patients would not be suspicious, I identified myself as a psychologist and the sessions in the doctors' consultation room were identified as routine psychology sessions and follow-up.

The participants in Mufakose were approached through a nurse affiliated with the Heartfelt Crisis Centre. The nurse provided women who had TOPs, and whom she had been following up on, with a letter requesting permission for their participation which I had prepared (see Appendix G). The document did not represent an agreement to participate but allowed the women an opportunity to ask for more information in a meeting I held with them later regarding their possible interest in participating. I visited Mufakose eight times to discuss the project with women who had showed interest and wanted to ask more questions. The meetings and the subsequent interviews were conducted at the nurse's house in a private room. The women usually visited the nurse so they came to the house as if it was a routine meeting to avoid suspicion from other people. The major concern was that the women were afraid that the researcher was perhaps a police informant and would report them to the police. I managed to deal with this and allay their fears by showing the women my Rhodes University student card and my ethical clearance letters which showed that I was a student conducting research.

The same concerns were noted in Epworth where the community health workers carried my information document during their recruitment for the Family Health and pregnancy project (a

separate project run by the University of Zimbabwe's Department of Psychiatry) and gave it to clients who met the criteria for the research. Related concerns about my possibly being a police officer posing as a researcher also arose in Epworth as Sheila, a participant from there, shared at the end of the interview:

Extract 1

Sheila: I think that's all but I want to ask if you will not get us arrested.

The community health worker in Epworth, and the nurse in Mufakose were thoroughly briefed (by the researcher) at the beginning of the process about how to approach potential participants so that they did not feel coerced into participating and so that their privacy and anonymity were respected. As was the case in Mufakose, the meetings and interviews in Epworth were conducted at the community health worker's house in a private room. The women also came to the community health worker's house as if they were coming for routine meetings. In both Epworth and Mufakose I had to park my car some distance away from the houses so that people would not become suspicious of my presence.

The data collected were stored using codes so that no information could be attributed to any particular participant. The data from the research would be seen by me, the principal researcher, the supervisor Professor Macleod and also researchers in the Critical Studies and Sexualities Research Programme. All transcripts were saved as encrypted data files and hard copies were stored securely in a filing cabinet in the primary researcher's office at the CSSR offices. Participants' names and identifying details were altered in the transcripts and the final report to ensure anonymity. The data will be stored in this manner for five years upon completion of the research, after which they will be destroyed.

4.4.2 Potential consequences of the research

Abortion is highly stigmatised and restricted, although new laws have meant that post-abortion care can be provided without prosecution. There was, and still is, however, the risk of being stigmatised if community members know that a participant has had an abortion. This was particularly pertinent in the case of the data collection in Epworth. As mentioned in Chapter 1, the area is largely made up of informal settlements where there is not much secrecy due to the proximity of houses. Every effort was made to ensure that the reason for the interview (talking about abortion) was not made public.

There was also a high risk that the participants might be distressed due to the content that they shared in the interviews possibly bringing up traumatic memories for them. For this reason, debriefing was conducted with all the participants to assess the level of distress, if any. Only one participant at Harare Hospital was distressed and was subsequently referred to a counsellor at the hospital. It came to light during the debriefing that another participant at Harare Hospital was being physically abused by her husband and was referred to the Family Support Trust that is based at the hospital.

There were, however, benefits that participants experienced due to the interviews. Participants spoke of feelings of relief in terms of being able to talk to somebody about something is that is surrounded with such stigma. Some of the participants, when asked how they were feeling after their interviews, expressed the following sentiments:

Extract 2

Mary: I feel good. I had not spoken to anyone about it.

Bell: I feel good because I was able to bring out what is underneath my heart. I am not sure I would have found someone to talk to so thank you.

Eli: I am happy, this is very therapeutic. I will not ask for a counsellor anymore because this has been helpful.

Tina: Since it is something that just happened I have not spoken to anyone so I think this is helpful for me. And since this a hard story to tell you are the only ones I will tell so you have helped me.

Fiona: It was good. I have not spoken to anyone like this. This was helpful.

Angie: I am happy because this is the first time telling my story. I feel like a weight has been lifted from my heart.

The above extracts show how the women felt the narrative interview process helped them feel better. For all the women above the interviews provided an opportunity or platform to tell their stories in a supportive non-judgmental environment. The interviews were a form of catharsis as the women were able to express what they felt, something that is hard to do in their communities due to the various risks in terms of stigma, arrest and shame.

4.5 Critical reflexivity in the research process

My understanding of reflexivity follows from Fegan (1999, p.242) who defined it as "a self-conscious revelation of my own relationship to the research – the impetus behind it, the personal values and theoretical allegiances framing it." Finlay (2002, p. 209) has noted that "the process of engaging in reflexivity is full of muddy ambiguity and multiple trails as researchers negotiate the swamp of interminable deconstructions, self-analysis and self-disclosure." Despite this, reflexivity is important as it allows researchers to focus on the discursive and macro socio-political forces shaping research narratives (Finlay, 2002). Macleod (2002, p. 20) states that "researcher reflexivity should address the interactional, relational and power dynamics of the research at hand, rather than focussing on a confession of emotional or discursive positionings of the individual researcher." This process of reflexivity does not serve to give a personal anecdote of the research but seeks to show "my identity and involvement in the research process that serves to illuminate the findings" (Morison, 2011, p. 133). The process of reflexivity in which I am engaged focuses on how my clinical psychology training influenced my experience of the interviews, being in a position of power, issues around data collection, my being a male researcher interviewing women, the process of writing, and my dealing with the prevailing attitudes regarding abortion in Zimbabwe. By focusing on these, I locate myself within my research and my relationship with those different aspects of it. Discussions with the co-researcher with whom I have an existing professional relationship helped as part of the research process. As part of the research I kept a journal throughout the process. Some of the discussion below comes from this journal.

Firstly, it is pertinent to speak of my clinical psychology training which invaluably helped and informed me with regard to the manner in which I approached the women and how I conducted my interviews. Given the nature of abortion in Zimbabwe and the stigma the women face, I was able to approach the women in an empathic way. My training also helped me in containing the women during the interviews as their stories were full of emotion and pain. I was able to hold the emotion and pain in such a way that I was not overwhelmed by the women's stories. My training however presented two problems: i) drawing the line between research and therapy and ii) being positioned as an expert. As I sat in the interviews, I heard most of the women tell their stories for the first time. In the beginning, it was difficult to stop myself from playing the role of therapist and let the process unfold. This also affected how, at the beginning, I saw the women as 'victims' requiring help in a therapeutic sense. However, as the interviews progressed, the resilience shown by the women allowed me to realise that I was helping them

by giving them a chance to narrate their stories. The women's resilience guided the way I approached the research: I ceased positioning the women only as having been traumatised but saw them as having agency and being resilient in resisting the dominant discourses around abortion.

With regard to being positioned as an expert, I was initially placed in a position of power. I was not only positioned as an expert but a male studying women and I was aware of debates around "the acknowledgement of the wider social power imbalance, alongside the recognition that women have traditionally been silenced through being 'spoken about' by science experts" (Bellamy, Gotta, & Hinchliff, 2011, p. 699). The way in which I was introduced to the participants by the nurses was as a psychologist and this had consequences for the way my participants saw me (for example, being there to 'treat' them). This was very apparent in the initial discussions where most of the women failed to understand the narrative interview which gave them room to tell their stories without being interrupted. However, "power is not a property that is *possessed* by one or another person in the research process, but rather it is negotiated just as it is in everyday interactions" (Morison, 2011, p. 146). This means that my being positioned as a psychologist was not a stagnant position. The process of explaining the research to the women helped them in relating to me as a researcher who was interested in hearing their narratives.

During the research, I also took on different insider/outsider positions. For example, I was an outsider in terms of gender (being male), and in terms of being from a different socio-economic background. However, I was an insider as a Shona speaker. All these positions manifested in different ways and I was aware of these micro-politics of research interactions as I was conducting my interviews. Being a man (see later discussion on the benefits of the position) and being from a different socio-economic bracket created obvious differences between me and the women in the research. These politics of difference influenced how I attended to my interactions with the women. I did not interact with them as a privileged male but rather as a student researcher who was there to hear their stories. My being a Shona speaker helped as the interviews were all conducted in a common language which maybe made the women feel at ease and also allowed them to provide rich, authentic experiences without the hindrance of speaking in another language. Being Shona speaking also influenced my understanding of some of the cultural understandings found in the women's stories.

Having zoned in on my theoretical lenses and conceptualised my research with the help of my supervisor, I was then faced with a realisation I had been avoiding: that of being a black man from a patriarchal system trying to undertake a project on the narratives of women about abortion – a controversial and emotional subject. I had to locate myself somewhere in this narrative. Would I ignore what my 'maleness' represented in the lives of these women who, given their backgrounds, have been engaged with struggles of 'patriarchy'? How would they see me as a man interviewing them? How would this affect my own view on their narratives? With all these questions at the forefront of my mind, I acknowledged my 'maleness' by providing the participants with the option of being interviewed by the female co-researcher. My 'maleness' in the end proved to be a benefit for the women as they felt more comfortable talking to a male researcher because of the held belief that women are 'judgemental'. An example of this belief which is disproved by the female's co-researchers attitude in the interview is when Tecla, who chose to be interviewed by the female co-researcher, said:

Extract 3

Tecla: I was shy because you are a woman and I thought you would judge me. The women I speak with in the local clinics are very rough and judgemental so I was worried that you were the same but however you have surprised me.

All the women, except one, chose to be interviewed by me. My understanding of the women's choices here was based on the notion that difference is not necessarily a negative thing when it comes to research.

In terms of theory I also was aware that I was: i) a male researcher engaged in feminist theory and ii) an African engaged in feminist theory. These two positions were troubling for a number of reasons. As a male researcher I was aware of debates surrounding men being able to study women, especially given the nature of abortion. In her seminal text *The Second Sex,* Simone de Beauvoir (1949) made the famous pronouncement that men cannot be feminists because of the intrinsic differences between the sexes. The debates have since grown with two schools of thought, one that agrees with Beauvoir (see Ashe, 2007; Elliott, 2008) and another that sees no problem with men being feminists (see hooks, 2000; Owens, 2013). My stance is that labelling or naming is a political process, especially the label 'feminist'. I do not identify myself as a feminist. Rather I go along with Ratele and Botha (2013), where Ratele advocates for the term 'pro-feminist'. In this pro-feminist identification I identify myself as a man who fights for

gender equality and uses feminist methods because they are appropriate and very relevant not only for the women I was researching, but for me as well.

As an African, I was aware of the debates surrounding feminism being considered un-African and being another form of colonisation. When feminism is accepted in an African context, feminists have tried to move away from mainstream feminism. Nnaemeka (2005) states that,

> the issue of balance is neglected in the one dimensional Western constructions of African women – usually poor and powerless. We African women have witnessed repeatedly the activities of our overzealous foreign sisters, mostly feminists who appropriate our wars in the name of fighting the oppression of women in the so-called ‘‘Third World’’. We watch with chagrin and in painful sisterhood these avatars of the proverbial mourner who wails more than the owners of the corpse. In their enthusiasm, our sisters usurp our wars and fight them badly – very badly. African women are not children, powerless and helpless (p. 57).

Nnaemeka’s (2005) assertion had very important implications for the way I conducted my research. I realised the need for an African way of understanding the women and as such I chose to use postcolonial feminism as part of my theoretical framework. I also approached the women in the study not as powerless beings but as people who, as Okome (1999, p. 11) puts it, “….like any other group [women in my study], are able to articulate their needs, evaluate the alternative courses of action.” Therefore I understood the women throughout the research process as strong, innovative agents and decision-makers in their specific contexts.

The women’s stories were very touching and dealing with their raw emotion was a good reminder of why this sort of work is important in my country. Sitting there in the interviews and listening to the women speak about things that are unmentionable validated my decision to partake in this type of research. As the women narrated their stories, I could sense a weight lifting off their shoulders by being able to share their narratives in a supportive non-judgemental environment. However, the joy of completing the women’s narratives and offering them a chance for catharsis through this, quickly disappeared when I came to interview the health service providers. The level of disdain and complete dismissal and disgust with women who terminated pregnancies took me aback. After having done my literature review and being aware of the negative attitudes that exist in the country, I was expecting some level of negativity but not to the extent that I experienced from the health service providers. I had to keep myself in check not to challenge their views and positions because that was not what I

was there for. Hearing these service providers speak allowed me a glimpse into the extent of the lack of acceptance and the contempt held of abortion in the country.

Newspaper articles I had read on women being turned away from hospitals by staff for post-abortion counselling began to make sense. It also brought to light the amount of courage and agency these women had shown by agreeing to be interviewed by me. Their experience with interviews was mostly limited to their interactions with some of these health service providers. The interviews with the health service providers also painted a dire situation in terms of the sexual and reproductive health of women in Zimbabwe. An already-struggling healthcare system coupled with very negative attitudes towards abortion suggests to me that accessing safe abortion and post-abortion care in Zimbabwe is still fraught with difficulty. The levels of agency shown here by the women who underwent a TOP reveals potential starting points for not only access to safe abortion and post-abortion care but also other sexual and reproductive health issues as well.

Negative abortion attitudes were prevalent not only among the medical professionals with whom I came into contact but also among family and friends. People always had the same response to my research and asked me why I should be involved with something that has negative connotations. This criticism helped in understanding the negativity these women faced and my empathy for them was strengthened.

Given the prevailing circumstances in Zimbabwe with regards to abortion, it would have been easy to feel overwhelmed. However, the importance of this type of work far outweighs any personal discomfort I might have felt. Conducting the data analysis and listening to the women's stories was very rewarding for me as a budding researcher. Being able to see them breaking set boundaries on what is appropriate for one to discuss was very motivating and reinforced my view that agency and resistance can be found in small but powerful doses. The levels of strength I witnessed in their stories were encouraging and gave me great hope that reproductive justice can be achieved in Zimbabwe. It is with the same level of resilience that I undertook the task of writing and completing this thesis. It provided me with a sense of hope and encouragement towards issues of social justice such as changing people's negative attitudes towards abortion.

4.6 Data analysis for the women's narratives

In this section I discuss my data analysis procedure. The interview data were analysed using narrative-discursive analysis (Taylor, 2005a, 2005b, 2006, 2007; Taylor & Littleton, 2006; Reynolds, Wetherell, & Taylor, 2007). Firstly, I explain Taylor and Littleton's narrative-discursive method and how I applied it to my research. After the conceptualisation, I turn my attention to the description of the iterative process taken in analysing the data collected during the interviews with the women.

4.6.1 Employing narrative-discursive analysis

Before describing the steps involved in the analytical procedure, it is important to explain the theory behind the analytical procedure chosen and how it works with narratives on abortion. Taylor's (2006) narrative-discursive approach borrows from several traditions that include social constructionism (e.g., Gergen, 1985), discourse analysis (Potter & Wetherell, 1987; Wetherell & Potter, 1992), discursive psychology (e.g., Edwards, 1997; Edwards & Potter, 1992; Wetherell, 1998; Edley, 2001), and narrative analysis (e.g., Bruner, 1990, 1996). The narrative-discursive method is concerned with how participants "do" narrative within a specific communication setting and in relation to the larger socio-cultural backdrop (see Reynolds et al., 2007; Taylor, 2005 & 2006; Taylor & Littleton, 2006). The focus on the socio-cultural backdrop here dovetails well with the postcolonial feminist Foucauldian approach.

As mentioned earlier a narrative-discursive analysis entails the examination of the details of talk rather than the structuring of the overall story. In this method, the analyst considers the discursive resources that enable or limit such talk as well as the various positionings within it (Taylor & Littleton, 2006). This is a process that links the talk to prevailing power relations. Narrative-discursive analysis looks to unearth features of the data that are not immediately apparent and to make central the performance, the activity of narrating and the interactional activities that take place between people and social relationships (Smith & Sparkes, 2008). The analyst thus "examines the details of talk (as opposed to the overall narrative structuring) and searches for patterns across the larger body of data" (Morison, 2011, p. 142).

Since this research is concerned with the narratives of women who have undergone TOPs, Taylor and Littleton's (2006) narrative discursive method provides an analytical focus concerning how the participants 'do narrative' in relation to the larger socio-cultural backdrop and power relations. The narrative-discursive method can also be utilised in relation to

focusing on narratives around abortion and positioning as it "takes into consideration both how the wider discursive environment is implicated in personal narratives and how available meanings are taken up or resisted and re/negotiated, thereby attending to both the macro- and micro-levels of analysis" (Morison, 2011, p. 98).

It is important to note that Taylor and Littleton (2006) are primarily interested in narratives surrounding identity work and that this is not my focus. I have adapted their method for my purposes of focusing on narratives concerning the decision to terminate a pregnancy and positionings within these narratives amongst women who have had TOPs. While identity work is not my key focus, there clearly are links between the work that will be put into telling a story about how a woman decided to have an abortion and identity work. The story about abortion decision-making will reinforce, negate, or side-step other stories that women tell about themselves. In some senses the stories that women tell about the abortion decision-making process is constrained by the identity work that they perform in their lives in general.

My point of departure, as I elucidate the narrative-discursive method, is that narratives, just as seen by Taylor and her colleagues, are "shaped by both the unique circumstances of people's lives and the meanings in play within the wider society and culture" (Taylor & Littleton, 2006, p. 23). The meanings and power relations within the wider society and culture include established categorisations of people and places, values attached to particular categories and expected connections of sequence and consequence (Taylor & Littleton, 2006). The understanding here can be further enhanced by postcolonial feminist theorising on culture. Postcolonial feminists purport that African women have been relegated to the 'private' sphere, where women provide the necessities of productive and reproductive social life (Tamale, 2003). In this private sphere, certain understandings on womanhood persist. Therefore, when narrating their abortion decision-making process, a woman in this postcolonial context will draw from wider societal and cultural understandings of what it means to be a woman (as already shown in Chapter 3 which includes understandings from domesticity and patriarchal power relations).

It also important to note Taylor's (2005a) view that identities in themselves are multiple and complex as the speaker is already positioned at the start of any occasion of talk including positions arising from previous talks and the way the speaker appears, what she calls 'always ready' (p. 48) positions before any occasion of talk starts. Even though this concept was meant

for identity, the same can be said for a woman speaking about her abortion decision. It means, therefore, that when the woman narrates her story, she is not just speaking in the 'here-and-now' but is drawing from other positions she has held before.

For Taylor, identity work is seen as a version of the speaker's ongoing work across different interactions. This leads to a person's biography being a situated construction which is produced for, and constituted within, each new occasion of talk. The biography is shaped by previously-presented versions and also by understandings which prevail in the wider discursive environment, such as expectations about the appropriate trajectory of a life (Taylor, 2003). This can also be true of someone re-telling their narrative about an abortion decision. The narrative that the person tells in an interview is a situated construction with different influences from a number of things. As women take part in the interview process, they are also creating meaning through that interaction.

The narrative-discursive approach was developed by Taylor and colleagues in relation to biographical talk and identity, and it assumes that talk is constitutive. Taylor (2005a) takes the basic premise of discursive psychology, which sees talk as being constitutive, as her departure point. The assumption is that, "meanings are not the stable properties of objects in the world but are constructed, carried and modified in talk and interaction" (Taylor, 2006, p. 24). This means that as people talk and interact with others, we are creating meaning in the process.

Taylor (2006) notes that discursive resources are not only limited to accumulated ideas, images and associations that are drawn from the wider social and cultural contexts but they are also other possible resources. Taylor (2007, p. 8) states that when people construct a life narrative they are not starting from scratch but they are telling a version of what has been said before, "albeit one shaped to do work in the particular circumstances of the telling." These told-before versions have the possibility of becoming resources for future talk (Taylor, 2005b). Taylor and Littleton state that these resources for future talk are what Davies and Harré (1990) call the cumulative fragments of a lived autobiography which accumulate over multiple tellings. Taylor (2007, p. 8) adds that "a life narrative can therefore be considered as a construction which is resourced by previous constructions which aggregate over time."

Taylor (2006) explains that her approach is 'synthetic' due to the fact that it sees identity work as being constructed partly by the wider social meanings with the speaker being active in

taking up and contesting these social meanings. The speaker is, therefore, not just absorbing and taking up social meanings but has agency to resist these social meanings. With regard to abortion decision-making, the woman making the decision, although drawing from social meanings and discourses about abortion, also has the ability to resist these meanings. In contexts where abortion is stigmatised, the woman considers the social sanctions that an abortion carries by balancing it with her own situation. The idea of the speaker being able to resist meanings can be expanded using postcolonial feminist understanding of resistance. Resistance, as already shown, involves African women challenging the gendered, restrictive and discriminatory practices that exist in their contexts. So, for example, a woman narrating an abortion decision, although drawing on the gendered understanding of womanhood, also has the ability to challenge these understandings by justifying having an abortion.

Morison and Macleod (2013) have provided an understanding of the narrative-discursive approach by Taylor and her colleagues that is fitting for my purposes. Morison and Macleod (2013) state that the narrative-discursive approach has three foci areas: 1) that talk is located in broad multifaceted contexts which constructs different stories depending on the situation; 2) talk is social and that speakers speak drawing from various discursive resources and 3) social constraints exist and speakers have to be consistent in their talk and identity with regards to their previous identities and what the society accepts and recognises. The three foci which are discussed below can be expanded by a Foucauldian conceptualisation of discourse.

As mentioned earlier, Taylor (2007, p. 3) states that “our understandings of who we are, our identities, are derived from the accumulated ideas, images, associations and so on which make up the wider social and cultural contexts of our lives.” These are the multifaceted contexts noted by Morison and Macleod (2013). This can, therefore, mean that one’s narrative about an abortion decision is accumulated over time from understandings found in the wider social and cultural contexts and what one says depends on the situation or place one finds oneself. These accumulated ideas, images and associations can be considered to be the discourse that exists within the wider social and cultural contexts. As shown in Chapter 3, discourse goes further than just creating meaning (accumulated ideas, images, associations) and being a way of thinking within a society but constitutes all historical, social, and institutionally-specific structures of statements, terms, categories, emotions and beliefs (Scott, 1988). This helps in expanding the wider social and cultural contexts envisioned by Taylor (2007).

The second focus identified by Morison and Macleod (2013, p. 13) is that,"...talk is social in that speakers draw on common discursive resources to construct their accounts." This means that a speaker draws from a large pool of norms, stories, mores and beliefs from their culture in order to construct their narrative. Taylor (2007, p. 3) argues that the idea that talk is social follows from the first assumption in that, "talk is the site and the range of practices in which our identities are constituted, out of the resources made available by those larger contexts." Taylor (2007) reiterates this by stating that the ideas, images and associations coming from these multifaceted contexts provide the discursive resources available to speakers. A woman going through the abortion decision-making process in Zimbabwe draws from discursive resources that include socio-cultural and religious discourses in constructing her abortion narrative. These discursive resources, as already shown, will include gendered understandings based on patriarchal power relations and constructions of femininity.

Morrison and Macleod (2013, p. 15) identify the third focus of the narrative-discursive analysis as linking to social constraints as "social constraints operate on talk in that there is an onus on speakers to be consistent, both with their own previous identity work ... and also with what is more generally recognised and expected." The social constraints are similar to Foucault's (1972) conceptualisation of discourse where a discourse is an argued dialogue within a culture. This means that the discourses are the social constraints that speakers deploy when constructing their narratives.

However, these social constraints, understood from a narrative-discursive approach, and a postcolonial feminist understanding of agency and resistance can be contested. The speaker is able to actively contest and negotiate their position as they talk. The narrative-discursive approach suggests, therefore, that a speaker cannot operate outside these social constraints but that a speaker has the responsibility to reconcile their identity work and to talk so that it is consistent with the discourses they draw from within the context that the social constraints provide/allow. In describing the role of the speaker in terms of identity, Taylor (2007, p. 3) states that, "identities are in part conferred, through positioning…. and in part actively constructed, contested and negotiated by active speakers." This suggests that identity work is an on-going process where the speaker interacts with the wider societal meanings and contexts in creating identity. Taylor (2005b, p. 254) summarises clearly by stating that "identity is therefore understood as in part chosen by an active speaker but in part socially determined or

conferred." Drawing from Taylor's theorising, a narrative about abortion can also be seen as conferred through positioning, actively constructed, negotiated and contested by the speaker.

The focus areas of the narrative-discursive approach, therefore, are all related to the importance of talk as being social, and located within wider societal meanings. This can be expanded using Foucauldian and postcolonial feminist understandings. As shown already in Chapter 3 Foucault saw discourse as being productive and linked within a historical context and displayed in a number of multifaceted ways which include the law, media, church, medicine and the government. In terms of a woman narrating her abortion decision making she can be seen as constructing her narrating drawing from discourses available in her society which are seen as 'normal' and 'natural'. Using postcolonial feminist understandings of agency and resistance these discourses are not taken up without contestations. The speaker, therefore does not create the abortion narrative in isolation, neither is it created by societal forces alone but by a process of conferring, construction, contestation and negotiation. The process is not uncomplicated and Taylor (2005b, p. 253) warns that "the shared or social nature of talk and its resources also set limits on the identity work that is possible."

Taylor and colleagues have also shown how their narrative-discursive analysis works with transcribed interview data. Taylor (2005b, p. 23) states that "an interview-based research project is presumed to be a context which selects for and makes salient shared features of participants' lives." This means that it provides the opportunity for participants to lay out their narrative. The narrative interviewing method suggested by Wengraf (2001) works well with the narrative-discursive method as it allows the participants to construct their own narrative without much direction from the interviewer. The participant is given space to take the interview in their desired trajectory especially in the first part of the interview. Taylor and Littleton (2006, p. 23) have argued that an analysis of interview data using the narrative-discursive approach provides room for explorations on "the commonalities in participants' biographical talk" and "by going through the interview participants construct personal narratives that involve the taking up and resisting of meanings depending on their unique situations."

The use of discursive resources (or, as referred to later in the thesis as discourses) is central in this study. Taylor (2007) notes, as aforementioned, that discursive resources include accumulated ideas, images and associations that are drawn from the wider social and cultural

contexts of people's lives and are available to speakers. As such it is closely linked to Foucault's concept of discourse. In analysing interview data, the researcher, therefore, looks at how people construct their narratives using meanings from their social and cultural contexts. In my analysis I am interested in identifying these discursive patterns (discursive resources or discourses) within individual narratives and across narratives. I now move to describing the analytical procedure I undertook in analysing the women's narratives.

4.6.2 Analysis procedure

The analytical procedure shown in Table 1 below is taken from Morison (2011, p. 142) and provides an overview of the process of the narrative-discursive analysis which is described in the remainder of this chapter. It is important to note that even though it is presented as a step-by-step process the actual analysis that was done was iterative. Figure 1 below shows the phases of analysis:

Figure 1: Phases of analysis

PHASE	Description of process
Familiarisation with data	Transcribing, active re/reading and noting initial ideas
Preliminary content analysis	
Generating initial codes	Systematic coding/categorisation of interesting features of the data across the data set, collating data relevant to each code
Decomposition	Searching for patterns across entire data set and gathering data relevant to each pattern
Synthesis	Collating relevant data into patterns that point to potential discursive resources
Narrative-discursive analysis	
'Task 1'	Exploring the micro level: This involves identifying discursive resources within and across accounts. The analyst searches for patterns that occur across interviews and within the same interview.

'Task 2'	Attending to the macro level: This entails exploring the operation and negotiation of the discursive resources within the particular constraints.

The first step of the analytic process began with transcription and in this study it meant transcribing in Shona. The transcription was done by myself, the researcher. The transcribed data was not cleaned as I wanted to hear the women's narratives without adding or removing anything. During the process of transcribing, I was able to familiarise myself with the data. Transcription is an important part of analysing data as Oliver, Serovich, and Mason (2005) have noted that it is a powerful act of representation that can affect how data are conceptualised. As a process, transcription can lead to a creation of meaning as it is an "interpretative act that entails the re/presentation of an interaction" (Morison, 2011, p. 143). The transcribed Shona data were then translated into English by an experienced interpreter, who signed a confidentiality form. After this, I then did back-translations to check if the meanings captured by the translation were consistent. This was done to increase the validity of the transcriptions and to ensure linguistic and conceptual equivalence.

After the transcription, the next process was the active reading and re-reading of the transcribed data. Morison (2011) suggests that the initial re/reading helps in producing tentative ideas about relationships and categories in the data. At this stage I re-read the entire data set in search of patterns of meaning in relation to the research questions as suggested by Braun and Clarke (2006). I also searched for repetitive features such as recurrent terms, phrases or positionings (Morison, 2011). The preliminary content analysis, which forms part of this stage, involved generating initial codes by using systematic categorisation of interesting features of the data across the data set, collating data relevant to each code. The coding or categorisation helped me in identifying language patterns. Maxwell and Miller (2008, as cited in Morison, 2011) suggested that this process provides potential discursive resources as the data becomes fractured into discrete, and sometimes overlapping, units. Using *Nvivo QSR 10* I then grouped the codes into meaningful categories in separate nodes along with the relevant chunks of text. This formed part of the 'synthesis phase' which is the re-composition and re-ordering of the data into meaningful groupings.

Following from Taylor and colleagues and Morison (2011), I then moved on to the analysis which comprised two iterative tasks. The first task entailed looking for common elements that

occur across several interviews as well as at different times within one interview and which point to particular discursive resources. Morison (2011, p. 143) notes that "this task …considers how this particular account is resourced and constrained by larger discursive resources or scripts." The task was guided by the question "what discursive resources are drawn on by the participants?" It involved examining commonalities within and between narratives. Established meanings, together with the diversity among the narrators' voices, were found during this task (Morison, 2011). In this task, I was interested in the larger discursive resources from which the women drew.

The second task involved studying the use of these discursive resources on which the participants drew in order to construct particular micro narratives. In this case I was looking at how the women in the study constructed their narratives through discursive resources manifested through power relations, subject positionings and socio-cultural discourses. Morison (2011, p. 144) notes that "each discursive resource does work for narrators in various ways and therefore comprise[s] different rhetorical or discursive tactics that allow participants to save face, reconcile ideological dilemmas, or ward off potentially troubled positioning." The guiding question for this task was "How do these particular discursive resources relate to this particular context?" After these two tasks I then moved to analysing how the micro-narratives and discursive resources found, enabled or constrained the concept of, or out-workings of, reproductive justice.

This approach also takes from Foucauldian work an interest in how people are positioned in talk (see theoretical chapter for discussion on narrative positioning). The contextualisation of the discursive resources necessitates attention to positioning. Following from Morison (2011) I examined positions from three viewpoints which are as follows;

(1) *The immediate discursive context (or interactional setting):* Morison (2011, p. 144) states that "one considers positioning in relation to the interview narrative-in-interaction and the particular discursive purposes they might serve in this setting." This means that a speaker is interacting with the researcher and might, therefore, position themselves in a good light so as to be a good participant (Morison, 2011). Morison (2011) also states that the interviewer's positioning is important in this context. In this case I looked at how my being male possibly influenced the interview as touched on earlier.

(2) *The broader discursive context:* This involves how speakers position themselves in relation to their wider societal discourses. Morison (2011) adds that the broader discursive context shows the operation of power in personal narratives. The analyst is therefore interested in seeing how the "narrators position themselves in relation to the discursive resources that they have recited" (Morison, 2011, p. 145).

(3) *Prior positioning:* Morison (2011) states that at this stage the analyst looks at how previous positions in the speaker's biography are negotiated during the interview. Taylor (2006) gave examples of prior positionings which include gender, race, age, or sexual orientation. A woman who decides to abort in Zimbabwe brings prior positionings pertaining to the stigma associated with abortion.

4.7 Data analysis for the health service providers

The data from the interviews with the service providers were analysed using an adapted version of thematic analysis suggested by Braun and Clarke (2006, p. 87). I was interested in seeing how the service providers positioned the women who terminated pregnancies and at the same time positioned themselves. The following phases were undertaken in the thematic analysis:

Phase 1

During this phase, I familiarised myself with the data during the transcription process by reading and re-reading the data and noting down initial ideas. The initial ideas included initial positionings. The transcription was done by the researcher. The interviews were conducted in Shona, translated by the researcher and then given to a professional translator for checking.

