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THE INFORMAL TRADING OF CONTRACEPTIVE PILLS IN KADOMA, ZIMBABWE

by

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in the

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of the

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Supervised by

Prof. Thea de Wet

February 2019

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ABSTRACT

The intended purpose of family planning is to allow men and women the right to decide how many children they want to have, when they want to have those children, how to have them and if they want to have them.

This paper draws from an ethnographic study that investigates the informal buying and selling of contraceptive pills in Kadoma, Zimbabwe with the main focus of trying to find out why some women would opt for informal means of access. Through the journey of coming to an understanding of this behaviour, a vital theme emerged from the interactions and it is that of autonomy, as some women utilised alternative pathways to access contraceptive pills to ensure they fulfilled their desired outcomes.

The investigation of this informal trade was qualitative in nature, with a particular use of participant observation, in-depth semi-structured interviews and field notes. 13 key informants consisting of 12 women who used an array of family planning methods and a population centre ambassador, helped fuel the information that contextualised this dissertation.

The experiences the women had with contraceptive devices in relation to their bodies portrayed the individual, social, cultural and political nuances that exist in Kadoma. Also, the existence of pharmaceutical products in the informal space is an indication of the social nature of contraceptive pills in Kadoma.

Keywords: pharmaceutical anthropology; contraceptive pills; informal; autonomy; body

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CHAPTER ONE:
INTRODUCTION

1.1 INTRODUCTION

On 1 December 2015, I embarked on a journey to Kadoma, Zimbabwe, from Johannesburg Park Station to research the buying and selling of contraceptive pills in Kadoma. My first stop in Zimbabwe was Bulawayo, where I spent a couple of nights in my childhood home, which is currently occupied by my maternal grandmother. Before the laziness of holiday kicked in, I had to keep moving. On a Saturday morning, my maternal aunt and I boarded a chicken bus in the city centre on 1st Avenue that was heading for Kadoma.

The term "chicken bus" is usually used to characterise local buses that are not up to the standards of the luxury coaches. The name stems from the fact that these buses used to transport animals, but over time that stopped and the meaning of "chicken bus" transitioned to anything anyone desired to transport. Chicken buses also compensate for the restrictions that exist in luxury coaches. For instance, there is no limit to the amount of luggage you can carry, and there are also few restrictions on the kinds of things you can take on the bus.

Kadoma is approximately four hours away from Bulawayo, excluding the stops to pick up or drop off passengers along the way. It was a hot day, and we had to wait three hours before the bus filled up. The bus ride was nothing close to dull. The last time I had taken a chicken bus in Zimbabwe was when I was too young to recall any events, so this was quite the treat. During the trip, a local movie played and repeated twice, followed by deafening gospel music the rest of the way. Every other stop we would pick up aspiring salespeople attempting to sell different items to passengers. They ranged from cleaning detergents to "top-class" cell phone chargers to chocolate bars where you would get the first one for free if you promised to purchase more after sampling the free one. Blind people, as well as financially disadvantaged individuals, would also board the bus and pour their hearts out in hopes of a donation. If the heartfelt speech failed, they would sing a song to pull at our heartstrings.

Finally, after an eventful bus ride, we arrived in Ingezi, which is one of Kadoma's main townships. It is located just before you reach the actual city of Kadoma heading from Bulawayo. There is no regular bus stop, so we had to get up while the bus was still moving to announce to the driver that we would be getting off by the road (*pa Tara*). At this stage, my aunt had already notified her close friend that we would be arriving shortly, therefore when we disembarked, the friend was already waiting with a man who had a *scania* (an open trailer operated by pulling manually, like a big wheelbarrow) to assist us with our luggage.

From the road, it takes about 15 minutes to reach 82 (affectionate name of the family home). As you enter the township, on the left is one of the local primary schools. On the right is a set of newly built homes. Straight ahead where the road parts into a T-junction are the toilets that were my fear for most of my childhood. Kadoma was a mining camp, so most of the infrastructure that is still standing reflects the lives of miners who live in the hostels. These hostels are single rooms they used and still use as family homes, called *ma bhakarum* (back room). The toilets were far from where people resided as they were pit toilets, but when non-mining people occupied the hostels, the municipality turned them into flushable pit toilets. As a result of the lack of local maintenance, they are out of order even though people still use them for lack of alternative facilities.

After a short walk, we finally arrived home, where I was going to reside as I investigated the informal trading and use of contraceptive pills in the small town. At the time, the house was occupied by my great aunt, two aunts, my cousin, and his four-year-old son. I gratefully shared a room with my great aunt, who had the most prominent space.

1.2 RESEARCH LOCATION

Kadoma is a city positioned at the centre of the mines. It is along the main tar road and the main railroad that connect Bulawayo and Harare. The mines surrounding Kadoma are mostly gold mines, as well as copper and nickel mines. The most prominent mines are Cam and Motor Mine owned by Rio Tinto Zimbabwe. They are also well known for cotton farming and having the largest textile industry in the country, particularly the David Whitehead textile manufacturing company.

Those were the primary sources of income for most of the residents of Kadoma before both sectors were affected by the country's political and economic crises. Now, most residents rely on informal means of making a living; it being a tiny city, job opportunities are limited. Kadoma has eight residential areas. The areas have two high-density residential spaces, namely Ingezi, which includes kwaGreen and Rimuka, and the city centre. Ingezi and Rimuka are structurally similar to the primary house structures being four-roomed houses with an outside toilet. Other sections that were predominantly occupied by miners still maintain their hostel aesthetic, therefore one household tends to fill a room. Other parts of the townships are spacious, particularly in Ingezi where some residents have been able to afford larger pieces of land to practise subsistence farming and build larger houses. The farms that used to be prominent in cotton farming now stand idle as those who reside on them do not have the resources to maintain the cotton-production process. Instead, they produce basic vegetables on a smaller scale.

The city centre still maintains some of the colonial-style buildings erected when Kadoma was still called Gatooma.

It is important to note that my choice of Kadoma as a research space was not because of familiarity but because it is a town that has an extensive focus on reproductive healthcare, as well as an informally managed contraceptive pill distribution system.

1.3 PROBLEM STATEMENT

There is much interest in informally distributed contraceptives in Kadoma, despite the risks of purchasing expired products and even counterfeit products. This dissertation therefore aims to unpack the reasons behind this interest despite the apparent dangers, which the women are aware of and have expressed. An understanding of their complex reasons sheds necessary light on the idea of pharmaceuticals as social entities. They are social entities in the sense that although they are physical in structure and are precise quantities of chemical concoctions, they seem to morph into objects that suit the consumers' political, cultural, and social ideas and needs.

In Kadoma, the social nature of contraceptive pills portrays itself in the choice of informal accessing, which is influenced by individual circumstances that motivate the informal space as the best point of access. Those circumstances are not considered in their entirety when the biomedical health space implements the status quo of how

and when one should access and use a particular method. Biomedicine is the dominant medical system in Kadoma, but that does not necessarily imply that people passively embrace its strategies. As a result, one can put into perspective how different ideologies interact and inform or reject one another. In particular, the informal accessing of contraceptives is not a rejection of biomedicine but rather a disagreement with procedures of practising biomedicine. Van der Geest, Whyte and Hardon (1996) perfectly sum up this idea by stating that at the heart of medicine are the medicines. This blatantly implies that the perception of, and interaction with, biomedicine is about the physical, tangible pills, injections, or creams.

In Kadoma, contraceptive pills have successfully found a way out of the healthcare facility system and landed in informal trading spaces. These informal trading spaces usually exist to provide easy access to everyday goods that the people of Kadoma typically need. Thus, it is the most convenient space to buy and sell these pills. The only required procedure in this context is the patient's (who then becomes the client) ability to produce a certain amount of money for the contraceptive pills. This transaction eliminates the biomedical procedure enforced by the healthcare facilities. These procedures are in place to ensure that patients use the right kind of method and adhere to them accordingly.

In the context of human existence, the need or desire for alternatives has always been present. Freeman (2017) reinforces this by discussing how that is in humans' biological makeup and social upbringing that equips them with the capacity to engage in alternative activities. Seeking alternatives is about people wanting to embody their political, cultural, and social ideologies into their everyday existence. Thus, mainstream methods or points of access fail to cater to ideological varieties as the desire and intention of maintaining a universal ideology exist. Kuksov and Villa-Boas (2010) justify this lack of inclusion through consumer behaviour. When presented with too many choices, they end up making poor ones, and if there are fewer options, consumers tend to make more informed decisions.

The process of accessing prescription medication is a clear reflection of standardisation. Obtaining contraceptive pills is usually accompanied by a set of procedures that are biomedical in nature. These procedures qualify one to gain access to a limited amount of medication. Sometimes patients receive the methods with

discomfort, for many reasons. It leads people to look for and create alternative ways of access that eliminate the standardised procedure.

It is essential to engage with this desire for the informal space for the distribution of contraceptive pills to understand the nature of medicine in Kadoma. Unlike complementary and alternative medicines, which embody a different healthcare system (World Health Organization Regional Office of the Western Pacific, 2008), the scenario in Kadoma has compartmentalised the healthcare-seeking experience by eliminating the doctor-patient process and only focusing on pharmaceutical products.

1.4 RESEARCH PURPOSE AND CORE RESEARCH QUESTION

The purpose of this dissertation is to engage with the reasons why some women in Kadoma prefer to access contraceptive pills informally rather than from formalised healthcare facilities. To determine the reasons, the question that is used to structure the conversation is: *What pathways to contraceptive access characterise the use of prescription contraceptives and under-the-counter contraceptives among women in Kadoma?*

Zimbabwe requires one to have a prescription to access oral contraceptives, particularly during the initial stage of access. After that, one is free to refill over the counter (Grindlay, Burns & Grossman, 2013), which applies to private healthcare. On the other hand, in the public healthcare space, every visit for a refill is accompanied by a blood pressure check and occasional pap smears. It limits the ability for these pills to be freely accessed over the counter. This restriction creates a market for the movement of under-the-counter contraceptives. Under the counter therefore connotes to the manner in which distributors gain access to pills and the way in which they are sold and used.

The response to the question deals with particular factors that paint a clear picture of what characterises prescription and under-the-counter contraceptives.

These factors involve determining the type of contraceptives the individual women used, how they accessed that particular method, why they chose that method, and further engage with why they decided to use that method in that manner.

It provides insight into why some women in Kadoma opt to access oral contraception informally. It will show health and healing perceptions, body perceptions, as well as the women's comprehension and interpretation of reproductive health. It also provides a glance at the state of the healthcare system in the country.

Initially, the traders of contraceptives on the informal level were of great interest to this study, but during the fieldwork it became clear that they preferred not to participate. The reason for this most probably lies in the illicit nature of their business. Therefore the study became more focused on formal and informal contraceptive users. This dissertation, therefore, will highlight the manner in which contraceptive pills are formally and informally traded in Kadoma. It will show how contraceptive pills have become social players by the way in which women in Kadoma decide to sell, purchase, and use them.

This information was collected using qualitative research methods, in particular an ethnographic approach, as a way of bringing out the women's contraceptive stories as authentically as possible. In-depth semi-structured interviews allowed for more personal accounts of those experiences, and participant observation at the different locations gave a more tangible experience of the trading activities.

1.5 RESEARCH RATIONALE

The motivation to investigate the trading and use of contraceptive pills in Kadoma stemmed from an observation of Zimbabweans in Johannesburg. They expressed a preference for Zimbabwean contraceptive pills over South African ones. Further probing led me to the knowledge that the Zimbabweans would usually obtain these pills from trusted cross-border business owners who would regularly smuggle them across the border for clients in South Africa. The preference appeared to stem from the idea that Zimbabwean medicines are more effective than South African ones and have fewer side effects. These ideas are influenced by the desire for migrants to maintain a connection with home, which is often done by consuming and using products from the country of origin (Vertovec, 2004).

As a result of ethical issues regarding the fear of implicating informants and participants, as well as their anxieties around these illicit activities in a foreign country, I opted out of Johannesburg as a field space. Instead, I decided to focus on the

informal pharmaceutical interaction in Zimbabwe, where people were less anxious about the activity because of the apathy presented by the police towards the trade. The informal traders portrayed a lack of interest to participate, therefore the focus became the women's contraceptive use.

The women involved in this study provide a necessary perspective of the way pharmaceutical products are tools that express the different ideologies they hold. The term "ideology" is used loosely to imply the fluidity of ideas that people hold close and the approaches they use to inform their thinking and behaviour.

1.6 DISSERTATION STRUCTURE

This dissertation is divided into six chapters, with each chapter providing in-depth information and discussions that lead to answering the research question at hand. Following this first introductory chapter is the methodology chapter, literature review, two separate findings and analysis chapters, and lastly, the conclusion.

The second chapter provides detail on the methods used to shed light on the informal trading of contraceptive pills. I approached the research qualitatively with the particular use of the ethnographic method, which provides thick descriptions of the field and encounters in the field. To complement this, participant observation was used to embody the experience of the informal space. Lastly, semi-structured interviews were utilised to give a voice to the women who represent this activity. In research, it is inevitable that you become immersed not only in the space but in the meanings that emerge from it. Therefore, I will reflect on some personal accounts on contraceptives in Kadoma.

The third chapter discusses literature that speaks to the study as a whole. It is crucial as it places the dissertation as academically relevant in a field that speaks to the same ideas and also allows the dissertation to contribute to extending those ideas. A framework of the reproductive healthcare system in Zimbabwe from past to present contextualises reproductive healthcare in the country. It focuses on what it means and how the system works, as well as providing primary meaning to issues of fertility and birth control in a space that has multiple ideological frameworks. It is accompanied by a description of the informal business sector in Zimbabwe. Pharmaceuticals and their social nature are then engaged with; examining how they are "social players" in other

informal spaces to provide a comparative analysis. Lastly, the discussion focuses on body meanings and perceptions around the effects of these biotechnologies on gender roles and gender interactions.

The first part of the findings and analysis sections, Chapter Four, considers body perceptions regarding contraceptives. This chapter introduces the women who are at the heart of this dissertation to contextualise their experiences. The essence of this chapter is to bring out the meanings that these women hold about the body and bodily functions, particularly those regarding reproduction. A discussion of the purpose of family planning will lay out the ideological mindset that they use concerning reproduction. In addition, the education they received growing up regarding sex and reproduction will also contribute to contextualising the ideological mindset of the space. This information will then make clear their decision-making process when it comes to deciding which form of contraceptive to use. As a continuation of the discussion, the chapter takes the opportunity to view in detail how the contraceptive pill plays its role as social in the way it is used to solve social issues. Lastly, the chapter explores the dynamics these pills create, which cause unease in relationships between partners and families.

The second part of the findings and analysis sections, Chapter Five, focuses on the movement of the actual contraceptive pills in the informal and formal spaces. Different informal areas where the buying and selling of the tablets occur will clarify whether under-the-counter access is widespread. In this regard, attention is also paid to the process for access in the formal sphere as a comparative basis. Lastly, a discussion of how these pills leave the formal space and enter the informal space shows the ease of movement of these pills and the looseness of their regulation.

Chapter Six brings the dissertation together by discussing the primary outcomes of this research and by providing a meaningful conclusion around the free trading of contraceptive pills in Kadoma.

CHAPTER TWO:
METHODOLOGY

> … an intersubjective process that entails an interaction of various subjectivities. These subjectivities include those of researchers, armed with the theoretical perspectives of their discipline, and the perspective and representations of study participants (Jacobs-Huey, 2002:791).

2.1 INTRODUCTION

At the heart of anthropological research is the process of ethnography, which is a useful method of gaining and expressing ideas that people have about particular behaviours. This chapter intends to pay close attention to how this study was conducted in order to gain the responses and findings. The methods used are under the umbrella of qualitative research; in particular participant observation, in-depth semi-structured interviews, and the use of fieldnotes.

