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Silent politics and unknown numbers: Rural health bureaucrats and Zambian abortion policy

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ABSTRACT

This article addresses the gaps between knowledge, policy and practice in reproductive health by exploring the processes involved in translating Zambian abortion policy from paperwork to practice in a predominantly rural province. Central to these processes are rural health bureaucrats, who are tasked with administering and monitoring a myriad of reproductive health policies and programmes. The articles is based on eleven months of ethnographic fieldwork in Zambia from September 2017 to August 2018, including in-depth interviews with rural health bureaucrats and participant observation in health management and policy meetings. It examines how health bureaucrats deal with the abortion-related challenges they face. Our findings reveal a complex landscape of reproductive health politics and moral double-binds and give insight into the gap between Zambia's seemingly liberal abortion policy and the lack of access to abortion services in rural areas. Despite the bureaucrats' knowledge about abortion policy, none of the hospitals in the study province offer legal abortion services. While many bureaucrats consider abortion to be a public health issue and see the need to offer legal services to abortion-seeking women, they often bypass abortion-related issues and treat them with silence in policy meetings and public settings. The silence corresponds with the lack of data on abortion and post-abortion care in district and provincial health offices and should be understood in relation to both the dominant moral regime of the Zambian state and global pressure towards specific reproductive health targets. This article calls for increased focus on politics and power dynamics in the state apparatus in order to understand the gaps between knowledge, policy and practice in sexual and reproductive health.

1. Introduction

Along with maternal and child health, sexual and reproductive health (SRH) occupies a central position in the global development agenda (Andaya, 2014; Austveg, 2011; Storeng and Béhague, 2014). Critical scholars have raised concerns about the narrow perspective of global evidence-based policies, suggesting that this may reduce complex SRH issues to technical solutions such as the distribution of modern contraceptives or skilled attendance at birth (Austveg, 2011; Behague et al., 2009; Jaffré and Suh, 2016; Storeng and Béhague, 2014). They contend that this technical focus fails to consider the important cultural and religious contexts in which potentially controversial SRHR policies are implemented (Austveg, 2011; Kumar et al., 2009).

While recent decades have seen improvements in worldwide indicators of reproductive health, there are still enormous inequalities in access to SRH services on the ground. Although sub-Saharan Africa has been a focus area for global commitments towards reproductive health for decades, such inequalities are particularly evident in this region. Two thirds of the world's 300,000 maternal deaths (WHO et al., 2015) and more than sixty per cent of all abortion-related mortality (WHO, 2011) occur in this region despite decades of family planning programmes and safe motherhood policies.

In the socio-religious context of global politics, abortion remains a

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contentious issue that is often neglected or left out of global treaties and goals on SRH to avoid controversy (Grimes et al., 2006; Kumar et al., 2009; Suh, 2019b). When it is addressed, abortion is commonly discussed in terms of legalization or criminalization (Berer, 2017) and permissive abortion laws are often seen as synonymous with access to safe abortion services (Ganatra et al., 2017). The passing of a law that allows abortions is far from sufficient to prevent girls and women terminating their pregnancies in clandestine and unsafe ways (Blystad et al., 2019). Since abortion policies are considered more controversial than other SRH policies, the dynamics of and challenges to their implementation emerge more clearly than in other areas of SRH. Abortion policies may thus serve as an analytical catalyst helpful in increasing our understanding of how SRH policies are implemented.

This article takes Zambian abortion policy as such a catalyst and explores the processes of translating it from policy documents to practice. In Zambia, where abortion has been legal on broad grounds since 1972 (GRZ, 1972), complications from unsafe and clandestine abortions are common and constitute a considerable problem for women's health (Owolabi et al., 2017). The paradox between an apparently liberal abortion policy and girls' and women's limited access to abortion services allows us to investigate the subtle mechanisms that maintain the gaps between knowledge, policy and practice in reproductive health.

We conceptualize policies as continuously contested and reshaped (Shore, 2011) and consider how they migrate into new settings and interact with social agents in dynamic processes with consequences beyond their original intent (Haaland et al., 2019; Shore, 2011:3). This conceptualization brings to the fore the actors involved in translating policy into practice, and provides insight into a broader set of social and political factors which condition policy implementation. In particular, this article focuses on rural district and provincial level health bureaucrats, such as district health directors or maternal health coordinators, as key policy actors (Bierschenk and Sardan, 2014; Goetz, 1997) and scrutinizes their way of handling Zambian abortion policy. In the hierarchy of the Zambian health system, they are placed immediately above, but in close contact with the managers of district health facilities who are directly in charge of clinical service provision. The bureaucrats' position allows them to instruct and advise hospital managers, including in questions of SRH policies. To better understand rural health bureaucrats' role in translating Zambian abortion policy to practice, this article also includes the voices of hospital managers. Rural health bureaucrats are tasked with coordinating and monitoring the health services of their districts (GRZ, 2017d) and form the lowest level of health administration They commonly have a clinical background, but have been promoted to positions in health administration where they work in district or provincial health offices that coordinate the local health systems through planning, budgeting and monitoring of health facilities. This locates them at the intersection between the rural clinical realities they are set to govern and the political state apparatus they represent (GRZ, 2017d), potentially a unique position to influence how and if legal abortion services are offered within their districts.