Phase 2

At this stage I started generating initial codes. The coding of interesting features of the data was done in a systematic fashion across the entire data set using *Nvivo QSR-10.* I collated data relevant to each code.

Phase 3

After the codes were in place I started the search for themes. I did this by collating codes into potential themes and gathering all data relevant to each potential theme. These themes were the different ways in which the health service providers positioned the women who terminated pregnancies and also positioned themselves. There were 25 initial themes identified.

Phase 4

The next phase involved my reviewing of the themes found in Phase 3. I did this by checking if the themes work in relation to the coded extracts and the entire data set, thus generating a thematic 'map' of the analysis. Some extracts which were closely related to each other were collated into one theme. The 25 themes identified in Phase 3 ended up being reduced to only 14.

Phase 5

The last phase involved defining and naming themes and involved on-going analysis to refine the specifics of each theme, and the overall story the analysis tells. The positionings that are the focus of Chapter 7 were labelled during this phase. After the thematic analysis, I focused on how inside the different themes the health service providers positioned women who terminated pregnancies and how they were positioning themselves as well.

4.8 Conclusion

In this chapter, I have outlined the methods I have employed in my data collection. I selected the participants using purposive and convenient sampling as the women were considered a hard-to-reach research population. Three sites were identified in order to allow some socio-economic diversity in the research. In terms of participants, a total of 18 women who had terminated their pregnancy and six health service providers were chosen. Given the sensitivity of the subject matter and the restrictive laws, ethical issues were very important for this particular research. I outlined the rigorous ethical clearance sought before the study was undertaken. I also described how privacy and confidentiality were maintained during the research process so that the women who took part could be protected. I discussed the high level of risk the women faced in being involved in the study and how these risks were handled in describing the potential consequences of the research. During the critical reflexivity section, I showed how issues of my identity as a black, male psychologist from a privileged background affected the way I approached the women in the study and the research process itself.

The chapter then moved on to explain the narrative-discursive method put forward by Taylor and colleagues and how it has been applied for this research. It was noted that Taylor and colleagues were primarily interested in narratives of identity which is different from this research which focuses on abortion decision-making narratives. I then explained discursive resources which are key to this study. The iterative data analysis steps adopted from Morison

(2011) were then described in detail. After this, I explored how positioning has been understood from a narrative viewpoint and the implications this has for my study. The chapter then described the thematic analysis which was used to analyse the data from the health service providers.

Having outlined my methodology and the relevant ethics and reflexivity linked to my research, I will now present my findings. The next chapter is the first of three analysis chapters and discusses the discursive resources the women drew from in narrating their stories. The second analytical chapter will examine the women's stories of their abortion experiences. The last analytical chapter will explore how women who have TOPs are positioned by health service providers who interact with them and how the health service providers position themselves as well.

Chapter 5: Shame, stigma, moralistic religion, culture, health and the missing discourse of reproductive rights

5.1 Introduction

In narrating their stories around abortion, the women employed discursive resources around shame, stigma, religion, health and culture. I argue that in so doing, the participants speak in a socially-sanctioned way where negative social 'truths' about abortion take precedence over other more positive or constructive 'truths'. In all their narratives, it is noteworthy to see that the discourse of 'reproductive rights' is missing completely.

The chapter begins by outlining the discursive resources that the women drew from and how these represent speaking in a socially-sanctioned way. The overarching discourse of 'shame' and 'stigma' is outlined first and it is then revealed how it dovetails with the 'moralistic religious' discourse and the 'cultural' discourse. I then move on to focusing on the 'moralistic religious' discourse and 'cultural' discourse. The chapter then discusses the 'conjugalised fatherhood' discourse, 'masculine provider' discourse and 'faithful female partner' discourse which also arose in the narratives and which are all related to the 'cultural' discourse. The 'health' discourse is explained next and the chapter closes by illustrating how all these discursive resources point to speaking in a socially-sanctioned way.

In the chapter, the term 'discourses' is used synonymously with 'discursive resources'. The women's use of these discursive resources points to discursive constructions of abortion which are embedded in the socio-cultural and gendered power relations of the Zimbabwean socio-historical space. This is in line with Bacchi's (1999) work which noted that the construction and discussion of social problems such as abortion does not occur in a social vacuum but are the products of historical, political and socio-cultural circumstances.

5.2 Discourse of 'shame' and 'stigma'

The manifestations of shame and stigma are linked and operate in tandem to render either the pregnancy or the abortion or both as something that needs to be hidden. The linkage of shame and stigma is epitomised by Rose who states:

Extract 1

Rose: The first thing was that I had lost my husband and I was ashamed that people would see me pregnant and I also had a baby who was not yet walking. Then I have

another pregnancy and the pregnancy belongs to a boyfriend who is nowhere to be found, people would laugh at me.

In this case Rose feels ashamed (that is, the internalised sense of having done wrong) by the 'wrongs' she has committed (the two reasons she provides are discussed in the cultural section 5.4 and point to the dovetailing of the shame/stigma discourse with the cultural discourse). Her shame is compounded by the stigma that she might face − what people would do if they found out about her pregnancy whilst her other child is still very young. Stigma here talks to actions engaged in by others to render the pregnancy/abortion problematic, while shame refers to the internalised sense of having done wrong.

Goffman (1963a, p. 3) first described stigma as an "attribute that is deeply discrediting", and noted that stigma transforms people from "whole and usual individuals to 'tainted', discounted ones in the minds of those around them." In Extract 1, Rose would be tainted and laughed at for having engaged in actions considered shameful. Stigma and shame go hand-in-hand as shown by Fife and Wright (2000, cited in Shellenburg et al., 2011, p. 114) who described internalised stigma as "the extent to which the stigmatised individual incorporates negative perceptions, beliefs and/or experiences into his/her own self" leading to feelings of guilt or shame or other negative feelings about oneself.

Stigma leads to othering, which can in turn lead to shame. The shame comes from the associations that other people place on the woman who terminates a pregnancy. The term othering refers to "the process whereby a dominant group defines into existence an inferior group" (Schwalbe et al. 2000, p. 422). Othering is seen as producing difference and at the same time problematising it, in that the group which is othered is also in the process defined as "morally and/or intellectually inferior" (Schwalbe et al., 2000, p. 423). In relation to these concepts of shame and stigma, Tanya and Abbie state:

Extract 2

Tanya: I am ashamed (.) I am ashamed to go back home because many people heard the shouting [sobbing]. I think everyone now knows it because (.) there were so many people at the clinic. I think (.) I am now (.) the laughing stock (.) of the community [soft sobbing]. I think people are (.) thinking and saying that I am a, a (.) prostitute, a killer [sobbing] (.) who killed a baby. Ah it is hard, (.) it is hard for me. Where I stay (.) the stands are small and people are all over each other's business. People speak about others all the time so now people are speaking about me.

Abbie: People look down upon those who terminate. People who terminate are called by different names. Some are called witches, while others maidens of Satan. Women who terminate shy away from people and isolate themselves and I did not want to do that. I have a good social standing and I did not want to lose it.

Here shame is firstly associated with two positions of othering – the sexual other and the criminal other. The two can be seen in Extract 2 where Tanya shares that she is afraid of being called a prostitute and a killer. Prostitute and killer are positions that are othered as they fall outside of socially-sanctioned sexual and social behaviour. Apart from the othering, what Tanya is afraid of is being laughed at or being spoken about – these are the actions through which othering is effected. Tanya's main concern in Extract 2 is the stigma she perceives she will face since people now know about her abortion. Abbie talks of more categories that are the feared 'other': 'witches' and the sinful other ('maidens of Satan'). These two categories also link to moralistic religious understandings and cultural interpretations. The othering of the women referred to in these extracts is consistent with the conceptualisation of abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideals of womanhood[9]" (Kumar et al., 2009, p. 628). Since they are tainted and partaking in actions seen as shameful, the women are called such names as 'maidens of Satan', 'prostitutes', 'killer', and 'witch' to show how they have deviated from what is acceptable.

Stigma and othering erodes social standing, necessitating silence/secrecy. The stigma associated with an unplanned pregnancy or abortion is complicated if it leads to a challenge to one's social standing as alluded to by Abbie above. This idea is continued in the following quotes:

Extract 3

Mary: I did not want them to know because they despise those who terminate. They would have started calling me names and I did not want that. My social standing is important to me.

Tecla: If local people were to know (.) what has happened then my whole social standing will be in tatters. I would never want anyone to see me anymore. I would be the laughing stock of the world.

[9] The ideals of womanhood are dealt with in the section on cultural discourse

In Extract 3 Mary shows the importance of secrecy in covering up the abortion since people finding out would have dire consequences for her social standing. She speaks of a form of othering – the calling of names which show social disapproval of people who go against the social norms and erodes social standing. For Tecla, the perceived treatment she will receive from other people is what is threatening to her social standing. This kind of treatment would lead according to Tecla to a self-imposed isolation. The importance of secrecy referred to by Mary and Tecla is in line with research in which Rossier (2007) found that women kept their pregnancies secret when considering abortion in fear of being stigmatised by other community members. This is also true for Zimbabwe where studies have shown that the stigma placed on abortion meant that woman act alone in their decisions in either keeping a pregnancy secret or choosing unsafe abortion options that are far away from their communities (Kambarami, 2006; Kasule et al., 1999).

Participants spoke about church-going (regularly attending church and being an active member) increasing social standing, and the necessity of secrecy. Talk around ideas that a person who goes to church should strive to keep a good name by not doing things that are 'shameful' like abortion came up repeatedly in the data. The following quotes speak to this:

Extract 4

Bell: I don't want people to know what I did because it is so embarrassing. I am a person that goes to church. I do not want people to despise me for such an act [abortion].

Toni: I was also afraid that it would get to my church. I go to a Pentecostal church so if people knew I was planning to kill it would not be good.

Abbie: I am a respected woman at church and what will people say if they knew that this is what I did [abortion]?

Abbie: The reason I did this [sought an abortion from a suburb that was far away] was that as a respectable church woman I did not want to be seen with these women [women who provide abortion services] because everyone knows them ah no (.) dying is better.

Here Bell shows the link between social standing and church-going, with church-going being seen as adding to one's social standing and therefore the greater necessity in keeping the abortion a secret. Secrecy is necessary because of how church-going people view abortion, as

shown by Toni. Toni also touches on the importance of her type of church which is Pentecostal. Pentecostal churches are on the increase in Zimbabwe and emphasise personal and social rebirth; abortion is seen as morally unacceptable (Biri, 2012). Abbie indicates that the way she would be viewed by church-going people would change if they learnt of the abortion. For Abbie, the respect she receives from church-going people necessitates her seeking an abortion in other parts of town where the risk of being seen associating with those already labelled as abortion-providers is low. In all this talk the abortion is seen as an 'act' that, if not concealed, will lead to humiliation for the women.

The operation of stigma is learnt through observations of its operation with others. This is shown in the following quotes:

Extract 5

Bell: I know a lot of people in Chitungwiza who have terminated a pregnancy who are the laughing stock of the town and they have no standing in the community. They do not even have friends. I also know some who have killed themselves because of the shame that was brought by people laughing and talking about them.

Tecla: ...but I was worried that people might walk around saying bad things about me like, 'look at that evil fool who wants to terminate a pregnancy'. There was this lady who stayed next door and terminated her pregnancy in the toilet and the toilet was blocked. People shouted obscenities at her and people (.) were calling her a killer because she had killed God's innocent soul. This is why I did (.) not consult with anyone close to me.

Bell and Tecla in Extract 5 talk of how their fear of perceived stigma was linked to how they have observed other people who terminate their pregnancies being treated by those in their communities. Bell shows how the shame one feels can come from the whole "town" laughing at one and can even lead to one committing suicide. Tecla is afraid of the othering that arises when people find out about one's abortion. In a sense, the stigma in Tecla's and Bell's cases is internalised through association or example. No direct stigmatisation is necessary.

Stigma and shame can lead to regret. This is shown when Fiona and Sheila share the following:

Extract 6

Fiona: Since, culturally I should have kids, my husband is troubling me saying he wants a child and we are always fighting in the house. I did not tell him that I terminated

pregnancy because I was afraid that he would leave me because what I did was shameful [TOP]. I am regretting why I did it [TOP].

Sheila: It troubles me emotionally now because the man who was responsible for the terminated babies is the one I am staying with now and he is always reminding me about the evil thing. Right now I have no children with him and he always says that he would have been happy if I did not kill his children as he is keeping someone else's children. It is during those times that I regret as he is telling me that I killed, I terminated a pregnancy…So that's why I am troubled by it as I cannot become pregnant as we have been trying.

In Extract 6, Fiona touches on how regret can come up due to the 'consequences' of having an abortion such as failure to conceive. Her regret comes from the fear of being left by her husband for having an abortion which is 'shameful' and also a failure to have children in the current marriage. By touching on culture and children, Fiona shows the gendered expectation of bearing children of which abortion is an antithesis. Thus, her regret is compounded by terminating a pregnancy, not being able to conceive and having to hide it from her husband who wants a child. Sheila's regret comes from the constant reminder by her current partner that she is a 'killer'. The constant reminder is the stigma that leads to the regret that Sheila is feeling.

The shame that arises is not simply personal but also extends to the family since there are certain obligations that are assumed (the individual is expected to be a representative and model for the family and any acts she performs in opposition to this are seen as threatening the family's name). This is seen in the extract below where Sheila and Mary state:

Extract 7

Sheila: ...and I didn't want to be a shame of my family by leaving the husband who had paid *lobola* for me.

Mary: Since it was too soon after leaving my first husband I would have lost my standing with them and they would have thought that I am sleeping around now.

Sheila here talks to her obligation of staying with the husband who paid *lobola* for her (another example of the dovetailing with the 'cultural' discourse). In this case, Sheila's shame can be traced to the stigma that may arise from the conviction that she has rejected the feminine ideal of staying with her husband. The obligation of staying with one husband is taken up by Mary,

who is worried about her problematic pregnancy (pregnancy outside of marriage) threatening her social standing. In these two stories, the extension of stigma to the family operates on two levels: the family is also affected by the stigma (shown by Sheila who does not want to shame her family) and the family perpetrates the stigma (shown by Mary who is worried about losing her social standing by being stigmatised for sleeping around). In these two extracts, shame or stigma is not only attached to the abortion but also to deviating from expected gendered relationships.

Stigma/shame is linked to moralistic religious and cultural discourses. Tina shares the following where she also touches on social standing, shame/stigma causing isolation and the extension of shame/stigma to the family:

Extract 8

Tina: In Shona culture I had done three things that are (.) shameful. I was so shy I did not want anyone to know what I was planning. So I decided that the best thing was to terminate the pregnancy without anyone knowing. I did not know how to terminate (.) so I asked the prostitutes. I knew I could trust them and that is why I asked them. I knew I was (.) killing a child. It is something that is frowned upon by the community and I didn't want to be arrested as well since it is a crime. People I stay close to would have reported me if they knew so I never even consulted them. I do not have money but my social standing is important to me. If my parents who live in the rural areas could hear this they will disown me because terminating pregnancy is associated with prostitutes (.) who do not have any social standing.

Idi: I think it has always been in our culture that abortion is not right. We grew up being told that it cannot be allowed. It is unbiblical. Eh, it is an abomination in the country as well. So these are things that are unmentionable. You can speak as if you heard about someone who did it but you cannot speak about your own personal experiences. Ha, it cannot happen.

The use of the term 'Shona culture' by Tina shows her view of a homogeneous culture, and by extension, the correct way of doing certain things as perceived by that culture. Tina's perception of Shona culture shows that certain actions are viewed as shameful, actions which include abortion. People in rural areas are positioned as being the custodians of this culture and thus they stigmatise those who go against cultural beliefs by terminating pregnancy. This is significant as common knowledge dictates, and as many writers on Shona culture have stated,

that the rural areas are the safeguards for culture (Chimhanda, 2014; Mawere, 2010). Urban areas are seen as corrosive to culture. Hence, negative things like abortion are prominent in urban areas. Tina, in Extract 8, also touches on the 'cultural' views of abortion where abortion is associated with prostitutes. Tina seems to reinforce this 'cultural' view by asking for advice from prostitutes on how to abort a pregnancy. As will be discussed later, there is a close link between moralistic religious discourse and cultural discourses. Idi, in the extract draws on 'culture', the Bible, and the country (a nationalist discourse) to indicate how abortion is positioned as wrong. Idi also shows how stigma involves silence since abortion is unmentionable.

Despite the linking of stigma to shame, silence, secrecy, and regret, there were infrequent narratives of resistance. Clara said:

Extract 9

Clara: In the first days it was hard, especially being laughed at by the community. It used to touch me and I used to cry a lot. But I just said to myself it was my decision and I will stick with it.

In Extract 9 Clara resists the stigma by asserting her power to make the decision to terminate her pregnancy. Clara shows that stigmatisation is a process that can be actively resisted by people who are vulnerable to the stigma (as indicated by O'Donnell, Weitz, & Freedman, 2011). Other narratives[10] of fortitude were found in moralistic religious discourse where the women had been forgiven by God and thus 'people' were not justified in continuing to stigmatise them.

5.3 'Moralistic religious' discourse

The 'moralistic religious' discourse was one of the main discursive resources drawn upon. The discourse draws upon moralistic interpretations combined with religious meanings. Hess and Rueb (2005) have shown that religion plays an important role in determining one's morality. My understanding of being moralistic is that these are a set of meanings through which individuals in a society understand their experience and make judgments about what is valuable and important. An example of this moral reasoning is seen when Sheila states that:

[10] These quotes can be seen under the section on moralistic religious discourse

Extract 10

Sheila: I wanted the pregnancy gone because it would bring shame to me as everyone would have known that I had cheated on my husband.

For Sheila here, cheating on her husband is morally wrong. Therefore, termination of the pregnancy provides a way to hide the act of infidelity. The women's use of the moralistic discourse does not end there but also extends to the act of having an abortion. The women in the study saw abortion as an act that was morally wrong. These moral values were infused with religious understandings and it is for this reason that I label this discourse a 'moralistic religious' discourse. The 'moralistic religious' discourse is drawn upon in the women's narratives about the practices, patterns of thinking and patterns of language that they use in narrating their abortion decision, how they proceeded with the termination and the sequelae that followed.

Before expanding on this discourse, it is important to remember the context in which it arises. As mentioned in the introductory chapter, Zimbabwe is a Christian country in which it is estimated that between 70 to 80 percent of the population identify themselves as Christians (International Religious Freedom Report, 2010). The women in this study all identified themselves as practicing Christians. A strong connection has been found between individual religiosity and general abortion attitudes, with people who saw religion as being important in their lives more likely to disapprove of abortion (Adamczyk, 2013; Hess & Reub, 2005). This, therefore, means that in a society where religion is important, like the three sites in Harare, abortion is something that is likely to be met with disapproval. Frohwirth et al. (2014) have argued that in such communities, religion provides what they call 'discursive prohibition' where matters like abortion are so taboo that they cannot be discussed. This discursive prohibition was seen in operation in the women's narratives in my research as they were speaking about their experiences for the first time in their interviews. The discursive prohibition is perpetuated by the stigma that people face. By framing abortion in terms of this 'moralistic religious' discourse the women view themselves from a standpoint of being in the wrong.

I now move on to showing how the 'moralistic religious' discourse was used. I begin by showing how abortion is equated with evil; how this equation is premised on the idea that abortion is murder and killing and thus wrong; how the equation leads to two potential

consequences which are eternal damnation and forgiveness, and how the equation of abortion with evil allows for the externalisation of responsibility. I then move on to discussing pregnancies which are complicated by religious understandings and how this leads to an abortion.

5.3.1 Abortion is 'bad' and 'evil'

After performing a termination of pregnancy, moral and religious convictions tended to trouble the women. Women drew on the notions of 'good' and 'evil' in describing their actions. Fiona states this in the following extract when she sees the problems she is now facing as a punishment for doing an 'evil act'. She states:

Extract 11

Fiona: …But I feel I might have made a mistake [undergoing the TOP] since I cannot conceive now. I am thinking I might have harmed myself with the medicine or that God is punishing me for doing such an evil act. That is the only regret and I am afraid I would not conceive again. I would not forgive myself if it happens but I understand that during that time [when faced with an unsupportable pregnancy] I had to terminate.

In Extract 11 Fiona constructs abortion as an 'evil act' based on Christian interpretations. Due to the wrongness of the act, the problems she is having now are seen as a punishment. The equating of abortion with evil based on Christian teachings means that the act cannot go unpunished. The punishment which is set down here (not conceiving) has serious repercussions for Fiona as it means she cannot be a mother and as such she would not be able to perform the gendered expectation of being a mother. Despite the punishment and realisation that she has done wrong, Fiona asserts her position of having had no options due to her pregnancy being unsupportable. (More discussion related to having 'no options' is found later in Chapter 6).

The reason abortion is perceived as being evil is because it is equated with killing: killing is murder and murder is wrong in Christian teachings as was noted in Extracts 4, 5 and 8. Ruth epitomises this when she states:

Extract 12

Ruth: I was so ashamed whilst she was saying 'this' [the abortion]. It's a very big shame up to now. Even now when I hear people talking about other people saying 'so-and-so killed a baby ...she terminated'. I see myself haaaa (.) I don't think I will support this thing ever. It's so horrible. I did a horrible thing.

Ruth: It does not having any standing in front of people. It is frowned upon especially by those who go to church. In front of God I am no different to a murderer who waits for people in the dark. So people see me as a murderer. I spoke to a bishop from my priesthood and she said if these things have happened they have happened and God can forgive you but as a person of flesh this should not be repeated because it's the same thing as killing. So for you this is now a lesson to learn about how bad this is and that the church does not encourage it. Forever! We encourage adoption instead of killing that human being.

In Extract 12, Ruth equates TOP with killing and as such it is seen as a 'horrible' act. This acknowledgement that one has performed an act (killing) that is contrary to the moralistic and religious duties is what leads to the shame. In Ruth's case, it is as if one has let the whole community/society/church down. The female bishop does some moralising by telling Ruth that she has 'learnt her lesson' from doing something wrong that should not be repeated but she attempts to soften it by saying that God has forgiven her. The idea of forgiveness, however, suggests that the act that was committed was wrong but that God has pardoned this as long as it is not repeated. The equating of abortion to killing can be seen in the Christian teachings around life beginning at conception (Norris et al., 2011). Thus, the conceptualisation of abortion as bad and evil is perpetuated by the church's teachings. In Ruth's case, the bishop reinforced this by telling her that she had killed and she should instead have given the baby up for adoption. It is this reprimanding from the bishop that fuels Ruth's guilt as now she is living with the knowledge of having done something bad.

The equation is seen in the women's talk, where abortion is seen as killing and murder means that abortion can lead to eternal damnation. The concept of eternal damnation is seen in the following quote:

Extract 13

Ruth: And now I am in pain and I know it should not be repeated in life. God gave me a child and I killed that child and sometimes you think I just should have kept the child. I know even the day I die that this child will be waiting for me because I killed a human being but I had no choice.

Ruth, in Extract 13, shows how she has performed an evil act, the consequences of which extend to spiritual matters. This can be seen in the idea that abortion, as seen by Ruth here,

does not only have consequences in social standing and social stigma but is something that one has to answer for when one dies.

The interesting part of the 'moralistic religious' discourse is that, on the one hand, there is eternal damnation as shown above and, on the other hand, reprieve and forgiveness. Despite the wrongness and evil of abortion, redemption exists and is meted out by a forgiving God. The following quotes show this:

Extract 14

Ruth: But I know that God has forgiven me and I am working on forgiving myself. That is God's love that heals.

Ruth: Yes, I made a mistake but I know God forgives me. If God forgives then who are we to refuse that?

In Extract 14, Ruth shows that despite seeing abortion as 'murder' there is room for forgiveness from God. The same God who is seen as punishing is also seen as merciful. The forgiveness seen here, while redeeming the individual act of abortion, does not undo the equation where abortion is seen as murder and killing, but actually reinforces it. The women have to acknowledge that they have done wrong and thus are sinners who recognise their error and are repentant. In the extract above, it is the same person who is declaring that she will have to atone in heaven, who indicates that she is forgiven. This illustrates how people can draw on discourses in contradictory ways in their narratives.

In continuing with the discussion of this idea, Ruth (Extract 12) picked up on the idea of being a sinner who needs absolution for having committed such a sin. Other women also spoke of the need for repentance as shown below:

Extract 15

Toni: God says it is a sin, it is killing but that same God is merciful so I prayed and I got forgiveness.

Abbie: I prayed to my God and I know he forgave me. He knows where he had put me.

Rose: You just repent in front of God saying that is what you did and ask God for forgiveness.

Ruth: She said [the bishop] she accepted me as child of God who is forgiven. She asked what I would do in future. I said mistake or no mistake I keep my babies.

In Toni's and Abbie's case, prayer is seen as showing that one is repentant and thus worthy of being forgiven. Rose indicates how confessing one's sin to God is the first step before forgiveness can be granted. The assumption around repentance, as shown by Ruth in Extract 15, is that by acknowledging that you have sinned you are showing how wrong your actions are and that you have learnt from the mistakes and commit to avoid carrying out the same act in the future. Ruth shows how the 'moralistic religious' discourse offers redemption, but only once certain actions are forsaken. The process of forgiveness can be seen, therefore, as actually reinforcing the ideas around abortion being wrong.

The equating of abortion with evil allows for the externalisation of responsibility. This is shown in the following quotes:

Extract 16

Abbie: I sit and think 'I am a bad person' but what was I to do? Satan had visited me. Now I am paranoid and thinking that everyone knows and ahhh (.) I am ashamed.

Ruth: Obvious these are the works of Satan. This lady bishop told me that Satan wanted me to die and he had made me his person because of the sin I had committed.

In Extract 16 it can be seen that the 'moralistic religious' discourse not only makes judgments on particular actions, but also pronounces on the actual person. Abbie now sees herself as a 'bad person'. Abbie finds justification by placing the blame onto an external force: in this case, Satan. Ruth also attributes the abortion to the works of Satan and this is supported by her bishop.

The placing of blame onto an external force is made possible by religious teachings where sin is brought about by evil forces. This understanding, as seen in Ruth's talks with her bishop, is shared amongst other church-going people:

Extract 17

Eli: The people at church think it's demons**…**

Tecla: I think they would do an all-night prayer for me to remove the demon that got into me because people who do what I did are said to be possessed by demons. I go to a

Pentecostal church and the pastors will definitely want to exorcise the demons in me.

In Extract 17, Eli and Tecla show how other church-going people see abortion as being influenced by external forces, in this case, demons. The demons operate by entering the women's souls and thus lead them to performing the evil act. The demon, once in possession of the women, can only be removed through exorcism and prayer. The existence of demons within women who terminate a pregnancy, although the blame is placed on an external evil force, can also lead to women being labelled 'maidens of Satan' (as seen in Extract 2) thereby making them an extension of the evil.

5.3.2 Religiously-complicated pregnancies

The 'moralistic religious' discourse was also drawn upon when describing circumstances that made some pregnancies complicated, leading to the need to have an abortion. In most instances, the pregnancy represented something so negative in their moralistic and religious understandings of gendered relations that it had to be terminated. Eli stated that:

Extract 18

Eli: I go to church and I did not want to have a child without a father. It is a shameful (.) thing and I was so ashamed of it. All my friends at church have their families and I did not want to be the only one with a child without a father. No I did not want so I decided to terminate.

Here Eli draws on the religious understanding of marriage being the correct place for reproduction. For her, having a child without a father is shameful especially since she goes to church. The church in this context serves as a place where certain values and practices are brought forward and enforced. A child out of wedlock is not permitted and she states that all her friends have families which is condoned by the church as being the correct place in which to have children (particularly within marriage). In this way, she also draws upon the idea of the nuclear family and how families are expected to be constituted within the church.

It is not just having children outside wedlock that is morally and religiously wrong, but also the perception that the pregnancy was conceived because one was 'sleeping around'. Sheila and Rose said the following respectively:

Extract 19

Sheila: I wanted the pregnancy gone because it would bring shame to me as everyone would have known that I had cheated on my husband.

Rose: I would be so ashamed and I would have been the talk of church with people saying she lost her husband and look now she is pregnant.

The eschewing of having children outside of wedlock and also protecting oneself from the perception that one is sleeping around are socially-sanctioned ways of acting. When one does not 'abide' by these unwritten rules and mores, then sanctions are brought to bear. In Extract 19, we see the consequences of a religiously-complicated pregnancy which brings about shame and stigma. Sheila was worried that the pregnancy would highlight her infidelity. For Rose, the pregnancy would have highlighted her sexual activity outside of marriage. Here, Rose shows the gendered expectations that exist. In Sheila's and Rose's cases, their pregnancies are seen to have been conceived in circumstances (no husband or husband is away) which are religiously unacceptable. Mojapelo-Batka and Schoeman (2003) in a South African study with women who had terminated their pregnancies found that the broader social morality and religion that exists in society plays a role in decisions around abortion. This suggests that women can internalise the church's teachings around sexual permissiveness. Sexual permissiveness here implies that those that have sex out of wedlock must find ways to hide what they had done.

Single parenthood was also seen as complicating a pregnancy. Eli states:

Extract 20

Eli: I also did not want to be shy at church as single mothers are frowned down upon.

Here Eli shows the contempt with which single parenthood is viewed. Eli in Extract 18 already showed how most of her church-going friends have families. In this context, being a single parent is a deviation from the norm and can lead to one being socially sanctioned. As already shown, single parenthood, together with adultery and fatherless children, are seen as religiously unacceptable/morally wrong and actions that should not be carried out by someone who attends church. When a pregnancy occurs in these circumstances, it therefore becomes religiously complicated. Women are then placed in a dilemma or double-bind concerning what is viewed as morally acceptable behaviour. On the one hand, single parenthood, relationships outside of marriage, fatherless children are seen as morally reprehensible; on the other, abortion is equated with evil.

5.4 'Cultural' discourse

The use of the 'cultural' discourse in the women's narratives points to the importance of culture in the lives of the women in this study. The cultural discourse here refers to practices, values, norms and mores that the women identify in their environment. Culture, in this sense, is referred as a 'real thing' (as in 'in our culture'). Particular practices are understood as being cultural. Idi and Angie share:

Extract 21

Idi: In Shona culture I had done three things that are (.) shameful.

Angie: And having a child in Shona culture is a blessing and a gift so killing that gift is seen as wrong.

The extract here shows the homogenisation of 'culture' in such a way that it becomes stultified and objectified. This means that Shona culture is seen as a systematically-harmonised whole comprising a shared and stable system of beliefs, knowledge, values, and sets of practices. The cultural discourse was drawn on in two ways: when pregnancies are complicated by cultural practices and cultural views on abortion. These are expanded below.

5.4.1 Culturally-complicated pregnancies

Culture, like religion, can make some pregnancies complicated due to the circumstances of the pregnancy. In this case, women drew from certain cultural practices/norms regarding their pregnancies and how these meant that an abortion was necessary. One of the cultural practices that complicates a pregnancy is having a child while you have another one still breastfeeding. This is epitomised in the following quotes:

Extract 22

Tina: I had a baby who was still young, who needed to be cared for and now I was pregnant again. I (.) thought again about the Shona culture which says that children should not drink breast milk from the same breast at the same time as this will affect their development. I also did not have any work so money was going to be tight and I could not take care of both children.

This draws from a cultural discourse surrounding children sharing breast milk and how this should be avoided. Tina gives the 'rational reason' (affecting development) for the cultural injunction of children sharing breast milk. Buying into this cultural injunction provides the justification to terminate a pregnancy to protect the already-born child from stunted development. She also had practical concerns around taking care of her children. To avoid

censure for being irresponsible (in other societal members' eyes), Tina sees an abortion as the solution. Tina follows a social script where a mother is responsible for ensuring that children do not share the same breast milk and that there is money to look after the children. Tina speaks of culture, a real thing that prevents particular actions. In popular Shona customs it is said that the milk will be spoilt and will produce certain chemicals that are poisonous and detrimental to children if one breastfeeds two children at once. Cosminsky, Mhloyi, and Ewbank (1993) have shown that those among the Shona who breastfeed their children at the same time would have the children treated by traditional healers to cleanse the children.