2.2 OVERVIEW OF RESEARCH

In Zimbabwe, people buy contraceptive pills at clinics, pharmacies, population centres, private doctors, and in informal trading spaces. When one makes a purchase at the clinic or the population centre, the pills sell for US$1 per six-pack, and if bought from the informal trading spaces, they sell for US$1 per two-pack.

Zimbabwe went through a political, economic and social crisis which let to the adoption of a multiple-currency system in the country to attempt to bring about some form of stability (Kwenda, 2015). So in Kadoma, depending on the trader, different currencies were used interchangeably, namely US dollars, South African Rands and Botswana Pula.

This study aimed to understand why people prefer to purchase oral contraception informally when they could access them at formal facilities for less money, especially when they run the risk of buying packets that are possibly expired or counterfeit. It is essential to understand how trust is built between buyer and seller, considering the seller's lack of medical knowledge. It is easy to make assumptions that everyone goes to the clinic or family planning facility to seek such products, but there are underlying nuances that must be contextualised and understood in order to understand the

medical culture of particular social and cultural contexts. Biomedicine is the primary medical system in most countries, but there are alternative forms of healing that some people rely on and prefer. Alternative therapies are often used complementary to biomedicine. In this context, common alternative forms of healing include traditional medicine and faith healing. Feierman (1985) addresses the setup of healing in Africa; people want to have at their disposal an array of healers whom they have the freedom to select at any given time. Therefore, the ability to choose accompanies the healing process, and the ability to exercise that choice in healing practice moulds ideology (Feierman, 1985). Perceptions that people have of healthcare systems are therefore essential as these inform how a system operates in a space and how it can better complement existing ideas.

As a result, this study proposed to investigate the pathways to contraceptive access that characterise the use of over-the-counter and under-the-counter contraceptives among women in Kadoma. Insight into how and why some Zimbabwean women opt to informally access oral contraception will provide broader insight into health and healing perceptions, body perceptions, as well as their comprehension and interpretation of reproductive health. We will also better understand the state of the healthcare system in the country. In order to gather the information, a qualitative approach was considered the most appropriate to address the matters at hand.

2.3 ETHNOGRAPHY

My research interest was sparked during a casual conversation with a group of women who were friends with my aunt who had come home for a social visit. This conversation gave me the direction I needed to take in order to gain a better understanding of contraceptive use in Kadoma. One of my aunt's friends expressed her curiosity about my research, which is I how entered the different field sites.

I responded by explaining my research topic and that it was a requirement for me in order to complete my master's degree and that the topic was of great interest to me. The women expressed their general thoughts on contraceptives and different contraceptive devices relating to their personal experiences. They then identified the different places they knew where contraceptive pills were accessed informally, as well as the people they knew who used and accessed informal contraceptives.

This discussion was vital, particularly because it occurred right at the beginning of my fieldwork, so I was able to map out the places I intended to go to, as well as potential participants in the study. When conducting anthropological research, the initial stage of immersion into the field is imperative, therefore one must always be alert to pick up the subtle prompts that exist in casual conversations and normalised acts.

Entering the field, I did not know what I was going to find with regard to the informal trade of contraceptives, or how I was going to find it. At that stage, all I knew was hearsay information, and my process of being in the field was first to verify the existence of the activities and then to find out why they were happening.

In the process of searching for informally traded contraceptive pills, I started at the local vegetable market in Ingezi, where I met my first participant, who was a young woman who sold vegetables along with contraceptives. The vegetable market came to be a vital focus in this research, as I will discuss in detail in the following chapter. It was in this space that I was able to first identify the intricate nature of the informal business of contraceptives. Participant observation was an initiating tool that allowed me to engage with this space. The researcher exists alongside those practising a particular culture and observes and interviews them to gain a better understanding of their behaviours (Petty, Thomson & Stew, 2012).

Before I approached anyone with regard to contraceptive pills, I observed how the area was structured and who was in that space. Upon entry into the gated vegetable market, I was able to identify dominant characters who I thought would feed information into the research. Unfortunately, I was met with hostility, as expected, considering what I was asking to know and also probably because it was a public space and my probing would draw unnecessary attention. Even the young lady I was finally able to speak to expressed a bit of anxiety in her engagement with me, which translated into her refusal to be recorded, which I respected and I therefore documented the information using note-taking. This anxiety can be attributed to various factors. Most of the people I engaged with were baffled by the fact that I was interested in the movement of contraceptive pills in the informal space. It caused unease as it implied that I had some hidden agenda to either expose their illegal businesses or to gain trade secrets, or even steal their customers. The audio recorder was another cause of anxiety as the Zimbabwean government has successfully

planted the idea in its citizens that they are under constant surveillance. This surveillance supposedly exists in the form of undercover spies in different communities who watch what people do and say that could be a threat to the government.

Additionally, people are also cautious about what they say on social media or over the telephone. As a result, the audio recorder could be viewed as a threatening device because they did not know me well enough to trust me with their voices on a device. The anxiety continued throughout the field experience as most of the women expressed discomfort with the presence of the audio recorder, therefore I decided to eliminate it to allow them the comfort to express themselves without restriction.

My first encounter in the field resonates with Scheper-Hughes' (2000) reflection on her time spent in Ireland. People are protective of their home spaces, and they always want to present those spaces in a positive light to outsiders. Scheper-Hughes (2000) therefore experienced much backlash from the residents of the small town in Ireland as they felt she portrayed their town in a negative light. This reaction shows how an anthropologist looks to provide ways to better understand why people do the things they do. Not necessarily to air a group of people's dirty laundry, as Scheper-Hughes (2000:127) reiterates that "the danger and the value of anthropology lie in the clash and collision of cultures and interpretation".

Although the vegetable market experience did not go the way I had hoped, I was able to validate the existence of the trade in contraceptive pills in that space and was also able to see the interactions between the vegetable vendors and their customers, which gave me a visual experience of how the transactions occurred. Also, my participation in buying vegetables gave me a better perspective. It was wise that I did not propose a desire to purchase contraceptive pills from the women, as that would have gotten me into a trickier situation as it later unravelled through my field experience that the initial stage of buying contraceptive pills from the vegetable vendors required a tangible referral, which at the time I did not have.

The first group of six women I spoke to lived in Ingezi; they told me about their formal and informal experiences with contraceptives. These women were acquainted with my aunt's friends, with whom I had the initial conversation. As a result, purposive sampling (Bernard, 2006) is the method I used to select the women I intended to speak to because it was clear that I had to speak to women who accessed and used

contraceptive pills in Kadoma. I met these women at their homes, where I then set up appointments with each of them so I could visit them at convenient times. I conducted in-depth semi-structured interviews with them to gain more information about their contraceptive use patterns. Interviewing is a core tool that is used within the field of social science to deal with issues that spark interest, creating a space where genuine accounts can be shared (Rapley, 2001).

A set of themes guides semi-structured interviews that need to be addressed but are not restricted to allow the participants to freely express themselves or to add any information they wish to (Bernard, 2006). It is a relevant method particularly when the research intends to gain participants' perceptions of the meanings of accounts (Rapley, 2001). I found using this interviewing structure to be very useful as it allowed for new ideas to emerge. Additionally, it allowed the women to share their stories to the depth and extent they desired. Rubin and Rubin (1995:103) correctly state that "people like to talk about themselves, they enjoy the sociability of a long discussion and are pleased that somebody is interested in them". The decision to conduct the interviews in the women's homes was wise as they were in their natural spaces; therefore there was a sense of security on their part to speak freely.

The main hindrance with this encounter was the audio-recording device. As mentioned previously, during the fieldwork I made the conscious decision to eliminate the use of a recording device. With the first two women an audio recorder was present, but with the first woman I switched it off mid-interview as I noticed her eyes continually glancing at the device and with each glance expressing a greater level of discomfort. After switching it off and putting it away, she was able to express herself with a bit more ease. Similarly, the second woman constantly asked who else was going to listen to the recording, despite my reassurance, which I had discussed before the interview and in the information and consent form. So once again I switched it off and put it away. With the following interviews I did not display the device at all, and I found that the discussions flowed more smoothly and the restricted barrier between interviewer and interviewee was less defined. Thus, I relied greatly on note-taking. Although it was a taxing endeavour, as we took occasional pauses to document the information, it was necessary. One of the women would occasionally double-check if I correctly wrote down her responses.

It is therefore entirely necessary during fieldwork to be aware of the social and political spaces participants exist in, as they define to a great extent how participants will respond to the different methods a researcher chooses to utilise to gather information. In this case, the political unease in the country at the time of my fieldwork involved constant threats around digital surveillance. Most people in the country were led to believe that whatever information they shared with others via digital sources such as video cameras, voice recorders, cell phones, and particularly on social media, was accessed continuously by the government. Therefore there was a constant level of guardedness around what people said, where they said it, and to whom. As a result, gaining the trust of the informants was very important, and I had to continually reassure them that it was a research project for university and that I had no affiliation with any government or non-governmental organisations.

The second group of six women I had in-depth semi-structured interviews with were from a farm compound at kwaGreen. They mainly focused on their experiences with formal accessing of contraceptives. The following chapters go into the detail of how I met them. Just like the first group, a friend of my aunt introduced me to the people on that particular farm. I thought this would be a particularly exciting space to find out how they accessed contraceptives as they were slightly isolated from the clinic and population centre. The discussions were not as in-depth as the those I had with the previous group, and I suppose that this was due to the space in which I had the interviews. As it was a compound, each home did not have any physical demarcation, therefore the other homes would be well aware of whatever was happening in a home. I had to conduct the interviews outside each home as I was not invited to enter. It meant that from the first home where I sat down with the first woman, we had an audience, which affected the manner in which they responded as most of them answered in a way that they thought was best desired. It would then cause them to portray themselves in ways that are deemed morally adequate (Goffman, 2005), particularly by their eavesdropping neighbours. I did not disregard their responses as their experiences gave a compelling picture of how regular access occurs.

My next journey was to Rimuka, a high-density neighbourhood just like Ingezi. Here I was to meet the informal traders of contraceptives, as well as a population centre ambassador. My biggest challenge, however, was accessing informal traders who were willing to talk about their businesses. My other aunt who lives in Rimuka knew a

few women who sold contraceptives from their homes, and she took me to the different homes to introduce me to them. The women admitted to selling but were not willing to discuss beyond that. I would assume two things, which are fear of being exposed and not wanting to share trade secrets with potential competitors. Therefore I mostly relied on the information provided by the buyers.

My cousin-in-law introduced me to the population centre ambassador as they were acquaintances. The population centre's central role is to oversee the local campaigns on family planning in town. The discussion with the ambassador turned out to be fruitful as it validated most of the information I received from the women. I had prepared open-ended questions for him, as I was not sure how he would contribute to the study. The open-ended questions were beneficial as they allowed the conversation to flow and he shared valuable information on the informal trade of contraceptives, as well as his own involvement in the trade. Open-ended questions provided the interviewee the opportunity to speak on the subject matter without restriction, and in most cases, it led to different themes. The downside to this encounter was that I only met him towards the end of my time in Kadoma, therefore I did not have the opportunity to spend the day with him and observe the day-to-day activities in the field of conducting family planning campaigns. The week after I was to leave, they were conducting a campaign in one of the rural areas outside of Kadoma where the primary purpose was to promote family planning by utilising contraceptives. Time was therefore a disadvantaging factor, as some of the events that occurred did not correspond with my allocated time in the field.

The population centre ambassador introduced me to a nurse at the local clinic in Ingezi. He connected me with this person as he thought she would contribute to the research (Cohen & Tamar, 2011). I had a brief talk with her, whereby she validated the procedures that were stipulated by the women. She did not have much to say about the informal trading of contraceptive pills; rather, she diverted and provided me with facts on the running of the clinic. She also allowed me to engage with archive literature on the policies on family planning and reproductive health in Zimbabwe. It gave me a proper perspective of the institutional ideologies around family planning in the country and the strategies for the country. The archive literature had guidelines that nurses had to follow when interacting with patients, therefore it was like an

instruction manual with step-by-step methods of dealing with different ailments and services.

At this point, I had come to terms with not having much verbal time with informal traders and realised that the core focus of my research would become the 12 women of Kadoma and the population centre ambassador. I then channelled my focus to their experiences, understanding, and conceptualisation of contraceptives and family planning as a whole. I implemented the key informant technique to ensure that I gained in-depth information on the behaviour, as key informants are experts in the subject being researched (Marshall, 1996). These women and the population centre ambassador were actively involved in the informal trade and had a deep understanding of the informal trade, and as a result possessed an insider's viewpoint. Marshall (1996) states that this technique produces quality data in a limited amount of time. Magnarella (1986:33) further reinforces the method by praising key informants as having "the patience and the charity necessary to transform cultural illiterates into passably civilised humans".

In my last week in Kadoma, I took the time to visit the city council located in the city centre to determine whether it had any recent background information on Kadoma. Unfortunately, the responsible parties were not present, and even after sending emails I did not get a response.

The benefit of going into the city centre is that I was able to casually observe the informal selling of contraceptive pills on the open market, which sold a variety of items. Each person had a stall where they sold different items, from clothing to electronics to kitchenware. On the side of those stalls were women walking around and rattling packets of contraceptive pills. My approach to gain more information was to no avail, therefore I resorted to observing and seeing who would buy and how the transaction would go. During the time that I sat on a bench watching the women, no one approached them to buy, but I was able to validate once again the existence of the informal space as a way of confirming the women's accounts.

My last piece of data collection was unstructured as it was a conversation that took place as an elderly neighbour who had come to see my grandmother asked what my research was about. She then gave me her perspective on family planning that involved indigenous methods that I had not taken into consideration, and other people

who were home at the time of this conversation also added other indigenous methods that they had heard of. I documented this information as it would have been extremely one-sided to assume that a diverse space like Kadoma would only possess family-planning methods that were stipulated by biomedicine.

2.4 POSITIONALITY

Researching home is always a cause for negotiating one's situatedness to avoid taking advantage of one's familiarity and managing to maintain the researcher mindset (Nordquest, 2008).

This trip to Kadoma was highly emotive; it evoked deep feelings of nostalgia, as I was born in the small city in 1987. Although I did not grow up there, I spent many school holidays there visiting my maternal grandmother before she moved to Bulawayo. At the time, she lived with her sister in a home that was and still is the focal point of all major family gatherings, events, or life processes, from funerals, births, to homelessness, and even just regrouping. The house is made up of four bedrooms, a living room, a dining area, and a kitchen. It is where I spent the month of conducting research.

Researching home or going "native" can be advantageous as you are familiar with the location and the people. Be that as it may, I knew the space well, but I found myself having to negotiate myself with the people I spoke to (Jacobs-Huey, 2002). Although I came from Kadoma and was conducting research there, I initially had assumed myself to be an insider. Upon introspection, it became clear that taking on an insider role would be extremely premature as the main aspect that I shared with the majority of my participants was cultural affiliations, and beyond that there were multiple factors that distinguished us, such as "education, gender, sexual orientation [and] class" (Narayan, 1993:672). As a result, even though I shared some cultural identity with the participants, my interaction with each participant was unique and isolated and was not influenced by my historical and cultural association with Kadoma, as Jacobs-Huey (2002:792) accurately describes the experience of an anthropologist doing anthropology at home as one who goes through "gradations of endogeny".

My positionality as a researcher in the space did not only revolve around my association with the participants. I also found myself feeling conflicted in the research

space because of family obligation. My fieldwork occurred during the festive season when family obligation is most warranted. This therefore implied having to be present for certain gatherings and spending time assisting in planning for those gatherings. Initially, this was a conflict as I felt I had to prove affiliation to the family group by participating in festive activities, but I was able to prioritise my research mandate without creating conflict. As a result, conducting anthropological research at "home" comes with its own complications that evoke personal and social conflicts as you feel that as a "native" anthropologist, you must represent and treat the space and participants in a manner that is less "alienating and intrusive" (Jacobs-Huey, 2002:792).

To accomplish this fully, I had to be reflexive in the space, and allow myself to address the preconceived ideas that I possessed about Kadoma and the people in Kadoma. This is not to say biases are easy to get rid of, but my awareness of these biases allowed me to engage with the research process as authentically as I could.