Central to our analysis is Morgan and Roberts' concept of *reproductive governance* (2012). Morgan and Roberts argue that sexuality and reproduction are governed by subtle mechanisms of differentiation organized in moral regimes that cut across multiple scales from personal and intimate behaviours to public and political judgements. Drawing on Foucault (1998) and Fassin (2007, 2009) they introduced reproductive governance to trace the "shifting political rationalities directed towards reproduction" (Morgan and Roberts, 2012:241). They emphasize how a variety of actors, including state institutions, religious organizations and NGOs, make use of "economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices" (2012:243). Morgan and Roberts provide an analytical terminology helpful in analysing the underlying mechanisms, beyond legal frameworks, which are involved in translating reproductive health policies from documents to practice.

Attempting to understand the gap between the "epidemiologically and demographically measurable logics of" SRH policies and the culturally-embedded structural and professional aspects of SRH services, Jaffré and Suh (2016:176) call for an anthropology of interfaces. They argue that the technical language and underlying assumptions of evidence-based health policies fail to consider local meaning-making around key topics such as fertility and family planning and encourage empirical investigations of the "social and technical interfaces of reproduction" (Jaffré and Suh, 2016:175). This article responds to Jaffré and Suh's call by examining the position of rural health bureaucrats as a "site of interface" (Jaffré and Suh, 2016:176). Their position constitutes an empirical entry point to the intersection between the technical rationalities of reproductive health policies, the political context that surrounds them and the realities of rural health facilities where policies are to be implemented. By situating the work of rural health bureaucrats within a larger context of reproductive governance, we use Zambian abortion policy as a case to argue for expanding the analytical perspective to include all actors involved in translating policies to implementation. In doing so, we call for increased focus on political contexts and power dynamics to make sense of the gaps between knowledge, policy and practice in SRH.

2. Study context - abortion in Zambia

The Zambian Termination of Pregnancy Act of 1972 allows abortions when the pregnancy endangers the physical or mental health of the woman or any of her already existing children as well as in cases of foetal malformation (GRZ, 1972). The act states that the woman's age and foreseeable environment should be considered when approving an abortion (GRZ, 1972, 2009, 2017c), and by implication allows abortions on socio-economic grounds broad enough to meet the needs of almost all abortion-seeking women. The law simultaneously restricts access to abortion services by specifying that legal abortions can only take place in registered hospitals and by demanding that three medical doctors, one of them a specialist, have to sign the necessary documentation (GRZ, 1972). In emergencies, the signature of one medical doctor is sufficient (GRZ, 2009, 2017c). Medical practitioners can make use of conscientious objection, refraining from signing off on abortion procedures (Freeman and Coast, 2019; GRZ, 1972). The penal code establishes punishments for unlawful abortions (GRZ, 2017c) and was amended in 2005 to decriminalize abortion in cases of incest or rape of underage girls (GRZ, 2017c).

Data on both legal and clandestine abortions in Zambia is scarce, but recent policy documents from the Ministry of Health refer to abortion complications, the majority from clandestine abortions, causing 6 deaths per 1000 women of reproductive age, and 30–50% of acute gynaecological admissions (GRZ, 2017c). It is well documented that knowledge about the legal status of abortion is poor in the Zambian population (Coast and Murray, 2016; Cresswell et al., 2016) and that access to legal abortion services remains difficult (Owolabi et al., 2017). The literature describes how unsafe abortions cause pain and individual level economic costs (Leone et al., 2016), and moreover constitute an important public health expenditure to the Zambian government (Parmar et al., 2017). While the majority of studies of abortion in Zambia have been conducted in urban areas (Coast and Murray, 2016; Dahlbäck et al., 2010; Fetters et al., 2015; Freeman et al., 2017; Macha et al., 2014; Owolabi et al., 2017), our study is set in one of Zambia's predominantly rural provinces.

As many as 90% of Zambian patients seek health care from the public sector (GRZ, 2017d). Each of the country's 117 or so districts has a district health office led by a district health director in charge of coordinating service delivery. District health directors are appointed and are given the responsibility of coordinating and monitoring health services at all health facilities in their districts. This places them in the lowest level of state administration (GRZ, 2017d). Although all districts

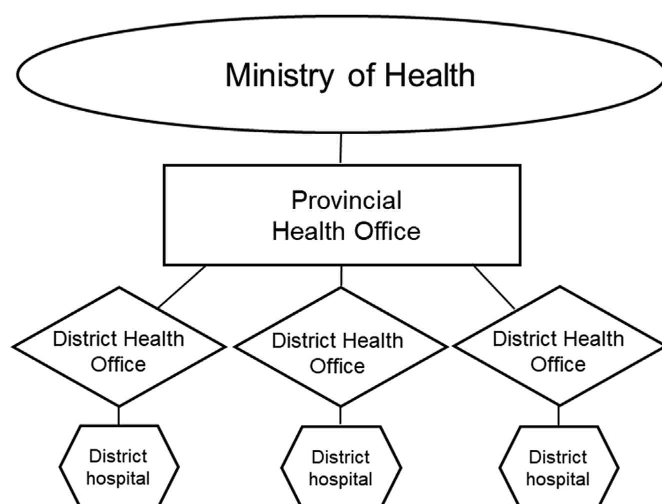

Fig. 1. Administrative structure of Zambian health system.