In the above extract, Tina shows that cultural practices are important in deciding what actions to take. For her, the fact that she had fallen pregnant when she was still breastfeeding meant she had to resort to terminating the pregnancy. Not abiding by this cultural practice means that she is defying the definitions of womanhood/motherhood in this particular setting. A woman or mother in this regard is constructed as someone who does not breastfeed two children at the same time. To avoid the social fall-out from this complicated pregnancy the woman decides to terminate so that the children are unharmed. This reinforces the notion of a mother as a protector.

5.4.2 Abortion as culturally shameful

Abortion was also seen as being culturally taboo and shameful. Mawere (2009), in a paper on euthanasia, has shown how, through idioms, Shona culture condemns issues like abortion. Mawere (2009) gives an example of the idiom *Kufa izuva rimwe, kuora igore* (death is one day, corruption is a year) which warns people to beware of what may harm a person and have long-lasting consequences to oneself and society.

The narratives of the women in this study drew from this cultural understanding of abortion. Idi, Angie and Tina show how abortion is viewed in this Shona culture when they state:

Extract 23

Idi: I think it has always been in our culture that abortion is not right. We grew up being told that it cannot be allowed. It is unbiblical.

Angie: In our culture terminating pregnancy is associated with prostitution; prostitutes who do not have any morals.

Tina: People are still keeping our culture…

In Extract 23, Idi touches on the links between culture and religion by showing how the wrongness of abortion in 'our culture' is based on biblical principles. Idi shows how culture and religion interact. This is in line with Lightfoot-Klein's (1989, cited in Okome, 2003, p. 71) observation that "customary practices have been incorporated into religion, and ultimately have come to be believed by their practitioners to be demanded by their adopted gods, whoever they may be." Angie and Tina touch on the gendered cultural association that termination of pregnancy has and how one is expected to follow cultural norms or risk being shamed.

Tina in Extract 8 and Angie in Extract 23 above show how abortion becomes culturally shameful because of the association it has with prostitution. This is significant as prostitutes have always been placed on the margins of society as they are viewed as people who do not adhere to the cultural norms and rules. Turyomumazima (2008) argues that it is because of associations between promiscuity and abortion that abortion has no place in African culture. Societal norms place sanctions on those who defy these norms of African culture. In a study of the attitudes of men towards abortion in Chiredzi, Zimbabwe, Chikovore (2004) found that men felt that women who terminated pregnancies were promiscuous and mostly prostitutes.

5.5 'Conjugalised fatherhood' discourse

The 'conjugalised fatherhood' discourse is closely linked to the cultural ideas around marriage being the appropriate place for reproduction. The general belief among the Shona people, according to Chingombe, Mandova, and Nenjo (2013), is that every person has an obligation to marry and contribute to the immediate and extended family through child bearing and rearing. This belief was seen throughout the narratives in my study as women became pregnant with the hope of becoming married to the baby's father soon afterwards. Lucy and Esther stated:

Extract 24

Lucy: He was saying he was looking for money to marry me and also to get me....

Lucy: My boyfriend ran away and went (.) to the rural areas.

Lucy: I was in trouble and had to decide whether to end my life as I know it by having a fatherless child….

Esther: He said if I had his child he would marry me.

Esther: I do not know what got into him. When I could not find him that is when I started thinking about termination. I would have kept it if he had stayed because he was able to look after us. His leaving gave me these ideas.

Here Lucy indicates how abortion would not have been necessary if the man had fulfilled his promise of marrying her, pointing to gendered expectations. By doing so, Lucy drew from the 'conjugalised fatherhood' discourse which implicitly assumes fathers are important figures in their children's lives. Esther, in Extract 24, indicates how failure to meet the gendered expectations of being married or falling pregnant in the context of marriage leads to an abortion. By allowing the pregnancy to continue to full-term without being married means that the woman will be stigmatised.

The 'conjugalised fatherhood' discourse was also taken up in talk around having fatherless children. The following extracts show quotes about having fatherless children:

Extract 25

Eli: …but I did not want to have a child (.) without a father. It would also influence my finding another husband.

Toni: I did not know who the pregnancy belonged to. I did not want to have a baby without a father.

The two women here show how failure to provide a child with a father made terminating their pregnancy a viable option. In Extract 25, Eli suggests that fatherless children are not only 'shameful' in the here-and-now but will affect how one is viewed in the future and in her case how future potential husbands would see her as tainted for engaging in sexual relations outside of marriage. For Toni, having a fatherless child means raising the child on her own. Having a 'child without a father' as well as her not knowing who the father of her child is, means that, according to society, she has not adhered to social norms and might be stigmatised. Some of these norms in this context, as already shown, might include rejecting the context of marriage as the appropriate place for reproduction and the association with sleeping around or prostitution. Johnson-Hanks (2002), in a study in southern Cameroon, also found that childbearing outside marriage was not socially tolerated. The findings in the study in Cameroon are similar here in that the women claim that an abortion can be hidden but not a baby.

Eli also takes up the ‘conjugalised fatherhood’ discourse when she states:

Extract 26

Eli: What do you do with a baby without a father? The child will be (.) there forever. You cannot hide the child and until you die. It will be a reminder that you had a child without a father.

When Eli asks the question, ‘what you do with a baby without a father?’, she is implying that fathers are fundamental to child-rearing. The response to the stigma of a fatherless child, as shown before, is silence and secrecy (the desire to hide the child). In this case, the stigma of having a fatherless child cannot be overcome (children cannot be hidden), so the option of having an abortion becomes more feasible as it is possible to keep the abortion secret but not the child.

The implication of fathers being inherently good for child rearing was repeated a number of times by the women as shown by the previous quotes. Having a child without a father is a clear violation of female ideals of sexuality and motherhood, where the women should have children with a husband in a family setting. Marriage is seen as sacred and a married woman is treated with respect; in fact, the desired state for most Shona women is matrimony (Chingombe, et al., 2013). This discourse of ‘conjugalised fatherhood’ and thus, the need to raise the child with both parents, is closely linked to the ‘masculine provider’ discourse which is discussed next. This discourse suggests that the man is supposed to be a provider and when he does not provide and denies responsibility, then the woman is left in a difficult position concerning whether or not to continue with her pregnancy.

5.6 ‘Masculine provider’ discourse

The women drew from the ‘masculine provider’ discourse when talking about instances of men denying responsibility for the pregnancy. This means that these men will not be available to provide for the pregnancy and the child once it has been born. The man in the following is seen as a provider:

Extract 27

Rose: That boyfriend then said we should have a child together. I agreed because I thought I had found someone who could take care of me. I had the pregnancy and when it was 2 months I told the boyfriend that what, I am pregnant. He just said ‘ok’ but he destroyed his phone line (.) you can’t get hold of boyfriend [hand

signals]. He stopped coming and he was not buying me any food anymore. He was not coming, he could not be found.

Rose, in Extract 27, draws from the 'masculine provider' discourse when she talks of the expectation of men to be providers. Being pregnant without a solid, reliable heterosexual partner means gendered expectations of the roles of men and women have not been met and this problematises the pregnancy. Rose points to the man 'taking care' of her and this might include both financial and emotional support under the socially sanctioned institution of marriage.

The disappearance of the man responsible for the pregnancy triggers thoughts around termination of pregnancy, as life without a financial provider has made life difficult for the woman:

Extract 28

Esther: After I became pregnant the man disappeared and I never saw him. His Telecel number that he was using was no longer working. The house he was renting in Hatfield was now empty and they said he had moved out. I did not know what to do.

Esther: He seemed happy and he actually bought the pregnancy test. I do not know what got into him. When I could not find him that is when I started thinking about termination. I would have kept it if he had stayed because he was able to look after us. His leaving gave me these ideas.

In the above extract, Esther sees her partner's role as providing for her and the child to be born. For Esther the partner's disappearance meant that she could not depend on him and this made termination of pregnancy a viable option. Esther shows the gendered expectation of men as providers. She does some labour to show that having a TOP was not on her mind until she realised that her partner was not going to provide for her during the pregnancy and after the child was born.

If the man cannot fulfil the role of the masculine provider, then his family is expected to fulfil this role if the family can verify with the father that the pregnancy is his. Lucy states:

Extract 29

Lucy: My boyfriend ran away and went (.) to the rural areas. When I went to ask at his house they said they did not know where he was (.) but he is used to (.)

disappearing like this. I told them about my pregnancy and they said they could not accept it if the person responsible (.) was not there and there was no way of verifying that it was his. I left their house in (.) tears.

In Extract 29, Lucy shows how the family refused to take over the role of the man (by accepting responsibility for the pregnancy). This meant that she could not take care of the child alone as she did not have the financial means to do so. The family, just like the man, have not stepped up to fulfil their masculine provider role.

The 'masculine provider' discourse was also drawn upon even in cases where the man was available. Angie and Bell said the following:

Extract 30

Angie: I told my husband about the pregnancy and asked what we should do. We had four other children and we were suffering. We had nothing to give to the children. My husband did not take any action and he just kept quiet. Seeing the way we were suffering I saw that we could not afford another child. We could not take care of the child. I then decided to terminate and I did not even consult my husband (.) since he was inactive.

Angie: My husband is useless. He was there throughout my ordeal but did not say a single thing.

Bell: I thought that my husband [-to-be] has no qualification and he is just a temporary teacher at a school where his father is the headmaster. I saw that my life was going nowhere….

The above quotes show that it is not only in cases where men have denied responsibility in which they fail to be masculine providers. Angie's pregnancy becomes unsupportable because the husband cannot play his masculine provider role. For Bell, the man who wants to marry her does not have the qualities of a masculine provider (having qualifications and a salary that can provide comfortable living) and this necessitates the TOP.

The idea of men as 'masculine providers' is in line with previous findings in other African settings where women chose to have a TOP because men had denied paternity and thereby withheld financial and emotional support from the pregnant women. In Zambia, Dahlback et al.

(2010) found that some women chose to terminate pregnancies due to a lack of financial and emotional support from their sexual partners who denied responsibility for the pregnancy.

The 'masculine provider' discourse draws expected gendered norms within the society (in this case, the societal context being the Shona culture in Zimbabwe) when it comes to abortion decision-making. The women in the study are speaking in a socially-sanctioned manner when explaining that since the men were not acting as they were supposed to act, terminating the pregnancy became a reality. From the above extracts, a masculine provider can be described as a man who: i) does not deny responsibility when there is a pregnancy, ii) can take care of the child and women financially, iii) can make decisions in the household, and iv) is truthful and honest. All these qualities of a masculine provider are missing in the men described by the women in the study.

5.7 'Faithful female partner' discourse

The women in the study drew from the 'faithful female partner' discourse in their narratives. This discourse was based on cultural interpretations and understandings of what a woman should be and how she should behave within relationships. In narrating their stories, it was evident that the participants thought there was a certain way women were supposed to act and behave. One of these stories was in relation to how a woman should be faithful. Sheila, who had cheated on her husband and was pregnant, said the following:

Extract 31

Sheila: I was four months' pregnant and I knew he would ask me where the pregnancy had come from. I thought…thought that 'what should I do?' knowing that he would say the pregnancy was not his and 'you cheated on me' so..so. Sure I took on the abortion idea.

Sheila: I didn't want the shame and being chased away from my home so I decided [to have an abortion] as soon as I realised that my husband was coming back.

In Extract 31, we see Sheila explaining her decision to terminate the pregnancy as being based on her having gone against the norm where wives are supposed to be faithful to their husbands. Not being a faithful female partner leads to shame that arises from the stigma associated with breaking entrenched gender norms. Sheila is worried that having not been faithful, her pregnancy would be visible evidence of her infidelity and would be associated with prostitution which, as mentioned earlier, has moralistic religious and cultural connotations. Sheila also

shows that shame is associated with having broken the conjugal bond and thus decides to have an abortion so that her husband does not find out about this. She also draws on the 'masculine provider' discourse as she is worried about being chased away and having to raise the child without the financial support of her husband

The faithful female partner is not just assumed for women who are married but also for those outside of marriage, for example, those who have become widowed and have not yet married again. Mary draws from this discourse when she spoke about having a pregnancy soon after leaving her husband. She said:

Extract 32

Mary: Since it was too soon after leaving my first husband. I would have lost my standing with them and they would have thought that I am sleeping around now.

In Extract 32, Mary, who has left her husband, indicates how her out-of-wedlock pregnancy could be construed as promiscuity (engaging in sexual intercourse outside of marriage). The association with 'prostitutes' threatens one's social standing and problematises the pregnancy. Mary can be seen as not playing the role of the faithful female partner. The faithfulness in this case is not to a particular person but the ideal of a woman who reproduces and engages in sexual intercourse only in the socially-sanctioned union of marriage.

The 'faithful female' partner discourse can be seen in the 'moralistic religious' discourses, 'shame' and 'stigma' discourses and the 'cultural' discourses where the ideal of how a woman should act and behave, especially with regards to sexuality, can be seen. A faithful or 'proper' and accepted woman is one who: i) does not sleep with men outside of a committed relationship or marriage; ii) sleeps with only a man to whom she is married. Coupled with these are other constructions of a woman who is dependent on the man, and adheres to all religious and cultural norms of sexuality (including no abortion and no pregnancies without fathers).

5.8 'Health' discourse

In narrating their stories, the women also drew from the 'health discourse'. The 'health' discourse featured in two ways. The first concerned the widely-held view that abortion is detrimental to women's health and the second involved being HIV-positive and thus there was the need to have an abortion so as not to infect the unborn child. Njagi (2013) has shown that in Kenya, anti-abortion discourse constructs abortion as being problematic because of the risks it

poses to women's health both physically and mentally. The operation of a 'health' discourse includes the fact that ill-health incapacitates people as is seen when Esther says:

Extract 33

Esther: I only started thinking about health when I had done it [the abortion] and I was sick. I could not even stand up. My friend helped to take care of my children during this time. When deciding I was only thinking about not wanting the pregnancy and nothing else matters.

In Extract 33, Esther indicates how she became aware of the need to protect her health after she was incapacitated and required help to take care of her other duties. Even though Esther recognises the physical risks involved with an abortion, these were outweighed by other reasons in the decision-making process such as the need to regain her strength to attend to her daily household duties.

The 'health' discourse was also mentioned with reference to the health concerns of terminating a pregnancy. Women spoke about how even though unsafe termination is risky and might lead to death, the continued pregnancy was more dangerous than any health concerns. The following quotes point to this:

Extract 34

Sheila: When I knew that my husband was coming [from Harare to the rural areas where she was] I just knew I had to terminate. I did not think about what it might do to my health or anything…I had a problem and the only way to solve it was to terminate.

Idi: Then you say 'alright let me not go ahead. What if I die? What will happen to my child?' This will all be going around in your head. Then you realise that both options are your death.

Sheila, in the above extract, shares that even though the potential physical health problems associated with undergoing an abortion are evident, the situation in which she found herself was greater than all these concerns and thus she decided to terminate the pregnancy. In Extract 34, Idi indicates how the 'health' discourse refers to both physical and mental health. On the one hand, she saw abortion leading possibly to physical death while continuing the pregnancy would lead to emotional, mental and possibly social death.

In other instances, women deployed a 'health' discourse to indicate how they managed both the outcome of the abortion as well as how to perform the abortion. Rose indicates that after undergoing her TOP, she watched for the symptoms that indicate health problems or illness:

Extract 35

Rose: It was scary, I was afraid and it became more when I actually saw the way I was bleeding. The blood that came out was too much.

In Extract 35, Rose only recognises the health risks only after she has had the abortion. This was also true in other instances and led the women to seek medical help despite the social and legal risks.

The realisation that there can be health risks leads to a consideration of remedies used to induce abortion as shown by Mary and Abbie who state:

Extract 36

Mary: I knew that it could harm me that is why I looked for friends' advice. Some told me to use tea, others chilli. I ended up taking [using] the tree [branch] because they all said it was the safest way. Even though I was scared my situation forced me to go ahead with it.

Abbie: I did not think about the health risks since my sister used the same medicine and she was fine.

Mary here manages the risk of harm by weighing up what can be used to perform the abortion with the least side effects. On the other hand, Abbie does not consider the adverse effects since she chooses a method she has seen work before with her sister. Both Mary and Abbie consulted other people for help; Mary asked friends who gave her different ideas until she picked a method that was said to be the safest amongst the choices whereas Abbie used her sister's successful and thus convincing experiences to choose her own method.

Only two women in the study drew from the 'health' discourse with regards to HIV. Toni, the first woman, said:

Extract 37

Toni: …I am HIV positive and I was worried that I might pass the disease to my child. Even though there are pills that can prevent this I did not want to take the risk.

Toni in Extract 37 draws on a 'health' discourse of prevention. She speaks of not taking the risk of infecting 'her child'. Two studies in Vietnam concluded that awareness of HIV-positive status was related to an increased likelihood of having an induced abortion (Bui, 2010; Chi et al., 2010). Whereas Toni was afraid of transmitting HIV to her unborn child Doris, the other women in question, said this:

Extract 38

Doris: I was afraid of being laughed at for having no husband and for having a child while I was HIV-positive. So I thought terminating would be better than being the laughing stock of the whole location.

Doris's quote points to stigma that surrounds having no husband coupled with being HIV-positive. She thus chooses abortion as it would eliminate this stigma. In relation to this, Orner et al. (2010) reported negative perceptions towards HIV-positive pregnant women in South Africa. These HIV-positive women were seen as irresponsible for not using contraceptive methods to prevent pregnancies. Doris's fear in Extract 38 was not that she would infect the unborn child, like Toni in Extract 37, but that she would be stigmatised for having a child while HIV-positive. With regards to infecting the unborn child, Doris is not worried, as she states:

Extract 39

Doris: …even though I was positive… there were pills that can prevent mother- to-child transmission.

Here Doris draws on a 'health' discourse in which medical intervention can prevent health difficulties. She shows how the availability of pills means that she does not have fear that her unborn child will become infected.

5.9 Conclusion

In this chapter I have outlined the discursive resources that were drawn upon by the women in the study. I started the chapter by showing how a discourse of 'shame' and 'stigma' is intricately interwoven in especially the 'moralistic religious' discourse and the 'cultural' discourse. Shame and stigma were shown to be important in determining what makes a pregnancy and also an abortion complicated. The link between shame and stigma was established and stigma was linked to othering which was seen as eroding one's social standing thus necessitating silence/secrecy when undergoing a TOP. Those who were church-goers were seen as having to undergo a TOP in secrecy as the TOP would degrade their social standing. The operation of stigma was seen to be learnt through observations of how other women who

had had TOPs in the community had been stigmatised before. Stigma and shame could lead to regret and could also be extended to the family. Despite the linking of stigma to shame, silence, secrecy, and regret, there are infrequent narratives of resistance.

In outlining how a 'moralistic religious' discourse was employed and how it arises from moralistic and religious understandings I showed how abortion was viewed as bad and evil with those who abort being equated with 'killers', 'murderers' and 'maidens of Satan'. Certain pregnancy circumstances, like procreating outside of marriage were complicated by religious understandings of marriage as being the appropriate context for reproduction. I explored how a 'cultural' discourse was employed by the women and also how culture was referred to as a 'thing'. This discourse drew from cultural understandings of how femininity should be perceived. Abortion was also seen as being culturally shameful. The 'moralistic religious' discourse and the 'cultural' discourse were seen as interacting in so far as certain constructions were shared by both discourses.

The women who had TOPs also drew from a 'conjugalised fatherhood' discourse which focuses on marriage being the right place for having children and fathers being inherently good for child-rearing. Linked to this discourse a 'masculine provider' discourse was also drawn which assumes that men should be providers for women and their children. In contrast to men being seen as providers, a 'faithful female partner' discourse was drawn from, in which women were constructed as supposed to be faithful not only to their husband but to cultural norms as well. The chapter ended by looking at the 'health discourse' and focused on how a 'health discourse' perceives abortion as being harmful to both the woman (physically and mentally) and her unborn child if the woman is HIV-positive.

All the discourses employed here point to speaking in a socially-sanctioned manner, where the women are restricted by what is allowed and acceptable and they adhere to these at the cost of their own desires and needs. Abortion decision-making is understood from a 'moralistic religious' discourse which sees abortion as not only 'murder' and 'wrong' but also makes certain pregnancies complicated, necessitating the need for abortion. The women also spoke in socially-sanctioned ways, drawing from a 'cultural discourse' that not only sees abortion as wrong but certain pregnancies as complicated and necessitating abortion. Certain cultural interpretations surrounding marriage being the right place for reproduction, matrimony as an ideal goal for every woman, males being providers, and the requirement for women to be

faithful are also used by the women and are examples of how they speak in a socially-sanctioned manner. The ‘health’ discourse was used in a socially-sanctioned manner with abortion being seen as physically and mentally harmful to women. Surprisingly, a ‘health’ discourse is not used to argue that abortion should be made safer (this is what buttresses much abortion activism around liberalisation of abortion legislation in that safer abortion decreases maternal mortality and morbidity). A ‘reproductive rights’ discourse is absent. Even though the women speak of abortion as killing, they do not refer to foetal rights directly − it is not the framework that they use to make these kinds of statements; rather it is the ‘moralistic religious’ discourse that enables this kind of understanding. The next chapter, which is the second analysis chapter, examines the women’s stories of their abortion experiences. These stories are narrated drawing upon the discursive resources unpacked in this chapter.

Chapter 6: Women's stories of their abortion experiences

6.1 Introduction

The previous chapter examined the discursive resources which are drawn upon by the women in narrating their stories. This chapter now focuses on the stories of the women's abortion experiences. This chapter speaks to how the discursive resources are put to work in the micro-narratives that the women tell and how these stories are enabled and constrained by these particular discursive resources. My interest lies in seeing how women negotiate constructions of femininity and motherhood through their abortion decision-making.

The chapter is divided into three sections which draw attention to the three main features of the narratives. The first section covers the narrative of abortion being shameful. The second section focuses on narratives that cohere around justifying abortion, these being that abortion assists in avoiding stigma/shame; abortion assists in protecting children already born; continued pregnancy results in lost opportunities; I had no choice because of poverty; I have no choice because of the unreliability of my sexual partner and partner's family and abortion is justified under the circumstances in which I found myself. The narrative of abortion being justified under the circumstances draws the other narratives together. The last section looks at narratives that speak to the act of abortion, these being: undergoing an abortion invokes fear; undergoing an abortion requires bravery, courage and resilience; undergoing an abortion leads to regret, guilt and conflict; secrecy is important and support can be found.

6.2 Abortion is shameful

The narratives shared by the women include narratives around abortion leading to an internalised sense of shame. Abortion in these narratives is an act of shame due to the associations other people make with it. It is the discursive resource of shame/stigma that underpins the narrative of an internalised sense of shame. This narrative, although closely linked to the discourse of 'shame and stigma' discussed in Chapter 5, is being revisited here because of the fact that it featured so strongly in the data. The narratives in this section talk about the women's actual experience of shame − the internalisation thereof, rather than their societal experience of abortion being a shameful act (as seen in Chapter 5). The shame of abortion leads to ostracisation from people and God – which is sometimes self-imposed. Shame is also generalised beyond the self to being experienced by the woman's family and community as well.

Drawing from the 'moralistic religious' discourse, the women showed how shame is linked to internal and external ostracisation. This is seen in the following quotes by Angie, Tanya and Rose:

Extract 1

Angie: I am even ashamed of walking outside now because I am worried people are judging me. I went to church last week and no one wanted to speak with me. All my friends are avoiding me and I think it is because they heard what I did.

Tanya: I am ashamed (.) I am ashamed to go back home because many people heard the shouting [sobbing].

Rose: I think I will run away from Harare because I do not think I will be able to go to church. All my friends (.) are at church.

The women in Extract 1 respond to stigma by deciding to find new social circles due to the shame they feel or perceive they will feel. Angie shares that she feels so ashamed that walking outside is not possible; this is a form of self-imposed ostracisation. Rose perceives the shame she would feel if her TOP became public, necessitating a change of residence. Similarly, Tanya shows how she ostracises herself (does not go home) because people knew what she had done. Church is seen as being one of the places where one is ostracised; the ostracisation is real in Angie's case and anticipated in Rose's case. The self-imposed ostracisation seen in the quotes above is similar to that seen in findings in the UK despite the different settings. The study in the UK by Astbury-Ward, Parry, and Carnwell (2012) found that women who had had a safe TOP saw the act as a personally stigmatised event that affected their relationships leading them to isolate themselves.

In some narratives, the shame is compounded by actions, both perceived and real, of what others, such as family members and the community at large, will do. The following quote shows this:

Extract 2

Clara: My parents came back and they heard about what happened. I was beaten (.) and they were shouting that I had shamed them in the whole location. Up until now I am the laughing stock of the whole community (.) [sobbing].

In Extract 2, Clara's shame is extended to her parents whose response is to beat her for shaming them by having a TOP. Clara shows how other people's actions, which include laughing at

them, gossiping about them and beating them compounds the shame. Clara also shows how shame impairs family relations in that her relationship with her parents turned sour after they found out about her abortion. Similar stories have been told in Zambia, where women undergo a public cleansing for having shamed the community by undergoing a TOP (Dahlback, et al., 2010).

The shame of abortion extends not only to the self but also to family members and the community at large. In this instance, cultural discourses and the importance of one's social standing are utilised. This is shown when Tina says:

Extract 3

Tina: People are still keeping our culture so if they heard that I did this I would have brought the whole tribe to shame. I would have been so ashamed.

In Extract 3, Tina shows how the shame of an abortion is shared with her tribe at large. Tina sees herself as a representative of her tribe and her actions, which are construed as 'evil', threaten not only her own social standing but also that of her tribe. In this instance, Tina cannot speak about what is good for her as she does not only speak for herself but her family and tribe at large (as already shown). In the extract Tina shows the multi-level complex nature of abortion stigma where it is not just an individual's shame but also that of the wider community (the tribe in Tina's case).

Rose shows how shame is generalised to her parents:

Extract 4

Rose: I would have brought shame (.) to my father and mother because they are church elders.

In Extract 4, Rose shows how shame is not only experienced by her but could be shared by her parents who have the social standing of being church elders and thus are expected to engage in certain behaviours and not in others (i.e. abortion) and to supervise and sanction the actions of their family members. Rose's shame is thus compounded by the position her parents hold in church. The generalisation of shame beyond the self to family and community acts in regulating women's behaviour. If shame extends beyond the self, then you become responsible for upholding the social standing of not only yourself but also of your family, location and community by being punished/shunned or attempting to make amends for the shameful act of abortion.

6.3 Narratives that cohere around justifying abortion

The narratives in this section all cohere around the women justifying the abortion. The justifications range from personal circumstances (poverty, lost opportunities) to considering other people (protecting children already born). These narratives are discussed below.

6.3.1 Abortion assists in preventing shame and stigma

Despite abortion being a shameful and stigmatised act, the women spoke about how an abortion also assisted them in hiding the shame and preventing stigma that was brought about by the circumstances of the pregnancy. To them, the pregnancy was much more shameful than having an abortion which helped them decide that abortion was the right course of action. Eli points this out perfectly when she says:

Extract 5

Eli: Ehh that is hard. But looking at my situation I think terminating is better. You can hide terminating and you can be successful. Even if people say you did you can always refuse and deny. Even if people say (.) 'you have killed an innocent soul, you are a killer; it will end in time.

In Extract 5, Eli draws from a cultural discourse in showing how her pregnancy (which would result in a child without a father as shown in Chapter 5, Extract 26), was more problematic to her than having an abortion which is shameful and stigmatised. To Eli, the difference was that an abortion can be hidden and will be forgotten in time, but a child resulting from the pregnancy will always be a reminder of the cultural complications of a fatherless child. This view of abortion being better than continuing with an unsupportable pregnancy has been noted in other research such as that of Johnson-Hanks (2002, p. 1337) who found that the women in her study "including those who reported having aborted, say that although abortion is shameful…they view its moral and social consequences as less grave than those of a severely mistimed entry into socially recognized motherhood."

In addition to cultural complications which could lead to a pregnancy being perceived as shameful, there were also considerations about how one is treated by other societal members for having a 'shameful pregnancy'. This is shown when Tina and Doris say:

Extract 6

Tina: No, telling people would have made (.) them laugh at me. I had done (.) shameful things, one having a child while still breastfeeding, two sleeping with someone's husband...

Doris: To me being laughed at because of abortion was better than being laughed at for having a child without preparation.

Here Tina shows that the perceived reaction (stigma) of her community to finding out that she had a pregnancy outside marriage (something seen as shameful and promiscuous) and having a child while still breastfeeding (which is seen as irresponsible by other community members) meant an abortion was justified to hide all these shameful circumstances. Doris speaks about the shame of having a child "without preparation", but it is not clear in this extract whether she means that she is unable to financially support a child or whether she means proper social preparation – being in a stable relationship, for example. Despite the lack of clarity, both situations are seen as shameful. This was also seen by Izugbara et al. (2009, p. 397) in Kenya where women used abortion to shield themselves "not merely against the shame of mistimed or socially unviable entry into recognized motherhood but more importantly against the negative socioeconomic consequences of mistimed or unnecessary childbearing and inconvenient entry into motherhood."

The talk around shame drew from 'moralistic religious' and cultural discourses, as shown in Chapter 5. Shame arose from associations that the pregnancy elicited. An example is Sheila's situation where she had cheated on her husband and was worried that the pregnancy would reveal this. She shared the following:

Extract 7

Sheila: I was worried that telling people would make them think that I was a prostitute since my husband was not there during that time.

In Sheila's case, an abortion helped in hiding her infidelity. This infidelity, as shown in Chapter 5, is associated with prostitutes who are looked down upon both culturally and religiously. The othering processes that stigmatise, disempower and potentially silence prostitutes is also well documented in other research (Hulusjö, 2013).

A combination of different circumstances can complicate a pregnancy, leading to an abortion being a solution to avoid shame or embarrassment. Rose said the following:

Extract 8

Rose: I also do not work although I used to go to the beer hall, I do not go anymore so there is no money. So I did not have any option. So I saw that instead of being

laughed at because of all these reasons I had to be brave and terminate the pregnancy.

In Extract 8, Rose (who had already shown a combination of things considered culturally shameful can combine to complicate a pregnancy in Chapter 5, Extract 1) illustrates the importance of having a TOP to hide 'shameful' acts and also survive if there is no financial stability. Rose had just lost her husband (who had died). Culturally she has to wait for a period of time before she remarries again. This coupled with the fact the man responsible for the pregnancy was not there and was not married to her, making her pregnancy shameful. She also had a child who was not yet walking (see discussion in Chapter 5).

The shame of a pregnancy without a father, which led to an abortion, was referred to repeatedly. The following quotes show this:

Extract 9

Eli: So I just started (.) thinking about what to do. I did not want to have a child without (.) a father

Toni: The other reason is that I did not know who the pregnancy belonged to. I did not want to have a baby without a father.

As mentioned in Chapter 5, raising a child without a father is seen as shameful. In Extract 9, Eli shares how she did not want a child without a father (she picks up on the ideas of how people at church view those who are single mothers in Chapter 5). Here she draws from a 'moralistic religious discourse' where marriage is seen as the most appropriate place for childbearing. For Eli having a TOP only becomes an option upon the realisation that she has to 'hide' the 'shameful' pregnancy. Toni draws from 'cultural discourse' where a pregnancy is complicated by not knowing who the father is. The narratives in Extract 9 point to the existence of gendered expectations of what it means to be a woman. A woman is expected to have sexual relations only in a heterosexual marital relationship and failure to adhere to this leads to sanction and censure from other societal members.

The narrative of abortion assisting in preventing shame and stigma is made possible by the regulative discourse of 'motherhood'. The women here have individual assumptions of what is accepted or forbidden in their particular society. In this case, motherhood entails being involved in a heterosexual marriage, having the finances to take care of the child and not being

HIV-positive. Those who enter into motherhood when these circumstances do not apply are, just like those who terminate, stigmatised and othered.

6.3.2 Abortion assists in protecting children already born

Abortion was also seen as a way of protecting children who were already born, for both cultural and practical reasons. The pregnancy was seen as a threat to the children already born and thus it had to be terminated. The extracts below demonstrate the influence of cultural and practical reasons for protecting children already born:

Extract 10

Idi: … I also could not have another child since I was still breastfeeding, it was not possible to carry another pregnancy.