2.5 ETHICAL ISSUES

In order to conduct a meaningful research project, it was vital to be prepared for whatever issues may arise. It was also essential to be cognisant of ethical factors throughout the process from field to write-up.

This study examines the informal trading of contraceptive pills, which implies that the pills are not only sold informally, but they are accessed illicitly. This knowledge requires measures to protect the informants even in the writing process. Kaiser (2009) discusses the dilemma that this kind of situation can create because you want to provide as much detail as possible, but at the same time you feel pressure to hold back on the detail to ensure anonymity.

In this study, anonymity was maintained as well as possible. Firstly, pseudonyms were created for each informant to protect their identity. Anonymity maintains the dignity of the informant as an active member of a community. It was quite apparent how anonymity was also crucial to the informants when I decided to eliminate the audio recorder. It was as if they were able to protect their autonomy over their voices, even after I had reassured them that I would be the only one listening. Scheper-Hughes (2000) reiterates this point as she believes that anonymity keeps us conscious of the

fact that our informants deserve the same level of respect not only in the field but also when documenting their stories.

Informed consent is used to maintain the informant's dignity as it is essential. Informed consent involves being completely open and candid with the informant. A consistent level of honesty about the study with the informants will solidify the relationship. Juritzen, Grimen and Heggen (2011) state that informed consent provides the informant with the power to negotiate their involvement in a study. Therefore, from the beginning, I notified the informants what information I was looking for and that I needed their help. I told them that they had the right not to participate and they also had the right to change their mind midway if they were no longer interested. Consent forms were signed by the informants to formalise their informed consent. Having this kind of relationship enabled the informants to ask for clarity on some questions, as well as a few requests to have the conversations in the local language of ChiShona.

During my time with some of the informants, they asked if I had come from the population centre and also if I had brought with me contraceptive pills to give away after they answered the research questions. It then became a situation whereby I had to continuously re-explain who I was and what my purpose for being there was. This experience I had speaks to a situation in Malawi that Biruk (2017) discusses regarding American anthropologists who visited Malawi to conduct research and then afterwards distributed soap bars to all who participated. It struck up a debate of whether or not it was ethical or not to provide incentives or gifts to participants. Biruk (2017) concludes by explaining that although it was a kind gesture to give to those less fortunate, it would create problems in the interaction between the researcher and informant as the power dynamics would then be more defined. Therefore, informed consent is very useful as I made it clear to the informants that their participation was purely voluntary and they would not receive any material compensation.

2.6 CONCLUSION

This chapter addressed the methodological processes that I went through in Kadoma, Zimbabwe, as I was attempting to outline the formal and informal processes of contraceptive access through the viewpoints of 12 women. The methods that were

applied took into consideration the social context in which they were being implemented and were subject to change when they did not suit a particular outcome.

In order to become acquainted with the research informants, I used purposive sampling. I needed to speak to women who met particular criteria; namely women who were using some form of contraceptive. The research as a whole was ethnographic and therefore implemented different methods such as participant observation, in-depth semi-structured interviews, and archive material review to obtain answers. To deal with ethical issues, I implemented measures that would protect the identity of the participants.

CHAPTER THREE:
LITERATURE REVIEW

3.1 INTRODUCTION

The institutional need to control populations emerged from a space that had a brutal manner of dealing with a distorted idea of the existence undesirable factors within human populations. These factors included signs of "pauperism, criminality and especially feeblemindedness" (Nguyen & Lock, 2010:119) which were thought to be hereditary traits. As a result the groups that were said to possess these traits were proposed to be prevented from reproducing as a manner of controlling the "type" of human allowed to exist.

Eugenics theorists spearheaded the initial implementations of population control. They firmly believed that those with undesirable traits were increasing at a rapid rate and some measures had to be implemented to curb this. The most prominent method to certify that the "undesirables" did not further reproduce was through sterilisation. Nguyen & Lock (2010) details the fact that in the United States 50 000 people were forced into sterilisation during the first half of the 20th century. So family planning strategies in America were mostly targeted at African American population groups particularly those in the inner city. Nguyen & Lock (2010) further elaborate that the hegemonic ideologies at the time, firmly believed there was a close link between reproductive behaviour and the success and stability of a nation, so controlling a population group that was not contributing to the success and growth of the nation was necessary.

This chapter will, therefore, draw on different literary perspectives to inform the different themes that emerged during this research study. Different perspectives provide a nuanced and contextually full perspective on the matters stipulated. The selected literature looks at history in the context of Zimbabwe around family planning that way the research does not rely on international histories, although equally valid, around family planning and reproductive health.

The nature of informal businesses will also be addressed to set the scene and provide a better understanding of the informal trading industry in Zimbabwe. It will allow a

possible manner of placing the transaction of pills in those informal spaces and zooming in on pills or medicinal products as social players in a space that is socially, culturally and politically defined.

As pills are becoming defined as social players, it is also essential to explore how them as tools to deal with social issues, here I will engage with literature that discusses medicalisation of aspects that require social attention.it will explore different perspectives on defining the body. Lastly, I will engage with literature that discusses the gender-related issues in relationships.

3.2 ZIMBABWE IN CONTEXT

3.2.1 Family planning and reproductive healthcare

Contraceptive methods were only introduced at a later stage to Africa, and the population in Zimbabwe. This is despite the white leadership expressing anxiety around the rapid population growth of the African population.

Kaler (2003) identifies three main issues that the white power had with African fertility, which defined the family planning strategy that was implemented specifically for the African population. The initial issue lay in the belief that African fertility patterns were problematic. The second tier to their qualms was that the problem with African fertility was not only a threat to the African group but also the political and social stability of the white population. The third aspect therefore was that the white rulers felt that it was their duty to society to help the Africans eradicate this problem. Based on other historical experiences, one would assume that the eradication would be by biological means, but this instance was a bit different. In order to curb the issue, they felt that restructuring the way African women played their social roles would contribute significantly to implementing order over the issue. Giving African women classes was their way of teaching them domestication according to European standards (Kaler, 2003). The classes were based on dress, cooking styles, and sewing, and within those spaces they also reinforced sexual and reproductive ideologies, which they deemed to be more acceptable. This reaction stemmed from a deep fear of African domination.

Despite this fear, hormonal contraceptives and clinics were only available to white women. The issue arose when African women working as domestic helpers for white women heard of the contraceptive methods that were giving white women a smaller number of children. It was something the African women desired, as well as reasonable age gapping between their children. They approached the clinics for assistance but were denied (Kaler, 2003).

When Ian Smith came into power, his regime pushed for African women to gain access to contraceptives. It was because his system was more aggressive than the previous. Their access was limited, however, as they still could not access contraceptives from the main clinics; therefore, to cater to the African population, they made use of mobile clinics. Africans who were selected and trained by the Rhodesian authorities administered treatment.

Family planning is now under the umbrella of reproductive health, and the Zimbabwean reproductive healthcare system is a large part of healthcare in the country. It is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health system and its functions and processes" (United Nations Fund for Population Activities [UNFPA] Zimbabwe, 2011). As a result, different strategies are always implemented in an attempt to make the process smoother. The Zimbabwe Multiple Indicator Cluster Survey (Zimbabwe National Statistics Agency, 2014) stipulates that 67% of women in the country between the ages of 15 and 49 years make use of contraception and 43.9% of those women make use of oral contraception. Oral contraception is one of many methods of family planning used and recommended to women in the country, and combined oral contraceptive pills with two hormones or progesterone-only secure pills with one hormone are provided (Zimbabwe National Family Planning Council, 2019).

3.2.2 The informal business of pharmaceuticals

In the context of this research, the informal spaces where people purchase food are the same spaces where people buy contraceptive pills. As a result, it is vital to unpack the nature of informal businesses in Zimbabwe.

The economic and political depreciation in the country presents situations where formal commercial outlets experience a shortage of products, leaving most of the store shelves bare. The informal business sector has always been part of the country's economic activities, but as a result of this downfall, the informal sector has increased in popularity.

In Kadoma, there is a heavy reliance on the informal sector, and the aspects of the informal sector that became of great interest were a petty commodity (Chirisa, 2013). Petty commodities are those goods that do not bring in much money, such as vegetables, sweets, and occasionally airtime. Women dominate this sector as the level of flexibility allows them to play their roles as wives and mothers and to also do other informal jobs that are usually characterised by short-term contracts.

The common spaces where these businesses operate are along the streets, on street corners and pavements, whereas others choose to operate from the comfort of their homes or other spaces they feel have business potential. Chirisa (2013) emphasises that even though these informal traders are economically active, they seldom get out of the "poor" bracket. Besides the fact that they produce and trade petty commodities, it can also be related to some of the following factors that characterise the informal business.

Firstly, they are family orientated, therefore this reduces the chances of there being formal records of the profits as most informal businesses already do not usually keep records (Chirisa, 2013). It leaves much room for the money that is intended to be distributed around the household when different members require it. Secondly, they are usually small and require a great deal of manual labour (Chirisa, 2013), which makes it difficult to conceptualise ideas of expansion. Chirisa (2013) states that these businesses are not regulated and there is much competition, as a host of vegetable vendors would be selling the same product. Lastly, their relationships with their clients are less rigid and more socially and personally connected, therefore customers can get away with not paying at times and other times obtaining products on credit.

3.3 PHARMACEUTICALS AS SOCIAL ENTITIES

Van der Geest et al. (1996:154) describe pharmaceuticals as "the synthesised, manufactured, and commercially distributed therapeutic substances that constitute the

hardcore of biomedicine". In essence, biomedicine cannot be approached without also engaging with the role of pharmaceuticals. Once distributed and purchased, they become social and cultural entities, meaning that the consumers attach particular meanings to them (Lock, 2004).

Lock (2004:88) describes the fact that "pharmaceuticals have become fetishes imbued with power". She provides examples where in South India for the past two decades the use of herbal remedies has decreased, as people prefer pharmaceutical solutions for their ailments. Collin (2016) reinforces this by stating that pharmaceutical products take over every life phase of people. They are powerful because of their "thinginess" (Van der Geest et al., 1996:154), which implies that their physical characteristics as solid, concrete substances translate into the social conceptualisation of the product. It gives the patients a greater reliance on and trust in the substances as they then translate them as concrete ways to solve their problems. This power that they have not only exists within that particular moment of treating an ailment, but goes deeper into redefining the ideologies that people live by.

Although this seems well and good, the differences in approach to pharmaceuticals between medical practitioners, pharmacists, and patients create a social misunderstanding as to how best to distribute, or administer, the pharmaceutical products. Practitioners see pharmaceuticals as a necessity in their interactions with practitioners; whereas pharmacists approach them as commodities and the patients have a deeper connection to them as they see pharmaceuticals as problem solvers of their social and physical issues.

The medical practitioners and pharmacists do not generally acknowledge the social and cultural attachments that patients place on medicines, therefore the manner in which they administer these products does not usually match the way in which patients would like to receive them. Practitioners and pharmacists follow a particular standardised procedure that qualifies a patient to gain access to particular medicines such as antibiotics and contraceptive pills. In the patient's eyes the medicines are things that solve their problems, therefore their primary goal is to gain access to that thing; however, the process of getting the thing is not always meaningful to the patients. Van der Geest et al. (1996) reinforce this as they stipulate the manner in which the state fails to administer drugs in a patient-friendly way. Firstly, in some

contexts, healthcare professionals are not easily accessible to most patients, which could be because of the distance from the facilities. Van der Geest et al. (1996) then point out that there are other states where there is a general drug shortage and on top of that, staff members are not adequately paid, so these issues affect the service outcome.

In the context of Zimbabwe, the kinds of issues that can affect the interaction of the patient with the healthcare facilities and practitioners were studied in a case study conducted in rural Zimbabwe in an attempt to obtain a different perception of reproductive health as a way of improving adolescent access to such services. Langhaug et al. (2003) obtained the perceptions of nurses, youths, as well as parents. Most of the youths complained that there was no sense of privacy when they consulted nurses with regard to reproductive health matters as they would embarrass them, or scold them for being too young to ask for condoms or sexually transmitted infection (STI) treatments (Langhaug et al., 2003). The youths also expressed an inability to speak with the designated traditional sexual health educators, who were mostly their aunts or uncles, as in Zimbabwe adolescence is a phase that is not acknowledged, therefore they are still considered to be children (Langhaug et al., 2003). The nurses explained themselves by stating that when the youths come to ask for contraceptives, they cannot help but see them as their children; therefore, they are justified in scolding them. In Zimbabwe, sex matters are culturally private and are treated secretly (Langhaug et al., 2003).

As a result, these inabilities to cater for the direct desires of the patients create opportunities for the informal sector to fill the gaps. Van der Geest (1985) describes his encounter with informal portals of pharmaceutical access during his time in Cameroon. As a result, Van der Geest et al. (1996) theorise this experience by stating that the field of medicine is defined by the medicines; therefore, if the medicines are available in spaces that do not involve the standardised procedures, then it makes sense as to why people would opt for the informal route.

Although Van der Geest's (1985) research in Cameroon was conducted a long time ago, some of the aspects he accounted in his field experience are quite relevant in the current time; mainly the reasons he discovered as to why people in a Cameroonian village would opt for informal access. Firstly, the issue of a shortage in the formal

medical spaces leads people to purchase from street vendors, who always seem to have a vast variety of pharmaceutical products. Van der Geest (1985) discovered one particular vendor who had close to 70 different types of medicines for different ailments, and some were prescription based and some were basic over-the-counter medicines. Another reason for the popularity of the informal medical market was the distance between pharmacies and where people resided, and topping that with unreliable transportation and poor roads, it seemed like a more feasible option to buy from vendors.

A similar study was conducted by Bishikwabo (1998) in the Democratic Republic of the Congo (DRC), which illustrates similar findings to Van der Geest's (1985) research. He came across vendors in the DRC who were selling pharmaceutical products that required a prescription to access, but people were buying without a prescription. Bishikwabo's (1998) perspective relies mostly on the vendors' accounts, where they attributed their reason for selling to the fact that it was the only way they could survive economically.

Van der Geest (1985) discovered that the informal vendors obtained most of their stock from three main portals, namely from Nigeria, as people were more attracted to products that came from across the border, therefore obtaining products from Nigeria was more of a business strategy than anything else. The second source of medicines was from pharmacists; informal vendors would buy from major pharmacies in bulk. Although it was not blatantly articulated, pharmacists relied heavily on these business transactions as they brought in significant profit. Lastly, medical personnel from formal institutions also played the role of supplier as they probably also required a boost in their income. Bishikwabo (1998) mirrors this as he stipulates that the vendors in the DRC obtain the medicines they sell from pharmacists, doctors, and pharmaceutical wholesalers.

The issue of information also arose in both field experiences. In the formalised setting of accessing medication, specific information is usually given by the administrator and, if not, it appears on the packaging. These two accounts indicate worrying results as the information provided was either based on the traders' discretion, and they would decide how much of a particular medicine to give to a client based on looking at them and from that visual analysis, they would decide the dosage (Bishikwabo, 1998). Some

packaging is in languages that neither the vendor nor the client can understand, therefore they would miss information regarding the expiry date of the product and, most importantly, the contraindications that would inform dosage (Bishikwabo, 1998). To exacerbate the misinformation, when informal vendors obtain their batches of medicines, they open them and repack them into smaller bottles (Van der Geest, 1985) or they measure by hand when a client comes and pack them in a small piece of paper (Bishikwabo, 1998). Furthermore, the packaging of these pharmaceuticals leads to suspicion of the quality of the product, as they are kept in the wrong environmental conditions.

In both cases, the informal vendors approach pharmaceutical products merely as commodities they must sell in order to secure their survival, which involves taking advantage of the vulnerabilities of their clients, who in most cases appear not to have any other choice but to access medicines from informal vendors. Bishikwabo (1998) elaborates by mentioning that the vendors and their clients have created a lasting relationship, therefore this system has become entrenched in the lifestyle of this community. Alternatively, Van der Geest (1985) depicts a certain level of ethnocentrism as he calls the clients of the informal vendors ignorant, therefore making it easy for the informal vendors to take advantage of them.