are supposed to have a district hospital, this is not always the case, but all district health offices administer a number of clinics and health posts that run a series of health programmes, including reproductive- and maternal health. The ten provincial health offices in Zambia function as links between the district health offices and the national Ministry of Health and also provide health care in referral hospitals, commonly located in the provincial capitals (GRZ, 2017d) (see Fig. 1). In Zambia, the health system has gone through a process of decentralization that has shifted power from national to provincial and district health bureaucrats. The process has left the Ministry of Health primarily in charge of coordination, policy formulation, and strategic planning (GRZ, 2017d). The Zambian health system faces considerable problems of staffing, and the severe lack of medical doctors and specialists particularly affects rural areas (GRZ, 2017b).

In the broader socio-political context of SRH, religion plays a significant role. This has become increasingly evident since the 1990s when the second president, Fredrick Chiluba, declared Zambia a Christian nation (Cheyeka, 2008). President Chiluba introduced Pentecostal language and symbolism to the political sphere where they have remained (Haynes, 2015; 2018). The declaration of Zambia as a Christian nation has had wide-ranging consequences for public debate and moral politics on issues of sexuality and reproduction in general (van Klinken, 2018) and on abortion in particular (Haaland et al., 2019; Zulu and Haaland., 2019).

3. Methods

This article draws upon findings from eleven months of ethnographic fieldwork carried out by the first author in Zambia from September 2017 to August 2018. The study employed a multi-sited ethnographic approach to inquiry (Marcus, 1995) and took Zambian abortion policy as the object of study across different sites and actors. The first phase of the study took place in Lusaka, where the first author investigated the origins of the Zambian abortion law and how it is being disputed by political actors today (Haaland et al., 2019). From January to August 2018, the first author relocated to the provincial capital of the study province where she followed the activities of a locally based NGO working on SRH issues and carried out participant observation at a semi-rural health centre with a youth-friendly corner. She took part in daily life activities in the health centre's neighbourhood. Although this article is informed by all the collected material, it is primarily based on participant observation in provincial and district level health management and policy meetings and in-depth-interviews with health bureaucrats and hospital managers in the study province.

The study province is predominantly rural and particularly scarcely populated. As in many Zambian provinces, the population is young with almost half of the population reported to be below 15 years of age in the last census of 2010 (CSO, 2012). The province has only one referral hospital which is in the provincial capital. While all the districts in the province have several smaller or larger clinics and health posts, only six of the districts have a district hospital. To protect the anonymity of the health bureaucrats and hospital managers, we have chosen not to name the study province.

Interactions with rural health bureaucrats started in January 2018 with the process of seeking a research permit at the provincial health office. Since then, the first author had regular contact with health bureaucrats at provincial and district level throughout the fieldwork period. The first author carried out a total of 10 in-depth interviews with rural health bureaucrats in five of the study province's districts. Health bureaucrats were recruited purposefully via e-mail communication. All districts that were contacted received the request positively and invited the first author to visit their district. One of the invitations had to be declined due to difficulties of transportation during the rainy season. The districts were chosen because they had district hospitals with the facilities necessary to provide legal abortions. In each of these districts, the first author also interviewed hospital managers (6) which allowed her to explore possible gaps between how abortion was discussed by bureaucrats in the district health offices and the clinical realities on abortion care in the hospital. She followed up the interviews over the phone. Contact with hospital managers was facilitated by the health bureaucrats in all relevant districts.

Interviews with health bureaucrats took place in the district health offices. Hospital managers were interviewed in the hospitals' administrative offices. All interviews were carried out in English, Zambia's official language and the working language for health bureaucrats and hospital managers. Each interview loosely followed an interview guide with questions about the interviewee's tasks and responsibilities, their opinions and knowledge about SRH in general, and abortion-related issues in particular, as well as their knowledge about the abortion law and its implications for unsafe abortions. All interviews were carried out by the first author and lasted between 40 min and 2 h, depending on the interest and availability of the interviewees. Informed consent was obtained before each interview and when permitted, the interviews were audiotaped. On a few occasions, the interviewees were not comfortable with audiotaping and detailed notes were taken during and right after the interviews. The first author or a research assistant transcribed all audiotaped interviews verbatim.

The first author participated in four health management and policy meetings with district and provincial health bureaucrats. These were meetings where reproductive and maternal health issues, such as maternal mortality, HIV/AIDS or community health services were discussed between health bureaucrats across the province, sometimes with selected NGOs or representatives from national and international agencies. The meetings varied in length from a few hours to entire working days. In each of the meetings, the first author presented herself and her project, making her role as a researcher clear to the participants. Many of the bureaucrats that were interviewed also participated in these meetings. This facilitated insight into the bureaucrats' interactions with the abortion policy and provided arenas to engage in informal conversations (Driessen and Jansen, 2013; Pigg, 2013:128) with health bureaucrats. Participant observation in management and policy meetings, and informal conversations with health bureaucrats were captured in detailed field notes that were taken during and right after the meetings.