Mary: When I found out I was pregnant I saw it was unfit to be pregnant because I had a child who was still breastfeeding.

In Extract 10, Idi and Mary draw from cultural discourses where two children cannot share the same breast milk. The 'you cannot have another child while breastfeeding' talk is steeped in culture as shown by Tina in Extract 22, Chapter 5. Mary uses the word "unfit" which means that carrying the pregnancy to full-term would have meant being an irresponsible mother. The protection of children here, is one that a good mother is expected to do.

Other women also focused on the practical consequences of having another child when deciding to terminate as a way of protecting children already born:

Extract 11

Mary: The other friends all supported me terminating because of how young my other child was. I also took into consideration how I would take care of two children. The father of my first child is not paying any maintenance so money was going to be a problem.

Rose: The issue about money was huge as well. What would l have given the children? I could not feed them or even send them to school. Even going back to the beer hall I would not have enough money. The money for the food was already a burden.

Rose: I was afraid that I had nothing to give to the children. I already had four children and what would I give the fifth one? The ones that are there I am already struggling to feed them. These are children from my first marriage. The life is difficult

especially when it comes to support. You would have seen that your problems are bigger than any risk that might come from terminating the pregnancy.

Here, Mary focuses on the practicalities of taking care of two children and also on the lack of money which makes termination a viable solution. Just as Idi shared before, Mary's narrative draws a discourse of responsible motherhood where she has to protect her children. The lack of money and resources to feed the already-existing children was also brought up by Rose. She shows how the presence of four children, whom they were already struggling to take care of, necessitated an abortion so that resources, that were already stretched, would not be further stretched by the addition of another child. The pregnancy is thus seen as a burden which could be resolved through abortion. Similarly, studies in South Africa and Gabon have shown that the issue of resources plays an important role in abortion decision-making (Harries et al., 2007; Hess, 2007).

Other women also focused on how the lack of resources for the already existing children led to struggle and suffering. The following quotes sum this up:

Extract 12

Esther: I had two other children already and I am struggling to take care of them. I would not afford to have a third child.

Abbie: I had three children already and we were struggling to look after them. Money is tight and we were scraping through. I sat down and thought, and thought about what to do.

Angie: We had four other children and we were suffering. We had nothing to give to the children.

Toni: Seeing the way we were suffering I saw that we could not afford another child. We could not take care of the child.

The women in Extract 12 all focused on the way they were already suffering with the existing children in terms of providing for them. The pregnancy is seen as a threat to an already-existing dire situation and could lead to more struggling and suffering. In all of the above cases, except for Toni, it is more than one child that needs the protection from this struggling and suffering.

In some instances, women referred to extreme suffering, equating the continuation of the pregnancy to death. The following quotes illustrate this:

Extract 13

Idi: There were times I said to myself, 'I will not do this'. But not going ahead with it was not possible because you look at the child you have, the child is such a small child and the situation is bad. Then you say, 'alright let me not go ahead. What if I die what will happen to my child?' This will all be going around in your head. Then you realise that both options are your death. If I say, 'I will keep the child' what about this other one? Will I be able to cope with both children?

Idi: … but I just said there was no option as I had to save my child because imagine now I would be six or seven months' pregnant with another child who has not even reached 1 year 6 months. So for you to be pregnant and on the other side to have a little child is just impossible.

Toni: So to have a second child was suicide. I did not have the money or the capacity.

In Extract 13, Idi utilises the discursive regimes around responsible motherhood to show how she perceives what motherhood should entail. By keeping the pregnancy, Idi would not have been able to take care of both children who would be very young and would have needed a lot of attention and resources for successful nurturing. Thus, she would be acting as an irresponsible mother. The same is shown in Toni's narrative where she shares that a lack of capacity to take care of two young children justifies the abortion. In this case, by having a child for whom one is unable to take care is irresponsible motherhood. Both Idi and Toni equate the carrying of the pregnancy to full term as being "death", "suicide" and "impossible", showing the extent of the dire consequences that they would face by not terminating their pregnancies.

6.3.3 Continued pregnancy will result in lost opportunities

There were also narratives on how continuing with the pregnancy would result in lost opportunities. In these narratives, abortion was seen as a way of protecting the woman against future prospects that were threatened by the pregnancy. Bell said the following:

Extract 14

Bell: I told him I did not want to be pregnant because I did not want to leave school. He asked me if I wanted to terminate and I said yes.

Bell: When I was in Glen Norah I started thinking about this pregnancy. I saw my friends finishing school and finding work while I am [would be] married with a child.

In Extract 14, Bell speaks of how the pregnancy threatened her schooling and thus termination was seen as a 'solution' for her to continue studies. Bell also compares herself to her friends whom she sees finishing school while she, if she does not terminate, has to continue with her pregnancy and possibly get married.

It was not only completing school that was threatened by an unplanned or mistimed pregnancy but also returning to school and the dreams that come with gaining a desired qualification. Clara said:

Extract 15

Clara: Alright, what made me terminate my pregnancy is that I wanted to go to school (.) to do my Form 5.

Clara: My father was already saving money for me to go to do my A levels. I also wanted to go to school and I saw my future threatened by this baby. So I decided then that I wanted to terminate the pregnancy.

Clara: These days I was thinking that this baby would end my life. I thought of all the dreams I have and I saw them being threatened by this pregnancy.

Clara here shows that a fear of losing future opportunities that come with having her A levels led to her decision to terminate. The equation for Clara is simple: having a child means putting her studies on hold in order to spend time caring for the newborn (and perhaps not being able to return to her studies and not become qualified for her desired career). Clara here can be seen as resisting the dominant narratives on motherhood and femininity; instead of embracing the pregnancy and being a mother, she chooses to continue her studies in the hope of finding work and earning an income. Clara and Bell's narratives in Extract 14 around schooling are similar to findings in Schuster's (2005) work in Cameroon where young, unmarried women overwhelmingly cited fear of losing their educational opportunities as reasons for terminating pregnancies. Education in these cases is seen as something that is socially desirable and thus should be protected. This points to a resistance of traditional roles of women, with economic emancipation being a new opportunity for women, as they prioritised education over becoming

a mother. Clara and Bell, together with the women in Schuster's (2005) research are, by prioritising economic empowerment, resisting domesticity.

Eli spoke of how having a child would have meant future prospects of finding a husband were damaged:

Extract 16

Eli: It [having a child without a father] would also influence my finding another husband.

In Extract 16, Eli shows how having a child without a father would negatively impact her prospects of finding a new husband in future. As shown in Chapter 5, having a child without a father has certain negative cultural connotations which might have led to Eli being seen as a 'loose' woman. Keeping the pregnancy would have led to Eli becoming a single mother which is frowned upon. Kambarami (2006) has established that the norm in Shona culture is to view women with children in marriages with respect and by extension those with children outside of marriage with disdain. Eli realised how this tag of being a single mother would impact on finding a husband in the future and thus chose to terminate her pregnancy in order to avoid being negatively viewed by potential suitors.

The narratives of potentially lost opportunities also included threats to jobs, as shown by Toni who said:

Extract 17

Toni: So I could not take care of the child as it will mean that I have to stop working and that is my only means of income. This job is the only thing I have and that is the only means of survival I have.

In Toni's narrative, the pregnancy threatened her job and way of survival since being pregnant would have led to her leaving her job. Toni's narrative focuses on how the pregnancy was a threat to financial survival and as such it was unsupportable. Keeping the pregnancy to full-term would also mean that the baby to be born could not be supported. Other women have reported pregnancies threatening jobs in different studies (Hess, 2007; Jackson, et al., 2011; Mitchell, et al., 2010).

6.3.4 I had no choice because of poverty

Some of the narratives focused on how the women had no choice but to terminate a pregnancy because of poverty. This is seen when Ruth states:

Extract 18

Ruth: I think it's being poor. Do you think if I was working I would think of killing my baby? No.

Ruth, in explaining her decision to terminate, shows how her decision was influenced by her economic circumstances. She indicates that her economic situation is so dire that it led to her committing an undesired 'act' that she would not have considered if she had been in a financially viable situation. In equating abortion with killing, she draws from 'cultural' and 'moralistic religious' discourses. The narratives about poverty and abortion, as already highlighted in the literature review in Chapter 2, are consistent with other studies in Gabon, Malawi, Mozambique and South Africa, which have shown that women who have unsafe abortions usually come from poorer backgrounds (Harries et al. 2007; Hess, 2007; Jackson et al., 2011; Mitchell et al., 2010).

The issue of money and food with regard to an unplanned or mistimed pregnancy was taken up in Esther's and Tanya's narrative:

Extract 19

Esther: I could not find money for food or even for clothes for the child.

Tanya: I had (.) no job and no money (.) and that is my situation even up to now.

Tanya: I saw the (.) way I was living uhhhh. At home I was not even uhhhh getting enough food to eat.

Tanya: There is no money at home, not even a cent. How would I buy the preparation, even the food for the child; where would I get it? I do not even own proper shoes.

In Extract 19, poverty necessitates an abortion for these two women as the pregnancy and the forthcoming baby are both unsupportable. Tanya shows how the failure to look after even herself (since she has no job or money to even buy herself a pair of "proper shoes") meant that she had to terminate.

The home situation (that is, living in poverty) raised by Tanya in Extract 19 can also be seen below in the extracts from Abbie and Doris. Here, the broader familial economic circumstances are described:

Extract 20

Abbie: The problem that happened was that my husband was not working (.). So at that time life was difficult for me. So (.) that is when I thought I should terminate the pregnancy because I had nothing to give to this child.

Doris: Ahh (.) so when I saw that the pregnancy was five months and that I do not go to work, I do not have rich parents as my mother is old and my father died when we were young and everyone is looking at me to provide some support at home. Ah that is when I decided to (.) terminate.

In Abbie's narrative, her husband cannot perform his masculine provider role, making it difficult for them to take care of the child that was to be born. By having another child under such circumstances, Abbie would have been perceived as being irresponsible for having a child without the proper means to take care of it. Doris, in her narrative, draws on the practicalities of her situation. As a result, her home circumstances, where she is the breadwinner, would mean that allowing her pregnancy to continue to full term would be irresponsible as she would not have enough finances to care for her family and for the child that was to be born.

6.3.5 I had no choice because of the unreliability of my sexual partner or partner's family

Drawing mainly from the 'conjugalised fatherhood' discourse and the 'masculine provider' discourse, this micro-narrative showed how the unreliability of the sexual partner or partner's family meant there was no 'choice' but to terminate. In some of the narratives the man deserted the woman after finding out about the pregnancy. Rose said:

Extract 21

Rose: … it did not take too much time [to decide to have the abortion] because when I saw that I was two months' pregnant and that guy was nowhere to be found, I could not see him and even calling him he was not picking up, that is when I starting planning on what to do. It took me about two weeks to decide.

Rose, in Extract 21, shows how the disappearance of the man responsible for the pregnancy led to her deciding to terminate her pregnancy. That is, in her narrative, the unreliability of the partner is what precipitated her abortion decision. Rose shows how women in this context are dependent upon males. Her reasoning, as with most of the narratives in this section, focuses on her capabilities (usually no employment or insufficient finances) to take care of the child. It can be seen as a continuation of the domesticity divide (mentioned in the theoretical framework section 3.10) where women have been consigned to the private sphere while remaining

economically dependent on their male partners who work and mostly go about their social activities in the public sphere.

In other narratives, after finding out about the pregnancy, the sexual partner had agreed to marry the woman but his disappearance off-set these plans. This is seen in the following stories:

Extract 22

Ruth: What happened is that we had agreed the two of us that he was going to marry me. So with that in mind he just disappeared. It was all of a sudden, he just packed up and said he is going to Zambia. I did not take it seriously that he was never going to come back. So after a little while I heard his friends saying that he had wasted my time and he had left and gone to his rural area and was not coming back. So ah (.) after I thought about it what would I tell my parents? (.) And the hard thing is that I do not have a mother or father and my grandmother takes care of me.

Ruth: But he was the one who had promised me that when I become pregnant we would be staying together. "So you, by the time they start saying something is wrong I would be preparing the money for *lobola/roora*". So I saw that it had failed and I was going to the fourth month so I decided that the way things were going I did not have anyone to help me as I do not go to work.

In Extract 22, Ruth shows how her decision to terminate her pregnancy resulted directly from her partner running away despite their decision to get married after finding out about the pregnancy. Ruth talks about how having no-one to take care of her made the decision to terminate the pregnancy the only option. Ruth waited until the fourth month because she expected her partner to have perhaps changed his mind and returned by then. The issue of women drawing from a 'masculine provider' discourse in their narratives around their abortion decision-making processes has been seen before in a study with elderly women in Zimbabwe (Batisai, 2013). In this study, the elderly women spoke of the notion that abortion was a coping mechanism for women in situations where men were refusing to acknowledge paternity. Schwandt et al. (2013) also found in Ghana that whether or not a male partner decided to accept responsibility for a pregnancy had a significant influence on a woman's subsequent decision to keep or terminate a pregnancy. In Ghana, just as in Zimbabwe, "taking responsibility for a pregnancy is synonymous with a male acknowledging paternity, as well as financially supporting the woman and the child indefinitely" (Schwandt et al., 2013, p. 513). Bankole et al.

(2008) has also shown in Nigeria that males' denial of responsibility is one of the main reasons for terminating a pregnancy.

In continuing the discussion of men not taking responsibility for causing the women to become pregnant, the unreliability of the partner only manifested after the pregnancy was confirmed. The following quotes show this:

Extract 23

Tina: I told the owner that I was pregnant but he denied responsibility (.) and he said it might be someone else's pregnancy especially since he said that I used (.) to smile too much at the customers. He fired me from the job and he said he never wanted (.) to see me again. My life ended then….

Clara: I told the man that I was pregnant and he said he did not want to see me or hear anything about it as he was happily married and he had four children. I was left speechless and clueless and I did not have anyone to discuss with on what to do.

Tanya: The guy was renting at the house he was staying in and he left (.) and I did not know where he went. He ran away. I had not seen his relatives and he changed his line and his old number was not available. I was at my wits' end (.) as I thought we were going to get (.) married and have a (.) family [sobbing].

Fiona: While I was working there I had a boyfriend (.) then he impregnated me [sobbing]. I was still at work and I told him haa ... I am pregnant and he said 'alright'. I knew where he stayed. After that I went to his house but I found that he was no longer there. He had moved.

In Extract 23, the common theme in the narratives is that the partner disappeared or denied responsibility after learning of the pregnancy. In Tina's case, the partner who was her employer accused her of cheating by flirting with other customers and denied responsibility. Clara's partner was a married man who told her that he was happily married and did not want anything to do with the pregnancy. Tanya's and Fiona's narratives show that the partners disappeared and this justified the abortion as their plans to marry and start a family had now fallen through.

The unreliability of partners was not only because of their denying responsibility or running away but, as in one story, because of abuse as well:

Extract 24

Tecla: I was having fights with my husband while I was pregnant. He was beating me up while I was pregnant and he was hurting me.

Tecla: When he continued beating me (.) I decided to terminate the pregnancy and try to leave him so that I can start afresh.

In Tecla's story, terminating the pregnancy is a response to an abusive partner. Keeping the pregnancy will have meant staying in a physically abusive marriage and having the TOP was the only choice. The TOP is made necessary both for physical (not wanting to harm the pregnancy and Tecla) and having a child with an abusive partner. Tecla might have been worried that the husband would claim his parental rights thereby meaning she would still be in contact with him.

6.3.6 Abortion is justified under the circumstances in which I found myself

The women spoke about how abortion was justified given the circumstances in which they found themselves. This narrative dovetails with many of the narratives shared and discussed thus far. The women's stories contained talk around being put in a 'tough spot' by the difficult circumstances surrounding the pregnancy. This is shown in the following quotes:

Extract 25

Toni: I was in a tight situation. They [people at church] know that life is not easy for me. I think they will understand why I did it.

Doris: It was a bad decision. But for a person who was in my situation there was nothing to do [nothing else that could be done]. Life was hard for me. I was put in a tough spot.

Esther: The pregnancy was hard to keep. I was placed in a difficult situation.

Ruth: It just happened; I was in a tight spot. I had no one to tell. Imagine telling my brothers that I have a pregnancy without a father. I had to be tough. Ah it was hard for me. I think I spent a lot of time thinking. Now let's say I had not terminated. What would I give to the child?

The women in Extract 25 show how life circumstances can lead to a pregnancy being unsupportable, leaving the women no other option but to have a TOP. In the stories above, there is a recognition that even though abortion is a socially undesirable act, having a TOP was

the only reasonable thing to do. Failure to have the TOP would have led to worse suffering, as shown by Ruth, who would have brought shame to her brothers and would had to have supported the pregnancy, and later the child, alone.

The women also spoke about how circumstances 'force' you to take a particular action – you have no choice. This is exemplified in Idi's story:

Extract 26

Idi: But there is nothing you can do; you do not have a choice at that point in time. For you not to do it, what do you do? Nothing. What do you do with the child? If you have money you can struggle and carry the pregnancy as you will be able to take care of the child. Now you do not have the money and this is what forces you to do the unthinkable so that things can go well.

Idi: Should I do it or not? But you are forced to do it because of your situation. You will be in a tight corner and for you not to do it it's hard. You will be saying, 'whatever happens, happens'.

In Extract 26, Idi shows how she was 'made' to go through with the termination of pregnancy as she was left with no other option. Idi speaks of how the direness of one's life circumstances, due to a number of reasons, makes the pregnancy problematic. Faced with this situation, abortion is not only justified but also necessary. In light of this situation, all risks associated with abortion are disregarded due to the toughness of the circumstances. This can be seen as a form of resistance were Idi, despite knowing all the 'problems', is able to face these problems. Hill et al. (2009) found that in Ghana, despite the problems surrounding abortion (including abortion being dangerous, shameful, and illegal), women also felt that in certain circumstances it was necessary and that others would understand the woman's decision.

Some of the women's stories showed how the difficulty of becoming pregnant without sufficient means and/or a partner to help support it remained, despite actions taken to ameliorate them. These can be seen in the following extract:

Extract 27

Ruth: I really tried to look for a new job and could not find anything. Things were not working on my side. So I said, 'what should I do?' The last thing was ummm… ahh I had no choice, I had no choice, I had nowhere to look. It was hard for me, life was hard.

Bell: I was in the middle of a hard time (.). Some of the solutions I thought of were not bringing the results I wanted so I think I was justified and that I think God forgives me. My options were to marry someone who had forced me to sleep with him and he did not have a great future [ahead of him].

In Extract 27, Ruth shows how efforts to try and change her situation failed and the pregnancy remained unsupportable. Bell speaks of how, despite trying everything to change her circumstances, she yielded no results and was thus left with no choice but to terminate the pregnancy. She also felt that it would be better not to marry the man who had forced her to sleep with him, resulting in her pregnancy. Trying to change circumstances, but being unsuccessful, justifies the final decision to terminate the pregnancy, and also positions the women positively as trying to prevent the negative situation of abortion.

The women also spoke of how the abortion was justified because not going through with the abortion would lead to calamity. The following quotes show this:

Extract 28

Tecla: The situation I was in whatever I chose to do was like dying for me. It was hard for me. I actually wanted to die as [then] I would find rest. My life was hard to live, it was (.) impossible. I did not want to have a child (.) with a killer. It would have meant I was tied to him all my life.

Clara: The pregnancy had put everything I had worked for in jeopardy so I had to terminate. If I had kept the baby my life would have gone into a river.

Tanya: It was my fault to be pregnant but keeping the child would have been far more evil than killing the child. So because of what I was going through it was justified.

Lucy: Yes I am justified. When you are not in the situation it looks like a selfish thing killing an innocent child. But what was I to do? I was in trouble and to decide whether to end my life as I know it by having a fatherless child without any money or just terminating and continuing life.

In Extract 28, the women show how not having an abortion would have led to further difficulties in their lives. For Tecla, not having an abortion was equated with death. Clara speaks of the pregnancy threatening the stability of her life. In Tanya's story, having a child is equated to being an irresponsible mother because of her life circumstances. Lucy speaks of the

pregnancy threatening her way of living. In all these stories, the abortion is justified because not going through with it would have led to disastrous consequences not only for the women but for the forthcoming children.

In justifying the abortion, the women also spoke about how any reasonable person would agree that this was the only thing they could do. The following quotes show this:

Extract 29

Tanya: Even my grandmother (.) when she came yesterday she said that what I did was okay because what would we have given the child?

Lucy: I will be honest I am happy I did it. Where would I have found the money for preparation, the money to go to the clinic maternity? You know it is $50 now. What was I to do? If you were me in that same situation I think you would have done the same.

Tina: Show me a woman in my situation that would have chosen differently.

In Extract 29, Tanya, Lucy and Tina all position themselves as being justified because of their circumstances. The justification is further cemented by the fact that any other person from relatives to the researcher, if faced with the same circumstances, would have had the TOP. The women show that given the positions in which they found themselves, having a TOP was actually a good thing. The perceived wrongness of the TOP, which has been shown before, is negated by a realisation that due to difficult circumstances that make a pregnancy unsupportable keeping the pregnancy to full-term is more undesirable than the TOP.

The women, in justifying the abortion, spoke of how the situation was at fault and not themselves for having made the decision to abort. They, as people, however, remained good people and their conscience was clear. The following quotes illustrate this:

Extract 30

Bell: The other option was to have a child without a father and this was more embarrassing for me than to just terminate. So I took an option that was good for me and my conscience is clear. I know that I killed but it was justified considering the position that life had put me in. I had to terminate the pregnancy and I think I did the right thing.

Eli: The people at church think it's demons but they are not. They do not understand that it was me who did the decision (.) because I did not want the child. I did not want to have a child who belongs to the forest. I actually prayed to God while making the decision and my (.) conscience is clear. I did not want to be the laughing stock at church. I do not think I killed because the pregnancy was not a child yet. Me and my God are alright.

Tina: Considering my situation I think I was justified. I am a nice person. I am not evil and I do not argue with others. I was in a tight situation. I was avoiding being (.) a laughing stock. I could not let my children share the same breast. I also did not have any money to look after two children … So even if people say I am a killer or prostitute I am okay. It was my idea and I was happy with it.

Bell, in Extract 30, speaks of how her circumstances were dire and how she was justified in, and happy with, her decision to terminate. Eli subverts the usual pronouncement of evil in the 'moralistic religious' discourse. She separates the church from morals, indicating that she would be a subject of stigma in the church, but that morally she feels she has done no wrong, and that she and her God "are alright". Eli is thus able to feel at ease and have a clear conscience about her decision, despite what other people might think or do in response to it. Tina still sees herself as a 'good' person, despite having done something regarded as 'terrible'. For Tina, her circumstances forced her to terminate her pregnancy and it has had no effect on her character and the person she remains.

6.4 Narratives that speak to the act of abortion

The women's stories also contained talk around the procedure of the abortion itself. This included emotional responses before and after undergoing the abortion. The stories also focused on what is needed in order to be able to go through with through with an abortion which includes secrecy and the necessary support. The section starts by exploring the narratives that speaks to the fear that is invoked by having an abortion; then the great courage, bravery and resilience that one has while undergoing an abortion; and the regret, conflict and guilt that is invoked whilst undergoing an abortion. The section concludes by looking at how keeping the abortion secret is important, leading to women acting alone and how support can be found from close trusted friends, family and traditional medicine practitioners.

6.4.1 Undergoing an abortion invokes fear

The women spoke of how undergoing an abortion invokes fear. The fear arises from the nature of the abortion and related health concerns. Idi said:

Extract 31

Idi: For me when I started I was very fearful, these things kill you but I just said there was no option.

For Idi, the knowledge that using unsafe methods for abortion could lead to death is what invoked her fear. She classifies it as "these things" meaning that it is common knowledge that an abortion can lead to death. Idi draws from a 'health' discourse where abortion is associated with dangers for the physical well-being of women (Njagi, 2013) and as such it is something that should not be done.

The fear that came with the health risks and dying was also shown by Lucy and Toni:

Extract 32

Lucy: I was scared and did not want to terminate at first. I was afraid of the health risks. I have heard stories about people dying.

Toni: I was afraid, really scared for my health. I was really worried and shaky that I almost stopped doing it but I had to be brave.

In Extract 32, Lucy indicates that it is common knowledge that abortion can lead to death and it is this that fuelled her own fears. For Toni, this fear means that the act of an abortion is not just carried through without doubts and uncertainties. Lucy and Toni draw from the 'health' discourse of how dangerous abortion is. The same reasoning around abortion invoking fear was seen amongst women in Ghana by Hill et al. (2009), where women chose termination methods based on minimal physical risk.

The fear about health concerns was brought about by the methods the women employed in terminating their pregnancies:

Extract 33

Sheila: … on the day that it happened I took what is it again? There are some leaves of the tree called baboon that tree called baboon which has little black fruits that are eaten then I did what, then I, I put the leaves into my vagina then I did what, I didn't take too much time before I took some soap. When I took the soap, I put it around the mouth of my birth canal like this [action with hands] going around like this

around like this. So I think I did it three times and on the fourth time I removed my finger and it had blood and then I took hot water and I started soothing my stomach so that the blood could dissolve so that it would not be hard when it's coming out.

Rose: The chilli plant, I took the chili plant root that was long like this (showing size). That is when I did what; I took it and placed it into my birth canal. I pierced myself, that is what I did. After I pierced I (.) when the day was about to end around 3 the root fell down and water started coming out of my womb. After I passed out water I started feeling real pain. I also started bleeding (.) bleeding but that egg still had not come out. In the evening the blood came out a lot and I also started to lose power [strength]. That is when I decided to sit on a bucket and I sat on that bucket. After I sat on the bucket I looked as if I wanted to pass something, I do not know what was happening. I squirted and something fell into the bucket. I looked at it and saw that this was what was causing me problems.

Sheila and Rose describe in detail the methods they employed in order to terminate their pregnancies which explains the fear about something going wrong and causing physical pain. In both cases they took traditional remedies which are usually not safe. The termination of pregnancy was done unaided increasing the fear due to risk of something going wrong whilst alone. The use and danger of traditional herbs and the fear it provokes is well documented in the literature (Hess, 2007; Schwandt et al., 2011).

The fears centered not only around health and death but also extended to abortion being a crime and women fearing arrest. This is shown in the following quotes:

Extract 34

Rose: Yes I was afraid because I knew that people might get me arrested. That is why I asked only close friends [for advice] and tried to keep it a secret from other people.

Esther: I told her I was scared because I had never done it before and I was afraid of being arrested.

Both Rose and Esther in Extract 34 show how they were afraid of getting arrested if they got caught. Rose keeps it a secret (this is covered in more detail in the narrative 'secrecy is important') so as to avoid being arrested. Both Rose and Esther show that they are knowledgeable about the illegality of abortion. This knowledge is common throughout the community (as shown by Esther and as seen by Rose's reluctance to have other people she does not trust know her plans of terminating the pregnancy).

The fear also extends to having people find out about the abortion. People finding out might lead to arrest and, as already shown, to shame and one being stigmatised and losing one's social standing. This fear of people finding out is shown when Tanya said:

Extract 35

Tanya: I did not know what to do because terminating pregnancy (.) is new to me. So I had to ask someone. I was scared that it would come out [be made public] (.) but I had to be (.) brave and ask (.) someone.

In Extract 35, Tanya sheds light on the fear of being found out, which is complicated when one has to ask for advice on ways in which one can terminate. The fear of people finding out is complicated by the fact she does not have any experience or knowledge on how to terminate a pregnancy and thus requires help. She emphasises the importance of bravery when deciding to go through with a termination of pregnancy which is discussed next.

6.4.2 To undergo an abortion requires great courage, bravery and resilience

Undergoing an abortion presents social, cultural, religious and legal complications. As a result, as the following stories will show, it requires great courage, bravery and resilience on the woman's part to go through with the abortion. In the following quote, Eli talks about the courage needed to stick with her decision to terminate her pregnancy:

Extract 36

Eli: When you are in the situation I was in you do (.) not think of such things [health risks]. I had already made up my mind as soon as I saw that I was pregnant with no husband. I said, 'come hell, come thunder, I am not going to (.) have a child without a father'. I did not think about anything else. Even if the doctors had come and told me all the health risks I would have still gone ahead with it anyway. You see the decision was already made.

In Extract 36, Eli shows how the difficulty of a situation negates all the risks, although they are acknowledged. Eli speaks about her courage in going through with the abortion, and shows how, when the decision to terminate the pregnancy is made, one goes through with it because one is in a difficult situation. She negates the 'health' discourses and common 'cultural' discourses (with regards to abortion) and considers other 'cultural' discourses (having a child without a father) in making her decision.

There were many stories about bravado in the face of consequences of terminating the pregnancy. These can be seen in the following quotes:

Extract 37

Rose: Yes I was thinking about it all the time. Every day, I was always thinking about what I was going to do because I was in a hard situation? So it happened [I continued weighing up my options] until the day I was brave enough to go through with it.

Doris: Yes I was afraid that something might go wrong. Ha … but I had to be brave and just go ahead with it.

The stories show how the situation demands the women be brave and resilient in going through with the act of terminating a pregnancy. Alongside the story of bravery, Rose talks about thinking obsessively about the abortion until she decides to go through with it and Doris discusses the fear that comes with the decision to terminate the pregnancy.

Bravado, courage and resilience are seen by the women as necessary traits because of the fact that termination is the only acceptable 'solution'. This is shown in the following quotes:

Extract 38

Tanya: The pregnancy had to go, that was without question. I was the one (.) in trouble so I had no other option. At the time I said to myself, 'dying or leaving is all the same to me because I did not want the child'.

Tanya: I was in pain, (.) pain, my sister, but it's not easy to terminate a pregnancy [sobbing]. But as I said the troubles (.) against me were many. I had to remove the pregnancy at whatever (.) cost. The pregnancy could not be kept.

Fiona: No, I had told myself that this was the only way and I had to do it no matter what. Death or injury it did not matter. I knew that the problem I was facing was much greater than being injured or dying. I thought about how I was going to be chased away from home if I went through with the pregnancy and I would not be able to continue work. So in my mind I wanted to terminate and go ahead working.

In Extract 38, Tanya and Fiona indicate the importance of having a TOP which requires one to negate any risks associated with the TOP. The toughness of having a TOP, although acknowledged, is seen as better than carrying on with a pregnancy that is unsupportable. Resilience and bravado come from the realisation that the pregnancy is unsupportable. The resilience and bravado are made all the more significant by the fact that the women are resisting

societal norms surrounding abortion by carrying out an unacceptable act. Both Tina and Fiona point to the fact that they were the ones faced with an unviable 'situation' and they were the ones who had to make a decision and that decision was theirs alone.

Bravado is also needed in hiding the abortion from others. Ruth and Tecla said:

Extract 39

Ruth: This needed bravado because you do not want anyone to know what you have done.

Tecla: I tried to be brave and not ask for any help but the landlady at the house we stayed heard my (.) moans and groans and came in to check what was happening.

In Extract 39, Ruth and Tecla show the importance of being brave in trying to hide the pain so that the termination of pregnancy remains secret. Maintaining the secret means that people will not find out and one will not be stigmatised and shamed. However, in Tecla's case her moans and groans were heard by her landlady and her secret was uncovered. The importance of secrecy when undergoing an abortion is seen in a later section.

The bravado, courage and resilience are traits that are considered to be inherent in women as shown when Tina said:

Extract 40

Tina: I thought about it [the pain I would experience during the abortion] but I had to be brave (.) like a woman. I thought the pain was just the same as the one you experience when giving birth so I had to be brave.

Tina here draws from a 'cultural' discourse, specifically idioms through which women are taught to be, and classified as, brave. This helps her go through with the abortion. A common term amongst the Shona is *shinga semukadzi* (be brave like a woman) and this is what Tina uses in describing the bravery she showed. Tina shows in her quote here how the same 'cultural' discourses can be drawn upon in deciding to terminate a pregnancy.

The levels of resilience are also shown in the following stories:

Extract 41

Angie: I had three days with the baby on my (.) panty until I was able to cut it off and throw it in the toilet. I was in pain for almost a month and there were things coming

out of me I did not want to go to the local clinic because people would (.) see me and know what I had done.