These accounts illustrate that the informal space allows people to pick and choose whichever treatment they want, and that the nature of the relationship between the informal traders and the patient has more respectful qualities in their interactions. The patient, during that interaction, becomes a customer and this fits Van der Geest et al.'s (1996) analogy of equating the effects of food on defining one's identity with pharmaceuticals having the same effects.

A more recent study reinforces the nature of these informal pharmaceutical markets in Africa. Baxerres and Le Hesran (2011) spent four hours every day for 69 days at an open-air market in Cotonou, Benin. Dantokpa Market is one of the largest open markets in West Africa, and provides an array of goods and services to the locals and tourists (Baxerres & Le Hesran, 2011). The market is divided into sections depending on the goods and services it provides. The section with pharmaceutical products has approximately 1 000 stalls (Baxerres & Le Hesran, 2011).

There are three categories of medicines at this market. The first category involves medication imported from Ghana and Nigeria. Benin has not authorised some of the medication from Ghana and Nigeria (Baxerres & Le Hesran, 2011). Other vendors in the market sell them because they also play the role of a wholesaler, or the vendor travels to Ghana or Nigeria to purchase them there. Such travels across the borders require someone who is street-smart who can manoeuvre their way across without the authorities finding out what they are transporting (Baxerres & Le Hesran, 2011). The second category is prescription medications, which, in the formal sector, are only accessible by a prescription from a qualified healthcare professional (Baxerres & Le Hesran, 2011). These are not difficult to access as the healthcare professionals are aware of the demand for them, therefore they sell them in bulk to the vendors. The last category is medicines that are locally manufactured or manufactured in Asia but that are not allowed to be sold, meaning they are pharmaceutical products that are usually administered by government healthcare facilities (Baxerres & Le Hesran, 2011). They are usually packaged in small plastic bottles.

In some instances, informal access to pharmaceuticals occurs because of the circumstances of the patients. These informal spaces allow patients to play the role of engaging with pharmaceuticals on a level that is socially fitting for them. Baxerres and Le Hesran (2011) refer to this kind of response as the liberalisation of pharmaceuticals, which allows people to treat the pharmaceuticals as their problem solvers.

This type of connection that patients have with pharmaceuticals can be placed under the concept of medicalisation, where matters that can be dealt with on a social and cultural level end up being biologically treated (Scheper-Hughes & Lock, 1987). It also allows people to avoid dealing with social and cultural issues, as a natural remedy is readily available to them. Hegemonic institutions that standardise human bodies reinforce these behaviours of dealing with matters on a biological level. Human reproduction is not only biological but involves social and cultural aspects treated with biomedical technologies that overlook the holistic nature of the body.

3.4 THE BODY, GENDER, AND POWER AT THE HEART OF BIOTECHNOLOGIES

3.4.1 Body perspective

The body is an entity that is subject to multiple meanings and perspectives, depending on the cultural, social, and political approach. It is important in the field of medical anthropology to discover how the body is experienced and understood.

In the act of taking medications of any form, different factors are at play to reach that stage of deciding what type of medication to take and how to take it. Scheper-Hughes and Lock (1987) compiled a breakdown of three bodies. These bodies allow us to engage with the body from different perspectives and give us a nuanced understanding that different people in different contexts experience their bodies differently.

The first kind of body is the individual body, which is phenomenologically experienced. It implies that there are personal reflections that inform meaning and action between the body and mind and soul, depending on the worldview of the individual embodying whatever experience is presented to the body (Scheper-Hughes & Lock, 1987). In the context of contraceptives, a phenomenological approach can be used to understand the lived experience that one goes through to determine which form of contraception to use and how. It is important to note that the three bodies generally overlap and influence one another; as a result, the body social and the body politic will influence the lived experience of the individual body.

As a result, the social body is a symbolic expression of nature, society, and culture. Whatever action or reaction the body expresses can therefore be deduced as an expression of what the immediate worldview that defines that body entity is saying. Kaler (2003) describes how some in-laws pressure women into having many children, and they use the fact that they paid roora (bride price) as a reason to justify their dictation over her reproductive devices. It illustrates the occurrence of the social body regarding that if she complies with the demands of the in-laws and she is continuously falling pregnant, then her body will be a symbolic expression of the cultural ideologies that guide the social context she is in.

Lastly, the body politic controls and regulates the body in all aspects (Scheper-Hughes & Lock, 1987). In the context of this research, the body politic is at play as institutional and patriarchal factors exert considerable power over the reproductive patterns of women. On an institutional level, the state shows its power through controlling bodily functions such as potency and fertility. As a result, not only is the body regulated but populations' sexuality, gender, and reproduction are also controlled by bio-powers.

Kaler (2003) focuses on body knowledge among the Shona, although she specifies that as new information and technologies fuel our spaces, body knowledge continues to evolve. She therefore states that discussing body knowledge among the Shona does not necessarily imply that they are "cultural dupes" (Kaler, 2003:103). Instead, it gives a general perspective on the social and cultural ideas that are at play when making a specific decision or behaving in a particular way.

The approach to the body among the Shona focuses on social networks and relationships, therefore the manner in which a person behaves in their body or whatever they do with their body radiates onto the next person. It compels people to be cognisant of how to act out social and cultural cues that link to the next person (Kaler, 2003). In the context of medicines, therefore, the choices one makes around that process have an impact on the social space they are in, in the sense that the choice declares certain beliefs and when one chooses to alter their medicine-taking patterns, particularly in the view of contraceptives, it alters the meaning of reproduction in that particular space.

3.4.2 The effects of contraceptive devices on gender relations

In patriarchal contexts, sexual and reproductive freedoms are highly limited. Although reproductive healthcare is readily available, some women are unable to access it without permission from their partners (Baer, Singer & Susser, 2003). Some men desire to continue reproducing whereas the wife may feel that she has reached her limit. In such contexts, women access healthcare without their partners knowing (Baer et al., 2003). Some healthcare providers take it upon themselves to impose their beliefs when prescribing contraceptive healthcare and if they feel a specific method is inappropriate for a particular woman, they prevent access (Chetley, 1995).

The emergence of contraceptives in African contexts had and still has different reactions and attitudes to them. On the broad spectrum, most women welcome these devices as they can adequately gap the years between their children, as well as have fewer children. With multiple children, women expressed that they are left with the responsibility of tending to the children's needs, which can be tiresome at best (Bawah et al., 1999). Bawah et al. (1999) further stipulate that some women use contraceptive devices only for gapping purposes, but stick to having a large number of children as they feel it is their obligation since their husbands' families paid bridewealth.

Before the emergence of contraceptive devices, couples used the process of abstinence to gap their children, therefore the positive outcome for men concerning contraceptive devices was that they were able to fulfil their sexual desires with their wives (Bawah et al., 1999). These benefits of contraceptives for relationships also had negative responses. Some women's husbands were not understanding of the women's plea for fewer children, therefore the women would avoid mentioning contraceptives at all costs, as a way of avoiding being beaten by their partners for mentioning the topic (Bawah et al., 1999). The women also expressed fears of their partners cheating on them because of the suppressed libido that accompanies some contraceptives (Bawah et al., 1999). Alternatively, Kaler (2003) discovered that some women in Zimbabwe were happy with the effects of the suppressed libido as it would give them an excuse to not engage in sexual relations with their partners.

Other fears involved the cost of contraceptives. Most women in Bawah et al.'s (1999) research indicated that they were unemployed, therefore they relied on their husbands for the majority of the financial expenses, and the thought of having to ask for money for contraceptive devices caused fear.

One aspect that emerged from both Kaler (2003) and Bawah et al.'s (1999) studies was the influence of the in-laws on the wife. They perceived contraceptive devices as entirely contradictory to the cultural ideologies as the primary purpose of the wife and paying the brideprice was for her to birth many children to expand their name. Therefore, most of the women experienced ambivalence in that regard, although Kaler (2003) discovered that some women in polygamous marriages would take contraceptives as a way of preventing falling pregnant as they did not want the burden of taking care of a large number of children after the husband died.

3.5 CONCLUSION

This chapter engaged with some significant literary contributions that speak to the social aspect of pharmaceutical distribution and use. It contextualised how contraceptive pills embody the character of the space in which they are. With a combination of background information of the reproductive healthcare in Zimbabwe, it further paints a useful picture of how pharmaceutical products, and in particular contraceptive pills, are used and perceived in Zimbabwe. The chapter also considered views from other contexts on how the presence of contraceptives impacts gender roles. The body itself is subject to cultural interpretation because whatever the body takes in, goes through a similar process of being defined based on the context.

CHAPTER FOUR:
SOCIAL UTTERANCES OF THE BODY

4.1 INTRODUCTION

The body is an entity that represents different things for different people in different contexts. The female body, however, evokes greater reactions and interrogations from different entities. For the longest time the female body has had people and institutions spending exhausting amounts of time and energy looking for ways and means to regulate and direct it. This chapter intends to engage with the experiences of contraceptive use among women of Kadoma concerning their bodies, as a way of canvassing the individual, social, cultural, and political influences that exist in Kadoma. This section discuss four aspects in order to bring the influences to light.

This chapter starts by introducing the 12 women who are at the heart of this research, as well as the population centre ambassador. Then, a discussion around sex education is essential, with a particular focus on the type of information that family, education systems, or peers provide to women. Knowing this information creates a connection with the kind of perceptions the women have of family planning. Secondly, a few of the women expressed the fact that they changed contraceptive methods for different reasons until they found a suitable one and others were still in the testing stage. It is a process that is important to highlight because the majority of the reasons lay in the altered states in which their bodily functions or feelings fell. The third aspect revolves around the issue of body ownership; this part engages with how they exercised their rights over their bodies in an unconventional manner, which leads to the interrogation of the concept of human rights and the societal manner in which it is expected to play out. Lastly, based on the observations and conversations, it became quite clear that the heavy presence of contraceptive pills in Kadoma is a medical solution to socially relevant matters, therefore a discussion on the medicalisation of these social ills is vital. These influences, as mentioned earlier, allow us to view the body as a fluid entity that negotiates between biology and social, cultural and political, depending on what occurs around the body at a particular time and setting.

4.2 THE TEACHERS OF CULTURE

During this research, I became acquainted with 12 women who had different and similar accounts on contraceptive use. Each of them welcomed me into their homes which are their personal space to share their stories. I also spent time with the population centre ambassador who ended up sharing more information than I had anticipated.

This section dedicates to giving a bit of background information on the difference these key informants, particularly highlighting the nature of our interactions. They freely imparted their knowledge on contraceptive use in Kadoma which richly fuelled this dissertation.

The first six women are residents of Ingezi Township and the other six women reside on a farm compound colloquially refer to as kwaGreen, positioned between Ingezi and the city centre of Kadoma. Lastly, the population centre ambassador was based at population centre in Rimuka.

4.2.1 Danai

The first home that I visited was Danai's house. Ingezi is structured in a way whereby there are a few wide roads demarcating the areas and in those areas the road stems off into narrow passage-like streets that cannot fit a car. A person would therefore have to park at the end of the narrow road and walk to whichever house they wished to go. Danai's house was located three houses down from the beginning of the narrow stretch.

Upon arrival, it seemed she was anticipating my arrival as she was waiting by the gate to welcome me. We entered her home through the kitchen door and she directed me to sit on the couch in the living room. The house was dark with very little light coming in through the window. The rooms that I walked through, which were the kitchen and living room, were also quite small but immaculately furnished with large furniture. She definitely took pride in the appearance of her space. She was living with her two sons as she recently got divorced. The former husband paid for most of the expenses pertaining to their children, so she was able to easily transition into the new setting.

I was offered a cup of tea and some biscuits, which I accepted. She sat with me and we had a conversation about her experience with contraceptives. She was very relaxed and comfortable, probably because she was in her home and we had prior interaction before I visited her. She was a former user of contraceptives as she stopped using them after her marriage ended. Her input was still important as she had the experience of accessing the pills formally and informally.

4.2.2 Fadzai

The next woman I spoke to was Fadzai, who lived a few streets from Danai. She is a 32-year-old unemployed qualified electrician and a single mother of a boy. She lived in the house with her grandmother and a younger male cousin. The month of December in Kadoma is not only wet but it also gets quite hot, so when I arrived, she was sitting outside with her grandmother, close to a makeshift kitchen they had created in the corner of their small yard. At that time, Zimbabweans were experiencing load-shedding almost on a daily basis. The electricity would go off in the morning and it would be turned on late in the evening. Therefore most households that could not afford gas or paraffin stoves created makeshift kitchens in the backyards where they could make fire for cooking purposes.

I was offered a seat, which was brought out from inside the house by her cousin. I was introduced to the members of her family, who stood up and left after the introduction, which indicated their awareness of why I had come.

The houses in that street were all connected wall to wall and each house had a small yard only in the front. Fadzai's front yard was paved, except for a small section that was turned into a vegetable garden with the essential daily vegetables growing there. Next to that was a large cage that was erected from the ground by large poles. In the cage were rabbits that they bred and sold as some people enjoy rabbit meat.

Fadzai did not have much financial support from the father of her child, therefore within their household they found ways of sustaining themselves and also relied on remittances from her aunt. She was not particularly interested in looking for employment in her field of qualification; rather she had hopes of returning to school and obtaining a teaching qualification. Like Danai, she also had experience with accessing contraceptive pills formally and informally.

4.2.3 Ruramai

Ruramai lived in a different section than Danai and Fadzai, as she was located where the mini-plots in Ingezi are located. Most people practise subsistence farming on these mini-plots, and they sometimes sell the produce if it is in excess, otherwise most people live on the produce. The most common crop is mealies, accompanied by a vegetable garden that has a variety of leafy vegetables, pumpkins, and sweet potatoes. Another item of produce that stands out not only in Ingezi but throughout Kadoma is the mango, therefore every mini-plot looks like a mango orchard. Very rarely are the mangoes sold as most people have at least one tree in their yard so it would be a wasted effort.

I arrived at Ruramai's gate, where I was assisted by a young man who told me she had gone out but she would be back shortly. He was her son and he suggested that I wait for her inside. I opted to sit outside in the yard as it was quite hot on that day. I perched myself on a rock, strategically under a mango tree.

Ruramai made use of her small piece of land, which she inherited from her parents, by building outside rooms that she rented out. She also made use of the main house, which is quite large, by renting out the rooms that are not in use.

When she arrived, she invited me in and I sat in the living room with her as I waited for her to settle. When she finally joined me, we exchanged pleasantries and went straight to the conversation. It seems the common pattern was to access contraceptive pills formally and then transition to the informal way, which is what Ruramai did as well.

4.2.4 Tendai

Tendai was a housewife who lived in the newly developed part of Ingezi. She was a 24-year-old mother of one and married to a local businessman.

Their home was more spacious than the other houses I had visited. After they bought the house, they renovated it and put in extra rooms. When I arrived, the gate was open so I let myself in. The yard, although small, was bigger than the others and it was covered with granite stones on the one side, indicating where their car would park. I approached the door and knocked, and she welcomed me in. She directed me to sit

on the couch in the living room. She had a few relatives over as their son was soon to celebrate a birthday and they had come to help with the arrangements of the party. They were in the middle of watching an Indian telenovela, which is quite popular in Zimbabwe, so I had to wait until it was finished to get private time with her.

After the programme was finished, she invited me to go sit outside in the shade while the relatives continued with their visual indulgence. As we settled down, the domestic helper brought us a tray of refreshing juice and some snacks.

Her experience with contraceptives was quite interesting. As a woman who had financial advantages, one would assume that she would access her contraceptives from private facilities. She expressed her awareness that she still was young and she wanted to go back and complete her O Level so she could get into a college to obtain a diploma in something. Having another child at this stage would therefore get in the way of this process. Unfortunately her husband saw no reason for her to go through that process as he told her he was capable of taking care of her and all she needed to worry about was their child and their potential future children. This led her to taking contraceptives secretly, therefore her initial and continued point of access was from informal traders.