Following ethnographic tradition, the process of analysis started during fieldwork and informed the progress of the study. While theoretical perspectives on power (Foucault, 1980) and gender (Moore, 1994) informed the planning of the study, reproductive governance (Morgan and Roberts, 2012) became increasingly relevant throughout the process of analysis and writing. The thematic analysis followed an inductive approach of coding, but these theoretical perspectives guided

the overall analysis process. The collected material that included detailed field notes, interview transcripts and relevant policy documents, was carefully read and re-read before it was coded to identify themes that could inform the overarching question about the gap between knowledge, policy and practice of abortion care in Zambia. The analysis was done at a latent level (Braun and Clarke, 2006:84) where emphasis was put on underlying assumptions and conceptualizations that shape the semantic content. The first author carried out the analysis in discussion about interpretation with the co-authors. The process of analysis included selection of ethnographic descriptions and quotes from interviews that could best convey the content of the themes. Throughout analysis, NVIVO12 was used as a software for organizing the material.

The process of gaining contact with the hospital managers, facilitated by their supervisors in the district health offices, may have influenced discussions. However, hospital managers often spoke in contradiction to statements made by their supervisors, suggesting that they spoke freely. The first author's position in the field, as a European researcher with a special interest in SRH shaped interactions during fieldwork. Health bureaucrats and hospital managers used phrases like "*it is not like in your country where you can just get an abortion*", or other statements revealing their preconceptions about her background and position towards induced abortions. Her position will have influenced how interviewees and others responded to questions about abortion. In some cases, interviewees are likely to have adjusted their answers to what they believed the first author would agree with, and in other cases, to mark distance between themselves and what they perceived a European researcher would believe. The first author's position in the field also provided some methodological advantages. She was regarded as someone unfamiliar with the rationalities of Zambian abortion politics and many bureaucrats and hospital managers put a lot of effort into increasing her understanding of the topic. Analysis and writing of the paper are unavoidably shaped by the authors' own positions towards the abortion issue as a question of both public health and women's bodily autonomy. At different stages of analysis, efforts have been made to present preliminary findings to Zambian stakeholders to fine tune the analysis.

University of Zambia Biomedical Research Ethics Committee (009–07-17) and the Regional Ethical Committee Western Norway, Norway (2017/1191) granted ethical approval for the study. Furthermore, the study was approved by the National Health Research Authority in Zambia (MH/101/23/10/1) and the Zambian Ministry of Home Affairs.

4. Findings

4.1. Politics of knowledge

The rural health bureaucrats all showed some familiarity with the Zambian abortion law, and many had experience from larger city hospitals where they had seen legal abortion services provided. The number of girls and women coming to district hospitals with abortion-related complications, a phenomenon that took up considerable time and resources, was a topic that came up frequently in interviews with bureaucrats. While hospital managers had varying personal opinions about the issue, health bureaucrats expressed a pragmatic public health position towards abortion, and considered legal abortion services necessary to save lives. A district health director, for example, was concerned about the lack of safe and legal alternatives for abortion-seeking girls and women and said: *"Even if you don't provide safe abortions they will do it* [have an abortion], *in one way or another. In the community they will do it, in very unhygienic environments and they end up with complications."*

Nevertheless, none of the district hospitals the first author visited offered legal abortion services, except in cases of medical emergencies. In one district, the health bureaucrats held that their hospital did indeed provide legal abortions saying that*: "I think in Zambia there is this service* [abortion] *legally provided and* [this district] *is not an exception. That service is legally provided in our hospital."* However, the doctor heading the district hospital in question stated that abortion services were not offered in his hospital*: "I think it is not legal. We don't do that here.*" He added that he had not discussed abortion services with his supervisors in the district health office since they had never requested information about it as they did for other areas of SRH like distribution of contraception or number of ante-natal check-ups.

At provincial level, another, yet similar, situation presented itself at where a health bureaucrat held that all the hospitals in the province, except for the ones owned by religious organizations, offered abortion services according to the law. He referred the first author to the province's only specialist, who happened to be an obstetrician and gynaecologist, for further information. The specialist, however, disclosed that:

> I'm a specialist, so I have received the training [in legal abortion services], but you know, the law allows you not to do abortions if you are not comfortable. Depending on your consciousness. And I don't feel comfortable, so I don't do that.

On further questioning, the specialist stated that as far as he knew, no other doctors offered legal abortion services at the referral hospital and that if abortions were provided, they were done secretly, without informing him. Considering the requirement of a signature from a specialist for a legal abortion to take place in a non-emergency situation, this specialist's use of conscientious objection effectively hindered most legal abortions in the province. Yet, the provincial health office held that all public hospitals in the province offered legal abortion services.

When discussing abortion, such discrepancies between the statements of health bureaucrats, hospital managers and health workers about provision of abortion services were not unusual. Bureaucrats may of course have wanted to present their district or province as one where national health policies, including abortion policy, are implemented. However the diverging statements about provision of legal abortions also suggests a poor flow of information between the clinical and administrative levels, giving health workers a freedom of action on the abortion issue, while leaving the bureaucrats poorly informed about the actual services provided.