Ruth: When I started getting sick I opened the window. I opened the window I saw [felt] myself feeling dizzy like I have never felt in all my life before. I was so dizzy that when I opened the window I first missed it and hit myself on the wall. I stopped and tried to stand but I kept falling down. Then I said to myself that death that I wanted is now here. And ah (.) I bled, heavy bleeding. I thought, 'in this house who can I wake up?' This needed bravery because you do not want anyone to know what you have done.

In Extract 41, Angie shows the extent to which she went and how resilient she was in going through with abortion. Despite the pain, she held off going to the clinic or seeking help so that people would not know what she had done. Ruth shows how, despite feeling pain, she had to go through with the abortion in secrecy. In telling these stories of the actual abortion event, women are displaying their amazing resilience in performing an abortion in unsafe conditions, with little or no help, and in secrecy. Although these stories may not directly refer to bravery, courage or resilience, the underpinning theme is one of great resilience.

6.4.3 Undergoing an abortion invokes regret, conflict and guilt

The stories told by the women also show that undergoing an abortion also invokes regret, conflict and guilt. Regret is shown in the following quotes:

Extract 42

Fiona: Now the problem I have is that I have stomach problems. I am also married to someone else but I cannot get pregnant. Since culturally I should have kids my husband is troubling me saying he wants a child and we are always fighting in the house. I did not tell him that I terminated a pregnancy because I was afraid that he would leave me because what I did was shameful. I am regretting why I did it.

Sheila: When I think about it now it pains me because I think it was a rushed decision and because the kids were twins. I sometimes think about it asking myself what I did but there was no other way to go about it. The regret I have is that my husband got a new wife soon after and I moved out and I am married to the father of the aborted babies. The father of the aborted babies had even threatened to get me arrested when he found out that that is what I did.

In Extract 42, Fiona's and Sheila's regret about their terminations arises from the changed circumstances with regards to their partners. Fiona is now married and is failing to conceive. She blames the abortion for causing this problem and this is the source of her regret. She takes up the shamefulness of abortion and this is added to by failing to become pregnant again. Here Fiona is using the narrative of regret to bolster the narrative of shame (that is, abortion is shameful and you will regret it). For Sheila, the regret comes from staying with the partner who was responsible for the pregnancy who constantly reminds her of what she did and also that she has not been able to fall pregnant again. These two narratives show that regret may arise as a response to changed circumstances, even though, at the time, abortion was the best option.

The women spoke of guilt and conflict in relation to abortion. This guilt and inner conflict can be linked to the wider societal discourses about abortion. The following quotes show this:

Extract 43

Abbie: I feel guilty about what I did (.) [sobbing], I committed a sin in the eyes of God. I am a respected woman at church and what will people say if they knew that this is what I did? I do not know how I thought of doing it (.) but ahh I was in a tough situation.

Ruth: And now I am in pain and I know it should not be repeated in life. God gave me a child and I killed that child and sometimes you think I just should have kept the child. I know even the day I die that this child will be waiting for me because l killed a human being but I had no choice.

Ruth: And when people are talking about these stories I struggle. I now know that abortion is not the answer. Maybe that is God's gift and that is the only child I was ever meant to have. But there is nothing I can do now. Memories never go away.

Fiona: At that time it was alright. But I feel I might have made a mistake since I cannot conceive now. I am thinking I might have harmed myself with the medicine or that God is punishing me for doing such an evil act. That is the only regret and I am afraid I would not conceive again. I would not forgive myself if it happens [failing to conceive] but I understand that during that time I had to terminate.

The guilt and conflict in Extract 43 arises in relation to wider societal discourses. Abbie draws from the 'moral religious' discourse as she sees abortion as a sin. She also shows how one's social status influences the reactions after abortion because as "a respected woman at church"

she should have known better than to abort. Ruth takes on the same 'moral religious discourse' which sees children as a gift from God: by terminating one is not only killing and sinning but also refusing God's gift. This, in Ruth's eyes, creates a sense that God will punish her by not giving her another child. This is shared by Fiona who feels that her failure to conceive might also be punishment from God. In spite of the guilt and conflict that arises, there is a lingering realisation that there was no other choice. The guilt and conflict contained in the women's narratives have also been found elsewhere. Rue, Coleman, Rue, and Reardon (2004) found that levels of guilt amongst Russian women (who reside in a culture more accepting of abortion) were high.

In the stories guilt and conflict also arise because of thoughts around what the unborn child would become, as shown below:

Extract 44

Angie: Even now I think about my dead child. Maybe he or she would have grown up to be something important but at that time the only thing that mattered was termination because of the way we were living. …In my mind it still pains me. I think about it always. Did I make the right choice? But what was I to do? Life was hard.

Ruth: I am pained at times because who knows? Maybe the child could have grown to be the president but I took the decision. It was better to live with the guilt than to bring this child into this suffering.

In Extract 44 Angie's and Ruth's guilt is sourced from thoughts about the successes that their unborn children could have made of their lives. In both narratives, the realisation that there was no other option but the abortion does not diffuse the guilt. Coleman, Rue, and Spence (2006) add to this idea by suggesting that a woman obsessing over what the child's life would have been like is caused by feelings of guilt taking on an existential dimension.

The conflict and guilt that arises is sometimes balanced with the realisation that there was no 'choice' about whether or not to keep the baby. This is seen in the following quotes:

Extract 45

Idi: I think about it sometimes but I had no choice. You always feel guilty about it most of the time. But you would have realised that is what needed to be done. There was nothing you could do about the situation that you were in. I had no option. For me

not to do it, you just comfort yourself saying, 'what else would I have done?' Yes, but the guilty conscience is always there. You will be asking yourself that you destroyed a person.

Ruth: … but I chose an option that now I'm seeing myself as evil. This was a mistake, the worst I have ever done. I just did it because I had no choice I had no choice.

In Extract 45, Idi feels guilty with the knowledge of having 'destroyed' a person. This is despite the acknowledgement that there was no choice or any other option. Ruth, in the same extract, extends this feeling further to show that this guilt is personalised and she sees herself as evil despite having had no 'choice'.

6.4.4 Secrecy is important

As a result of the way abortion is viewed socially, secrecy was seen as being important in making the decision and going through with the abortion. The following narratives show the element of secrecy involved in this process:

Extract 46

Sheila: Sure, I took on the abortion idea. I terminated alone, I terminated, I took a whole week doi (.) ng. I didn't have the experience but I did it alone it was successful.

Sheila: No, when I made the decision I did it alone, it was my decision and mine alone. No, no one knows and I want it to keep it like that.

Idi: Eh (.) I told no one about what I wanted to do because it is something that is unacceptable in this area and also it can get you arrested. So I thought I just thought about what to do.

Idi: I did not even tell my husband. These are things that are unacceptable, can you tell your husband that you are pregnant when you are still breastfeeding? It's not possible.

In Extract 46, Sheila and Idi show the importance of secrecy. Sheila's need for secrecy was linked to the circumstances of her pregnancy (infidelity) which had to be hidden. Idi's secrecy even excludes her husband who would have blamed her for the irresponsibility of getting pregnant whilst still having such a young child. Idi shows the gender expectations of women being responsible for avoiding pregnancy in relationships. Idi's pregnancy was complicated by having another child who was still being breastfed. For her she hides one culturally

unacceptable act (children sharing breast milk) by performing another culturally unacceptable act (the termination of pregnancy) and thus secrecy is important.

Secrecy is also seen as important because there is fear that once people know, then the news would spread and one would be stigmatised and feel ashamed about one's actions. This is seen when Ruth, Bell and Tanya said:

Extract 47

Ruth: The counsellor would have told some other people if I spoke to her. We live in an open space. This is a ghetto and stories move very quickly. I was afraid of my aunt, I was also afraid of a lady from church who looks after the girls [church-going young women]. I was worried that she would tell everyone my story. I would have been ashamed that I might have ended up killing myself. Since it's an open space stories travel. Like now just say some story ah it will be across the whole location within 30 minutes.

Bell: I did not even tell the people I played with at school because I did not want the rumours to travel. I did not want to give people stuff to say about me.

Tanya: I was worried that if I asked people (.) close to my house [for advice] they would spread (.) my story and I would be embarrassed. I only asked about how to terminate (.) as I had already made my decision. I was worried of the (.) rumour mongers.

The women in Extract 47 all indicate the importance of secrecy both before and after the TOP. The need for secrecy comes from the fear of what other people might do if they learn of the plan to have a TOP or the TOP after it is done (e.g. stigmatise and shame the women and spread rumours). Ruth indicates the problem brought about by living in poor areas where people are interested in each other's business as there is maybe not much else to do. Bell and Tanya also point to the worry and fear of the news of their TOPs spreading through their social circles.

In addition to avoiding shame and stigma, secrecy has a practical element in terms of avoiding being arrested.

Extract 48

Esther: I only spoke deeply with my friend about it. I was afraid that other people would get me arrested. I knew a neighbour of mine who terminated and people found out

and they reported her to the police and she was arrested and spent some months in prison. This was what I was afraid of. I did not want to go to jail and leave my children in trouble.

Angie: I did not tell anyone about my decision. My mother passed away and I have no relatives that are close by. I did not tell anyone about my decision because I knew I wanted to commit a crime and I did not want to get arrested.

Here, Esther shows the importance of keeping an abortion secret from other people, except for a close friend, due to past experiences of people in her community being arrested. Angie also shows the same fear of being arrested since she knew she was committing a crime and thus her secrecy in the matter was important in order to avoid being arrested.

Secrecy can also be seen as protecting one's social standing and current relationships, as shown below:

Extract 49

Tina: I was so shy I did not want anyone to know what I was planning. So I decided that the best thing was to terminate the pregnancy without anyone knowing.

Fiona: … he will divorce me for sure since he goes to church and terminating pregnancy is not allowed and frowned upon so I have to hide it from him.

In Extract 49, Tina's shyness (possibly arising from the associations that abortion has in the community) makes her decide to terminate alone. Tina draws from a discourse of shame and stigma in choosing to act in secret as other people would stigmatise her if they knew her plans of having a TOP. Fiona keeps the abortion secret from her husband as a way of protecting their marriage. Tina draws on the 'masculine provider' discourse perhaps by being fearful of her husband leaving her if he were to find out.

6.4.5 Support to terminate a pregnancy can be found

Despite the importance of secrecy, the women spoke about how support to terminate a pregnancy could be found. This support came from various sources including friends, traditional medicine practitioners and family. The following quotes show the support provided by friends:

Extract 50

Rose: That is when I thought of telling my friends the situation I was in. I did not know what to do, what to do. So (.) my friends gave me some advice that I should go to

the hospital and abort. I told them that I did not have the money to go the hospital...at the hospital they want a lot of money and I do not have any money. That is when I spoke with one of my friends and she told me that I should use what (.) the root of a chili plant.

Rose: I only asked my best friends, people I trust.

Mary: Seeing my predicament I spoke to a friend who suggested I terminate since the other child was still young. I asked for advice on how to terminate since it was my first time and I was afraid. She told me I could use the psychic nut tree.

Mary: I asked my friends for their thoughts and they all backed my termination and suggested piercing myself with the psychic nut tree.

Esther: I told some of my friends there and my closest friend Jane [pseudonym] told me that crying over spilt (.) milk will not help and I needed to make a decision and take action. She told me that terminating pregnancy was easy.

In Extract 50, Rose, Mary and Esther show the role that friends play in helping them to decide to go through with an abortion and also in recommending the methods to be used. All the women in the above quotes asked for advice on what to do about their pregnancies and it is their friends who suggested termination of pregnancy to them. Rose emphasises the need to speak to only those who can be trusted. This is similar to work by Hill et al. (2009) who indicated that Ghanaian women carefully chose their confidants.

Support can also be found from people who are qualified herbalists as seen below:

Extract 51

Ruth: She is a qualified herbalist. She has the certificates. She advised me against termination but I cried today and she knew my situation that is why she ended up giving me [some herbs to assist with the termination].

Angie: There is an old woman who does a lot of African medicine and she stays close by. I went to see her at dusk because I did not want people to see me with her because everyone knows what she does. She gave me some powdery stuff and said it works for termination. She charged me $10 which I would only pay if the termination was successful.

In Extract 51, Ruth and Angie found support to terminate from two different practitioners in medicine: a herbalist and traditional practitioner. The role played by the two practitioners points to some acceptance of abortion by some people in the community though for different reasons. For the herbalist in Ruth's case, she was touched by her situation and saw abortion as justified and for the 'old woman' in Angie's case the motivation might have been monetary judging from the amount Angie paid for the medicine.

Drawing from 'cultural' discourses on the association between abortion and 'loose women', other women approached 'loose women' with the presumption that they were experienced in terminating pregnancies. This is seen in the following two narratives:

Extract 52

Idi: Ah as a woman you start asking others in passing about how other people terminate pregnancies as you gather information in a way that they do not suspect that, that is what you want to do. So (.) there are others whom I asked who frequent the beer halls and they told me that they had used the physic nut tree.

Tina: I looked for girls who used to frequent the bars and I knew they were experienced in terminating. One of them showed me this little tree called the physic nut tree and that I should take the roots and chew [on them].

Both Idi and Tina found support on how to terminate from women who frequent the beer halls. Tina points out that she knew they were experienced in terminating pregnancies. These narratives point to the stereotypical light in which 'loose women' are seen and also the kind of people who frequent the beer halls.

In other narratives that the women shared, support was found from people who were known to have terminated a pregnancy before, as shown below:

Extract 53

Bell: When I was at school I knew some girls who had terminated pregnancies properly so I looked for their numbers and I called one of them. She told me that terminating was her thing so I asked her to help me. She told me that she had pills called Cytotec which would be used to terminate pregnancy. I went to see her in town and she charged me $20 and told me to place them into my womb after every 4 hours.

Clara: This is when I approached a girl whom I used to learn with and asked how people terminate pregnancy. I approached her as I knew she had been rumoured to have terminated a pregnancy before. She told me about using a crochet [hook/needle]. So I took her advice and I had crochets at home that my mother used to use.

Abbie: I consulted with my sister whom I knew had successfully (.) terminated a pregnancy before. She told me about some lady in Mabvuku who is well known for her medicine that terminates pregnancy safely. I went to the lady and she gave me the medicine.

In Extract 53, Bell and Clara approached girls with whom they had attended school and who they thought knew how to terminate pregnancies from previous personal experience. These girls were able to provide support on how to terminate pregnancy. In Abbie's case she asked her sister for advice, whom she knew had terminated her pregnancy successfully, and she was able to get support on how she could go about terminating her pregnancy. The use of people who are known to have experience limits the risks that are involved. The women from whom the advice was sought were likely to keep the termination wishes confidential if they did. This might also have made the women feel more comfortable about 'working' with them and going through with their abortions.

6.5 Conclusion

This chapter looked at how the discursive resources discussed in Chapter 5 are utilised in the micro-narratives of the women in the study. Eleven micro-narratives were identified and were and discussed. The narratives were divided into three sections which draws attention to the three main features of the narratives. The first section focused on the narrative 'abortion is shameful'. The narrative was closely related to the ideas of shame noted in Chapter 5. The narrative differed in that, while in Chapter 5, abortion was seen as a shameful act, here the focus was on the women's actual experience of shame. This internalised shame was seen as leading to their ostracisation from people and God; this ostracisation is sometimes self-imposed. Shame was also seen to be generalised beyond the self to family and community. This narrative dovetailed with the one where the women justified abortion as it assisted in preventing shame and stigma that arises from the circumstances of the pregnancy. Shame was also seen to be involved in avoiding other 'cultural' and 'moral religious' shameful circumstances like breastfeeding two children at once, having a child without appropriate financial support and having a child without a father.

The next section focused on narratives that cohere around justifying abortion. Abortion was described as preventing the shame and stigma that arises from a complicated pregnancy. Abortion was also seen as protecting children already born; these narratives focused on practical and cultural reasoning. Circumstances surrounding pregnancies also meant that continuing the pregnancy could lead to lost opportunities. Other narratives touched on how abortion was the only choice given poverty and the unreliability of the partner or partner's family. The last narrative in this section drew the others together as women justified the abortion given the circumstances in which they found themselves.

The last section focused on narratives that speak to the act of abortion. Abortion was seen to invoke fear which needed women to have bravado, courage and resilience in order to go through with it. The narratives also showed how an abortion brings about regret, guilt and inner conflict in the process of deciding whether or not to go ahead with an abortion and after the abortion. Secrecy was also seen to be important, but women could also find support from sources they trusted. The utilisation of the wider discursive resources in the women's narratives show how women's micro-narrative are not just isolated stories. The micro-narratives discussed in this chapter were enabled or constrained by already existing meanings in the wider societal discourses.

Having looked at the women's micro-narratives and the discursive resources employed in constructing these narratives, the next chapter examines how women who have TOPs are positioned by health service providers who interact with them. The health service providers' positionings of women who have had TOPs is compared to the positions that the women took in Chapter 5 and 6.

Chapter 7: Evil, selfish and irresponsible vs. unsupportable pregnancies

7.1 Introduction

The previous two chapters focused on the micro-narratives deployed by the women[11] and the discursive resources that the women drew upon in order to construct their narratives. In these narratives, the women took on certain subject positions that are now going to be compared to those deployed by the health service providers. The health service providers' positioning of women who have had abortions differs in many ways from the positioning enabled in the micro-narratives told by the women themselves. Despite the many differences in these positions, there are areas where the women and the service providers drew from the same discursive resources with regards to abortion decision-making. As already shown in the review of literature, health service providers' attitudes, feelings and actions towards women who have had, or are choosing to have, abortions have implications for the type of services rendered and how women seeking abortions relate to the reproductive health system. While positioning the women who terminate pregnancies, the health service providers also took on certain reflexive positions which will also be discussed.

This chapter shows how the discrepancies and similarities in the ways in which women who have had abortions position themselves and the ways in which health service providers position them has had negative implications for the enactment of reproductive justice in the reproductive healthcare system. The chapter begins by looking at the different positions seen in the health service providers' talk that includes women being immoral and acting against cultural norms, being irresponsible and reckless, killers, prostitutes, manipulators, selfish, oblivious and foolish. These different positions are compared to the way the women positioned themselves in their narratives. The chapter ends by looking at how service providers position themselves. Some of these positions include sympathising with post-abortion pain, protectors of culture, helpers and advisors.

7.2 Women who terminate pregnancy are immoral and going against cultural/religious norms

The service providers positioned the women who have had a TOP as immoral. This is seen in the following quotes:

[11] 'Women' in this chapter refers to the women in this study who have had abortions

Extract 1

Mimi: They are people with no morals already so terminating is not a problem for them.

Sife: One thing when speaking about proper morals terminating is immoral.

In Extract 1 the women who have terminated are perceived as lacking morals in general. Mimi links this lack of morals to what she perceives as the ease with which these women undergo an abortion. Sife talks about what she calls "proper morals", which means that there exists a certain moral framework that determines how women faced with a pregnancy should behave, with abortion falling outside of these norms.

The positioning of the women who terminate as being 'immoral' differs from the way the women positioned themselves. Although the women acknowledged the immorality of abortion, it did not define their personal morality or standing. The women went through a lot of emotional turmoil after the abortion until they felt that they were in right standing with themselves, God and their community, and put a lot of thought into whether the abortion was the best option, as was noted in some of the earlier narratives. The abortion did not define them as people and they still remained "nice" people. Mimi's (Extract 1) view of abortion as being 'easy' for these women stands in contrast to how the women viewed abortion. For the women in Chapter 6, an abortion was seen as a difficult event that invokes fear and requires bravery, courage and resilience and is not an easy procedure to undergo as shown in the health service provider's talk.

Women who undergo a TOP were seen by the health service providers as acting in way that goes against already-established cultural standards. The following quotes show this:

Extract 2

Terry: A child is sacred and they should not be killed. That is why people do it in hiding. They are running away from our culture and do not want to be seen.

Tasha: Culture says no, never, it is not allowed. A child is a gift from God and there is no child who dies of hunger when living in our community. People help each other in raising the child so abortion is never the answer. The child does not belong to one person alone it belongs to all of us. So by deciding to terminate you have taken the child from the whole community.

Here, Terry and Tasha see the women as 'killers', who are killing children who should be protected. Terry attributes the secrecy involved in abortion to the women's fear of purposely not following the cultural norms. The woman who has had a TOP is placed in a position by both Terry and Tasha where she has taken a child's life which is against the 'laws' by which people live. Tasha shows how the child who is born belongs to everyone and no reasons justify abortion as the child is raised by the community. In this way, Terry and Tasha are drawing from a 'cultural' discourse, attached to which is a set of cultural standards and expectations.

The positioning here of the woman who aborts as being a killer and not a protector also contradicts the way the women viewed themselves in light of their circumstances. Most of the women had an abortion because of lack of monetary support or a reliable and supportive partner and realising that they could not take care of the child. Although women also spoke about abortion as 'killing', using cultural interpretations around abortion and thus drawing from a similar 'cultural' discourse to the service providers, they also saw the abortions as justified for the afore-mentioned reasons. Therefore, despite the women in this case also seeing themselves as 'killers', (leading to conflict, guilt and regret), they depict their actions as justified given the circumstances in which they found themselves.

Having gone against the cultural norms, the women who have had a TOP are seen by the service providers as deserving the way they are treated by the community. They are transgressors who must be and should be punished, as can be seen in the following quotes:

Extract 3

Joan: Stigma is there in the community especially if people know that you terminated. The community are the protectors of culture and culturally you cannot abort. A person ends up being stigmatised with people pointing at them saying that these are the murderers. When there are reasons like rape there is no stigma it just comes up when the community considers your reasons to be invalid and selfish.

Vovo: It discourages those who are thinking of terminating. The person should be arrested or laughed at, that is how they learn that what they have done is bad and unacceptable.

Vovo: The community does not want us to lose our morals, that is why it punishes us when we do.

Tasha: You have done something that is immoral so we are not related to you anymore, you have lacked morals. You have failed to do a service to your community so they will spit you out. People become disgusted by you and you also start being disgusted at yourself. And I do not blame these people in the community who are disgusted because by terminating you would have done a selfish act so you deserve to be frowned and looked down upon. You are disgusting.

In Extract 3, women who have terminated their pregnancies are seen as having challenged the community stakeholders who are viewed as the protectors of culture. These women should thus be sanctioned for going against the cultural norms which are assumed to be known and accepted as right by every member of the community. However, Joan shows that not all people who abort are seen in the same light as those with acceptable reasons, such as being raped, are spared of the stigma.

The speakers in Extract 3 point to the punitive aspect of stigma, which is how cultural sanctions are brought to bear on the women. The punitive aspect is seen in people's actions like having them pointing and laughing at you, punishing and rejecting you (not being related to you anymore, spitting you out). Other actions include being frowned upon and being looked down on. Vovo shows how stigma or legal actions against the women who have aborted a pregnancy act as deterrents for them to do it again. Tasha shows how the way one is seen by the community is then internalised by the individual. Tasha also shows how she also shares the community understanding and sees the woman who terminates a pregnancy as repulsive. Tasha's reference to 'people being disgusted' suggests that there is an automatic bodily response, just like when one is confronted with something foul. The abortion decision is seen as an egoistic act which must be discouraged for the greater good of the community. The health service providers also seem to justify stigma as they indicate that it is the appropriate collective response from the community and helps to regulate people's behaviour.

The representation of women who have had a TOP as the 'stigmatised other' above is the same found in the women's narratives. Stigma and othering seen in the health service providers' narratives above is the one that erodes the social standing of women who terminate their pregnancies. The operation of abortion stigma was shown in the women's narratives. Stigma was seen in the negative comments people share about those who terminate a pregnancy and in the end this necessitated secrecy when aborting due to fear of being isolated. The women in Chapter 6 spoke about the labels they were given when people found out that they had

terminated the pregnancy which included that of 'prostitute', 'killer' and 'sinner'. All these subject positions show how the woman who terminates a pregnancy is seen as an outcast who deserves to be punished. The fear of being isolated and punished is seen in women not reporting to clinics in time for post-abortion complications.

Women who terminate a pregnancy are also seen as causing problems for the whole community by their actions. Vovo states:

Extract 4

Vovo: I actually think that all the problems we are having as a country comes from karma from all these bad and evil things people do. It is a sacred thing and people think that it just ends with terminating. Killing babies destroys the moral fibre of the society together with the gays, thieves and the corrupt. The heavens are angry and all the economic woes are punishment for us for allowing such things within our midst. That is why the rain is not falling. The heavens are dark. People have lost the moral compass. You cannot think that you can kill a person and it ends there, no it does not end.

Vovo: If we do not do that [shaming people for their immoral actions], people will do as they wish like they do in South Africa where it is available on demand. Look at how poor their morals are. The country will be destroyed because of all this talk about rights about terminating and gays getting married.

Vovo here places the women who have a TOP in the same light as "gays, thieves and corrupt" people who destroy societal morals and this leads to bad karma. This bad karma is seen when the 'heavens are angry', which is a notion of divine retribution that is brought to bear upon the entire nation because of the actions of the few. She even attributes the economic situation in Zimbabwe as national punishment because of these people who go against the societal norms. For her, the consequences of abortion impact on the whole community. Vovo uses South Africa as an example of a society with low morals and says Zimbabwe should not follow the talk around rights for gays and abortion as this will lead to more very severe consequences. This is the only place where the rights discourse is referred to directly in the data. The rights discourse is problematized as aiding to a breakdown of moral fibre of the society; abortion rights are equated to gay rights and seen as unacceptable.

Here, women who have a TOP and gays and those who are thieves and are corrupt are aberrations, 'others' who do not form part of our 'good proper' communities. The othering expressed here is what leads the women in Chapter 5 and 6 to act in secrecy while deciding to, and then undergoing, an abortion. Secrecy is important in hiding the act of the abortion so that women who undergo an abortion can continue to be seen as 'good' and 'proper'.

7.3 Women who terminate are irresponsible and reckless

Women who have had a TOP are positioned by health service providers as irresponsible and as making poor choices in terms of supposedly not abstaining and using protection or family planning.

Extract 5

Terry: Condoms are free, birth control pills are there but people do not use and they want us to feel sorry when they get pregnant. It is their fault.

Sife: Why is a person killed? Why didn't they use protection in the first place if they did not want the child. Why hasn't she used a condom, or having a jardel [a device inserted into the birth canal to avoid conceiving] implement. Probably some say they do not want condoms but why not jardel. Why not use pills? They are so many methods of family planning. I think they should utilise all these methods than to kill.

Vovo: As for me they disgust me. If you have sex and fail to protect yourself you should live with your decision. We give condoms for free. Use them. In the community we see them as murderers and that is why we laugh at them and isolate them. As for me I don't want to be associated with these people. They are the same as Chidhumo and Masendeke [two notorious Zimbabwean murderers who were executed in the early 2000s] and they are all murderers, we do not want them in the community.

In Extract 5, the woman who has a TOP is seen as failing to access easily available contraception and therefore deserves no sympathy for the situation in which she finds herself. Terry shows how free contraception is available and how women seemingly purposefully fail to use it. Thus, they are to blame for the pregnancy and should not justify abortion. The health service providers seem to be assuming that there is open negotiation between partners before sexual intercourse takes places about whether or not to use contraception and the women is held responsible for failure to protect herself. Sife poses rhetorical questions that suggest that there is

a wide range of contraception which the women fail to access, making their decision to 'kill' incomprehensible as they should have been responsible enough to prevent the pregnancy in the first place and there is no excuse for not having used contraception. Vovo becomes the community's voice and justifies how the woman who is having a TOP is positioned as a murderer and should be stigmatised for her failure to use protection.

The positioning of the women who terminate their pregnancies as the reckless and irresponsible other who deserves to be stigmatised for being a 'murderer', seen above, differs from how the women viewed themselves. Most of the women's pregnancies became complicated due to the unreliability of a male partner who either denied responsibility or disappeared. The male partners in this case are the irresponsible ones as they deny or run away from the responsibility of taking care of the pregnancy and the resultant child which leaves the pregnant women with little or no choice as to whether or not to continue with the pregnancy. As shown in Chapter 6, the women in this context are dependent on their male partners for financial support and abortion becomes the only option as the women cannot take care of the child to be born. The male partners who are implicated by the women who terminate their pregnancies are surprisingly missing in the health service providers' positionings and it is thus only the women who are seen as reckless and irresponsible.

As well as women being accused for not using of contraception, the women who terminate their pregnancies are seen as failing to abstain due to reckless and selfish desires and needs, as can be seen in the quotes below:

Extract 6

Tasha: And you see a lot of these children making the wrong choices these days as well. We preach abstinence all the time but no one is listening to us.

Terry: What touched me was how young she was. Why have sex in the first place? Wait for marriage.

Vovo: No it is not because it is a bad thing. The people have selfish desires and when they are engaging in sexual intercourse they forget about tomorrow because of pleasure. Everyone knows that if you sleep with a man without protection or if you not on any family planning pill you will become pregnant. So if a person says they cannot take care of the child or the person responsible has run away we ask, 'why did you do it in the first place? Aren't you the one who enjoyed unprotected sex so live

with the consequences that come with it? You are the one who wanted it so do not give us a problem by wanting to do something that is immoral'.

Here, Tasha sees termination of pregnancy as being carried out by 'children' who are failing to abstain from sex. By seeing the women as a children, it means that they are immature and do not know what is good for them or how to make relevant and appropriate life choices. Terry brings up the idea of waiting for marriage which is the right place for sexual intercourse where abortion would not need to happen. Vovo touches on the irresponsible need for pleasure in which the women partake, forgetting the consequences. For Vovo, the woman who terminates her pregnancy has no reason to justify what she does as she should take responsibility for having failed to prevent the pregnancy. The women in Vovo's talk are seen as seeking physical pleasure without considering the effects.

The pleasure-seeking, irresponsible, immature child positioning here differs significantly from the positionings seen in the women's micro- and macro- narratives in Chapters 5 and 6. The women's pregnancies mostly occurred in relationships and their narratives contained no pleasure-seeking element. In some cases, the women saw themselves as 'protectors' of children already born and also protectors of the future child from poverty. The termination is not as a result of any 'pleasure seeking irresponsible immature child' positioning but is necessitated by an array of complex factors, as mentioned above and as seen in Chapters 5 and 6.

The health service providers were clear that those who are sloppy and irresponsible enough to get pregnant should live with the consequences:

Extract 7

Terry: But however people should stop getting pregnant. Those who are foolish enough to become pregnant should keep their babies.

Joan: But in cases where the person is not under age, they are not positive, and there is no incest; the person was just having fun without using family planning haaaa in those situations the person is being selfish because she must stand by her works and keep that baby.

Tasha: So we treat for free people who have been irresponsible on their own. That money would be better used somewhere else. If you cannot abstain use a condom. Do not

give us a problem saying I want to terminate a pregnancy but you are the one who had the sex. It is your problem so why make it a problem for the whole country?

Terry in Extract 7 takes the woman who has a TOP to task for failing to prevent pregnancy and since it is her 'fault' she should keep the baby as a punishment for her irresponsible actions. In Terry's, as well as in other health service providers' talk, the 'pregnancy' is seen as a baby and this automatically assumes that the pregnancy was going to reach full-term. Joan lists circumstances where abortion can be seen as being acceptable (rape, incest, under-age mother and if the woman is HIV-positive); all the others are seen as being the result of seeking pleasure and being self-serving. Due to this, she feels, the women should take responsibility and keep their 'babies'. Tasha picks up on how the already over-burdened healthcare system suffers because of the foolishness of the women who fail to use protection as they now have to have free post-abortion care. The women, according to Tasha, should pay the price for their irresponsibility.

The talk about the foetus being a baby at conception, found in the health service providers' talk, is also contained in the women's micro- and macro-narratives. The women felt guilt and regret due to having killed a 'baby'. However, the foolish self-serving woman seen in the health service providers' positioning, as already shown, differs from the 'protector' subject position that the women adopt in their narratives.

The health service providers also sometimes perceived the woman who has a TOP as an irresponsible adulterer who seeks an abortion to hide her shameful actions:

Extract 8

Sife: ... and then some it is because they have been impregnated when the husband is in South Africa.