4.2.5 Kundai

Kundai lived in the street I was currently residing in at the time. She went through the process of changing contraceptive methods because of side effects that caused her discomfort as well as an unexpected pregnancy.

She was living with her parents as her boyfriend had not completed the process of paying the bride price (*roora*) so they could reside together. He would therefore visit every weekend to see her and the baby.

I arrived at their home, where she was sitting outside, anticipating my arrival, while she watched over her 18-month-old baby playing in the yard. She stated that she did not want to have to answer questions regarding contraceptives in the house as her parents were home and she did not want them to hear anything she said. She therefore felt that there would be a bit more privacy outside. I did not protest as her

ease during the interview was my main concern. It is important to note that she was pregnant and a few months away from giving birth.

4.2.6 Sekai

Sekai is a 19-year-old mother who had a baby at the age of 17. Although the father of the child is still in her life and they live together, her relatives took great concern with her reproductive health after she gave birth, urging her to utilise a contraceptive as soon as possible.

Her boyfriend, whom she lives with, is a soldier in the Zimbabwean army, therefore he is not home most weeks as he is based in a different town. He usually comes home for two weeks, then he goes back. When I went to see her, her boyfriend was at work and she was alone with her son. She lived in the newly developed area in Ingezi, therefore their house did not have a wall or a fence to demarcate it from other houses or the street. Their home was small and cosy, suitable for a small family and these newly developed homes had toilets built inside the house, not outside like the other parts of Ingezi. It was a one-bedroom house with a living room and they used the small passageway as a makeshift kitchen. Since they had just recently moved in together, they did not have much furniture – just a few things that their parents had handed down to them to help start them off.

When I entered, she placed a pot of water on her two-plate stove to boil for our cups of tea. I was invited to take a seat on the couch, where she joined me. Her son was out in the front yard playing with the children from the neighbouring houses.

Although she was quite young, she did not seem overwhelmed by the responsibilities of being a young wife and a mother; however, she expressed missing the nonchalance that comes with not having too much responsibility. This ease, I would assume, comes from the fact that she chose to live with her boyfriend regardless of protests from her family members, who advised her to go back to school in order to gain a form of independence. This scenario is contrary to other situations experienced by young women who fall pregnant around the same age as she did. The population centre ambassador whom I spoke to expressed that if a girl falls pregnant while still under the parents' guardianship, they are immediately sent to the house of the child's father, whether she lives with the father of the child or the parents of the child's father.

Although it is treated as a “cultural” act to make the process dignified, it is actually done because most households are not economically capable of managing an additional person, therefore it is easier to transfer the responsibility to the paternal family members of the child, who are deemed the real family of the child on a kinship level.

One of my many cousins arrived on Monday morning to fetch me as she knew a place where she thought I could find people to speak to with regard to the matter at hand. One skill I perfected while I was in Kadoma was the skill of walking, even though public transportation is readily available, accessible, and affordable (going for R5 a trip). If you are not in a hurry to get to where you want to go, the general perspective is to rather walk. So we walked to where my cousin had a connection.

My cousin’s in-laws live on a farm between Ingezi and Kadoma along the main Harare road. We did not use the main road to get there; we walked inland, which consists of bushveld that was being cleared to accommodate new homes. The farm next to the farm we were headed to was previously owned by a family with the last name Green for decades. Therefore the area is referred to as kwaGreen, implying Green’s place, regardless of the numerous different owners to succeed and regardless of the fact that there are other farms with their own histories in that space.

We arrived at my cousin’s in-laws’ farm, where we were received by her aunt-in-law, who came out and directed us into the house. We were asked to sit in the lounge. It was an old farmhouse that still had many of the antique furniture of the previous owners. She served us flying termites, which were pan roasted, and Mazoe juice, as we waited for her to join us.

When she sat down with us, my cousin introduced me to her and after the formalities of greetings, I explained my research topic and requested to speak to the ladies who stayed on the farm compound on her property. She granted me access but before she let us go through, she expressed her thoughts on contraceptives. She stated that many mothers were now sending their children to the clinics to get a new implant contraceptive called *Jadelle.* Most mothers, according to her, were terrified of how much teenage pregnancy in the area was increasing, therefore they, in panic, thought the best way was to protect their teenage daughters with contraceptives.

We left her farm house using the back door and we took a walk across the fields where cattle were grazing alongside a man-made path. The farm compound was behind the fields and is where the workers and their families lived. The houses were thatched *rondavels* (huts) with no fences to demarcate one household from another. From the outside looking in, the structure of the compound therefore portrays a strong sense of community. When we arrived in the space, most of the people were sitting outside on their verandas. I could see from a distance that they had noticed our arrival. At that point my cousin returned and I was left to my own devices.

4.2.7 Chido

I approached the first home at the compound, where a lady was sitting outside. I introduced myself and stated the purpose of my visit. I asked if it would be okay to ask her a few questions and she welcomed the proposal, and this pattern was repeated throughout my time at the compound. She was a conservative 40-year-old woman with three children. She lived with her husband and survived by doing odd jobs on and off the farm. Chido started using contraceptive pills in 1999, which she stated she has only ever accessed from the clinic. Her role was vital as she presented a viewpoint of formal accessing which emphasised the idea of choice is a part of the health-seeking process.

4.2.8 Chipo

Another woman, 42 years of age, who uses contraceptive pills, was particularly interesting. I was anticipating to meet her as the farm owner had made me aware of her and stressed that I should not leave without speaking to her. She was of particular interest because she had nine children, therefore I wanted to find out whether it was her wish to have a large family or it just happened, as some would say.

She was seated on the floor outside her *rondavel*, breastfeeding her new-born baby. She was very welcoming and I joined her on the floor. I sang praises of her baby and introduced myself and my intentions. At the time I was not aware that she was the “infamous” woman that the farm owner was raving about, and although there were a few children playing close to us, I did not make the connection. After getting through

the introduction, she stated that she had nine children and that she had overreached her limit.

Her current husband had erected extra rooms in order to accommodate the large family as she was living with her children even though the current husband was not the biological father of them all. They made ends meet by the father working on and off the farm, along with her oldest child, who was born in 1987. At the time of the research, she was not working as she had to be home to take care of her 10-day-old baby, whom she was nursing during our conversation. She expressed that she used the contraceptive pill for as long as she could remember but it did not work in her favour as she ended up with so many children. Her reason for not trying other methods rested on the fact that she had lost her clinic card and had not had the chance to obtain a new one, although she was considering using *Jadelle.*

4.2.9 Vimbo

The following household was met with rejection as the woman was not interested, but her neighbour, Vimbo, called me over as she wanted to talk. She was a 24-year-old mother of one. She invited me to sit down with her on a straw mat in the shade of her home. Ever since the birth of her child, she had been taking the pill as she and her husband were not ready for another child. She expressed that she accessed her pills formally from the population centre, and she was more interested in asking me questions. All of the women I spoke to at the compound stated their dedication to the formal points of access.

4.2.10 Rudo

At this point, I had attracted some kind of attention among the women in the compound, to the point where I was being summoned to the different households as opposed to me going to attempt to negotiate interview time. This was slightly worrying to me as I feared it would compromise the responses I received. At that point I did not think too intensely about it as I was immersed in the field, and I continued with the conversations.

Rudo was one of the youngest women I spoke to. She was an 18-year-old mother of one living with her boyfriend. After she gave birth to her daughter, she used

contraceptive pills obtained from the population centre for the first few weeks after birth, then she stopped and had the *Jadelle* implant put in.

4.2.11 Paidamoyo

This 24-year-old mother of three was working as the domestic helper for the farm owner and her husband tended to the odd jobs around the farm. She represented the young women in Kadoma who got married at an early age. It was a common trend as few had opportunities to further studies, let alone finish school. So economic stability lies in matrimony. This was a convenient job for them as they did not have any expenses for transport. She previously used the pill but then shifted to having the loop inserted at the clinic for free, which, according to her, was better than having to buy pills she occasionally forgot to take.

4.2.12 Runako

This was the last woman I spoke to as the rain started pouring as we were rounding off the conversation. She was a 20-year-old married mother of two whose husband, and like the other women, worked on the farm. She stayed home to mind the children, therefore she was not working at the time of the interview. She was comfortably using contraceptive pills, which she obtained from the population centre, although she was having thoughts about changing to the birth control injection *Depo-Provera*.

I ran to the main farm house for shelter, where I reviewed my notes as I waited for the rain to subside so I could make my way back home. When the rain eventually stopped, I thanked my cousin's aunt-in-law and left. As I was about to exit, it just so happened that some of the women I had spoken to were also making their way to Ingezi to pick up a few groceries. On our walk back, the conversation turned and they asked me questions to satisfy their curiosity as to why exactly I was asking questions about contraceptives. After reaching a point of understanding, they expressed that they thought I was from the clinic or population centre so they were quite disappointed when I left the compound without giving them any pills. This made me wonder whether some of the responses were strategic as a way of gaining favour from the "care worker" to gain access to free contraceptives.

4.2.13 Itai - Population Centre Ambassador

He is the population centre ambassador, and I met him through my cousin's husband who took me to his offices opposite the population centre. The offices are also supposed to function as a recreation centre for the community but the only recreational activity I noticed was a small marimba group. His central role is to create campaigns around family planning

He gave me background information on their role as a centre and what their aim was. He was a big advocate for contraceptives as a way for eradicating the issues that exist in his community. The motto that they were pushing in their campaigns was "children by choice, not by chance". I had approached him to get a general sense of how the rightful distributors of contraceptives felt about the pills being available on the black market. I had wrongfully assumed he would not have much to say about the matter, so I initiated the conversation by allowing him to explain what he did and what role the centre played in the community. So the majority of the conversation he gave me a necessary perspective on what community members expect as well as how they deal with those expectations. He also painted a picture of the nature of the gender dynamics among people of Kadoma which added texture to the conversations I had had with the women. As an end not I asked him I asked him if he knew about contraceptive pills from their centre being sold on the street and in people's homes. He responded with ease "yes of course, sometimes when we go for outreach programmes I give away boxes to the women in the community, and I also give to my friend who lives in South Africa so she can sell to other Zimbabweans there". His response confirmed the role that health professionals play in fuelling the informal market.

4.3 SEX EDUCATION AND FAMILY PLANNING

Family planning is the manner according to which people decide how they want to manage their child-birthing processes by the use of clinical methods, particularly contraceptives.

The population centre ambassador nicely summarised the most commonly favoured contraceptive methods in Kadoma, which were confirmed by the women I engaged with throughout the research:

> *"Most women use tablets. There is breastfeeding secure and non-breastfeeding control. Tablets are affordable. You get tablets for six cycles going for one dollar. So one of the requirements is a pregnancy test, so some women cannot afford so they buy informally. Another form of contraception used is* Depo-Provera*, it is cheap and it works for three months at a time. There is the morning-after pill, which is used a lot by students. The problem is they use it regularly as a form of family planning whereas it is only supposed to be used once in a blue moon when there is an emergency. We also try to look for long-term methods to make available to disadvantaged women as we cater to many people who earn little or nothing at all. Examples are* Jadelle*, the loop, and* Implanon*. We are seeing many women dying because of lack of adequate gapping."*

The women had a similar understanding of family planning as the population centre ambassador, showing a level of clear understanding of the reason behind their contraceptive-usage behaviours. Fadzai, in her definition, emphasised the idea of choice about family planning as an essential factor and the ability for one to control a situation:

> *"Family planning is all about having a baby when you want, and when you are prepared for parenting instead of having it by mistake."*

On the other hand, to Chido it was simply about *"preventing having many babies"*, about having an adequate number of children, and the ability to have methods to control these aspects.

Sekai's notion of family planning was more emotively based as she reflected on her role as a parent:

> *"It means a lot to me, and it is my way of preventing unwanted pregnancies so that I can take care of my son and provide things he needs since we do not have much to provide for more kids at the moment and to also give him a long period of love and affection without sharing with another kid."*

Ruramai agreed with Sekai, and added to the idea of gapping as an important factor as

> *"it is helpful so you can raise your children well and have their ages properly spaced"*.

Chipo provided a direct translation from English to ChiShona, stating that *"[f]amily planning means* kuronga Mhuri*"* (literal translation: to plan a family). Danai gave a more holistic take on family planning as she also included the prevention of HIV/AIDS as a part of family planning.

These women's definitions of family planning biomedically showed a clear understanding of what the contraceptive pills were for and how they were to be used based on clinical standards. This is important to mention as Kadoma is a space that embodies different ideologies around health and illness. Identifying these women's thought processes around family planning therefore allows this research to position the behaviour that occurs regarding contraceptives.

From there, I took it a step further and asked their source of information with regard to sexual matters and family planning. Most of the women stated that the talks family members gave them were not explicitly about sex but rather about how not to get in a situation where you were tempted to engage in sexual activity or fall pregnant. This general perception correlates with the definitions of family planning as there was very little to no detail on the connection of family planning and the actual sexual act but rather the general view was that family planning was for the management of what results from sex.

Tendai expressed that her sexually related education came from her grandmother:

> *"She advised me about* zvinhu izvi *[these things] growing up, she said I must get married first then have children as that is the proper way."*

Tendai referred to the education around sex and sexual health as "these things", implying that there was a substantial dialogue that occurred between her and her grandmother. Kundai's account confirms the dialogue as her account gives specific details that Tendai most probably did not feel comfortable sharing. It is not to imply that their experiences and information received are the same, but the involvement of

a senior woman who is not the mother is similar, not because the mothers are not present but because that is the protocol.

Other women were given guidance after they made their families aware that they were pregnant. As one woman recalled:

> *"My mom advised me about it when I was pregnant, and she was advising me not to have another one too quickly."*

Other women expressed how family planning, or rather ideas of it, came from sources outside the family unit – mainly learning from school, peers, and healthcare service centres.

Vimbo, on the other hand, indicated that not all growing-up situations entailed guidance, as she recalled:

> *"Just figured things out on my own, never really got guidance growing up on these matters."*

It did not seem to bother her as she managed to reach certain milestones without guidance from parental figures in her life.

In the realm of African knowledge sharing and receiving information exists a certain level of secrecy that protects that information, where it can only be accessed by elders or those who would have reached a particular milestone to gain access to it. Ashforth (2005) explains this as a way of protecting the information from misappropriation. Also, the secrecy maintains the image of sacredness that exists around the information.

Kundai, on the other hand, gave an account of her experience with regard to her sex education from her family when she turned 13. She described this ritual as a rite of passage that articulates a transition from being a girl to being a woman. This transition rests on creating a physical distinction between girl and woman. Turner (1967) discusses the presence of certain acts in a ritual that clearly defines the transition from one social status to another. Although Kundai, after the ritual, was not a fully fledged woman based on their definition of a woman, she was on the transitional path of becoming a complete Shona woman who will possess all the social qualities, acquired through information passed from her female elders as well as physical qualities, as she illustrated in her account:

"So when I started my period, my mother is the one who helped me with the small things like getting pads and teaching me how to put it on and stuff. She also gave me a talk about hygiene during periods. So the following weekend, when I had completed my cycle, we visited my aunt (father's sister) who lives in Rimuka, it was a typical visit, so I did not think anything funny. Later on, when everyone was finished eating, and people were relaxing, my aunt called my cousin, who is the same age as me, to the spare room and me, so we thought she needed help with something. She made us sit down, and she said she wanted to talk to us. So she started by saying that we were now big girls and there were things we needed to know. She also gave us a talk about being clean all the time and staying away from boys before we got married. Then she explained that in order for us to find a suitable husband we had to have particular things on us to attract the guy. So our older cousin was also there during the discussion, and she showed how her privates looked. So my aunt said ours had to look like that also so that we could attract a husband and he will not run away. She showed us how to pull the sides of the privates using some herbs and that if we did it every day, they would grow fast. So because she did not check, I decided not to do it because it was too much work. I think it is those things they did long ago, but these days people do not follow that much."