Despite their familiarity with the abortion policy, some bureaucrats would, when asked by health workers, argue that abortions were illegal and instruct health workers accordingly. A district hospital manager described such a case when he explained how he had approached the district health director for advice after a substantial increase in the number of girls and women coming in for post-abortion care: "*but the answer has always been that there is no law allowing abortions."* The feedback confused him, as he had worked in a hospital ward that offered legal abortion services before coming to the study province. Nonetheless, respecting the administrative hierarchy of the Zambian health system (Fig. 1), he accepted the instructions and refrained from offering abortion services he knew were legal. Instead he recommended his abortion-seeking patients to seek help in Lusaka.

The material indicates that the bureaucrats' knowledge of the abortion policy is strategically employed depending on the context at hand, suggesting the political sensitivity of the abortion issue. While in interviews bureaucrats revealed their knowledge of the abortion policy, this knowledge was downplayed or even concealed in situations of direct influence on the provision of abortion services. Abortion policy thus appeared to be an area where silence or avoidance of the topic was preferred, and indicates how a politics of knowledge is played out in the uncomfortable "site of interface" in which rural health bureaucrats find themselves. In the following sections, we further explore some of the subtle mechanisms that underlie the bureaucrats' ambiguous way of handling the issue of abortion.

4.2. Silencing the policy

The silence and avoidance that surrounded the question of legal abortion services became particularly evident when one of the district health directors tried to raise the issue during a provincial level meeting. On a regular basis, the provincial health office convened all district health directors for a regional Maternal Death Surveillance and Response meeting in which all maternal deaths that had occurred in the province during the last three months were discussed. After starting the meeting with words of welcome and a collective prayer, the bureaucrats presented the maternal deaths from their districts, suggested their causes and ways to prevent future deaths. The other participants critically reviewed each case, discussing treatment options, delays in caregiving and other obstacles the deceased had encountered. One of the cases presented was a woman in her thirties who died during the 24th week of her 5th pregnancy. The district health director presented the case in detail, from the woman's first visit to the rural clinic for antenatal check-up, to each step of treatment she had received when she, a few months later, approached her local health post with symptoms of an incomplete abortion. After transport from a health post to the district hospital and a manual vacuum aspiration to complete the abortion, the hospital staff had not been able to stop the bleeding and the woman passed away. At the very end of the presentation, the district health officer added:

> She asked for help to terminate her pregnancy when she came for the antenatal, but the clinical officer present at the time was not comfortable with this. So, we cannot rule out an induced abortion. This is something I would like us to discuss. What can we do when a patient asks for termination of pregnancy? Are there any guidelines?

The case was debated at length: *"The health system has failed this woman"* said one of the participants, *"She was not received by a medical doctor when admitted to hospital, only by a clinical officer."* Others discussed the timing of the manual vacuum aspiration and the delay in transferring her from health post to hospital. *"There are no records of her blood pressure from the antenatal,"* said one bureaucrat, and another complained about the absence of the woman's partner. No one responded to the request to discuss what to do when someone asks for termination of pregnancy.

Present in the meeting were many of the health bureaucrats who, in interviews and conversations, had shown knowledge about the legal status of abortion in Zambia, including the province's specialist in obstetrics and gynaecology who had received specific training on the abortion policy. Notwithstanding, the question about abortion guidelines was never discussed, and was drowned out by details of treatment and delays. After the meeting, the bureaucrat who had posed the question expressed disappointment, but was not surprised about the lack of answers and said, "*You know, Zambia being a Christian nation, I don't think we can do any sensitization about abortion.*"

As pointed to by the bureaucrat, the declaration of Zambia as a Christian nation plays an important role in Zambian politics and figures prominently within the state apparatus. It is annually reinforced in grand state-organized events for the National Day of Fasting and Prayer, declared a public holiday by the current president. Moreover, Zambia is continuously referred to as a Christian nation by central political actors (Haynes, 2015) and in key policy documents such as the 7th National Development plan which states that: "*Zambia being declared a Christian nation will ensure that the development agenda of the nation promotes Christian values and principles at every level of society and governance"* (GRZ, 2017a:30). The declaration thus seems to mark the boundaries of a moral frame within which the state can operate. The bureaucrat's comment about why his question was left unanswered alludes to how the declaration appears to affect unspoken norms about what is socially and morally acceptable for a state representative to say and do, with possible consequences for implementation of the abortion policy.

There are many possible reasons why bureaucrats may express progressive views on abortion in one setting while not in another. Independent of their motivations, the bureaucrats present in the Maternal Deaths Surveillance and Response meeting, chose to keep silent about their knowledge of and experiences with legal abortions taking place in larger city hospitals that could have answered the question raised about how to deal with-abortion-seeking women. This silence suggests a morally confusing situation for the bureaucrats. Placed in an awkward position, they have to choose between acting on their knowledge about the legal status of abortion, that may be considered inappropriate within the state apparatus of the Zambian Christian nation, or silencing the policy by not sharing the knowledge they have. Their silence on the question of abortion-seeking patients draws the moral contours of the scope of action available to rural health bureaucrats.