Tasha: In this area there are also cases of the pregnancy belonging to someone else's husband and the girls will be ashamed that they have conceived through adultery.

Sife shows how women get pregnant when their husbands are not around, thereby complicating the pregnancy. Tasha shows how the irresponsibility of adultery brings shame which makes the women want to terminate the pregnancy. The irresponsible adulterer position was taken up by Sheila in Chapters 5 and 6 when describing how she had slept with another man and became pregnant while her husband was away. What is interesting in the irresponsible adulterer

position is that all blame is put on the woman not only by the health service providers but by other women in the community too. The woman is positioned by the health service providers in such a way that she has to take full responsibility for her actions. In Sheila's case, the full story is that her husband had found another wife but he remained blameless and the man she had slept with, to whom she was now married, also remained blameless.

7.4 Killers of innocent children and sinners against God

The women who have terminated their pregnancy were seen by the health service providers as killing innocent children and sinning against God. The service providers here take on the 'moralistic religious' discourse which was discussed in Chapter 5. Abortion is seen as a sin can be noted in the following narrative quotes:

Extract 9

Tasha: There is no religion in this country that permits such evil. Speaking in Christian terms it is not acceptable. This is a lowly act in the eyes of God. Deuteronomy says, 'thou shalt not kill' and whoever kills has committed a grave sin. So those who terminate will get their punishment in full from God. That is why you see people in the community looking down upon this act because most are Christians. So if you choose to abort you have acted as an instrument of Satan. You have committed one of the sins that are probably unforgivable in front of God.

Vovo: I think it is a sin in front of God because God says, 'do not kill and if you do you have committed a sin'. I think God punishes those who do terminate.

Mimi: For me, (.) I do not support it. I believe that whoever terminates has committed a great sin.

Tasha in Extract 9 sees the women as 'evil' by choosing to end a life. Concepts from the Bible are used to justify this view. Her "sin", according to Tasha, makes the woman unpardonable in front of people and God. Vovo also uses the Bible to show how the woman who has had an abortion has transgressed against God. Both Vovo and Tasha show how an abortion does not go unpunished by God. Mimi shows that her disregard for women who have aborted is because of her belief of abortion being a sin. These strong religious views amongst health service providers have also been seen in Ghana where family planning nurses expressed strong religious views and negative attitudes toward abortion (Schwandt et al., 2013).

The ‘evil sinner’ positioning expressed by the health service providers above was also taken up by some of the women who had terminated a pregnancy. This position is enabled by the prevailing moral religious context were abortion is seen as an evil, bad deed that goes against the Christian principles/instructions for moral living and is considered a grave sin. The difference in the health service providers’ positioning and the women’s is that although God punishes, the women believe that God also forgives. There was a lot of talk around an understanding God in the women’s narratives, a God who understood the difficult situations in which the women found themselves. Some of the women in Chapters 5 and 6 acknowledged the ‘immorality’ of their actions, but they also believed that God understands the situation in which they found themselves and has forgiven them.

Terry also shows how the view of abortion being a sin extends to the circumstances surrounding the pregnancy. He states:

Extract 10

Terry: Abortion is killing and having a [becoming] pregnant outside wedlock is a sin as well. You have committed adultery. So if you abort a pregnancy that was outside marriage you have two sins.

Terry here shows how the conception of the pregnancy which is outside marriage (marriage being the appropriate place for reproduction, as noted earlier) and the ‘killing’ are both sins which paint the woman in a negative light. Talk of marriage being the appropriate place for reproduction was also seen in the women’s narratives, although it differed slightly in that abortion, in some of the cases, was necessitated because the pregnancy had occurred outside marriage.

Most of the health service providers indicated that the women who terminate their pregnancies are in fact killing children and for this they are perceived as immoral and evil people. The following quotes show this:

Extract 11

Mimi: You cannot kill children full stop. It does not matter the reason. Children are a blessing from God and you cannot kill them. From conception that becomes a child.

Terry: Haaaa because life is sacred. It is killing, it is murder. It is the same whether you kill an old person or a small baby in the stomach.

Joan: It is killing and it is not allowed.

Tasha: It is a bad thing to do. Why kill God's innocent creature?

Here Mimi and Terry speak of the pregnancy as a child, using the rationale that at conception, the foetus is a child. They both show that the woman who has a TOP is seen as a sinner, killer and evil-doer because she has taken a child, something which is a 'blessing' and 'sacred'. The women, in Tasha's eyes, are evil due to killing a 'poor innocent soul'. Terry equates the abortion with the killing of an old person, thereby invoking the notion of vulnerability. As noted earlier the same positions were taken up in the women's narratives where the women felt they had committed murder by having an abortion. The positions taken up by the health service providers here are similar to what has been found amongst Mexican midwives who also referred to women who had abortion as murderers who killed innocent children (Castaeda et al., 2003). Women in South Africa were also referred by nurses as murderers and baby killers (Harries et al., 2009).

7.5 'Prostitutes' protecting their jobs

Women who terminate their pregnancies were seen by the health service providers as 'prostitutes' who are having abortions to protect their jobs. The following quotes show this:

Extract 12

Mimi: Some of them do not want to work as they are used to this bar-hopping. These ladies terminate because they already have no money so a pregnancy is a burden. The reason they have many pregnancies is that it is a risk of [to] their business. They go out [to earn money] every night so a pregnancy or child is an inconvenience so terminating is the only option.

Terry: And the problem is most of the people who terminate are prostitutes. They would have seen that, 'how can I have a baby when I want to work? I want to see my customers and the baby is a hindrance' so they abort.

Terry: The prostitutes are not careful in preventing pregnancy.

Sife: I think most of them are prostitutes and they would not want children because they want to go to work. You cannot go ahead with the business if you are pregnant or have a child.

Tasha: They are also prostitutes who terminate because a pregnancy disturbs their work.

In Extract 12, the profile of the woman who has a TOP is seen as a prostitute who is irresponsible in getting pregnant and is only terminating her pregnancy so that she can continue work. Representations of prostitutes have already been discussed, including prostitutes being looked down upon socio-culturally and religiously.

Mimi, in Extract 12, portrays the women who terminate their pregnancies as enjoying the bar-hopping and failing to find other sources of income. These women, as seen by Mimi, only terminate pregnancies because they have to continue work and do not want to take care of the children that result from the pregnancy. Terry sees abortion as something done mostly by 'prostitutes' who see the pregnancy as not ideal for their job and thus it is done away with. These 'prostitutes', according to Terry, are irresponsible as they allow themselves to get impregnated. Sife and Tasha also speak to how abortion is a behaviour conducted mostly by prostitutes to protect their jobs.

The stereotypical ways in which 'prostitutes' are regarded by society have already been discussed in Chapter 6. None of the women took up the 'prostitute' position in their narratives. When prostitution was mentioned, it was in relation to women trying to avoid the prostitution label by terminating a pregnancy that would make people see them as 'prostitutes'. It was also noted that none of the women stated that they had resorted to prostitution as a means of gaining an income. 'Prostitutes' are looked down upon both culturally and religiously. The label 'prostitute' leads to marginalisation as prostitution is viewed as a shameful, immoral and sinful act. Viewing the woman as a prostitute makes it easy for the health service providers to reconcile the idea of a woman having an abortion. The reasoning here is that no 'proper' woman would consider having an abortion unless, of course, they are a 'prostitute' who is already seen as immoral, reckless, irresponsible and can 'kill' an 'innocent soul' easily without remorse in order to continue their work unburdened. As was noted earlier, some of the women terminated the pregnancy for fear of being labelled a 'prostitute', which shows that these women would not be proud to carry this label. This is contrary to the way prostitutes behave, according to the health service providers, by frequenting public spaces ("beer halls") and making their line of work known.

7.6 Manipulators of a lax legal system

The service providers view the women who terminate their pregnancies as taking advantage of a lax legal system to get away with their crime of aborting. Corruption is seen as playing an important role in the women not getting arrested:

Extract 13

Sife: … you never quite know now living in this time of corruption that those who terminate are actually tried [in court] or they just pay off the police and judges. It is very possible. So you find that corruption is making the laws weak. It is there but it does not work. People just buy and their crime disappears.

Vovo: The law is in name only. There is corruption so people just pay off the judges or the police and the case disappears. This is what makes people continue terminating because they know they will get away with it. If a person would go to jail this practice would end. If they were given ten to fifteen years in jail the problem would end quickly.

Sife and Vovo speak to how the women who terminate a pregnancy get away with the 'crime' by bribing policemen and judges. The women in this case are shown as continuing their immoral acts, from having the abortion to covering it up by taking part in corrupt activities (paying bribes). For Vovo, this continuing corruption partaken by the women means that they never learn from their mistakes and thus continue to fall pregnant and then abort. Vovo calls for a stricter law which would dissuade people from terminating their pregnancies.

The manipulative woman constructed in the above narratives is seen as part of a corrupt system that needs to be strengthened. Abortion in this case is referred to as a 'practice' that only happens because the women can corruptly influence the system. All the other complicated and multifaceted 'factors' seen in the women's narratives are rendered non-existent by this positioning. Thus, if the law is made a little tighter, the woman would choose to carry the pregnancy to full term. The legal system featured in the women's stories when they spoke about the fear of community members getting them arrested. However, there was no talk of the women manipulating the system.

The law is seen by the health service providers as being weak and, therefore, easy to manipulate, as noted below:

Extract 14

Tasha: Ah the law is only in name. There is no one who listens to it. People know that even if they are caught nothing usually happens. They go to remand for a few days and get community service as punishment. They say the jails are too full and I think this encourages them. If they were thrown in prison for a while they would learn that abortion is killing. A person who kills another … person gets 25 years and some are hanged but we say those who have terminated should go when they have also killed. So if the law is applied and people face jail time they would learn and will not terminate anymore.

Tasha, just like Vovo in Extract 13, talks about the law being weak and not applied consistently. Tasha also indicates that if the punishment was increased and applied consistently, then women who abort would stop committing such an immoral act. She compares the punishment that people get for other murders, which includes hanging, and shows that abortion deserves similar punishment as it should also be considered murder. Just as seen before, in Extract 13, the health service providers argue that if women were punished then abortion would stop. In this context, abortion is seen as only occurring due to the failure of the authorities to punish the woman who aborts. The idea of punishment here is in contrast to how the women saw themselves in Chapters 5 and 6. The woman felt they punished themselves for having the abortion by feeling ashamed, regretful and going through inner conflict, and were also in a way punished by the man by being left alone once he found out that she was pregnant.

The women who terminate their pregnancies were also seen as taking advantage of other selfish and immoral health service providers who offer them abortion for money:

Extract 15

Sife: It is very true they are there who offer the service. I think they [those health service providers who offer the service] should be arrested. If someone is found that they have aborted we should find out who did it, we should get to the bottom of this. Ha because the thing is we do not deny that doctors are there.

Tasha: Those are our enemies. They are abusing their work and knowledge for selfish reasons. We have many of them who are writing prescriptions and also operating in the hospital theatre using the backdoor channels. They are making this evil grow in the society. What surprises me is that no one is arrested yet; they are there. If we do not deal with these abortionist, Ahh we won't solve this problem. We also have

n'anga [traditional healer] and traditional practitioners who are abusing their jobs as well and providing this service. There are so many of them and they allow this evil to grow.

In Extract 15, Sife indicates that there are medical professionals who are offering abortion services and who need to be arrested and punished so that the practice of abortion can be curtailed. Tasha indicates that traditional practitioners are also implicated in helping women to have an abortion. The medical and traditional practitioners are seen as perpetuating the "evil" of abortion that exists in the society. These health service providers who help women abort are seen here as part of a system that is failing to curtail abortion, thereby leading to many more cases of abortion. According to the health service providers, if these people do not offer help to women and the system punishes those who get caught then abortion would stop.

7.7 Seeing no options due to selfish reasons

The women who terminate their pregnancies were seen as selfish and only concerned about their own needs. Health service providers indicated that these selfish reasons make the women think abortion is justified, but it is not. The following quotes show this:

Extract 16

Mimi: Both culture and religion says that it is bad and evil and all ask the question of, 'why did you become pregnant in the first place?' All the talk about having no money does not apply because you were not supposed to get pregnant. Even if you have ten, have you ever seen people say, 'the kids at this house died of hunger because they are many'? I do not know how God does it; even if people are suffering they do not die of hunger. Culture says, 'who did you see die of hunger? You have no reason to terminate.'

Terry: People who terminate are selfish and only worried about their needs and not thinking about the baby.

Terry: There is no justification. It is bad. Terminating a pregnancy is terminating. If it is too difficult they should say at the clinic and they can get help from NGOs who feed children.

In Extract 16, Mimi shows how cultural and religious interpretations do not provide room for any justifications as abortion is wrong no matter what the situation. Mimi argues that children are always able to be looked after, even when there are many. Therefore, there is 'no reason' to

terminate a pregnancy. For Terry, the women only care about their own egoistical needs and ignore those of the baby who should be kept alive. Terry also argues that the women still have other options available which they do not consider, in the form of their local clinic or NGO feeding schemes.

The selfish woman position seen here places the blame for abortion squarely on the woman who is seen as not thinking of the 'community' by terminating her pregnancy (as shown by Tasha in extract 2 earlier in the Chapter). The role of the community here is seen in two parts: 1) blaming the woman for being selfish and "killing" a child that belongs to the community 2) making the pregnancy complicated due to various situations which necessitates a woman terminating the pregnancy. The first part is the one taken by health service providers and the other one mostly by the women who terminate pregnancies. The position taken by the health service providers (blaming the women for being selfish) is contrary to the way the women positioned themselves in their narratives. To them, abortion was not performed only for 'personal reasons' but due to a number of issues. Some abortions were made necessary as ways to protect children already born as well as the one to be born. Women also terminated their pregnancies as a way of hiding the shame that the pregnancy brought not only to the woman but to her family and, by extension, her tribe. In these instances, the abortion was not a selfish act but rather an act to protect their immediate and extended families. The women saw themselves as facing pressure in light of cultural and religious norms which made the pregnancy unacceptable. Therefore, cultural and religious understandings complicate a pregnancy making it unsupportable.

The health service providers indicated that the women failed to consider other options which were available, as noted earlier, as well as other reasons which will be explored below. This failure is because the women were only considering their selfish reasons and because of this, the health service providers did not support abortion, as can be noted in the following quotes:

Extract 17

Terry: I do not agree with their reasons. It is getting to the end of the road and (.) they should not do that as it is a dark deed. If you speak to other people you might get help and not abort. Abortion is a crime so that is why they do it in secret. Those that have terminated will think they have done a nice thing because they would say, 'I no longer have to take care of the baby'. So for them it is alright.

Joan: I think the person in that circumstance can just give up the child for adoption.

Sife: If someone cannot take care of the child it is better that they deliver and leave the child at the hospital. Adopted babies are taken care of. Why kill innocent babies?

Terry argues that the women could find help from other sources but they see their selfish reasons as being good enough for them to go through with the abortion. Terry positions the woman who has a TOP of being out of ideas ("end of the road") and intellectually incapable of realising the wrongness of her act. Joan and Sife suggest adoption as an option as there is no reason to kill a child. This is contrary to what was found in the women's narratives where abortion was seen as the only option in light of the prevailing circumstances. Poverty, no partner support and no capacity to take care of the future child meant abortion was a justifiable option. In the women's narratives, they positioned themselves as having no other option available and an abortion was done not because they were evil and selfish, or because they wanted to, but because they found themselves certain circumstances where it was the only viable option. Abortion was not an easy option for the women as they faced great fear, conflict, regret and guilt during and after the abortion.

7.8 Oblivious of the pain and hurt caused by an abortion

Women who abort are seen by the health service providers as being unaware of the consequences of an abortion. Joan and Vovo said:

Extract 18

Joan: What touched me was she bled a lot and she almost died and it got me thinking about why she would risk her life for a pregnancy.

Vovo: It touched my heart as she died and left three children. Why did she do it? Ah, if she had only kept the pregnancy and left the husband. Ah, to die for that, leaving your children to suffer because of bad choices. She failed to think and she died for that.

In Extract 18, Joan and Vovo position the women who terminate a pregnancy as not being aware of the physical dangers of abortion. Vovo spoke of how being unaware of the consequences of abortion led to the woman's death. The death in this case is a consequence of a series of bad choices starting from the pregnancy leading to the abortion. Joan and Vovo also positioned themselves as sympathetic to the pain that the women who have a TOP go through.

The sympathy, however, only extends to the post-abortion pain since it was the women's fault for finding themselves in such positions.

The oblivious woman position here is different to what is found in the women's narratives. Women saw themselves as being 'fearful' of the consequences of an abortion. The circumstances in which they found themselves, meant that whatever fears they had, be they physical or psychological, were irrelevant, and did not deter them from going through with the abortion. The abortion had to go ahead no matter the risk or dangers involved. The women in Chapter 6 showed how risks are negotiated in the face of their circumstances.

The health service providers indicated that the consequences of the abortion are not just physical but also emotional. The women were seen as being oblivious to these emotional effects which would affect them for the rest of their lives. The following extract shows this:

Extract 19

Tasha: I do not think it is right. Abortion is not easy and it does not matter it has been done by a doctor or it is African medicine or the person has done it on their own. It has severe emotional problems and those who terminate do not know this. They become scarred for life. I have worked with people who terminate for 20 years and I have not seen anyone who has been happy about their decision. All of them have guilty conscience that eats them all the time and the wounds will be with them all their life.

Tasha argues that the woman who terminates a pregnancy is tainted emotionally for life ("wounds" will be present forever). She states that no matter if it is a safe or unsafe abortion, the emotional trauma is always evident and women who terminate a pregnancy are never the same. Here, while physical morbidity and mortality as a result of abortion are easy to see (as shown in Extract 18), the psychological or emotional outcomes are more difficult to prove. Therefore, Tasha draws on a position of expertise to convince the listener of its reality ("I have worked for 20 years"). What is also interesting in her talk is that she attributes the trauma to the abortion per se and not the circumstances surrounding an unwanted pregnancy, having secretly procured an abortion or facing stigma and shame which might be valid causes for any emotional or psychological outcomes. The emotional consequences seen here are similar to some of the women's descriptions around the guilt and regret they experienced after the abortion, although it was balanced by a feeling of relief. Some of the women took up the 'remorseful yet relieved woman' subject position where, despite having regrets and feeling

guilty about the abortion decision, they are also relieved that the pregnancy is gone as the pregnancy was unsupportable.

7.9 Foolish in wanting money from older man and foolish for not realising the potential of children

Some of the women who terminate are seen as young children who are foolish in wanting money from older men in exchange for engaging in sexual intercourse with them. This is seen in the following quotes:

Extract 20

Terry: The school kids like fancy things and are fooled by older men.

Tasha: This story touched me as she was such a young girl who for the love of sugar daddies she almost died. She had made some poor choices in her life and she almost paid for it with her life, twice.

In Extract 20, Terry shows how the love for material things leads young girls to sleep with older rich men and then become pregnant which leads them to terminate. Tasha shares a story of a young girl who slept with a rich man and almost died during the process of terminating her resultant pregnancy. The girl had made bad choices that almost cost her her life.

Here, the immature, fun-loving, material-chasing woman is seen as only having an abortion because of sleeping with richer men which is the beginning of their 'poor choices'. The health service providers refer to the women here as 'girls' and 'school kids' who show their reckless behaviour by being impregnated by older men. The 'girl' is seen as the one at fault and should know better but nothing is said of the richer, older man. Being seen as a 'girl' points to some level of immaturity, yet that same 'girl' is expected to be responsible enough to not make poor decisions. In the women's narratives, women positioned themselves as being vulnerable to lying, manipulative men who ended up denying responsibility or disappearing. The silence about men in the health service providers' narratives, as mentioned earlier, points to a situation where the entire 'fault' is laid at the women's door, and men are devoid of any blame.

The health service providers also indicated that the women were foolish in not realising the potential of the 'child' they were 'killing'. This potential is so great, to the extent that no reason or circumstance to terminate except saving the women's life, is seen as good enough. This can be noted in the extracts below:

Extract 21

Joan: But you wouldn't know the medical argument because you see our parents had us at a young age. They were 14, or 15 years. So I would not know what the medical arguments are. Maybe 12 years would still be too young but if it was me I wouldn't want an abortion in whatever circumstances except to save a life. For me, abortion is taking a life, there is a life that would have been taken. Of course people would be saying, 'what would I give the child?' Maybe I am saying from a Christian perspective, 'how many children are born after not being wanted but have a great life? How many children have great lives but the mother was raped at conception?' So ah, the thing called abortion whether one has been raped by criminals or relatives I am against it. Even the legal termination I am against it. Ah it does not do it for me.

Sife: Ah on the rape issue I say the child should be kept. What does the child know? You do not know what the child is going to become so why terminate. You might terminate the future president of the country. Keeping a pregnancy resulting from rape is a better evil than the evil of terminating. When it comes to age I think if a child is 12 years and above they are able to have a child. Our mothers were married when they were 12 or 13 and we are here now. We survived so age only matters if it is below 12 for me.

Tasha: When it comes to rape I think the child should be kept. If a person is counselled the trauma disappears and they can keep their baby, what crime has the child committed? The child does not know anything. Ah the child should be kept.

The above extracts show how the women are as seen as being foolish: foolish to think that they cannot keep the baby, foolish to not follow 'our parents' footsteps and foolish not to understand the future potential of the foetus. Joan and Sife argue that abortion is not even justified in cases of rape, when the woman is young (under age) or incest. Joan goes on to draw from 'religious' discourses around how children should be kept as termination is considered to be evil. The woman who terminates is seen as destroying a future child who has the potential to become successful. Tasha states that in rape cases, the child should not be punished for something they did not know about. It is surprising that counselling is seen by Tasha as a quick and effective fix, but this may not work for everyone, and may also not be able to change the woman's circumstances which are causing her to think about terminating the pregnancy. The health service providers here point to a total non-acceptance of abortion even in cases which are seen

as culturally, legally and religiously wrong like rape and incest. In these cases, rape and incest are seen as lesser evils than abortion, which should be forbidden at all costs.

7.10 Service providers' positions

In the process of positioning the women who had terminated their pregnancies, health service providers also took up certain positions in relation to the women and also to the act of abortion itself. These positions include health service providers as being: sympathetic to some of the women's stories, against abortion, protectors of cultural/religious norms and the law, helpers and advisors. Some of the ways the health service providers positioned themselves were contradictory. For example, despite being against abortion and being "disgusted" by the woman who terminates a pregnancy, the health service providers saw themselves as still being able to do their job and help women who present for post-abortion care without any bias. The subject positions that the health service providers took up are discussed in turn below.

7.10.1 Sympathisers

Joan and Vovo, in Extract 18, have already shown how the health service providers took up a position of being sympathetic to the pain that the women felt when they presented for post-abortion care. The same positions were taken up by Mimi and Sife when they said:

Extract 22

Mimi: The story touched me a lot, if she had not terminated [her pregnancy] she would be alive. She left other children, what will happen to them?

Sife: It touched me to see such a life being thrown away for something that could have been avoided.

The sympathy shown above by Mimi and Sife is similar to that shown by Joan and Vovo in Extract 18, in that their sympathy is not directed to the woman who has had TOP per se but for the 'sorry' situation she has created for herself. It is sympathy for the pain that the woman who has terminated a pregnancy puts herself and those around her through by making 'poor choices'. Mimi's sympathy is with the other children that are left after the woman died from abortion complications.

The sympathetic position taken by the health service providers positions the woman who terminates a pregnancy, not only as oblivious and foolish, as shown before, but as weak and

someone to feel sorry for. The taking up of this position ignores all the other circumstances surrounding a woman's pregnancy and puts the focus squarely on the woman and her 'poor choices'. The health service providers' sympathetic position communicates that the woman who has a TOP should be felt sorry for getting themselves into a bad situation (physically harming themselves) and having an abortion which was avoidable. The abortion decision in this position is reduced to just the physical effects of having an abortion − pain and death and largely lacks the consideration of the emotional trauma that the woman undergoing the TOP may experience.

7.10.2 Protectors of culture/religion norms and the country's laws

The health service providers also took up positions of being protectors of cultural and religious norms as well as the country's laws. This position is enabled by an 'us versus them' mentality:

Extract 23

Mimi: It [our country's laws] does not allow it. Not at all. It is the same as our religion, there is no difference.

Mimi: You have done something that is frowned upon so we stigmatise you.

Terry: That is why people do it in hiding. They are running away from our culture and do not want to be seen.

Terry: We look down upon them obviously and we say they have committed a crime….

Tasha: We have culture and religion that guides us and forbids these things so if you choose to terminate people will obviously be disgusted when they see you.

In Extract 23, Mimi, Terry and Tasha position themselves as belonging to a 'us' group that has the right to stigmatise and look down upon those who terminate pregnancies, who are placed in the 'them' group. The women who terminate pregnancies are seen as going against 'our' religion, 'our' culture and 'our' laws. The position occupied by Mimi, Terry and Tasha is not questioned as it is the correct and only way of seeing those who terminate pregnancies. Here, culture and religion are homogenised and everyone is seen as having the same beliefs and the same responsibilities to maintain the cultural and religious norms.

The members of the 'us' group are not only protecting culture, religion and legal systems from the women who terminate their pregnancies but also from those who provide the means to have an abortion. In Extract 16, Sife and Tasha speak to this when they refer to health service providers who help women terminate pregnancies as 'problematic' by allowing people to continue having abortions by offering them this service. In their talk, they also refer to the 'us' group which is fighting against those who terminate pregnancies and those who provide the means to do so. Both are seen as being in the wrong and these identified prosecutors need to be to be arrested for their breaking of the law.

7.10.3 Against abortion in most forms

The health service providers positioned themselves as being against abortion. This position was enabled by the health service providers seeing themselves as protectors of culture, religion and legal systems as noted in Extract 23. This position influenced how the health service providers positioned the women, as shown before. An example is in Extract 18 where Terry indicates that abortion is wrong and the reasons that women provide for undergoing TOPs are not justified. The following quote also shows this position:

Extract 24

Sife: Ah (.) I do not allow it [abortion]. I am totally against it [abortion]!

The position taken by Sife here, of being totally against abortion, is the same as that taken by Joan and Tasha in Extract 21 where they view abortion as unacceptable for any reason. Joan takes the position that abortion is not justified even if the woman is 'underage' (12 years). Joan's position is enabled by what she terms her experience of seeing the potential of children born under any circumstances. She takes up a Christian position where abortion is not allowed for any reason whatsoever. Tasha, in the same extract argues that solutions like counselling should be sought for those who are raped so that their trauma is taken care of and they do not have to go on to have an abortion.

The taking up of this position has consequences for the enactment of reproductive justice in the arena of healthcare. The health service providers take up positions of authority where the responsibility is fully that of the woman who is having an abortion. The position taken up is that the immorality of abortion is absolute and any 'reasons' (the conditions that might make a pregnancy unsupportable or unsupported) do not come into the equation. The reasoning that comes from this position does not allow the health service providers to try and understand the

different circumstances that make an abortion necessary. Since the health service providers interact with the women who terminate their pregnancies, the position of being against abortion perpetuates these women being stigmatised, judged and chastised. These actions might lead to women acting in secrecy and not reporting for post-abortion care, both of which could cause health complications. The same position was taken up by the editor of the *Daily News* in Chapter 1 who saw abortion as being evil, and wrong and thus called people to take a stand against this practice.

7.10.4 Helpers and advisors

The health service providers also took up positions where they saw themselves as helpers who try to advise women wanting to terminate pregnancies. The advice is also seen as targeting those at high risk of terminating pregnancies – such as prostitutes as noted earlier. Mimi said the following:

Extract 25

Mimi: These are bad people [prostitutes]. I usually talk to them and ask them how much they get from the bars. And they say there is not much money but they have no choice. What can we do? If only we could find something to do. I asked one if she got implements to farm tobacco if she would do that and she said yes she could work. They know that what they do is not sustainable and they want to work but they have no choice. I told them that as you grow older the man will no longer be finding you attractive.

Mimi: I even try to help out those that are of risk to terminate by giving them food when they are pregnant if I know them and I have extra. I say to myself maybe they will keep the baby. I have suggested to some of the girls to start a round society to help each other with money or food even those who go to bars with the little they make they can get something out of it. I try to help them with ideas because I think, 'maybe they might stop terminating which is such an evil thing'.

In Extract 25, Mimi positions herself as a caring and loving person who wants to help prostitutes to stop doing their work and provides a hypothetical suggestion for alternative employment, such as tobacco farming. In this way, she gives ideas on how they could find better forms of making money. Her positioning is enabled by her being against abortion. The help she offers is in the hope that women would stop terminating pregnancies and in turn conform to her worldview on abortion being negative and an act that should be avoided.

The position of helper taken up by the health service providers is linked to their identities as nurses/community health workers, as seen in the following extracts:

Extract 26

Terry: As a person who is used to it I just work. I actually encourage people to try and use safe methods if they want to terminate.

Tasha: But I gave an oath to give help as a nurse despite what I believe. So now it does not affect me. When I get a chance I talk to the women sharing ideas so that they won't commit the sin again. Our job is necessary because if we do not help these people will die in their home which is a much bigger shame. So we just help despite our beliefs.

Vovo: When we are at work we work. Whatever I believe in does not influence how I work. I help everyone no matter what they have done. So hating what they do does not stop me from doing my job.

In Extract 26, Terry, Tasha and Vovo take up a position of being professionals who are there to help women who terminate pregnancies despite their personal opinions towards abortion. Terry takes up a helper position as he encourages women who terminate pregnancies to use safer methods and Tasha takes up the same position as she shares ideas with the women who terminate pregnancies. The three health service providers do not see their personal opinion having any influence on the women, which, as shown before in the review of literature, is not necessarily true.

The professional helper position portrays a good-hearted professional who does their job without bias. This position is, however, inconsistent with the previous position of being against abortion. The health service providers reconcile this inconsistency by taking up the professional tag where help is the end goal, despite one's personal beliefs. What is interesting in this position is that there is a complete lack of introspection on how the health service providers' personal beliefs can have an effect on the women who terminate pregnancies. The helping that happens here is for the woman who has a TOP who needs physical care and 'advice' so that they would not have an abortion again. This totally ignores the circumstances that made the pregnancy unsupportable and unsupported.

7.11 Conclusion

It can be seen in the narratives here that the positionings seen in the health service providers' interviews differed from how the women positioned themselves in their narratives. In the chapter I showed how women were seen by the health service providers as immoral, irresponsible and reckless, killers, as being evil, 'prostitutes', 'girls', manipulators, immature, selfish, oblivious and foolish. The tone of the positionings was one of 'pity' for women who because of issues like immaturity, foolishness and selfishness saw themselves performing an act (the abortion) that is unacceptable. These positionings drew from cultural and religious discourses where the act of having an abortion was seen as wrong and unacceptable under most circumstances. By having an abortion, a woman was tainted and was seen as deserving of any punitive actions directed towards her.

The act of having abortion, which was seen as evil, defined how a 'woman' is seen. For example, a 'proper' woman was seen as one who does not partake in such an evil deed and practice, but one who accepts her reproductive status no matter what the circumstances, including rape and incest. The abortion decision was seen as being vile and wrong that only women without any morals like 'prostitutes' could partake in it. The woman who had a TOP was blamed for making reckless and irresponsible 'choices' that led to the abortion. The complete absence of any mention in the health service providers' talk around the men's role in the relationship, was a sign of how the woman is vilified and seen as the only culprit in the abortion decision-making process.

The health service providers' positioning of the women was in sharp contrast to how the women positioned themselves in their narratives. To the women, an abortion decision was not made lightly but was done after the realisation that it was the only viable option. Pregnancies were seen as unsupportable due to the circumstances in which the women found themselves and the decision was made against a background of conflict, guilt and regret. Unlike the health service providers' views, the abortion did not define the women as some continued to see themselves as good people who were 'forced' into difficult situations where abortion was the only option. The view of women being 'killers', which was seen in the health service providers' talk, was also taken up by the women due to the prevailing 'cultural' and 'moralistic religious' discourses that exist in their contexts.