Kundai's account is not intended to speak for the other women, but it shows how sex education in that context focuses on working towards getting into the institution of marriage and staying in it, then having children within that marriage. Perez, Bagnol, and Aznar (2014) state that the purpose of this rite of passage is to qualify a woman as suitable for marriage because elongated labia is believed to increase the sexual pleasure of a man, and as a result, not only can she please him but she can also keep him. Having them elongated also means a woman would encounter fewer complications during childbirth (Perez et al., 2014).

Kundai's choice to not follow the recommended methods is a reflection of her response to the transitional process, as well as the ability to not conform to set expectations because of her ideological mindset that she has developed and acquired.

Although all of the women I spoke to were on some form of contraceptive method that they seemed to be satisfied with, they did not wish their children to use those methods. Therefore, even though they subscribed to using contraceptive pills or getting an injection every three months, they did not necessarily feel as though that was the right way to approach family planning. Chipo portrayed this notion by saying that she

> *"would not recommend a teenager to go on family planning [and] would rather work hard as a mother to get her to preserve her purity"*.

Fadzai agreed with Chipo's viewpoint as she rejected contraceptives as a sustainable method, by saying:

> "*I would rather advise my children* kuti vazvichengetedze *[directly translated: to take care of themselves, implying to maintain their virginity as long as possible until marriage] rather than advising them to use contraceptives*."

These women's perspectives were slightly contradictory to their situations as most of them had children out of wedlock and at a young age, but they maintained the importance of having sex and giving birth to children in the sanctity of marriage. Their discomfort in expressing matters relating to sex further emphasises the secrecy around it and how someone must reach a particular milestone to gain the privilege of knowing certain things.

4.4 TRIAL AND ERROR

An understanding of family planning and how it should work for each person is accompanied by a particular method that is well suited for each person based on different factors to characterise that suitability. Some maintain the method they started with as they encountered no problems, others go through a few before they reach a suitable method, and others have to experience some discomfort to be compelled to change from one to another.

In a context where biomedicine is at the core of health matters, indigenous knowledge tends to be overlooked. Although the women did not give accounts of personal experiences with indigenous forms of family planning, a sense of knowledge around the different methods did exist. It is an important aspect to document because we can assume that, accompanied by a need to access contraceptive pills in alternative

spaces from the centralised place, there will also be a need to access alternative methods.

This idea arose during a casual conversation I had with my great aunt's friend who usually came to the house to visit. She pointed out that not everyone uses Western forms of contraceptives because some churches shun them, and she knew that some very remote communities around Kadoma practised alternative forms. She pointed out one that she knew, and from there I made a point of casually asking if people knew of any alternative forms. Unfortunately, I did not come across anyone who actually practised the methods to corroborate the stories. However, I felt it was interesting to mention that the knowledge of them existed, regardless of my lack of tangible evidence.

She said she knew of a traditional method where an elderly lady in your family takes you to a particular shrub, which you have to jump over. Another method involves a woman placing two seeds from the marijuana plant in her vagina before sexual contact to prevent pregnancy. Similarly, one can smear the juices from a tree called *mukutura* on the underwear you intend on wearing when you engage in sexual activity with your partner; it is said to be useful if you keep the underwear on one leg during sexual intercourse.

Ntozi and Kabera (1991) recorded similar accounts in Uganda. Their intention was first to learn what types of family planning methods the people of a small rural area in Uganda knew and which ones they used. These included both biomedical and traditional methods (Ntozi & Kabera, 1991). They found that the women knew a variety of family-planning methods that were traditional and biomedical in nature. The women who knew most of the methods were women between the ages of 30 and 49; the age range is significant because these were women who wanted to wait a bit longer to have another child or to stop having more.

The government of Uganda is aware of the traditional methods, therefore the nurses usually discourage the women who visit the clinics from using them (Ntozi & Kabera, 1991). These methods consist of herbs, amulets, and rituals.

The herbs are used in different ways, depending on the type. Some are made into a medicinal drink to be drunk regularly, and others are attached to a belt worn at all

times (Ntozi & Kabera, 1991). The herbs are inserted into small incisions on the body, or they create amulets using the herbs (Ntozi & Kabera, 1991).

These methods presented from Uganda, as well as the ones I heard of in Kadoma, illustrate how people have always wanted to control or manage fertility also probably because traditional methods do not have side effects (Yurdakul & Vural, 2002). In the context of Uganda, people searched for ways to manage fertility because of the age issue. If a woman is above the age of 50, it means she is at a stage where having a child would be shunned and considered taboo, even though she is still able to conceive. Ntozi and Kabera (1991) describe methods that speak specifically to traditional methods for older women.

A woman who is above the age of 50 and who has not yet reached menopause goes through the rituals to ensure she does not continue to have children. One of the rituals consists of the first-born child serving the mother a hot plate of porridge or any other dish. As the first-born child serves the dish, he/she chants to the mother that her/she is burning her ability to produce with the hot dish and taking over the responsibility of bringing more children into the family (Ntozi & Kabera, 1991). Alternatively, if her daughter is married, the mother asks for her son-in-law's clothes so she can wear them during her periods, which is believed to induce menopause (Ntozi & Kabera, 1991).

Although these practices occur, they are not common. Ntozi and Kabera (1991) discovered that most women in the Ugandan village where their study took place preferred the umbilical cord method. It consists of a mother taking her last-born child's umbilical cord and tying it around her waist, and whenever she feels ready to have another child, she removes it (Ntozi & Kabera, 1991). They also use other methods that are universal, such as prolonged breastfeeding (any time more than 19 months), the withdrawal method, and abstinence. Although biomedical options are readily available, some opt for these alternative options.

Religious methods in Kadoma involve women leaving their homes during their ovulation periods. They go to a designated area specifically built for that purpose and return after their ovulation period is over. It requires one to be acutely in sync with one's bodily functions. Woodsong, Shedlin and Koo (2004) discuss how the use of

contraceptives in some religious spheres are denounced as they tamper with the natural state.

Religion and regulating fertility are closely linked. In a more extreme case than mentioned above, Sudan practises a severe kind of birth control that had and still has many human rights activists fighting to get it banned and some parents are also starting to question it (Almroth et al., 2001).

Infibulation occurs within some Muslim communities in Africa (Hayes, 1975). The reason this is done to young girls before they reach puberty is to ensure chastity, to ensure that she and her family are honourable when she gets married (Hayes, 1975).

A midwife usually does the operation. When this happens, the girl's grandmother squats behind the girl and holds her so that she does not move or run away. When the girl is secured, the midwife uses a razor blade to cut off the labia minora and to remove the clitoris (Hayes, 1975). Thereafter the midwife inserts a reed, tube, or matchstick in what is now a wound so that when it heals, a hole remains to accommodate the release of urine and menstrual blood. (Hayes, 1975). The wound heals within 40 days. The girl's legs are kept together for those 40 days so that the wound can close. Hayes (1975) describes this act as a mechanism that slows down population growth because of the challenge women face in engaging in sexual activities.

When a woman first consummates marriage with her husband, the husband first inserts a candle in an effort to attempt to make the hole wider. If they fail, they are forced to call in a midwife to reopen her vagina (Hayes, 1975). In order to maintain the woman's honour, if she divorces or is widowed, she is forced to have the hole reclosed, so she is not get tempted into promiscuity.

Western contraceptives fulfil other purposes besides preventing pregnancy; for example, some are prescribed to regulate menstrual cycles. The traditional method once again involves an older lady taking a young girl to a specific tree in the bush. A girl with menstrual issues is instructed to pluck a leaf from the tree and chew it as she walks away from the tree. As she is doing this, she is not allowed to look back at the tree, otherwise the treatment will not be effective.

Kundai's experience with contraceptives, based on her tone, caused her frustration as she had not found one that suited her well yet. She stated that

> *"after my first child, I tried the pill then it gave me headaches, so I stopped using it. Then I decided to try* Depo*. While I was on* Depo*, I fell pregnant, so now I am going to try* Jadelle *after I give birth and hopefully it will work*".

Her account shows how side effects play a role in the process of negotiating suitability. In the process of taking the contraceptive pill, Kundai had an awareness of a physical interaction that caused her discomfort. Ruramai and Fadzai also used physical bodily reactions as a way of compelling a desire to change from one method to another. Etkin (1992) discusses how side effects are part of a drug's reaction in the body and represent their functioning, even though the reaction produces an uncomfortable feeling. Side effects are a social construction as different social contexts define the state the body should be in when interfacing with a particular scenario.

Ruramai had a similar experience as Fadzai regarding starting with the pill and shifting to the *Depo-Provera* injection and then back to the pill. Her qualms with the injection distinguished her experience from Fadzai's experience:

> *"I am currently on the pill, but I have used* Depo *before. I stopped the injection because I was not going on my cycle, which is not natural ... so I decided to go back to using the pills."*

On the other hand, Fadzai's experience with contraceptives involved two different types, as she started with the pill, then she tried *Depo-Provera*, and then she went back to using the pill. She said:

> *"I stopped with the* Depo *because I bled for three months."*

Therefore, even though contraceptive therapies portray an unexpected reaction, there is a certain expectation that even under the influence of altering mechanisms, the body must stay in its normal state. A state of normalcy is also a subject of debate. Littlejohn (2013) discusses the kind of bodily discomfort brought on by the side effects of contraceptives. Her study illustrates how women in the United States of America feel that contraceptives counteract their role as women, as well as the image they feel they have to portray as women. Hormonal contraceptives are known to alter weight and emotions, which goes against the cultural expectation of what a woman should be, as

well as her ability to fulfil cultural roles adequately (Littlejohn, 2013). Concerning Ruramai and Fadzai, their contraceptive experiences altered their defining factor of femininity, which was menstruation; the one stopped altogether, and the other went on for too long. Therefore neither extremes correlated with the cultural norm of being a woman, which motivated the decision to change methods.

Some women use other women's side-effect experiences to decide whether or not they want to try a particular contraceptive. Fadzai discussed how she engaged with her husband when she was attempting to decide which method to use. They used her friends' experiences as a way of deciding whether or not one would be an appropriate method or not. Fadzai retold her friends' experiences by stating:

> *"Most women we know experience bleeding problems when using* Jadelle *so when my husband heard that, he refused that I use it*."

Other women were aware of the side effects but did not feel compelled to change methods because the side effects probably did not cause too much discomfort or were not significant enough to require a change, as stated by Tendai that the only side effect she experienced was appetite loss.

Moreover, side effects caused great discomfort, but they were unable to afford the shift, so they looked for ways to manage the effects, as well as understanding that side effects are part of the functioning of the therapy. Sekai recalled:

> *"At first I was bleeding for almost a week, and then I was told to use control pills as well to stop bleeding but now I think I am used to it because there is no more bleeding for a week now. It's just my normal period or I can skip a month or two but still it's normal for anyone using* Jadelle.*"*

On the other hand, Rudo expressed distress as she said:

> *"I did not experience any side effects. I only bled when the* Jadelle *was put into my arm. I wanted to have it removed, but it costs 10 dollars to get it out even though it was free to get it put in."*

The effects that contraceptives have on the body alter certain cycles and functions that occur naturally, and this idea does not sit well with some women as anything that alters the natural process is not a good sign. The idea of something occurring naturally,

especially bodily functions, is an expression of the body behaving in a manner that is natural and correct. Woodsong et al. (2004) emphasise this by articulating how culture, not biology, defines what is healthy and normal, and therefore resistance blocks anything that attempts to alter the normal state. For instance, Ruramai stated:

> *"I am currently on the pill, but I had used* Depo-Provera *before. I stopped the injection because I was not going on my cycle, which is not natural so I decided to go back to using the pills*."

The notion of tampering with nature was therefore reinforced by some of the women as they expressed why women who do not have children yet should steer away from contraceptives. Chido said that she would not recommend the pill to young girls until marriage as the pill could prevent them from bearing children as contraceptives interrupt the childbearing process. It was not only directed towards the pill, as Paidamoyo added:

> *"I would not advise my children to get the loop because I want to have grandchildren one day."*

The population centre ambassador refuted these points by saying: *"Contraceptives do not have any effect on women's fertility"*, which is reinforced by scientific evidence (Woodsong et al., 2004).

The other three women used other forms of contraceptives than the pill, although they had initially tried the contraceptive pill but changed methods due to displeasure related to administrative issues. For instance, Paidamoyo mentioned:

> *"I was on the pill when I was breastfeeding my child, but I would forget a lot to take them, so I decided to go for the loop at the population centre, and it was free to get it put in."*

Runako corroborated the effort of having to take pills on a daily basis:

> *"I use the pills which I get from the population centre, and I have to go with a card to get pills. I am thinking of going for* Depo *because taking pills is becoming a job*."

These accounts of the process of method choice and use are a reflection of how different contextual and ideological factors have an impact on the final decision.

4.5 MEDICALISATION OF SOCIAL ILLS

In earlier times it was easy to avoid certain social issues from occurring because the family structure in Kadoma for many households was quite stable, and it was easier for parents and guardians to protect their children from certain things they felt were not good for them and their wellbeing. The economic transition in Zimbabwe caused many guardians and parents to migrate in order to maintain their children's livelihood. Unfortunately, with their migration, they left their children behind, which makes them vulnerable to many social pressures and influences. Remittances from those who migrated also do not arrive at a constant rate. Those parents who did not migrate are unemployed and continuously look for ways to maintain their households. A result of the disintegration of family structures is an increase in child-headed households, or households where the grandmother is the guardian.

A conversation with the population centre ambassador was an eye-opener to the issues they were attempting to deal with on an institutional level:

> *"Right now we are running a major campaign around the town of Kadoma because there are too many incidents of unwanted pregnancies. Another issue we face in the communities is that there are not enough recreational activities that cater to the youth, so the next best thing is sex and alcohol. The biggest issue is that of transactional relationships. People in Kadoma are genuinely disadvantaged, so some parents cannot afford to take their children to school; this negatively affects the young girls because they fall into these relationships with older men so that they can provide for their families. The families will not refuse because the poverty will be unbearable. As a result, we see a lot of teenage pregnancies because the sugar daddies do not want to use condoms and many girls are embarrassed to go to the clinic, so they do not get any form of contraceptive assistance. So they buy pills informally, but that does not eliminate exposure to HIV."*

He also stated that whenever the population centre conducted outreach programmes, they would give away contraceptive pills without the procedure that is done by the clinics, which contradicts what they are aiming to do and instead sends the message that contraceptive pills are a way to deal with the issue. He discussed transactional relationships, which were becoming an issue for young girls. Even though they were

buying contraceptive pills informally and preventing pregnancy, the pills do not address the issue of STIs and HIV.

Scheper-Hughes and Lock (1987:27) assist in defining the scenario above as a form of medicalisation of matters addressed on a social level. Instead, there is a biological solution as “radical changes in the organisations of social and public life in advanced industrial societies, including the disappearance of traditional cultural idioms for the expression of individual and collective discontent … have allowed … medicine to assume a hegemonic role in shaping and responding to human distress” (Scheper-Hughes & Lock, 1987:27).

The population centre ambassador identified the issues as social, but as they undertake the outreach programmes for social change, instead of bringing in social structures to curb the issues, they distribute contraceptive pills. It confirms Scheper-Hughes and Lock’s (1987:28) notion that “reproduction, sexuality, women and sexual deviants” are regulated as a way of serving the interests of the state.

As mentioned before, in the campaigns the population centre pushes the idea of contraceptive pills more than anything else. This brought about questions around condom use in relationships. Some of the women freely expressed how they viewed condoms and their use. During our conversations, none of the women mentioned the condom as a form of contraception, which also affirmed their definitions of family planning.