4.3. Unknown numbers

The health bureaucrats showed detailed knowledge about many areas of their work, including abundant information about local metrics of reproductive health. By heart, they repeated statistics on subjects like maternal mortality, facility deliveries and contraceptive use, indicators used within the Sustainable Development Goals framework (United Nations, 2017). Their descriptions entailed a technical language centred on established indicators for reproductive health, as exemplified in the following statement made by a district health director: *"For 2016, we were at 66* per *100,000. That was the maternal mortality ratio. In 2017 we reduced* [the maternal mortality ratio] *by half and we came to 33* per *100,000 deaths.*" When asked how they had achieved the reduction, he explained that: *"facility or hospital deliveries is one of the indicators which is brought in the results financing* [pay for performance] *project so, SMAGs* [Safe Motherhood Action Groups of community volunteers] *have taken a keen interest to make sure they register women for antenatals, take women to the clinics to go and deliver there."*

When the topic changed to the issue of abortion and post-abortion care (PAC), however, few of the bureaucrats had similar information or used a comparable technical language. On questions of how many of the clinics in his district had equipment and skills to provide PAC, a district health director replied, "*I need to learn about that. I know that* [the district hospital] *has that package. They can provide PAC. But for the clinics, I may not be in a good position to tell who does and does not."* The rural health bureaucrats would use far more imprecise terms when talking about PAC. To describe the magnitude of the problem, they used terms like "*enormous*" or "*it's a problem*", without making references to numbers or statistics. PAC figures were, however, possible to retrieve in the district hospitals. Handwritten sheets displaying monthly numbers of PAC patients and services covered the walls of female wards and staff corners. But PAC numbers did not follow the same flow of information as other reproductive health metrics, and did not occupy a central position in health bureaucrat's descriptions of the reproductive health situation in their districts. A provincial level health bureaucrat offered to "*pull the current numbers on maternal mortality from the real-time database"* for the first author, but he also informed her that *"we do not keep records of PAC on provincial level. You might find them in the hospitals."* Among the many areas of SRH, it was notable how abortion and PAC were given low priority and visibility.

This did not mean that the bureaucrats were indifferent to abortion-related issues. Many bureaucrats specifically welcomed the study because they found its topic important. A provincial health bureaucrat introduced the first author in a policy meeting by saying: "*When she requested to participate in this meeting we thought that it was good to let her, not only because we think she can benefit from it, but also because what she is researching* [abortion] *is very important to us. It is something we should all think about."* The discrepancy between bureaucrats' lack of knowledge about-abortion-related metrics and their view on abortion as an important public health issue reveals a hierarchy of reproductive health

policies and indicators upon which the work of the bureaucrats is evaluated in both a national and a global context. In this hierarchy, the provision of legal abortion services and PAC is placed towards the bottom. This creates a set of conditions that allows and encourages health bureaucrats to bypass the question of legal abortion services as there are few, if any, demands for reports and accountability.

4.4. A policy for urban areas?

Health bureaucrats and hospital managers often talked about abortion policy as something that was only relevant for larger cities. Many questioned whether rural district hospitals were allowed to offer legal abortion services. One district health director elaborated on this point when discussing what he, as head of the local health authority, would answer should hospital staff ask him what to do when someone seeks an abortion: "*I think for our situation we might need guidance, I don't think we can easily go in and say let us do it (…). We need policy guidance.*" When asked why abortions were not provided in his district, the same bureaucrat responded: "*I have worked in Ndola* [Zambia's second largest city]*, where there are many women asking for abortions (…) For bigger towns, yes they can have access to the process. For the smaller towns like here, I haven't yet learnt of that.*"

While there is nothing in the abortion law text that distinguishes between rural and urban areas, health bureaucrats pointed to important social and structural conditions which have implications for its implementation. Lack of qualified health personnel was a problem that caused frustration among health bureaucrats and health workers alike. The medical superintendent of the only referral hospital described the situation in these terms: *"It is a major problem that our hospitals are very understaffed. All these hospitals with one doctor who is always on call. It is not safe."* Lack of medical doctors to provide the necessary signatures for a legal abortion to take place is particularly severe in rural areas. The Ministry of Health, in collaboration with NGOs, have developed a set of national standards and guidelines to provide guidance on how to interpret and implement the Termination of Pregnancy Act (GRZ, 2009, 2017c). The newly revised version (GRZ, 2017c) allows for abortions to take place with only one signature in situations where no other doctors are available. However, at the time of the study, neither the new nor the old guidelines had been disseminated through the communication lines of the Ministry of Health. The absence of the standards and guidelines document, that could facilitate legal abortion services in district hospitals, has particular consequences in rural areas, as compared to urban areas where there are more doctors available.

At the time of the study, most district hospitals in the study province had two medical doctors employed who were rarely present at the same time. Since these were not medical specialists, they were not able to fulfil the requirements for approval of non-emergency abortions. As described above, the only medical specialist in the province, who was based in the province capital, refrained from approving any abortions in the province. The specialist reflected on how his conscientious objection affected access to safe and legal abortion services for girls and women in the province, stating that: "*The problem is that we are not more* [doctors]. *If we were more doctors and specialists, there would be some who were comfortable and who would do this.*"