In positioning the women who had TOP the health service providers also took some reflexive positions. These positions were sometimes contradictory and placed the health service providers in a place of being helpers, advisers, sympathisers and protectors. The positions taken by the health service providers constrained reproductive justice for the women who had TOP as the 'blame' for having an abortion fell squarely on the women's shoulders. The health service providers took up positions of being the 'good' people trying to 'save' the cultural and moral degradation that was being caused by those who partake in 'evil' acts like abortion. As gatekeepers for the moral fibre of the society, the health service providers took it upon themselves to discipline those who stray from the 'right' and acceptable paths through techniques like stigma. In these positions abortion was seen ultimately wrong and any actions taken to discourage it were justified. The next chapter presents a concluding discussion for my study based on the findings presented in the three analytical chapters.

Chapter 8: Concluding discussion

8.1 Introduction

As a way of concluding, I now revisit the research questions I sought to answer. The main question for the study was: How do women and health service providers construct the process by which women come to decide on and proceed with a termination of pregnancy? The following were the sub-questions for the study: 1) How do women who have elected to have an abortion narrate the process by which they came to the decision to terminate the pregnancy? 2) How do health service providers construct and position women who have elected to have an abortion? 3) What power relations underpin a pregnancy becoming unsupportable? 4) What social/cultural discourses/practices are deployed in these narratives?

The rationale of the research was to add to the scant literature that exists in Zimbabwe by linking the narratives evoked in the interviews to social discourses and power relations that work to enable or constrain reproductive justice. The literature showed that while not many studies take narrative/discursive approaches those that do exist look at the experiences about abortion and public discourses. In so doing, they have shown how the 'choice' to seek an abortion is not only an individual decision due to personal circumstances but is located within, and influenced by, socio-cultural and socio-economic circumstances. In terms of the theoretical lens, a Foucauldian postcolonial feminist approach was used to illuminate the abortion decision-making process. The data that I examined in order to answer my research questions were collected from three sites using narrative interviewing and analysed using Taylor and Littleton's (2006) narrative discursive approach.

In attempting to answer the research questions, the analysis of the data was separated into three chapters (Chapters 5, 6 and 7). In Chapter 5, I focused on the discursive resources that the women used in narrating their stories. These discourses were put to work in the micro-narratives that women shared as seen in Chapter 6. The micro-narratives seen in Chapter 6 are enabled and constrained by particular discursive resources which were unpacked in Chapter 5. Chapter 7 focused on the health service providers' positioning of women who terminate pregnancies and also how the health service providers positioned themselves in relation to women who terminate pregnancies and abortion. It also revealed how the narratives of the women and the health service providers differed according to their experiences of, and perspectives of, abortion.

This chapter provides a summary of the research findings and also picks up on the central problematic of this thesis which is how reproductive justice is enabled or constrained by the way women who terminate pregnancies construct and narrate their stories and how they are positioned by the health service providers. The chapter will also look at how the women challenged the 'norm' by speaking about their abortion stories, even though stories were constructed in a socially-sanctioned manner where abortion is collectively viewed as immoral and illegal.

8.2 Summary of findings

One of the main findings of the study was that when narrating their abortion stories, the women spoke in a socially-sanctioned manner. The discursive resources employed by the women, which include a discourse of 'shame/stigma', a 'moralistic religious' discourse, 'health' discourse and 'culture' discourse, show the limited range of social discourses available to women to make sense of their abortion decision. Shame and stigma, which were seen to be important in determining what makes a pregnancy unsupportable, and also an abortion complicated, can be seen as a way of sanctioning what is allowed and what is forbidden in the context.

Shame and stigma are used to discipline women's bodies in regards to their sexuality – making pregnancies unsupportable by shaming women who get pregnant outside marriage and also those that have an abortion. This sanctioning is very much attached to gendered understandings – women being responsible for ensuring that pregnancy occurs only 'within' a heterosexual conjugal relationship and women accepting their reproductive role should pregnancy occur. Women spoke of how they were caught in a double-bind, where the circumstances of a pregnancy could be viewed as shameful and thus stigmatised. Here it is precisely the double-edged nature of shame/stigma ('incorrect' pregnancies and abortion) that contributes to the regulation of women's reproductive behaviour.

In these gendered understandings, fathers were also seen as inherently good in children's lives; women were expected to be faithful and males to be providers. The gendered understandings of male and female roles seen here point to the subtle function of patriarchal power relations where sexed and gendered bodies are produced (Kesby, 1998). These patriarchal power relations provide limited possibilities for men and women, and especially for women who step outside the bounds of accepted gendered roles. This has implications for women who become

pregnant in the ‘wrong’ circumstances (without a male provider, without a father figure for the children, outside wedlock). Using cultural understandings of the role of a man in a woman’s life, the women spoke of how fathers are inherently good to have in children’s lives and they also saw men as being providers. The ‘conjugalised fatherhood’ and the ‘masculine provider’ discourses, drawn on by the women in narrating their stories, were all based on gendered ideals of sexuality, motherhood and masculinity. The ‘masculine provider’ discourse shows the operation of domesticity where women are expected to be economically dependent on male partners while providing gratuitously the necessities of productive and reproductive social life (Tamale, 2003). Marriage (assumed always to be a heterosexual union) was seen as the aspiration of women and also the appropriate place for reproduction. Men were also seen as financial providers for families and if women were pregnant without male partners, then the pregnancy became unsupportable. It is not only the financial support that men are thought to provide but social capital as well. Being in a marriage was seen as the ideal by the women and a pregnancy was seen as needing to occur within marriage. When this did not happen, then women were faced with fatherless children and no financial support, which made the pregnancy unsupportable and problematic. The women in the study spoke of how having children without the child’s father or a husband caused them to be stigmatised, leading to the pregnancy becoming problematic.

Feminine ideals were also seen when the women drew from a ‘faithful female partner’ discourse. Here, the ideals focused on how a woman should act and behave with regards to sexuality. Faithfulness was a hallmark trait that a woman should possess. This proper woman was one who did not sleep with men outside of a committed relationship and sleeps only with the man to whom she is married. The proper woman was also seen (as shown by the ‘masculine provider’ discourse) as being dependent on men and aspiring to marriage.

The women spoke about how abortion and pregnancy could bring shame/stigma not only to them but to their families and tribe as well and how secrecy was important in hiding both the pregnancy and the abortion. This communalisation of stigma adds to the imperative to act in a particular way – to take action to avoid shame accruing to the whole family or tribe. The woman is thus regulated through having to take responsibility for the good name of both the family and tribe. The fear of tainting the good name is what leads to either acting in isolation or only getting support from those who can be trusted.

Shame and stigma are enabled by social scripts deployed by the women in which abortion is viewed as bad and evil with those who abort being equated with 'killers', 'murderers' and 'maidens of Satan'. Cultural and religious understandings of pregnancy, abortion and marriage were seen in the women's talk. By speaking in a socially-sanctioned manner, the women are restricted in what they can feel and think about their abortion decision. The women spoke in the terms made available in 'their society', expressing such thoughts as: "I have done a terrible thing"; "I am ashamed"; "I should be punished"; "I regret what I did". Speaking in a socially-sanctioned manner is related to the hegemonic character of discourse which places boundaries on what can be said. It also allows these women to position themselves as understanding the 'wrongness' of their actions, thereby not completely stepping outside of socially approved ways of being.

A 'health' discourse was also drawn upon by the women and featured in two ways: the first one concerned the widely-held view that abortion is detrimental to women's health, and the second concerned HIV/AIDS and abortion. Here, the talk was on the realisation that unsafe abortion causes detrimental physical and mental effects. The women focused on how they were aware of the physical risks of having an abortion but that their circumstances meant that the risks did not matter. In all this talk, what was surprising was that the physical detriments of abortion were not used to argue for making abortion safer by the women (as shown earlier, this is what has buttressed a lot of the activism around changing abortion laws).

The women also did some labour in justifying the abortion. The justifications included narratives on personal circumstances (poverty, lost opportunities, unreliability of partner and partner's family) and considering other people (protecting children already born). These narratives pointed to the overpowering circumstances which meant terminating pregnancy was the only viable option. The focus of circumstances dovetails well with the notion of an 'unsupportable pregnancy'. The various circumstances mentioned by the women 'made' there terminate the pregnancies and as such it was not an individual choice but something one has to do because of circumstances. By focusing on the external circumstances the women saw themselves as being 'forced' into terminating pregnancies and as such they are blameless. This blameless discourse was overpowered by the cultural, religious and social understandings of what was permitted and as such the women ended up having guilty feelings and regret.

Linked to the narratives that cohered on justifying the abortion were narratives around the act of an abortion. In these narratives undergoing an abortion was seen as invoking fear thereby requiring bravery, courage and resilience. Undergoing an abortion was also seen as leading to regret, guilt and conflict arising from cultural and societal understandings. Despite the importance of secrecy, support to undergo an abortion was also seen to be found from people one trusts. The narratives here showed how despite undergoing an abortion (which is seen as 'wrong'), the decision and going through with the termination was not an easy decision.

Despite speaking in a socially-sanctioned manner, there were infrequent narratives of resistance. One of these forms of resistance can be seen in the next section that focuses on how the women challenged the norm by speaking about their experiences of abortion. Resistance was also evident in how the women justified their decisions, given the circumstances in which they found themselves, with some women stating that it was their decision to make and that they did not regret going through with the abortion. The resistance seen here shows how women have the ability to challenge the gendered, restrictive and discriminatory practices that exist in their contexts. Women also showed that they had agency when faced with an abortion decision. The women actively sought to change the circumstances in which they found themselves by looking for ways to terminate a pregnancy and also hiding the termination to protect themselves from ostracisation.

The positioning of the women by the health service providers pointed to the operation of power in this context. The health service providers' talk about abortion was negative and this was expressed in how they spoke about dealing with women who approached them for post-abortion care. By drawing from a 'moralistic religious' and 'cultural' discourse, the health service providers constructed or positioned the women as immoral, irresponsible, reckless, killers, evil, prostitutes, young 'girls', manipulators, immature, selfish, oblivious and foolish. Some of these positionings were taken up in the women's narratives and, in turn, point to how society has constructed abortion and restricted the scripts that women can follow when narrating their experiences of it. The difference is that, while the health service providers saw these positionings as essential and stable, the women saw these positions as being placed upon them by the wider circumstances and as not a reflection of themselves. Women shared varying stories about how their decision to abort was not a matter of 'choice' but because they had been placed into circumstances where it was the only viable option. The role of the health service

provider becomes to discipline the women, through stigmatisation and telling them that they are wrong as they have done an unacceptable bodily practice.

The health service providers also took up reflexive positions in relation to the abortion and the women who terminate pregnancies. Some of these positions were contradictory. While the health service providers took up positions of being against abortion and being protectors of culture, religion and legal systems, they also took up positions as sympathisers, helpers and advisors. These positions, of being sympathisers, helpers and advisors were taken from a point of pity, where the women who terminated pregnancies were viewed as immature, oblivious and needing advice on how not to end up needing abortions. The health service providers' positions were also enabled by existing societal discourses.

Abortion decision-making is thus an area where wider societal discourses are taken up not only by women who terminate their pregnancies but also by health service providers who interact with women. Societal discourses here regulate what a model woman is and the kind of related behaviours that are acceptable and unacceptable. By aborting, the woman was seen as breaking some form of societal code and as such we see the type of positionings (evil, immoral) that are enabled in the health service providers' talk. The health service providers here operate as societal regulators and 'punish' women who terminate in a number of ways. These include humiliation, discouraging them from abortion and telling them how wrong they are.

8.3 Challenging the norm: Resisting the 'discursive prohibition'

As mentioned in Chapter 5, communities, like the ones in this study, where religious and cultural discourses construct abortion as taboo, place a 'discursive prohibition' on the discussion of abortion (Frohwirth et al., 2014). From newspaper articles positioning women who have abortions as evil and "destroying our culture" (see Chapters 1 and 7) to health service providers turning them away with post-abortion complications, it is clear that abortion is not just forbidden legally but socially as well.

The dearth of studies on abortion in Zimbabwe can also be attributed to this 'discursive prohibition'. During my initial applications for permission to conduct the research, I was met with a brick wall of resistance. The general reaction from the authorities and people to whom I spoke was to ask me why in the world I would want to be talking about such a sinful, culturally-shameful thing, especially being male. One response from a female official stood

out. She told me that I needed to change my research topic as I would find no participants for no-one who had done such shameful things will want to talk to anyone about their abortion. Instead of following this discursive prohibition, the women in the study spoke freely to me. It is this that I take as a sign of resistance: the women were able, at least in part, to reject the discursive context and to speak about their stories (in all but one case) to a man.

The resistance goes beyond just narrating their stories but also discussing in detail how they performed the termination of pregnancy. The quotes in Extract 33 Chapter 6, where Sheila and Rose described the way they terminated their pregnancies in detail, point to a pattern of resistance I term 'going beyond resistance'. To put these two extracts into context, it is important to restate the statement they were given beforehand which is: "Please tell me the story of your decision to have an abortion, all the events and experiences that have been important to you. You can start anywhere you want".

In answering this question with graphic detail of the procedure in Extract 33 (Chapter 6), the women show that they are rejecting the norm of not talking about their abortions. These three particular women spoke to a male researcher and went on to discuss intimate details which, according to the existing societal environment (as was noted in the responses I received from the healthcare stakeholders when asking permission to conduct my research) cannot be shared with anyone. This speaking beyond the decision-making process was witnessed in all of the participants' narratives. Resistance, as mentioned in my theoretical framework in Chapter 3, takes different forms and shapes and can include silences, direct challenging or, as shown in this case, by the telling of stories, doing what is traditionally seen as unacceptable (speaking about abortion and speaking about intimate reproductive issues with a man).

8.4 Why the reproductive rights discourse is problematic for Zimbabwe

Feminist writers and activists have, for a long time, been calling for reproductive rights for all women. This discourse has been at the forefront of the 'fight' of the feminist movement for access to abortion (Macleod, 2012). WHO (2010) states that:

> Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include

> the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

The above definition which was adopted at the International Conference on Population and Development (ICDP) in Cairo in 1994 does not refer to abortion as a right. Knudsen (2006) has stated that:

> When negotiating the Cairo Programme of Action at the 1994 (ICPD), the issue was so contentious that delegates eventually decided to omit any recommendation to legalize abortion, instead advising governments to provide proper post-abortion care and to invest in programs that will decrease the number of unwanted pregnancies (p. 6).

Despite legalizing abortion not being included in the ICPD definition, activists have seen access to safe abortion as being a fundamental right (Knudsen, 2006). Using feminist theory which largely focuses on a woman's right to govern her body, including with regards to abortion, activists argue that a woman should, and is entitled to, decide whether she wants to keep or to terminate her pregnancy without conditions being imposed upon her.

Resistance, especially from African countries, has come in the form of an argument that abortion is 'uncultural' and immoral. As noted, neither the women nor the health service providers drew from a 'rights' discourse in the interviews. I argue that the 'reproductive rights' discourse is absent as the women speak in a socially-sanctioned manner that does not include reproductive rights. Therefore, trying to argue for the access of abortion from a reproductive rights framework becomes problematic in a context where a rights discourse is not appreciated or given any weight. Joining Macleod (2012) and other feminist writers (Fried & Yanow, 2007; Ross, 2006) I argue that a move from the 'rights' discourse to a discourse of 'reproductive justice' fits well with the continuing struggle of women in African countries where abortion is illegal or highly restricted.

In unpacking this call for reproductive justice, I will expand on three points: i) reproductive rights are rebutted by the claim of the right of the foetus in African contexts (Macleod & Hansjee, 2013); ii) a 'reproductive rights' discourse assumes the presence of choice; and 3) reproductive rights are seen as uncultural and thus a project of Western countries forced upon ''Third World'' countries. These three points are expanded upon below.

The women in this study drew from certain discursive resources that point to issues surrounding foetal rights. From moralistic religious understandings to cultural interpretations, abortion was seen as killing a child and as such this evoked feelings of guilt, conflict and regret. Understanding this phenomenon from this perspective, it is understandable why a 'reproductive rights' discourse would not hold any water in such circumstances. The importance of motherhood and the sanctity of life in Shona culture have already been shown. For women in these contexts, to speak from a 'rights' framework would mean letting go of their cultural understandings which, as shown in their narratives, is important to them. In addition, the role of foetal rights is seen in many anti-abortion discourses in Africa (D'Souza, 2014; Njagi, 2013). Here there has been talk around the foetus having rights and deserving to be protected from being 'killed'.

Njagi (2013) has shown that in Kenya, strict abortion legislation has survived through the drawing of the 'sanctity of life' discourse. In a study in Cape Town, South Africa, Macleod and Hansjee (2013) revealed that foetal rights are pitted against women's rights and that in the end, women's rights will be trumped by men's rights. In Macleod's and Hansjee's (2013) study, foetal personhood was closely linked with ownership of children by the fathers rather than allowing the women to choose as it is her body. The men in Macleod's and Hansjee's (2013) study felt that by granting women rights, their own rights were being violated. It can be seen, therefore, that by evoking foetal and men's rights, the 'rights' discourse can be challenged and in this way made obsolete (Macleod & Hansjee, 2013).

As mentioned earlier, reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on their sexual and reproductive health and thus it has been linked with choice. Macleod (2012) has pointed out that choice "foregrounds a particular behaviour around which an individual is supposedly making rational and informed decisions, and suggests that a range of possible behaviours are equally available for use, thereby masking the social contexts and power relations within which a person is situated" (p. 159). This study has shown that by not speaking about reproductive rights, the women were speaking from a socially-sanctioned position where their social contexts are important. Thus, these women do not make free, unfettered 'choices' regarding their own lives and behaviour (Macleod, 2012), as their social context is imbricated in what they feel they are and are not permitted to say and do. Although the women did, to some extent, draw from a 'choice' discourse in their resistance talk, this was minimal.

A common critique of reproductive rights is that they are a Eurocentric construct forced upon ‘‘Third World’’ nations by the US and other powerful nations. In Kenya, anti-abortion discourses “have pointed out that abortion is a Western project that violates African traditions and culture” (Njagi, 2013, p. 189). In Zimbabwe, talk around ‘un-Africanness’ has also focused on issues like homosexuality. The question of what is ‘African’ is extremely relevant in Zimbabwe given the fraught relations between the country and the West. If one embraces the ‘reproductive rights’ discourse, and does not view abortion as immoral and/or problematic, one is viewed as being counter revolutionary or a sell-out. The abortion issue then becomes a political one. By drawing on this un-Africanness of abortion, it becomes very easy for “opponents to discredit efforts to liberalise abortion laws” (Njagi, 2013, p. 59). Long (2005) has shown how ‘culture talk’ increasingly opposes itself to ‘rights talk’ where rights are treated as invaders. African presidents like Mugabe (Zimbabwe) and Museveni (Uganda) have constantly referred to abortion and homosexuality as un-African.

8.4.1 The move to reproductive justice

Having problematised the ‘reproductive rights’ discourse, I now move on to suggesting how a move towards a reproductive justice framework or discourse broadens the lens and helps in challenging the preconceptions, especially within African countries, with regards to abortion. Reproductive justice is a concept that links reproductive rights with social justice (Ross, 2006). It arose in the 1980s after organisations representing American women of colour and native women felt the need to “expand the rhetoric of reproductive rights that focused primarily on choice within the abortion debate and was seen to restrict the dialogue to those groups of women they felt could make such a choice in the first place” (Luna, 2009, p. 350). In addition to advocating, as do traditional reproductive rights platforms, for the access of birth control for women, reproductive justice provides a framework that focuses additional attention on the social, political, and economic inequalities among different communities that contribute to the infringements of reproductive justice. As such, reproductive justice has been defined as:

> the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives (Asian Communities for Reproductive Justice, 2005).

Applying this concept to abortion in Zimbabwe, reproductive justice would mean paying attention to the gendered power relations and economic contexts from which the women in the study narrated their stories. Instead of locating their actions within a choice framework, one can begin to unpack how these social/cultural discourses and power relations combine to make a pregnancy unsupportable, thereby undermining reproductive justice. Macleod (2012, p. 159) supports this by stating that "a reproductive justice approach highlights the contextual nature of women's lives."

The framework further allows us to "emphasize women's agency to make decisions while at the same time recognizing that individual women live their lives as members of communities that have distinct histories of oppression" (Roth, 2012, p. 2). Reproductive justice also helps in addressing the social reality of inequality, specifically, the inequality of opportunities that control one's reproductive destiny (Gaard, 2010). This allows one to move to a realisation that abortion is not separate from other social justice issues in Zimbabwe, such as issues of economic justice, the environment and discrimination based on sex, to name a few. Reproductive justice allows for the empowerment of women as one starts realising that 'reproductive choice' does not occur in a vacuum, but in the context of all other facets of a woman's life. In Zimbabwe one will then focus on the barriers that stem, *inter alia*, from poverty and gendered power relations and how these can be addressed politically and socially.

As shown in the analytical chapters, (Chapters 5, 6 and 7), reproductive justice is undermined by gendered power relations that exist in the Zimbabwean context. Gender power relations which arose in the narratives meant that women who terminate pregnancies were seen as rejecting their 'roles as mothers' in which they are expected to be caring and loving. In comparison, men were seen as inherently important in their children's lives and played the complementary gendered role of masculine providers. For rejecting the mothering role, sanctions were imposed as a way of ensuring that the women did not repeat the 'same mistake' of terminating a pregnancy. The women who had terminated pregnancies regretted their decisions and felt guilty due to the realisation of having gone against the norms, even though, after much thought, they could not see that keeping the baby would be the best option. The gendered power relations were shown in that, while the women spoke of men abandoning their responsibilities, the health service providers absolved men all responsibility and placed the blame squarely on the women. Where men were mentioned in the health service providers'

narratives, it was because the women had been foolish to sleep with married men and foolish to chase after sugar daddies.

In cases of areas like Epworth and Mufakose, economic problems have led to poverty and limited access to healthcare. Focusing on reproductive rights without dealing with the underlying socio-economic issues present in these areas will not be beneficial. An abortion decision made under these circumstances is a matter of life and death given the circumstances in which women find themselves, as noted in the women's narratives. In relation to this, Petchesky (1990) states,

> What is lost in the language of liberal privacy is the concept of social rights…that the society has a responsibility to ameliorate the conditions that make either abortion or childbearing a hard, painful choice for some women; and that the bearers of this right are not so much isolated individuals as they are members of social groups with distinct needs (p. 25).

The issue of social rights is already part of Shona culture. Within *hunhu/ubuntu*, social justice is understood as important. I argue that if the right to abortion was seen in this light, it would not be perceived as a foreign or problematic concept. How to understand social rights and reproductive justice within an African context, specifically in Zimbabwe is taken up in the next section.

8.4.2 Extending reproductive justice: the introduction of *hunhu/Ubuntu*

Researchers have long been interested in *ubuntu* or the Shona equivalent *hunhu*. Here, I use the concept *hunhu/ubuntu* as a way of grounding the notion of reproductive justice in African philosophy. As I do this, I am aware of Praeg's (2014) warning that "Ubuntu is about power…to write about Ubuntu is to engage in a struggle of power" (p. 13). I am not interested in the politics of *hunhu*/*ubuntu* and debates on the politics of the concept can be found elsewhere (see Chabal, 2009; Praeg, 2014). Instead, I pick up on aspects of the concept that speak to an understanding of reproductive justice that is useful for abortion decision-making in a context such as that of Zimbabwe.

Hunhu/ubuntu is an African philosophy or a concept which focuses on a shared humanity. Central to the concept of *hunhu/ubuntu* is the insistence that each individual's existence is interconnected with that of the community and the overall environment in which he/she lives (Nussbaum, 2003). In addition to interconnectedness, Nussbaum (2003, p. 2) has observed that

"*ubuntu* is a capacity in African culture to express compassion, reciprocity, dignity, harmony and humanity in the interests of building and maintaining a community with justice and mutual caring." Taking from the definition above, I will focus on three aspects of *hunhu*/*ubuntu* and how these can assist in changing perceptions on abortion decision-making and reproductive justice. My focus is on: i) interconnectedness and shared humanity; ii) compassion, mutual caring and iii) justice.

The idea of interconnectedness and shared community values is important in *hunhu*/*ubuntu.* Van der Merwe (1996, p. 1) has noted that the concept *ubuntuism* is that "to be human is to affirm one's humanity by recognising the humanity of others in its infinite variety of content and form." In this understanding of *hunhu/ubuntu,* respect is shown for particularity, individuality and diversity of practices, perceptions and perspectives (Louw, 1998). Praeg (2014) extends this idea by stressing the importance of logical interdependence which shows how we cannot deny the humanity of others without denying our own humanity.

The woman who terminates a pregnancy is then seen, through the lens of *ubuntuism*, as not just an individual making a choice to have an abortion but as a member of a community who has an *unsupportable* pregnancy. The use of the term *unsupportable* here fits well here it allows for an analysis of the interaction of micro- and macro-level power relations in which pregnancies occur. Thus, the focus will move from the individual woman and her decision to terminate pregnancy but to understanding how religious, biological, cultural, economic, legal, and medical issues complicate her pregnancy. The questions, for example, that people pose in the community may have changed from, 'Why is the woman terminating pregnancy?' to, 'What, as a community, have we done to make this pregnancy unsupportable?' Such an understanding speaks to reproductive justice, as shown before, in that abortion ceases to become an event that is focused on the woman who has TOP alone, but rather something in which the aspects in her life that contribute to making the pregnancy unsupportable such as her socio-economic status and access to necessary resources are foregrounded. Interconnectedness makes the abortion decision a societal event and not just a personal event, allowing reproductive justice to be enacted. The change of focus then allows people, such as the health service providers in this study, to interrogate their positioning of women who have TOP. The importance of the respect of diversity seen in *hunhu/ubuntu* has great significance for abortion decision-making. This is because it removes the existence of one 'truth' (abortion is wrong and therefore should not be allowed) as seen in the health service providers' positionings, and would allow them to

understand why the women may be thinking about abortion due to circumstances and power relations which make their pregnancies unsupportable.

The role of compassion and mutual caring in *hunhu/ubuntu* comes from the understanding of the concept that 'personhood is developed through other people'. This then means that the point of departure in any analysis of decisions made and actions taken within an African society is that of showing compassion and caring. This, then, means that a woman who has had a TOP is shown compassion and is not judged and stigmatised by those who are supposed to help and support her, as shown in the health service providers' positioning of the women who terminate pregnancies. This change of focus allows for a better understanding of the processes that led the women's pregnancies to be unsupportable and blame is not, as aforementioned, placed squarely on the woman.

Keevy (2008) argues that "*ubuntu* embodies not only values and morals, but also justice" (p. 374). Justice, in this case, is perceived as "*ubuntu* fairness; doing what is right and moral in the indigenous African society" (Letseka, 2014, p. 548). As such *hunhu/ubuntu* is a negation of any form of oppression (Ratele & Botha, 2013). An understanding of justice can be enhanced by Foucault's conceptualisation of power relations. Foucault's ideas on how power relations operate in day-to-day interactions between people and institutions can allow for an analysis of how justice is practised by the different members in a community. Through this analysis of fairness, questions can begin to be asked around how women who choose to have TOPs are being treated.

The importance of fairness for abortion decision-making is that it takes away the focus on the women who terminate pregnancies and rather examines other actors within the same context, including partners, families and the community at large. By focusing on justice, one will be able to look at the conditions that lead to women wanting to terminate pregnancy. Macleod (2012, p. 160) has suggested that "the social and interpersonal conditions under which unwanted pregnancies occur, as well as the experience and outcomes of the unwanted pregnancy, shift to the foreground, with abortion decisions and women's experiences of abortion forming part of this broad landscape of understanding." Therefore, the reproductive justice focus would mean that abortion is not taken as a choice only one woman makes, devoid of all the social, cultural and power dynamics within which she finds herself.

In the areas in Zimbabwe where data were collected for this research and considering situations women face when needing to make an abortion decision in other similar African countries, a reproductive justice framework will allow us to ask different questions. Abortion decision-making will not be a question of whether women 'choose' freely to terminate their pregnancy or choose to bring the pregnancy to full-term. One will, instead, be able to look at issues surrounding structural change and to challenge power inequalities. We will be able to ask questions about how the state is complicit in the exploitation of women's bodies, sexuality and reproduction. As Macleod (2012, p. 160) argues, by looking for ways in which to share the concept of reproductive justice, we will be able to "locate abortion within its sociocultural discursive context." Macleod (2012) also argues that due to the

> overarching socioeconomic inequalities, racism and sexism that shape many women's lives, a reproductive justice approach locates abortion within the social dynamics surrounding the occurrence of an unwanted pregnancy, and focuses on achieving conditions that are necessary for comprehensive reproductive and sexual freedom (p. 161).

I will now close the chapter by reflecting on my research, where I will identify the limitations and outline possibilities for future related research trajectories.

8.5 Reflecting on the research: limitations of this study and possibilities for future research

In closing, I reflect on the limitations of this study and the future possibilities for research on abortion. As shown in Chapter 1, there are few studies on abortion that foreground a gendered or contextual reproductive rights/justice approach in Zimbabwe. This study has shown that abortion studies that take these approaches can be done. The importance of such studies is clear as the statistics continue to show that the levels of unsafe abortion are high. Before I began my data collection, there was apprehension regarding whether or not I could access the hard-to-reach study population. Added to this apprehension was the lack of studies in Zimbabwe that have taken this approach, as well as the fact that the research that has been conducted has mostly been done only at healthcare institutions and does not look at the stories of the women who are undergoing TOPs. The fact that I was able to access the relevant participants for my research and that they willingly shared their stories with me bodes well for further research into this neglected population.

Although I became frustrated in the early stages of my research, due to an ethical clearance process that took more than eight months, seeing the importance of such research has proved worth it. The importance of having patience when conducting research is a lesson that any future researcher in the Zimbabwean context will need. Listening to the women's stories and seeing how, despite the circumstances in which they found themselves, they continued to be strong is an image that will remain with me. Listening to most of my participants share their stories for the first time and seeing how this affected them positively showed me how research goes beyond just collecting data. The use of a narrative interview technique was very important in this aspect as it allowed the women to tell their own stories without being directed by pre-constructed questions by the researcher based on assumptions of what the women may have experienced or be experiencing. This interview structure was important as women who had terminated pregnancies had the space to create the stories in whatever manner they wished without a heavily-structured trajectory-type interview as is the case with structured or semi-structured interviews. The follow-up questions also helped in clarifying and seeking further information after the initial interview.

The findings have shown that socio-cultural and religious understandings play an important role in the lives of women who share stories about terminating their pregnancies. Thus, it is important that any intervention or activism starts from that realisation. For example, it will be disastrous to try and call for a change of laws without addressing some of these underlying discourses such as the 'moralistic religious' discourse and the 'cultural' discourse. Zimbabwean laws regarding abortion need to change so that women can access safe abortion, but the way this has to be done includes paying particular attention to how gendered power relationships, as shown in this study, constrain reproductive justice. The recent constitution-making process, which kept the status quo, points to how abortion is seen as corrosive to culture. This view of abortion was evident in the women's stories and points to a need to address these underlying discourses. As I showed in the previous section, abortion need not be looked at as an individual woman's issue or act, but one needs to look at all the conditions that render a pregnancy unsupportable and thus necessitate abortion. From the women's stories, it is clear that abortions will continue to take place whether they are legal or not. What is of importance for future research, therefore, is to focus on all the aspects of the life of a woman who has undergone a TOP.

Focusing on all aspects of the life of a woman who has had a TOP will mean that abortion is not viewed as just an individual woman's 'problem'. Research can then start interrogating the economic, physical, mental, spiritual, and political lives of women with unsupportable pregnancies and see how these aspects contribute to the circumstances that make a pregnancy unsupportable. For example, the role of poverty in the narratives in this study shows how abortion is not just a health issue but an economic and developmental one as well. Unsafe abortion, surprisingly enough, has not been considered a development issue in most of the advocacy and research related to Zimbabwe. The study has shown how, by engaging in unsafe abortion practices, women are putting their lives at risk but given their unsupportable pregnancies this is the only option they have.