Fadzai said:

> *“Usually condoms are commonly used by singles involved in sexual activities, but when it comes to the married in our black communities, the men do not want because the condom is also used for preventing HIV. So they feel accused of transmitting the virus; also some say condoms give them an itchy infection if they use them.”*

Kundai confirmed this perception by stating:

> *“They say that condoms are exposed to the sun, which makes them ineffective, so I do not trust them.”*

Most of the women distanced condoms from the marriage realm, as they expressed that other contraceptives that are not condoms are not for anyone who is not married or who do not have a child, because marriage and having a child is a package that goes hand in hand. The justification was that if they used other contraceptives other than condoms, the childless would subject themselves to becoming infertile. These viewpoints are reminiscent of Rwandan relations to bodily fluids. Taylor (1990) indicates how in the Rwandan context bodily fluids are meant to be shared and exchanged. As a result, the use of condoms is not favoured as they create a blockage between people. In this context, therefore, condoms act as a blockage that stops the flow of trust between couples who are married.

Fadzai further emphasised her point as she stated:

> *"I would not recommend contraceptives for my child if she is not yet married, maybe I would give her condoms."*

4.6 WHOSE BODY IS IT ANYWAY?

The social issues addressed above evoked a discussion about the power relations that are at play in the context of the women. Once again, Scheper-Hughes and Lock (1987:28) accurately describe the kind of interplay that occurs in the context of Kadoma, as they state that the "regulation of female sexuality involves, at an institutional level, a system of patriarchal households for controlling fertility; and at an individual level personal asceticism".

Most of the women were either married or living with their partners, and few were single. The discussion about taking contraceptives often occurred between two parties; sometimes it was an individual choice, and in other instances, other influences such as parents, guardians, and peers were involved.

Fadzai was very adamant in mentioning that she had the final say in her choice in using the contraceptive pill. She just engaged with her husband on the matter as a way of having him help her reach a decision that was comfortable for her. An example she gave to support her position was:

> *"He wanted me to use the loop, which goes for 12 years ... I refused!"*

Kundai, on the same matter, followed a more diplomatic approach where she insisted that once a couple is together and are having children together, the womb becomes an entity for both the man and the woman:

> *"The partner must have a say because you both have to agree on a method that doesn't affect your ability to have another child when you are both ready"*.

Ruramai agreed by stating that the partner should have a say in deciding which contraceptives to use but

> *"[i]f he wants me to have children continuously, that is when I will start using behind his back"*.

This is what Tendai and Chido did as they did not have the same ease of communication with their partners as Fadzai did. Tendai felt that she had to resort to using contraceptive pills secretly rather than confronting her husband and telling him she was not ready for another child:

> *"I was advised by my friends to get from the lady because my husband does not know that I am taking, I am not ready for another child, even though he wants more. It is easy to take them without him knowing. I pretend like I am going to the kitchen to do something and then I take. I keep them in the kitchen in the container for mealie meal because I know he never goes there because he does not cook. The other time I put them in the cistern of the toilet but I realised that it was not a good idea because the pills can get wet."*

Chido reflected on having to leave her family planning card at the clinic with the administration of the clinic out of fear that her husband would find out:

> *"I usually request to leave my card at the clinic because I do not want my husband to find out that I am using so I just bring my identification documents when I go to my next appointment."*

The population centre ambassador weighed in on the issue by justifying that *"having lots of children makes some men feel like they are complete men so preventing pregnancy is sort of like taking that privilege away"*.

He further added why the population centre promoted the idea of keeping women's secrets because of the imbalance of power in the relationships, especially in situations where women had become the breadwinners:

> *"One of the main hindrances to women when it comes to family planning is men because most guys are unemployed and are dependent on the women. However, the women believe they cannot refute what the man says because they are raised to be submissive. So by controlling their family planning is how men gain control over the women. So our job is we protect the women's choice to use contraceptives and to keep it a secret."*

The patriarchal desires of their partners govern Tendai and Chido. They have turned the situation around to temporarily suit their lifestyle as at some point the conversation of why children are not coming will probably arise. Their situations interrogate the notion of the action of rights; they may not blatantly come out and loudly denounce their husbands' disapproval, but their act of secretly accessing contraceptive pills indicate that they do not feel ready. The patriarchal system in which they exist is multi-layered, as there are complexities that define and solidify relationships to the extent that an issue they disagree with and which has an accessible solution does not interfere with the relationships. On the other hand, radical feminists may reject this as a form of activism by describing it as "feminism lite" (Kapur, 2012), which is a form of activism that suits the already existing societal standards and is therefore not very transformative.

On the other hand, Sekai had only experienced one form of contraceptive, which is *Jadelle*, an implant inserted inside the arm. She went to have it inserted on the advice of her mother, who did not want her to fall pregnant again soon:

> *"I am using* Jadelle*, and I started using it in August 2013 when my baby was seven months old. My mother advised me to get* Jadelle *because it is for five years and I do not want to have another child so soon*."

In the context of Sekai, socially, she had her child at a stage that was considered too young and as a result she harbours a certain level of guilt that was fuelled by family members who emphasised that she needed to finish school and she had to attempt by all means to avoid having another child soon. Therefore, even if Sekai and her partner may desire to have another child, they felt they had to adhere to the family members' wishes.

Chipo on the other hand stated that the contraceptive methods she tried did not work, which is why she ended up with so many children, and she did not intend having so

many. Maybe she did intend to have a large family, but the hype around her and her children from her neighbours probably made her feel pressured to denounce her outcome, even though she seemed content surrounded by her large family:

> *"I have been using the pill since 1987 after I had my first child, but it seems not to be working. I now get them from the pharmacy, I used to get from the clinic, but I lost my card. I would get six packets for one dollar and the pharmacy it is R5 for one packet. I do not buy from informal sellers because the pills could be expired. Right now I am considering using* Jadelle *because I cannot have any more children. I do not want anymore, this is more than enough."*

4.7 CONCLUSION

This chapter provided insight into the mindset of the women in Kadoma with regard to reproductive matters that affect their daily lives. On an institutional level, they have to deal with certain structures that cause internal battles within themselves. Some manage to work around those structures by strategically exercising their agency, and others emphasise these structures by making them their own. This chapter also provided a necessary perspective of the meanings they attach to the body and bodily functions, which give a clear understanding of the methods they choose to use and their reasons for using those methods. Ultimately, these choices are influenced by the multilayer of factors that exist in Kadoma.

CHAPTER FIVE:
THE SOCIAL LIFE OF CONTRACEPTIVE PILLS

> As medical technology, pharmaceuticals are not only products of human culture, but producers of it. As vehicles of ideology, facilitators of self-care, and perceived sources of efficacy, they direct people's thoughts and actions and influence their social lives (Van der Geest et al., 1996:156-157).

5.1 INTRODUCTION

The distribution of prescription pharmaceutical products occurs in controlled environments that require a formal document certified by a medical practitioner who grants one access to a particular product. It is assumed to be how pharmaceutical distribution universally plays out; however, Van der Geest et al. (1996) prove that the best way to understand the nature of a medicine's lifeline is by focusing on the local perceptions and activities around a particular medicine.

Kadoma is a perfect demonstration of this conceptualisation as informal traders are significant players in the distribution of contraceptives in Kadoma. The reason for this lies in the personal experiences of consumers of the contraceptive pills as they are the ones who make the active choice to choose informal traders over readily available medical practitioners. It shows pharmaceuticals as social and cultural entities (Van der Geest et al., 1996).

The reproductive healthcare system itself shows no signs of distress concerning staffing and resources. It had and still has active campaigns and promotions around sexual health, but surprisingly a segment of this system finds itself situated in the informal sector where it seems to be thriving more than the formal.

People of Kadoma thrive off the informal sector. As a result of the economic depreciation in Zimbabwe, it has become the primary source of accessing and distributing goods and services. Although the situation has slightly improved and people are able to find what they need in the retail shops, a sense of informality stayed with them and they continue with this form of trade.

During the time that I spent in Kadoma, I encountered three different types of informal businesses that differ in operation and location. Although these informal business

spaces provided different things, they each also seemed to distribute pharmaceuticals. I did not, however, “chase” the other type of pharmaceuticals that were available on the market as my focus was on contraceptives. This section therefore uses these three informal business encounters as a way of articulating the social life of contraceptive pills.

5.2 MUSIKA

My first encounter with the informal sector was when I visited the vegetable market near the grocery store in Ingezi. A vegetable market is a characterisation space for most towns in developing countries as this is where the favourite cuisine of the town or city is clearly defined and portrayed.

The vegetable market, Musika, is five minutes away from my home, adjacent to the grocery stores and bottle store. Musika comprises multiple stalls enclosed in a fenced area that is locked up after trading hours. The stalls belong to different people who sell the same type of vegetables. Common vegetables found here are onions, tomatoes, spinach, kale, cabbage, Chinese spinach, and, very seldom, green pepper. To add a special touch, some add fruits, sweets, and biscuits to enhance their stall because almost every stall has the same items and their businesses thrive on regular customers and maintaining those relationships. As a result, most people buy from the same stall every time they visit the market.

I slowly approached the fenced area, paying close attention to the vendors and attempting to determine whom to approach first. I made my choice; she was a short chubby lady who looked as though she was in her late 40s. She was dressed conservatively in a dress and a head wrap. Her mannerism exuded confidence so I figured she would be open with whatever information she might have. I purchased a bunch of kale, onions, and tomatoes for the evening’s supper. After making the purchase, I politely asked if she could help me with some information. I felt that I had to be honest about my intentions to maintain ethical requirements. I therefore introduced a watered-down version of my topic: “I am researching the use of contraception in Kadoma for my university project, so I need to speak to people who use them and people who sell pills.”

She was very quick to dismiss me and tell me that she knew nothing about it, and she suggested I go to the clinic. Her tone was quite aggressive, and she spoke quite loudly, drawing attention to me as a way of discouraging the other vendors from talking to me. It felt quite tense to be in that space, and I decided to leave. As I was walking, I could not shake the instinct that there was something at Musika. I was determined to find out, but I needed to regain my confidence before I returned.
I figured it would be better if I made a second attempt with a different person and get rejected than not try at all.

I took a walk to the grocer, bought a few favourite snacks for the house, and went home to drop off my purchases. After 30 minutes I decided to head back; it was at the heart of the afternoon, so I could take my time.

This time I approached a lady whose stall was slightly separated from the others but very close to the entrance. She looked younger than the rest of the vendors and did not seem to be interacting with the other vegetable vendors. She was wearing a long skirt and a T-shirt with her hair combed back. She seemed quite bored to be there so I assumed she would not mind talking.

I politely approached her and told her my story. She agreed to speak to me. The first question I asked was whether she knew anyone who sold contraceptive pills. She responded that she did. Her willingness to participate probably stemmed from the fact that she was not usually at the stall as she was standing in for her mother who had gone to buy more vegetables for their business. Although she answered most of the questions, she was very hesitant to say where they obtained the contraceptive pills and how. Musika clearly illustrates the importance of the informal sector in Kadoma. It is a space where people feel comfortable buying their vegetables and trust the quality of the vegetables.

Van der Geest et al. (1996:168) state that “[p]harmsceuticals affect people as intimately as food”. This implies that where one buys food and how they prepare it reflect one’s identity and position in society. Pharmaceuticals produce the same kind of reaction; they cannot detach from an individual’s socio-cultural makeup, therefore, where possible, people do their best to enculturate pharmaceuticals to fit their daily lives.

Tendai is a clear reflection of this as she obtained contraceptive pills without her husband's knowledge and she used them in secret. Therefore, in order for the secrecy to play out well, it must be incorporated neatly into her daily life so that it does not blatantly feel like she is leading a double life:

> *"I am using pills, and I started using them after I gave birth to my son, so I usually buy from the lady whom I buy vegetables ... I was advised by my friends to get from the lady because my husband does not know that I am taking. I'm not ready for another child, even though he wants more."*

This setting is therefore convenient for her as she can buy her contraceptive pills at the same time as her vegetables, which avoids any suspicion from onlookers, and particularly her husband. Going to the clinic or pharmacy would require her to make a trip to these facilities, and because she does not work, her husband would be suspicious of her regular trips to town. It also merges the contraceptive pills into her usual routine of buying vegetables.

The vegetable vendor articulated their role in the community as providers of what the people need:

> *"They come to us because they do not want the hassle of going to the clinic."*

Fadzai confirmed the vegetable vendor's views. She was using the contraceptive pill; she started by obtaining them from the pharmacy in town, but then she changed to buying them from informal traders at a market near her:

> *"I got the pills from both the pharmacy and an informal seller. The pharmacy was okay, but it was becoming too far to go there, and they also asked too many questions sometimes. The informal seller was much easier to access, five minutes I would be there."*

This is reaffirmed by Van der Geest et al. (1996), who stress that at the heart of the field of medicine are the medicines themselves, therefore if the medicines, which are the tangible things that people are after, are readily and directly available with no other processes except purchasing power, then there is no reason to visit a healthcare facility to get the "thing".

This is confirmed by Fadzai, who said:

> *"I would not have to stand in a queue, and she did not do any tests. Also, you are familiar with the person at the market."*

Fadzai's last statement articulated a factor that is desirable in the informal space that is not available in the formal space, which is a sense of familiarity. Njaya (2015) discusses this as a form of social capital, and he explains that informal businesses work best when there is a form of connection between the customer and the supplier. Informal businesses thrive on the interpersonal aspects of a relationship, and in order for them to be successful, they must cater to the customers' needs. Van der Geest et al. (1996) confirm this perspective by stating that informal traders are closer to the customers than healthcare practitioners and they engage with customers with much more respect.

5.3 MUDZIMBA

In the fourth week of December, I travelled to Rimuka, another popular township, where I was hoping to meet people who sold contraceptive pills from their houses. Rimuka is a high-density location, just like Ingezi. Most of the houses are four roomed, and those with the financial capacity usually take the liberty of extending the houses, in the process sacrificing the yard space that is already minimal. I was to spend the week in Rimuka with my aunt, who occasionally sells contraceptive pills in South Africa to Zimbabweans. I travelled from Ingezi by taxi to the city centre of Kadoma, where I got onto another taxi to Rimuka. Similar to Ingezi, I spent much time in Rimuka as I also have many family members there. My familiarity with Rimuka is not as deep and emotive as Ingezi, even though I was born in the township of Rimuka when the clinics used to have maternity functions.

My aunt was also quite resistant to go into the details of how she obtained the contraceptive pills. She just stated that if someone placed an order for them, she would obtain them and deliver them when she travelled to South Africa. She was very keen, however, to connect me to women who she knew were selling.

When I arrived, I rested for about an hour before we went around the area. We spent most of the day going to different houses of people she knew who sold contraceptive pills. We visited five different homes of different women in different sections of the

location during the week, each of the houses accessible by foot. We did not have an issue gaining access to their homes as they were familiar with my aunt. A problem arose, however, when it came to attempting to extract information. In each of the houses, they admitted to selling contraceptive pills at some point but mentioned that they no longer sold them and therefore could not talk about their experiences, or that they did not have supply so they could not talk. It was clear that what they were saying was "I know what you want to know, but I choose not to tell you". I did not probe further as I did not want to put my aunt in a difficult position with her peers and I did not want them to feel as though I had come to challenge them in their own homes. At this point, I was at a dead end with regards to those who sold contraceptive pills. I was happy, however, that I had confirmed the speculation that people sold contraceptive pills from their homes.

The distinctive factor about home businesses is access. The only way you can know that someone sells a specific good or service at a particular home is through networks. One must have heard in passing or asked where to obtain them and be told in order to know that a particular home sold contraceptive pills. If it was not for my aunt who connected me to the women who sold from their homes, I would not have had access to their homes, even though I did not obtain much verbal information from them. It reiterates Njaya's (2015) point that the key to the success of an informal business is through the relationships that are created and maintained.