The presence of NGOs came up as another relevant factor for provision of legal abortion services. In Zambia's bigger cities, access to abortion services by and large relies on the presence of NGOs advocating for and facilitating access to abortion services. In major urban centres, NGOs run a handful of private non-profit clinics that provide abortion services, but the more common mode of operation is for the NGOs to work within the public health system. By supporting abortion services in specific health facilities through training of staff, procurement of necessary equipment and facilitation of the required signatures, the NGOs enable the provision of safe and legal abortion services. This means that access to legal abortion services, though limited, is found primarily in areas prioritized by the NGO sector, predominantly urban areas. While the study province was firmly supported by NGOs in distribution of contraceptives and in other areas of SRH, none of the NGOs working to increase access to safe and legal abortion services were present in the study province, leaving a void both in the political push for and the practical facilitation of such services. A national level representative from a professional organization for health workers explained the situation by making rough estimates on how he thought the uneven presence of NGOs affected abortion services:

> There are some regions that have safe abortion services provided, for example Lusaka, Copperbelt and Southern province. These are the three biggest in our country and they have sort of the most elite populations. So abortion services in these areas are provided through support from some donors and NGOs. So you will find that in these particular areas, abortion is only the fifth cause [of maternal mortality]. In the remote areas you tend to find that it is the second or third [cause of maternal mortality].

The combination of severe lack of doctors, absence of NGOs working on abortion issues and absence of standards and guidelines that offer legal clarity and practical instructions for comprehensive abortion care, constitute important challenges to rural health bureaucrats' actual possibility of facilitating legal abortion services.

5. Discussion

Our findings reveal a situation in which implementing abortion policy in Zambia is far from straightforward. Despite their uncertainties about abortion, rural health bureaucrats did have knowledge about the abortion policy, and many expressed opinions about how legal abortions should be offered within the public health system. However, there seemed to be little room to convey progressive opinions or present knowledge about the abortion policy in health policy meetings or in other public settings. The bureaucrat who raised the question about how to handle abortion-seeking patients represents an exception. While the bureaucrats held some power to influence practice in the health facilities they coordinate, they had few incentives to prioritize abortion services over the myriad of reproductive health programmes given higher national and global priority.

The rural health bureaucrats are located at the crossroads between the clinical realities they administer and the political and administrative system they represent, making their work an interesting "*site of interface*" (Jaffré and Suh, 2016:176). Most bureaucrats were employed in their current post after serving a few years as rural medical doctors in district hospitals. They were often posted to unfamiliar districts and sometimes did not speak the local language. Their new positions as state officials differentiated them from the more clinically oriented role of the hospital managers and offered an attractive alternative to the hardships of clinical work in a rural province with understaffed hospitals. Such positions moreover represented a first step towards a possible career path within the Ministry of Health. There is therefore reason to believe that their new roles oriented them towards the expectations and tasks within the state apparatus with possible implications for their priorities and aims.

Through his studies of African bureaucracies, Bierschenk (2014) has shown that internal motivation and notions of a personal moral contract with the state are strong among those he calls "interface bureaucrats" (Bierschenk, 2014:239) placed in lower ranking positions within the state apparatus. They navigate a complex moral landscape with multiple, often contradictory and rapidly changing official regulations combined with informal, pragmatic and more locally produced norms. Bierschenk argues that informal practices, often contradictory to official regulations and policies, emerge locally within state bureaucracies in response to the conditions the bureaucrats work within that makes them "masters in the selective application of contradicting norms" (Bierschenk, 2014:238). He moreover contends that bureaucrats who work towards the bottom of the administrative hierarchy are easily

paralyzed by a double set of messages from superiors who will promote official regulations and policies, while simultaneously, unofficially, encouraging informal norms and regulations. Such "doublespeak" (de Sardan, 2009:52–53) makes it difficult for bureaucrats to know if their actions are being evaluated on the basis of the official or informal norms, with possible consequences for their future promotions or next postings, creating a situation similar to what Bateson at al. (1956) describe as a double-bind.

The rural health bureaucrats' way of handling abortion policy in Zambia exemplifies such a moral double-bind. In situations such as the Maternal Deaths Surveillance and Review meeting, the bureaucrats must position themselves between the abortion policy, allowing legal abortions on broad grounds, as a formal regulation, and the informal norm of not addressing the question of legal abortions in public settings. Adding to their uncertainty is the lack of national level political commitment to the abortion policy and a failure to disseminate the standards and guidelines document that could offer clarity on how the abortion policy should be implemented. In her study of "kuccha bureaucrats" in Bangladesh, Goetz (1997) similarly notes how bureaucrats may be hesitant to implement what they believe are unpopular policies if they sense a lack of genuine commitment to the policy from policymakers.

Situating the work of the rural health bureaucrats within a larger context of reproductive governance (Morgan and Roberts, 2012) and the dominant moral regime in which they operate, can help us make sense of the bypassing and silencing of the abortion policy. As suggested by the bureaucrat who posed the question about abortion-seeking women in the Maternal Death Surveillance and Response Meeting, the declaration of Zambia as a Christian nation provides some insight into the moral regime of the state apparatus. Since it was first pronounced in the 1990s, the declaration has had important bearings on what actions are considered morally possible and politically viable within the Zambian state (Haaland et al., 2019; Haynes, 2015; van Klinken, 2018). Within the context of the Christian nation, taking a public stand in favour of provision of abortion services, even when they are legal, may become a loud political statement, defying the ideology upon which national identity is grounded. This has created a paradoxical situation in which implementing and supporting the abortion law is politically and morally controversial, while avoiding or silencing it is politically and morally safe.