Engaging with the analysis has revealed the extent to which socio-cultural and religious discourses permeate the lives of women in this context. The positions taken up by the health service providers point to an existence of a 'culture' of not questioning their own positions nor their own views. The health service providers in this study regarded their statements as being the 'truth' and understood themselves as implementing cultural and religious beliefs or practices. These positions need to be questioned and challenged in future studies as the provision of post-abortion care is important in stemming the high levels of maternal mortality. If women fear going for post-abortion care due to concerns around what health service providers might say or do, then the rates of maternal mortality will continue to increase.

In closing, in terms of the limitations of my study, there was perhaps not enough diversity amongst the participants. More studies are needed, especially those that use economic backgrounds as a differential. Most of the women in this study came from low socio-economic backgrounds and it would be important to see the different experiences that more well-to-do women, with access to more and better resources, have with regard to abortion decision-making. Another limitation has to do with the possibility of the women's narratives being influenced by my being an African man. Due to this women might have performed particular narratives as not to appear to contradict common views about abortion. A final word with regard to diversity and the study's limitations is that the study only focused on the narratives of urban Shona women. More studies also need to be conducted with rural women where resources are much more stretched as well as with women from different ethnic backgrounds, in order to gain a broader sense of their experiences of the abortion decision-making process and the women's relationships with, and responses from, health service providers.

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APPENDICES

APPENDIX A: CONSENT FORM FOR PARTICIPANTS

RHODES UNIVERSITY

DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND PARTICIPANT

I _____agree to participate in the research project of Malvern T. Chiweshe that focuses on abortion decision-making.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Doctoral degree at Rhodes University.

2. The researcher is part of a bigger project at the University and the results of the study may be seen by members of this bigger team. However the results will be presented in such a way that I will not be identified as the individual participant.

3. The researcher is interested in participants' narratives and experiences on abortion decision-making.

4. My participation will involve narrative interviews to be conducted by the researcher and/or Mrs. Tarisai Bere, a psychologist. There will be two interviews on the same day – both approximately one hour. Also I am free to request a male or female interviewer, and to not have the male researcher present at all, if that suits me best. My refusal or agreement to participate will not in any way affect the treatment I will receive in the ward/pregnancy centre/family health project.

5. I am invited to voice to the researcher any concerns I have about my participation in the study and to have these addressed to my satisfaction. I can contact the researcher if I feel any distress related to my participation on 0772636168, m.chiweshe@ru.ac.za or malrumy@gmail.com.

6. I am free to withdraw from the study at any time – however I commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation which I did not originally anticipate.

7. If I require individual feedback I will inform the researcher, Malvern Tatenda Chiweshe. I am also free to access the complete thesis that will come out of this project at the library at Rhodes University http://eprints.ru.ac.za/

8. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader

Signed on…….....

Participant…… Researcher……

Witness……

APPENDIX B: CONSENT FORM FOR SERVICE PROVIDERS/COUNSELORS
RHODES UNIVERSITY

DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND PARTICIPANT

I _____agree to participate in the research project of Malvern T. Chiweshe that focuses on abortion decision-making.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Doctoral degree at Rhodes University.
2. The researcher is part of a bigger project at the University and the results of the study may be seen by members of this bigger team. However the results will be presented in such a way that I will not be identified as the individual participant.
3. The researcher is interested in narratives and experiences on abortion decision-making.
4. My participation will involve narrative interviews to be conducted by the researcher. There will be two interviews on the same day – both approximately one hour. The research is not a part of any evaluation process on my work performance.
5. I am invited to voice to the researcher any concerns I have about my participation in the study and to have these addressed to my satisfaction. I can contact the researcher if I feel any distress related to my participation on 0772636168, m.chiweshe@ru.ac.za or malrumy@gmail.com.
6. I am free to withdraw from the study at any time – however I commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation which I did not originally anticipate.
7. If I require individual feedback I will inform the researcher, Malvern Tatenda Chiweshe. I am also free to access the complete thesis that will come out of this project at the library at Rhodes University http://eprints.ru.ac.za/
8. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.

Signed on…….....

Participant…… Researcher……

Witness……

APPENDIX C- LETTER FOR THE MEDICAL RESEARCH COUNCIL OF ZIMBABWE

The Director

MRCZ

Cnr Josiah Tongogara / Mazowe Street

Harare

Zimbabwe

06 June 2013

Dear Sir/Madam

Re: Request to conduct a research project

I am currently a Doctoral Student at Rhodes University in South Africa under the supervision of Professor Catriona Macleod. This letter requests permission to conduct a research study at three sites in Harare that include Harare Hospital, Heartfelt Pregnancy Crisis Centre and Epworth. Permission to conduct the research will be applied for from the three sites. The overall aim of this research project is to investigate, in a Zimbabwean context, the narratives of women who have undergone an abortion about how they came to make the decision to terminate the pregnancy; the discourses employed in constructing these narratives and how women position themselves in these narratives and discourses. These will be compared to the narratives of health service providers on the same topic. These narratives will then be linked to the social discourses, social structures and power relations that work to enable or constrain reproductive (in)justice.

The research project will involve collecting data by audio recording interviews with patients and staff in Ward B at Harare Hospital, users and staff of the Heartfelt Pregnancy Crisis Centre and participants of the University of Zimbabwe Family Health project and nurses who are part of this project. Before the study is implemented, informed consent will be gained from the all participants. Participants from the hospital will be approached in the ward by the researcher after consent has been obtained from the hospital. The participants at the Heartfelt Crisis Centre will be approached through the counselors at the end of their first counseling process The counselors will give them a document prepared by the researcher that provides an introduction of the project (please see the attached document). The document will not represent

an agreement to participate but will ask the users of the service to ask for more information in a meeting with the researcher if they are possibly interested in participating. The same will be done in Epworth where the community health workers will carry the document during their recruitment for the Family Health and pregnancy project and give it to clients who meet the criteria for the research. The community health workers and counselors will be thoroughly briefed at the beginning of the process by the researcher to discuss ways of approaching potential participants so that they do not feel coerced into participating.

Information shall be obtained through an initial meeting with potential participants who will sign an informed consent form on agreement. Please find attached the informed consent form that will be used. The ethical principles of voluntary participation, assurance of confidentiality and anonymity, and the right to withdrawal, will be addressed. The staff will be told that the research is not a part of any evaluation process on their work performance. The participants at the three sites will be explicitly made aware that refusal or agreement to participate will not in any way affect the treatment they receive. The users will be given a choice of either being interviewed by the researcher who is male or a female co-researcher.

It is envisaged that the research may be of some immediate benefit to the participants in the sense of communicating caring and compassion by listening to their stories which are usually viewed with social stigma. The benefits for the staff might include a better understanding of the stories of their clients through a process of reflection. The risks that are envisaged include emotional distress and discomfort. The researcher and the co-researcher are trained psychologists and are able to contain the participants in the interviews and refer them appropriately to the nearby Harare Crisis Centre.

Once the stages of data collection and analysis have taken place, the principal researcher will conduct feedback meetings with all of the stakeholders and participants (hospital administration, pregnancy centre management, counselors, nursing staff and participants). The feedback meetings will be held in such a manner that the confidentiality of the participants is protected. A full ethical protocol served before the Rhodes University Psychology Department Research Projects and Ethics Review Committee Ethics Committee and ethical clearance was obtained. Please do not hesitate to contact me, should you have any further questions regarding this project. The contact details of the principal researcher are Malvern Tatenda Chiweshe, cell: 00263772736168; email- m.chiweshe@ru.ac.za and my supervisor, Prof Catriona Macleod: tel:

046 603 7377; cell: 002782 802 9187 and email: cmacleod@ru.ac.za.

Please feel free to contact me with any questions you may have regarding the research. Your positive response in this regard will be highly appreciated.

Kind Regards
Chiweshe Malvern Tatenda (Doctoral student)
……

APPENDIX D- LETTER FOR HARARE HOSPITAL

Dr Pasi

The Ethics Committee chairperson

Harare Hospital

Mazowe Street

Harare

Zimbabwe

06 June 2013

Dear Sir

Re: Request to conduct a research project

I am currently a Doctoral Student at Rhodes University in South Africa under the supervision of Professor Catriona Macleod. This letter requests permission to conduct a research study at your hospital involving the patients in Ward B and some of the staff in this ward. The overall aim of this research project is to investigate, in a Zimbabwean context, the narratives of women who have undergone an abortion about how they came to make the decision to terminate the pregnancy; the discourses employed in constructing these narratives and how women position themselves in these narratives and discourses. These will be compared to the narratives of health service providers on the same topic. These narratives will then be linked to the social discourses, social structures and power relations that work to enable or constrain reproductive (in)justice.

The research project will involve collecting data by audio recording interviews with patients in Ward B and staff working there. Before the study is implemented, informed consent will be gained from the patients and staff. Information shall be provided through an initial meeting with potential participants who will sign an informed consent form on agreement. Please find attached the informed consent form that will be used. The ethical principles of voluntary participation, assurance of confidentiality and anonymity, and the right to withdrawal, will be addressed. The staff will be told that the research is not a part of any evaluation process on their work performance. The patients in the ward will be explicitly made aware that refusal or agreement to participate will not in any way affect the way they are treated in the ward. The users will be given a choice of either being interviewed by the researcher who is male or a

female co-researcher.

It is envisaged that the research may be of some immediate benefit to the patients in the sense of communicating caring and compassion by listening to their stories which are usually viewed with social stigma. The benefits for the staff might include a better understanding of the stories of their clients through a process of reflection. The risks that are envisaged include emotional distress and discomfort. The researcher and the co-researcher are trained psychologists and are able to contain the participants in the interviews and refer them appropriately to the nearby Harare Crisis Centre.

Once the stages of data collection and analysis have taken place, the principal researcher will conduct feedback meetings with all of the stakeholders and participants (hospital administration, nursing staff and participants). The feedback meetings will be held in such a manner that the confidentiality of the participants is protected. A full ethical protocol served before the Rhodes University Psychology Department Research Projects and Ethics Review Committee Ethics Committee and ethical clearance was obtained. Please do not hesitate to contact me, should you have any further questions regarding this project. The contact details of the principal researcher are Malvern Tatenda Chiweshe, cell: 00263772736168; email- m.chiweshe@ru.ac.za and my supervisor, Prof Catriona Macleod: tel: 046 603 7377; cell: 002782 802 9187 and email: cmacleod@ru.ac.za.

Please feel free to contact me with any questions you may have regarding the research.
Your positive response in this regard will be highly appreciated.

Kind Regards
Chiweshe Malvern Tatenda (Doctoral student)
……

APPENDIX E- LETTER FOR HEARTFELT PREGNANCY CRISIS CENTRE

Mrs. Christine Mhlanga
The Director
Heartfelt Pregnancy Crisis Centre
P.O Box 86
Harare
Zimbabwe

06 June 2013
Dear Madam

Re: Request to conduct a research project

I am currently a Doctoral Student at Rhodes University in South Africa under the supervision of Professor Catriona Macleod. This letter requests permission to conduct a research study at your Centre**.** The overall aim of this research project is to investigate in a Zimbabwean context, the narratives of women who have undergone an abortion about how they came to make the decision to terminate the pregnancy; the discourses employed in constructing these narratives and how women position themselves in these narratives and discourses. These will be compared to the narratives of health service providers on the same topic. These narratives will then be linked to the social discourses, social structures and power relations that work to enable or constrain reproductive (in)justice.

The research project will involve collecting data by audio recording interviews with users of your services and some of your counselors. Only those users who give permission to their counselors will be approached to participate. Before the study is implemented, informed consent will be gained from the users and counselors. Information shall be provided through an initial meeting with potential participants who will sign an informed consent form on agreement. Please find the attached informed consent form that will be used. The ethical principles of voluntary participation, assurance of confidentiality and anonymity, and the right to withdrawal, will be addressed. The counselors will be told that the research is not a part of any evaluation process on their work performance. The users of your service will be explicitly made aware that refusal or agreement to participate will not in any way affect the way they are treated in the ward. The users will be given a choice of either being interviewed by the

researcher who is male or a female co-researcher.

It is envisaged that the research may be of some immediate benefit to the users in the sense of communicating caring and compassion by listening to their stories which are usually viewed with social stigma. The benefits for the counselors might include a better understanding of the stories of their clients brought about by the counselors putting themselves in the shoes of their clients during the interview. The risks that are envisaged include emotional distress and discomfort. The researcher and the co-researcher are trained psychologists and are able to contain the participants in the interviews and refer them appropriately to the Harare Crisis Centre. It is envisaged that the research may be of some immediate benefit to the users and counselors in the sense of communicating caring and compassion by listening to their stories which are usually viewed with social stigma.

Once the stages of data collection and analysis have taken place, the principal researcher will conduct feedback meetings with all of the stakeholders and participants (Centre management, counselors and participants). The feedback meetings will be held in such a manner that the confidentiality of the participants is protected. A full ethical protocol will be served before the Rhodes University Ethics Committee and ethical clearance will be obtained. Please do not hesitate to contact me, should you have any further questions regarding this project. The contact details of the principal researcher are Malvern Tatenda Chiweshe cell: 00263772736168; email- m.chiweshe@ru.ac.za and my supervisor, Prof Catriona Macleod: tel: 046 603 7377; cell: 002782 802 9187 and email: cmacleod@ru.ac.za.

Please feel free to contact me with any questions you may have regarding the research.
Your positive response in this regard will be highly appreciated.

Kind Regards
Chiweshe Malvern Tatenda (Doctoral student)
……..

APPENDIX F: LETTER FOR THE UNIVERSITY OF ZIMBABWE

Dr. Chidzonga

The Dean of College of Health Sciences

School of Medicine

University of Zimbabwe

Box A 178

Avondale

Harare

Zimbabwe

06 June 2013

Dear Sir

Re: Request to conduct a research project

I am currently a Doctoral Student at Rhodes University in South Africa under the supervision of Professor Catriona Macleod. This letter requests permission to conduct a research study as part of the Department of Psychiatry Epworth Family Health Project. The overall aim of this research project is to investigate in a Zimbabwean context, the narratives of women who have undergone an abortion about how they came to make the decision to terminate the pregnancy; the discourses employed in constructing these narratives and how women position themselves in these narratives and discourses. These will be compared to the narratives of health service providers on the same topic. These narratives will then be linked to the social discourses, social structures and power relations that work to enable or constrain reproductive (in)justice.

The research project will involve collecting data by audio recording interviews with women and service providers in Epworth. Only those women who give permission to the service providers will be approached to participate. Before the study is implemented, informed consent will be gained from the women and service providers. Information shall be provided through an initial meeting with potential participants who will sign an informed consent form on agreement. Please find the attached informed consent form that will be used. The ethical principles of voluntary participation, assurance of confidentiality and anonymity, and the right to withdrawal, will be addressed. The service providers will be told that the research is not a part of any evaluation process on their work performance. The women will be explicitly made aware that refusal to participate will not in any way affect their participation in the family

health project. The women will be given a choice of either being interviewed by the researcher who is male or a female co-researcher.

It is envisaged that the research may be of some immediate benefit to the users and counselors in the sense of communicating caring and compassion by listening to their stories which are usually viewed with social stigma. The benefits for the service providers in Epworth might include a better understanding of the narratives of their clients brought about through putting themselves in the shoes of their clients during the interview. The risks that are envisaged include emotional distress and discomfort. The researcher and the co-researcher are trained psychologists and are able to contain the participants in the interviews and refer them appropriately to the Harare Crisis Centre.

Once the stages of data collection and analysis have taken place, the principal researcher will conduct feedback meetings with all of the stakeholders and participants (Department of Psychiatry, service providers and participants). The feedback meetings will be held in such a manner that the confidentiality of the participants is protected. A full ethical protocol will be served before the Rhodes University Ethics Committee and ethical clearance will be obtained. Please do not hesitate to contact me, should you have any further questions regarding this project. The contact details of the principal researcher are Malvern Tatenda Chiweshe cell: 00263772736168; email- m.chiweshe@ru.ac.za and my supervisor, Prof Catriona Macleod: tel: 046 603 7377; cell: 002782 802 9187 and email: cmacleod@ru.ac.za.

Please feel free to contact me with any questions you may have regarding the research.
Your positive response in this regard will be highly appreciated.

Kind Regards
Chiweshe Malvern Tatenda (Doctoral student)

……..

APPENDIX G: REQUEST FOR PARTICIPATION
ATTENTION: REQUEST FOR PARTICIPATION

My name is Malvern Tatenda Chiweshe and I am currently doing my PhD degree in Psychology at Rhodes University, South Africa. I am looking for women volunteers to participate in my research project, which is about abortion decision-making. Participants must have had an abortion in the past year and be 18 years old and above. Volunteers will be asked to take part in two interviews both approximately two hours on the same day. You will be given a choice of either being interviewed by the researcher who is male or a female co-researcher. Deciding to take part or not take part in this research will not prejudice your participation in the Family Health project/the service your receive from Heartfelt pregnancy crisis centre. Please indicate to the counsellor/community health worker if you would like to meet with the researcher for further information on the research project. Please note that by indicating you wish to meet with the researcher you are not agreeing to participate but merely to hear more. You may decide to participate or not once you have full information concerning the project and what your participation would entail.

Thank you

Malvern Tatenda Chiweshe

APPENDIX H: LETTER OF APPROVAL FROM RHODES ETHICS COMMITTEE

RHODES UNIVERSITY
Grahamstown • 6140 • South Africa

DEPARTMENT OF PSYCHOLOGY
Tel: +27 (0)46 603 8500 • Fax: +27 (0)46 622 4032 • Website: http://www.rhodes.ac.za/academic/department/psychology

RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

11 June 2013

Malvern Chiweshe
Department of Psychology
RHODES UNIVERSITY
6140

Dear Malvern

ETHICAL CLEARANCE OF PROJECT PSY2013/23

This letter confirms your research proposal with tracking number PSY2013/23 and title, 'A narrative-discursive analysis of abortion decision making in Zimbabwe', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 11 June 2013. The project has been given ethics clearance.

Please ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

CHAIRPERSON OF THE RPERC

APPENDIX I: LETTER OF APPROVAL FROM MRCZ

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/A/1820 **29 May 2014**

Malvern Tatenda Chiweshe
Rhodes University, Department of Psychology
P.O Box 94
Grahamstown
South Africa

RE: A narrative-discursive analysis of abortion decision making in Zimbabwe

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

a) Study proposal
b) Informed Consent Form (English and Shona) version 1.2 dated 6 May, 2014

- **APPROVAL NUMBER : MRCZ/A/1820**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING : Full Council**
- **EFFECTIVE APPROVAL DATE : 29 May 2014**
- **EXPIRATION DATE : 28 may 2015**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

.....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2014 -05- 29
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

APPENDIX J: LETTER OF APPROVAL FROM HARARE HOSPITAL

Telephone: 621100-19
Fax: 621157

ZIMBABWE

HARARE CENTRAL HOSPITAL
P. O. Box ST 14
SOUTHERTON
Harare
Zimbabwe

28 January 2013

Mr Malvern Tatenda Chiweshe
16366 17th Close
Sunningdae 2
Harare

Dear Mr Chiweshe

RE: PERMISSION TO CONDUCT A STUDY AT HARARE CENTRAL HOSPITAL: "A NARRATIVE – DISCURSIVE ANALYSIS OF ABORTION DECISION MAKING IN ZIMBABWE"

I am glad to advise you that your application to conduct a study entitled "***a narrative – discursive analysis of abortion decision making in Zimbabwe***" at Harare hospital has been approved by the Harare Hospital Ethics Committee.

This approval is premised on the submitted protocol. Should you decide to vary your protocol in any material way please submit these for further approval.

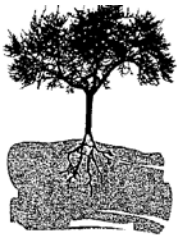
You are advised to avail the results of your study whether positive or negative to the hospital through the committee for our information

Yours sincerely

HARARE CENTRAL HOSPITAL
DEPARTMENT OF MEDICINE

Dr C Pasi
Chairman – Harare Hospital Ethics Committee.

APPENDIX K: LETTER OF APPROVAL FROM PREGNANCY CRISIS CENTRE



21 January 2014

To whom it may concern

RE: PERMISSION FOR DATA COLLECTION FOR MR MT CHIWESHE

This letter serves to inform you that Mr Chiweshe has been granted permission to use the Heartfelt Pregnancy Crisis Centre as a data collection site for his Phd research with Rhodes University. His research on abortion decision-making is in line with some of the work that we do. Mr Chiweshe is familiar with the organisation as he once was part of the management board.

Yours Sincerely

Simbiso Chitiki

Acting Chairperson

Schitiki

16 Bishop Gaul Ave, Belvedere, Harare Tel 0772 897 040, 0772 408 188
Email heartfeltpcc@yahoo.com

APPENDIX L: LETTER OF APPROVAL FROM UNIVERSITY OF ZIMBABWE

DEPARTMENT OF PSYCHIATRY

P.O. Box A 178
Avondale
Harare, Zimbabwe

Telephone: 791631
Telex: 26580 UNIVZ ZW
Telegrams: UNIVERSITY
Fax: (263) (4) 724912/333407

MEDICAL SCHOOL

UNIVERSITY OF ZIMBABWE

20 January 2014

TO WHOM IT MAY CONCERN

RE: Application for Research for PhD in Family Health Project – Epworth

This is to inform you the Department of Psychiatry has looked at Malvern Tatenda Chiweshe's PhD proposal submitted to Rhodes University.

The department has given Malvern Tatenda permission to conduct his research in the Department of Psychiatry's Behavioural Sciences Family Health Project in Epworth subject to obtaining ethical approval.

Yours faithfully

DR WALTER MANGEZI
DEPARTMENT OF PSYCHIATRY

APPENDIX M: SEMI-STRUCTURED INTERVIEWS FOR HEALTH SERVCE PROVIDERS

1) Why do women terminate pregnancy?

2) Of all your experience about abortions have you had one story that touched you?

3) How is the law handled in the community?

4) What does culture say about termination of pregnancy?

5) What does culture say about the children?

6) What does religion say about termination of pregnancy?

7) Is there stigma in the community against people who terminate?

8) Why are people who terminate pregnancy isolated?

9) Do you think terminating is justified?

10) What are your personal beliefs?

11) Do your beliefs impede on your work?

12) How prevalent is termination here?

13) Who is to blame for termination of pregnancy?

14) What do you think about doctors and nurses offering top services unlawfully?

APPENDIX N: IAN PARKER'S (1992) TRANSCRIPTION CONVENTIONS (ADAPTED)

Symbol	**Meaning**
Round brackets ( )	Indicates doubts arising about the accuracy of material
Ellipses …	To show when material is omitted from the transcript
Square brackets []	To clarify something to help the reader
Forward slashes / /	Indicates noises, words of assents and others
Equals sign =	Indicates the absence of a gap between one speaker and another at the end of one utterance and the beginning of the next utterance
Round brackets with number inserted, e.g. (2)	Indicates pauses in speech with the number of seconds in round brackets
Round brackets with full stop (.)	Indicates pauses in speech that last less than a second
Colon ::	Indicates an extended sound in the speech
Underlining _____	Indicates emphasis in speech

APPENDIX O: LEGALITY OF ABORTION TABLE

Country	1. Permitted to Save Life of Woman	2. Physical Health Grounds	3. Rape, Incest & Foetal Impairment	4. Mental Health Grounds	5. Socio-Economic Grounds	6. Without Restriction (On Demand)	Other Indications
LIBERAL LEGISLATION							
China	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	
France	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	An abortion must be performed before the end of the tenth week of pregnancy by a physician in an approved hospital. Beyond the tenth week of pregnancy, it may be performed only if the pregnancy poses a grave danger to the woman's health or if there is a strong probability that the expected child will suffer from a particularly severe illness recognised as incurable. In this case, two physicians must attest to the risk to the health of the woman or foetus.
South Africa	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	Any woman of any age can request an abortion if she is less than 13 weeks pregnant. If she is between 13 and 20 weeks pregnant, she can get the abortion under specified conditions including on socio-economic grounds. Abortions may be performed after 20 weeks gestation if the woman's or the foetus's life is in danger or there are likely to be serious birth defects. Minors do not require the permission of their parents/guardians.
Sweden	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	Abortion is legal in Sweden on a wide variety of grounds, including on request, up to 18 weeks of gestation, provided that the procedure will not seriously endanger the woman's life or health. For pregnancies between 12 and 18 weeks of gestation, the pregnant women is required to discuss the abortion with a social worker; after 18 weeks, permission must be obtained from the National Board of Health and Welfare. The abortion

Country	1. Permitted to Save Life of Woman	2. Physical Health Grounds	3. Rape, Incest & Foetal Impairment	4. Mental Health Grounds	5. Socio-Economic Grounds	6. Without Restriction (On Demand)	Other Indications
							must be performed by a licensed medical practitioner and, except in cases of emergency, in a general hospital or other approved health-care establishment. Abortion is subsidised by the government.
USA	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	Abortion is available in all states on request prior to foetal viability. After foetal viability, a state may prohibit abortion only if it provides exceptions for endangerment to the woman's life or health. Although federal law grants a woman the constitutional right to terminate her pregnancy before foetal viability, individual states are permitted to impose restrictions on abortion throughout pregnancy if they do not unduly burden a woman's right to choose.
Vietnam	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	A legal abortion must be performed by a physician.
RESTRICTIVE LEGISLATION							
Botswana	**YES**	**YES**	**YES**	**YES**	**NO**	**NO**	An abortion must be carried out by a registered medical practitioner in a government hospital or registered private hospital or clinic approved for that purpose. An abortion performed in the case of rape or incest or foetal impairment must be approved in writing by two practitioners.
Brazil	**YES**	**NO**	**YES**	**NO**	**NO**	**NO**	An abortion must be performed by a physician. If an abortion is

Country	1. Permitted to Save Life of Woman	2. Physical Health Grounds	3. Rape, Incest & Foetal Impairment	4. Mental Health Grounds	5. Socio-Economic Grounds	6. Without Restriction (On Demand)	Other Indications
							performed in the case of a pregnancy resulting from rape, the consent of the pregnant woman must be obtained or, if she is incompetent, the consent of her legal representative.
Burkina Faso	**YES**	**YES**	**YES**	**YES**	**NO**	**NO**	Two physicians to attest to danger to woman's life or that the unborn child will be afflicted with a condition of exceptional and incurable seriousness. Rape or incest to be established by the State Prosecutor. Abortion must be performed during the first 10 weeks of pregnancy.
Cameroon	**YES**	**YES**	**YES/ YES/NO**	**YES**	**NO**	**NO**	In the case of rape, the prosecution or the Public Prosecutor's office must certify a "good case".
Ethiopia	**YES**	**YES**	**YES**	**YES**	**NO**	**NO**	An abortion also permitted for minors who are physically or psychologically unprepared to raise a child and in the case of grave and imminent danger that can be averted only through immediate pregnancy termination.
Fiji	**YES**	**YES**	**NO**	**YES**	**YES**	**NO**	An abortion must be authorised by a physician and performed by a licensed physician in a hospital.
Ghana	**YES**	**YES**	**YES**	**YES**	**NO**	**NO**	An abortion must be performed by a registered physician with the consent of the pregnant woman. The consent of next of kin or a guardian is required if the woman is not capable of giving consent. The abortion

Country	1. Permitted to Save Life of Woman	2. Physical Health Grounds	3. Rape, Incest & Foetal Impairment	4. Mental Health Grounds	5. Socio-Economic Grounds	6. Without Restriction (On Demand)	Other Indications
							must be performed in a government hospital or a private hospital or clinic registered under the Private Hospitals or Maternity Homes Act of 1958 (No. 9) or in a place approved for the purpose of abortion.
India	**YES**	**YES**	**YES**	**YES**	**YES**	**NO**	Contraceptive failure on the part of the wife or husband constitutes valid grounds for legal abortion. Unless a medical emergency exists, a legal abortion must be performed during the first 20 weeks of gestation by a registered physician in a hospital established or maintained by the government or in a facility approved by specific legislation. A second opinion is required in cases where the duration of the pregnancy is between 12 and 20 weeks, except in urgent cases. In general, the consent of the pregnant woman is required before the performance of an abortion, while written consent of her guardian must be obtained for a minor (defined as under age 18)
Kenya	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	An abortion must be performed by a certified physician, with the consent of the woman and her spouse. Two medical opinions, one of which must be from the physician who has treated the woman and the other from a psychiatrist, are required before the abortion is performed. The abortion must also be performed in a hospital.
Mexico	**YES**	**NO**	**YES/NO**	**NO**	**NO**	**NO**	Under most state provisions on abortion, legal abortions must generally be performed during the first 12 weeks (or 90 days) of gestation. Except in emergency cases, all induced abortions must be performed by a physician whose opinion on the necessity of the abortion is corroborated

Country	1. Permitted to Save Life of Woman	2. Physical Health Grounds	3. Rape, Incest & Foetal Impairment	4. Mental Health Grounds	5. Socio-Economic Grounds	6. Without Restriction (On Demand)	Other Indications
							by another physician. Consent of the woman, or in certain instances (minors, etc.), that of her husband, parents or guardians, is required before the abortion is performed
Mozambique	**YES**	**YES**	**YES**	**YES**	**NO**	**NO**	New law that came into effect in June 2015. The new law specifies that abortions will have to be carried out in recognised and designated health centres by qualified practitioners. Termination must be carried out within the first 12 weeks but in case of rape, the period is extended to 16 weeks
Nigeria	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	Two physicians are required to certify that the pregnancy poses a serious threat to the life of the woman.
Pakistan	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	Under the 1990 revision, the conditions for legal abortion depend on the developmental stage of the foetus—that is, whether the foetus's organs are formed or not.
Papua New Guinea	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	A legal abortion is permitted within 12 weeks of gestation. It should be performed by a registered physician in a government healthcare institution.
Peru	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	An abortion must be performed by a physician with the consent of the pregnant woman and after consultation with two physicians.
Rwanda	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	An abortion must be performed by a physician in a public hospital or other authorised health-care facility. Two physicians must confirm in

Country	1. Permitted to Save Life of Woman	2. Physical Health Grounds	3. Rape, Incest & Foetal Impairment	4. Mental Health Grounds	5. Socio-Economic Grounds	6. Without Restriction (On Demand)	Other Indications
							writing that continuation of the pregnancy would seriously endanger the woman's health.
Tanzania	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	Two physicians must certify that the abortion is necessary in order to preserve the life of the pregnant woman.
Thailand	**YES**	**YES**	**YES/NO**	**YES**	**NO**	**NO**	A legal abortion must be performed by a physician.
Uganda	**YES**	**YES**	**NO**	**YES**	**NO**	**NO**	A legal abortion must be performed by a registered physician. Although the law does not require the approval of a committee, the consent of two physicians is usually sought before a legal abortion can be performed.
Zambia	**YES**	**YES**	**YES/NO/ YES**	**YES**	**YES**	**NO**	An abortion requires the consent of three physicians, one of whom must be a specialist in the branch of medicine related to the woman's reason for seeking an abortion. However, the requirement may be waived if the abortion is immediately necessary to save the life of, or prevent grave permanent injury to, the physical or mental health of the woman. A legal abortion must be performed by a registered physician in a government hospital or other approved institutions unless the patient's life is in danger.
VERY RESTRICTIVE LEGISLATION							
Bangladesh	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**	A therapeutic abortion requires the approval of two physicians and must be performed by a qualified physician in a hospital. No approval is required in the case of menstrual regulation, as the procedure is considered a family planning method rather than an abortive technique. Menstrual regulation may be performed, within eight weeks of the last

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							menstrual period, by paramedical personnel on an out-patient basis.
Gabon	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**	The physician performing the abortion must obtain the advice of two consulting physicians, one of whom must be chosen from a list of experts provided by the court. The physician must attest to the fact that the life of the woman cannot be saved by any means other than the intervention contemplated.
Malawi	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**	Authorisation must be obtained following consultation with a professional. Permission of the spouse is, in theory, required.
Nepal	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**	The Penal Code of Nepal, as amended up to 1976 (Part 4, Sections 10 and 28-33) prohibits the performance of abortions except when carried out during an act of "benevolent" nature. However, the Code does not define what constitutes an act of benevolent nature, and very few, if any, pregnancies have been terminated on this ground.

Information from www.un.org/esa/population/publications/abortion/doc was used in constructing this table.