Ruramai's reason for buying from informal sellers seemed to be about the idea of privacy, which reflected in her response when she stated that

> *"Going to the clinic is not a problem; I favour the woman who sells from her house because I know her and it is just easy. And no one needs to know what you are doing; that's what I like. At the clinic sometimes you bump into people you know, and then they ask you what you are doing there and all. I feel it's not their business, but you do not want to be rude so instead go to the lady and avoid seeing neighbours. I trust the home seller because I know her and I always check the expiry date. You should not just buy from anyone who says they sell pills. If you go to just anyone, then it is risky."*

This is another illustration of how a consumer of medicine chooses to define the manner in which they experience how they gain access to a product. The informal

sector provides the type of platform that reflects the manner in which the women of Kadoma want to engage with the healthcare sector, particularly in the process of accessing medicines. Despite the risks of accessing informally, which Ruramai was well aware of, she continued with the informal trader because feeling a sense of privacy when accessing something so personal as contraceptive pills was very important to her.

5.4 OPEN MARKET

I then went into the city centre to the open market where one can buy second-hand clothes and other items at cheap prices. The open market is in what was supposed to be the parking lot of Pick n Pay. As I was walking out of the supermarket, I saw a few women rattling pills that looked like contraceptives. I eagerly approached them, and my biggest mistake was to propose to ask questions for my research rather than expressing interest in buying, which I think would have elicited a bit of information. They were quite blunt and stated that if I was not buying, they had nothing to say to me. I walked away and sat by the benches outside the supermarket, and I watched to see who came to buy from them. Unfortunately, I discovered this late as I would have dedicated a few hours a week for that observation. During that time, no one came to buy but because the women did not stop rattling the pills implied that there was some demand. What was also outstanding about this observation was that even though police officers walked past them, the traders did not seem threatened by their presence.

Based on Danai's explanation, when accessing pills from the open street, you approach whoever is advertising the tablets and you make your purchase with no questions asked. She stated that she used contraceptive pills from 2005 to 2009 after the birth of her first child. Initially, she obtained the pills from the population centre, then she changed to obtaining them from the informal traders located on the side streets in town because of the strenuous process of the population centre:

> *"Back then it was not a problem to get pills from the population centre, but it started to become a bit of a mission because the process to get them was becoming too much. So what you have to do first when you get there is to take a pregnancy test if you are not on your period. Then you have to buy a book*

which they keep at the clinic as a record of your visits. Then you also buy a card, which you keep and take with you to the clinic, so when you get the pills, they put a stamp on that card. It is just too much work."

She also mentioned that it was too stressful to go to the population centre and that the process at the population centre caused her to experience some form of anxiety towards the process and/or space. Her statement shows that the process of accessing contraceptive pills at the population centre can be an inconvenience, therefore obtaining from an informal trader is easier. She supported her buying from informal traders by saying:

"The packets are sealed so there is no reason for me to feel suspicious about them."

Danai's account reflects standardisation of population control on a global scale. Her experienced is mirrored by Lock and Nguyen (2010:122), as they discussed the process that women in Pakistan go through to access contraceptive pills.

"Clients must pay a 'small cost' consisting of initial and follow-up fees. The service will not be valued unless people are made to pay for it. Women wait minimally for over an hour to be seen (during which time they could be working) and are then granted a minute or two by the doctor unless it is the first visit, when an internal exam is required. It is not explained to women why such an exam is necessary. People on injectable contraceptives must buy their syringe and for any other test."

This similarity in experience implies that the same procedure is used to distribute pharmaceuticals in different contexts and this is where miscommunication occurs as the context does not always embrace the procedure for social, cultural, and political reasons.

5.5 EFFECTS OF FORMALITY

The vegetable vendor was not too keen on sharing how the process of obtaining the contraceptive pills occurred, probably assuming that I had intentions of infiltrating the business. All she said was:

"We usually travel to Harare to get the batch of pills every month".

Luckily other informants generously expressed how people can easily gain access to contraceptive pills for personal businesses ventures, such as the population centre ambassador who is responsible for campaigns at the centre, who expressed his hand in distributing contraceptive pills to women who sell informally as he felt there was nothing wrong with it and that access was everyone's right.

> *"I do not have a problem giving away pills for free when we go for our outreach programmes. I do not see anything wrong with it at all. I am … helping our women. I also supply for my friend who lives in Johannesburg so she can sell to Zimbabweans in South Africa."*

His positive response showed how easy it is for people to access contraceptive pills to sell informally. Although he portrayed himself altruistically, I am sure he sold the pills to the women for redistribution as opposed to just giving them away. His response also speculatively justified why the young lady at the vegetable market was slightly resistant to reveal their distributor out of justifiable fear of getting in trouble.

A similar outcome was discovered by Van der Geest et al. (1996) as they saw how healthcare workers had a hand in the informal distribution of pharmaceuticals, not only within the realm of the institution but also outside of it. The justification from his perspective is financially based, whereby the state inadequately pays its staff, therefore staff members look for alternative ways to boost their earnings.

A casual conversation with a group of women revealed another method some people, particularly women, used to access contraceptive pills in excess without having to involve an intermediary. Most access points do not have computerised systems, therefore it is effortless to manipulate the system.

One of the women described it as follows:

> *"It is straightforward, there is a clinic here, in town, KuRimuka and Waverley and other places. One person can open an account in all those clinics using the same name and ID, and they leave with pills. So you do not even have to have an inside connection."*

This "rebellion" against the system is a clear response by the people of Kadoma to how they think and feel about the distribution style of contraceptives. As a result,

explanations such as lack of education do not fit in this context as the women were well aware of what is available to them, how to get it, and make use of those resources.

This type of response to the functionality of the healthcare facilities produces two outcomes. The first is “non-compliance”, whereby the behaviour of the patients reflects their thought processes against that of the healthcare practitioner, and in the process, the medical practitioner loses a bit of their authority over the patient as their authority lies in the compliance of the patient (Van der Geest et al., 1996). In this context, Kundai portrayed the success of the medical practitioner because of her positive experience in the clinic setting:

> *“I got the pills from the clinic. It was easy because there are no queues for family planning. It is more expensive to get from the women who sell from their houses because they sell a packet for a dollar whereas at the clinic it is a dollar for four packets. It is just that if it is your first time you have to take a pregnancy test so they can put you on record, so that is why others buy from homes because they do not have to go through that process.”*

Chido also expressed a good experience with the formal sector:

> *“I use pills I get from the clinic or the population centre. At the clinic you can get six for one dollar, and at the population centre, you can get five for one dollar. I avoid those that are sold outside the clinic because they could be expired.”*

Vimbo’s decision to access from the formal traders was because of economic reasons on her part:

> *“I use the pills, I started using in 2012. I get from the population centre because getting from people who sell from* dzimba *(homes) are too expensive*.”

5.6 CONCLUSION

This chapter illustrated how the social construction of an object occurs. Before selling or distributing a pill in a particular space, it is just a pill. Once it is in a particular context, it plays a social role because of the political, cultural, and economic perspectives that the receivers of the pill possess. It then defines how that pill circulates within the space and also what it means as a social entity.

This chapter also illustrated how the manner in which these pills are bought and distributed reflects what the people of Kadoma look for in such an interaction. We also see that the already existing structures can be altered to fit what they want and what makes them comfortable. In this case, the informal business space allows them to play out pharmaceutical transactions in ways that best suit their needs, from avoiding their bodies being prodded and probed to avoiding strict husbands from knowing their secret activities.

CHAPTER SIX:
CONCLUSION

6.1 CONCLUSION

This dissertation examined informally traded contraceptive pills in Kadoma, Zimbabwe. The question that guided this dissertation was: *What pathways to contraceptive access characterise the use of prescription and under-the-counter contraceptives among women in Kadoma?* It allowed for an adequate interrogation of the informal and formal spaces of distribution.

The research location was Kadoma, Zimbabwe, and the main reason for examining the informal trade of contraceptive pills in Kadoma was to shed light on the new trend of buying prescription medication from informal spaces. The main aim was to understand the reasons for this despite threats of expired and counterfeit pills. Interest in this research topic emerged from the discovery of the sale of contraceptive pills between the borders as Zimbabweans sold these pills to Zimbabweans who live in South Africa. I therefore decided to trace where the contraceptive pills were coming from, and I discovered that there was also a market for the informal pills in Kadoma. I then concluded that the issue was not Zimbabweans not wanting South African contraceptive pills, but it was instead an already entrenched culture of informality that they continued. My focus on Kadoma was therefore strategic in understanding the foundational cause of this phenomenon.

Initially, the research intended to focus on both the consumers and the distributors of the contraceptive pills, but as a result of resistance from those who sell them, it was difficult to collect stories from their perspective. The research then turned its focus to 12 women who actively used contraceptives. These women were not only informal users but formal users as well. It was strategic to bring light to both perspectives and to therefore make sense of one over the other.

The research occurred from the end of November 2015 to early January 2016 during university recess. During this time, I conducted a qualitative study on the informal trading of these contraceptive pills with a particular focus on 12 women's perceptions as the greatest informers of the information produced. A population centre

ambassador provided necessary information that contextualised the nature of contraceptive use in Kadoma, and different casual social encounters directed me to spaces where I could find the active trading of such pills.

Within the qualitative method, I made use of ethnographic research as my core method. Doing ethnography allowed me to immerse myself in the space, which gave me much insight into the activity of buying, selling, and using contraceptives. I focused on three different neighbourhoods, and in each neighbourhood, I encountered different forms of informality and formality. The starting point of the fieldwork was Ingezi, then kwaGreen, and lastly Rimuka. The city centre at the end of my stay became very useful and provided necessary observations to conclude the study.

A casual conversation was the starting point of my field experience as the women I had the casual conversation with led me to the 12 women who participated in the research. The use of purposive sampling assisted in narrowing down the necessary criteria in picking the women. Along with the ethnographic experience, which involved observations and participant observations, in-depth semi-structured interviews were used to gain more detail of the 12 women on different occasions.

During this fieldwork, the dilemma of doing ethnography at home appeared as I found myself renegotiating my position in a place that was home. It was a necessary exercise as I was then able to embody my role as a researcher and was able to engage in and be aware of occurrences that I would not have noticed if my positionality was not in question.

I was also able to gain access to archive material from a nurse at one of the clinics. This information provided detail on the protocol that nurses are trained to follow in order to administer contraceptives. It gave me great perspective as it reinforced the standardised nature of the clinic spaces that evoked anxiety among those who then shifted to informal access.

Different types of literature influenced this dissertation. Outlining the nature of family planning and reproductive health in Zimbabwe from its emergence into Zimbabwe to date gave the dissertation a necessary foundation of being able to trace the way forward. It allowed a better understanding of the transformations. In the same vein, a similar approach was used to understand the nature of informal businesses in

Zimbabwe. It gave meaning regarding possible reasons why the informal space is a safe space for accessing contraceptive pills. The informal space provides social qualities that are lacking in the formal space, such as familiarity with the seller and a relationship of trust, as opposed to the rigid interactions in healthcare facilities. The next stage of literature analysis spoke to the social nature of these pills. Their social nature presents itself in the distribution, as per the general population. The literature around this allowed viewing pills not just as a tool of biomedicine but rather as an entity on their own that provide healing and relief for whatever the person who was taking it wanted to heal or fix. Lastly, the relationship that the pills have with the body further informs the role the pills play in gender dynamics, as well as the kind of power the pills can give or take away.

The findings that emerged from the fieldwork agreed well with the presented literature. The findings diverted into two major themes that appeared throughout the research. The first stage of findings introduced the women as a way of describing the physical experiences with the contraceptive pill. These findings dealt with socialisation as a way of informing the contraceptive method choice, as socialisation teaches one how to view the body and how to treat it. As an extension of that experience, the side effects related to the different methods the women tried also contributed to informing them whether or not they were suitable methods for their bodies or not. The side effects for some of the women were also related to the cultural construction of the natural state. The issue of medicalisation is a reflection of how contraceptive pills have become embodied in Kadoma's ideological constructions, and as a result, these pills are used to solve social issues. Lastly, the negotiation of autonomy over this provides the viewpoint that reproductive organs belong to the collective, as opposed to the individual, after marriage. The presence of these contraceptive devices therefore creates a redefinition of those ideas.

The second part of the findings engaged with contraceptive pills as social entities. It identified the significant informal spaces that were commonly used to obtain these pills. These spaces, which are the vegetable market, people's homes, and the open market in town, possess their own stories and characteristics despite all being under the umbrella of being informal. Within that, women chose different informal spaces depending on which space resonated with them the most.

Ultimately, this dissertation has told a story about women in Kadoma who informally access contraceptive pills. The different reasons articulated lead to the idea of autonomy, “the ability – technical, social and psychological – to obtain information and to use it as the basis for making decisions about one’s private concerns and those of one’s intimate” (Hindin, 2000:257).

The informal access of contraceptive pills by these women is a representation of their ability to decide to access them where they choose to and not where they are instructed to as it is not power that they seek but rather autonomy. It also portrays their ability to access even when they are told not to. Their purchasing actions are not a form of activism against the patriarchal contexts in which they exist or the government system that defines the processes of accessing. Preferably, this is a creation of a space that suits their lifestyles and ideological influences as a woman’s autonomy lies in her ability to control her fertility (Browner & Perdue, 1988).

Women’s bodies are subject to constant surveillance and scrutiny, especially their reproductive functions as the value of a woman’s body to society is in its ability to reproduce (Browner & Perdue, 1988). The women in this research study purchased informally as a way of reclaiming their bodies for themselves.

Browner and Perdue (1988) developed hypotheses relating to autonomy and fertility. Although these hypotheses were not confirmed in their study in Mexico, certain aspects of them resonate among the women of Kadoma. The women nicely summed up what the informal buying and selling of these pills meant to them, as well as their journey to attain autonomy over their bodies. In a patriarchal society where female fertility is regularly monitored, women tend to look for alternative ways to secretly accomplish fertility regulation, be it traditional or other methods (Browner & Perdue, 1988). Some of the women detailed how they secretly accessed contraceptives so that their husbands would not know to give them the freedom to attain personal goals because women who exercise reproductive autonomy exercise autonomy over their lives (Browner & Perdue, 1988). Zimbabwe is a country that is deeply entrenched in the value system that in a household the final say for whatever discussion occurs goes to the husband, including family planning decisions (Hindin, 2000). The two married women who accessed contraceptives informally were therefore reacting to the

negative response from their spouses and decided to take matters into their own hands to satisfy their own needs, and thus reclaimed their autonomy over their bodies.

The informal traders take it a step further by creating a space where these women can exercise their autonomy without feeling any sense of guilt. The interaction between the trader and the women represents precisely that – they do not ask questions or give any unwanted advice. They maintain a consumer-retailer relationship. In order for this to be genuinely successful, a certain kind of trust must be in place.

Grimen (2009) explains how to trust one person can be a power base to another, and this euphemises the kind of relationship that a doctor and a patient normally has. The patient has no choice but to trust the doctor because the doctor possesses the knowledge, which gives the doctor power. In the context of Kadoma, the informal traders did not play the role of healthcare practitioner, therefore no power dynamics were involved. As a result, they allow the women to feel free and comfortable to maintain those relations.

Another leading factor that emerged was the nature of the pills in the informal space. Informal medicines are not only available in Kadoma. The demand for them goes right across the African continent. In some countries, there is a legitimate shortage of drugs at healthcare facilities, while others do not have a medicinal access issue. There is simply an overall interest and preference for pharmaceutical products on the street.

This “liberalisation of pharmaceuticals” (Baxerres & Le Hesran, 2011:1255) gives people the opportunity to access medication in whichever manner they wish, despite the apparent risks of expired products, counterfeit drugs, or poorly stored ones. This type of access therefore seems to be about people taking control of their bodies and what goes in it, as well as having the ease of not feeling interrogated just so they can access objects. The women in Kadoma confirmed this liberation because they do not have to be present for their contraceptive refills, which makes the experience well suited to their lifestyles.

6.2 RECOMMENDATION

A recommendation for further research on this topic is to provide a type of inventory of the array of prescription pharmaceutical products that exist in the informal spaces in Kadoma to further define the nature of pharmaceutical products in social spaces.

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