The lack of implementation of abortion policy in rural Zambia is closely connected to this national moral regime (Morgan and Roberts, 2012) and political context of reproductive governance. It should also be situated within a larger global framework of reproductive politics (Morgan, 2017; Suh, 2019a:276; Zulu and Haaland, 2019). The hierarchy of reproductive health policies that was encountered in our material is best understood in the context of an immense global pressure on SRH. Recently, the current Zambian president added to the pressure as he declared a public health emergency of maternal and perinatal deaths (Bwalya, 2019) enacting his commitment to maternal health with the UN slogan *"No woman should die while giving life."* Global reproductive health politics primarily focusing on technical interventions and limited indicators (Melberg et al., 2018; Storeng and Béhague, 2014; Suh, 2019b) have produced a fragmented landscape for the bureaucrats. At district level, such fragmentation, creating an overwhelming number of targets to reach and policies to implement, allows health bureaucrats to bypass policies with lower priority, such as abortion policy.

Suh (2019a) has argued that metrics are key avenues for global reproductive governance (Morgan, 2017) through which certain practices and interventions are valued over others. The difference we found between how statistics were reported, aggregated and repeated for some SRH issues and not for others exemplifies how such differentiation takes effect in the work of rural health bureaucrats. Notably, the areas of SRH where statistics seemed to flow easily between the clinical and administrative levels coincided with those used as national and global health indicators. Global commitment to SRH is expressed in treaties and goals, such as the International Conference on Population and Development (ICDP) agenda and the Sustainable Development Goals (Austveg, 2011). These are in turn operationalized as specific targets and indicators that become the criterion on which national progress is evaluated and states build their moral authority and legitimacy (Andaya, 2014:50; Bevan et al., 2019; Evans, 2018). Maternal mortality ratio, skilled attendance at birth, use of modern contraceptives and adolescent birth rates are all indicators used in the Sustainable Development Goals framework (United Nations, 2017) and were among the metrics rural health bureaucrats used to describe the situation of SRH in their districts. Abortion-related metrics were not included in such descriptions. While it is difficult to determine whether the bureaucrats are responding to national or global political pressure, Evans (2018) has argued that benchmarking progress towards the Millennium Development Goals, with a certain level of competition between neighbouring countries, led to significant changes in how district level bureaucrats prioritize maternal health issues. Quantification of progress may be effective but paying attention to what is left uncounted (Fassin, 2009; Suh, 2019b) can provide substantial insight into the national and global agenda of reproductive governance (Morgan, 2019). In Zambia, abortions, both legal and clandestine, are left out of the continuous regime of quantification that characterizes other areas of SRH governance.

The moral and political context of the Zambian state apparatus and global political pressure for improvements in SRH operationalized through reproductive metrics, create challenging conditions for the implementation of Zambian abortion policy. These challenges are reenforced by the particularities of a rural Zambian health system entangled in global reproductive governance (Morgan and Roberts, 2012).

6. Concluding remarks

In examining how Zambian rural health bureaucrats handle abortion policy, we have been informed by Jaffré and Suh's (2016:176) call for an "anthropology of interfaces." While Jaffré and Suh focus on studies of hospital settings to increase understanding of persistent reproductive health disparities, our study scrutinized health bureaucracy as a different "site of interface" (Jaffré and Suh, 2016:176). Our findings suggest that increased understanding of the situation of rural health bureaucrats who administer and monitor multiple SRH policies can give insights into why some policies are implemented while others are not. We argue for the need to further expand the perspective from juxtaposing the logics of global evidence-based policies with those of health workers and clients (Jaffré and Suh, 2016) to include more actors involved in translating reproductive health policies from paperwork to practice. When we view rural health bureaucrats as policy actors, working under structurally challenging conditions of rural health systems, and situate them within a larger national and global context of reproductive governance (Morgan and Roberts, 2012), the political climate and dominant moral regimes emerge as highly relevant to successful implementation of SRH policies. By considering the political landscape health bureaucrats manoeuvre, and the moral double-bind in which they find themselves, we gained insight into the gap between Zambia's seemingly liberal abortion policy and the lack of access to abortion services in rural areas. With this article, we add to the voices highlighting the absence of the political in SRH scholarship (Andaya and Mishtal, 2017; Austveg, 2011; Buse et al., 2006). This absence undermines our understanding of stagnating progress in reducing reproductive health inequities. We call for increased focus on political dimensions and subtle power dynamics at play in the field of SRH governance and their implications for girls' and women's reproductive possibilities.

CRediT authorship contribution statement

Marte E.S. Haaland: Conceptualization, Methodology,

Investigation, Formal analysis, Writing - original draft, Writing - review & editing, Funding acquisition. **Haldis Haukanes:** Conceptualization, Methodology, Formal analysis, Writing - review & editing, Funding acquisition. **Joseph Mumba Zulu:** Conceptualization, Methodology, Formal analysis, Writing - review & editing. **Karen Marie Moland:** Conceptualization, Methodology, Formal analysis, Writing - review & editing, Funding acquisition. **Astrid Blystad:** Conceptualization, Methodology, Formal analysis, Writing - review & editing, Funding acquisition.

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