Beyond the Law

An Ethnography of Zambian Abortion Politics

Marte Emilie Sandvik Haaland

Thesis for the degree of Philosophiae Doctor (PhD)
University of Bergen, Norway
2021

UNIVERSITY OF BERGEN

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Date of defense: 18.06.2021

Year: 2021

Title: Beyond the Law

Name: Marte Emilie Sandvik Haaland

Print: Skipnes Kommunikasjon / University of Bergen

Contents

List of Abbreviations

CSE – Comprehensive Sexuality Education

GRZ – Government of the Republic of Zambia

ICPD – International Conference on Population and Development

INGO – International Non-Governmental Organization

MDGs – Millennium Development Goals

MoH – Ministry of Health

NGO – Non-Governmental Organization

PAC – Post-Abortion Care

SDGs – Sustainable Development Goals

SRH – Sexual and Reproductive Health

SRHR – Sexual and Reproductive Health and Rights

TOP – Termination of Pregnancy

UNESCO – United Nations Educational, Scientific and Cultural Organization

UNFPA – United Nations Population Fund

US – United States

USAID – United States Agency for International Development

WHO – World Health Organization

ZDHS – Zambia Demographic and Health Survey

Scientific Environment

The research presented in this dissertation was conducted while I was a PhD candidate (2017-2021) at the Centre for International Health, Department of Global Public Health and Primary Care at the University of Bergen Norway. Throughout this period, I have been affiliated with the Global Health Anthropology Research group, and I have been a member of the Norwegian Research School of Global Health.
I had two periods as a visiting PhD candidate at the University of Zambia, School of Public Health, in 2017-2018 (11 months) and in 2020 (3 months), and I had a short stay as a visiting PhD candidate at the University of Sussex, Centre for Cultures of Reproduction, Technologies and Health (2019).

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Funding for the PhD project was granted through the University of Bergen and the Centre for Intervention Science in Maternal and Child Health (CISMAC) and by Meltzer Research Fund and the Falkenberg Foundation.

Acknowledgements

This dissertation is based on years of work that would have been impossible without the collaboration, companionship, and contribution of many, and I am sincerely grateful to all who have helped me in small and large ways.

Most importantly, I am forever grateful to all my friends and neighbours in Zambia who welcomed me into their daily lives by taking me to church services, the fields, the market and the saving groups. Special thanks to the girls and women who shared difficult and intimate stories from their lives with me; I am still amazed by their strength. I am also grateful to the local NGO that aided my introduction in the study province and included me as a member of its small team. Moreover, a big chunk of this fieldwork would not have been possible without the help of the rural clinic and the enthusiasm of its head, Peter. I am particularly thankful to Christine for hours of practical assistance and her patience in answering my many many questions on our walks on narrow paths.

I would also like to thank my research assistants Kabuswe and Siku for the many hours of work they have put into this project and for our interesting discussions on language, culture and interpretation over the last few years.

I have been blessed with a team of supervisors who not only critically assessed my work and guided me in the right direction, but also provided friendship, laughter and joy. Astrid, I am forever grateful for your careful remarks in unreadable handwriting, but more importantly for our excellent discussions and your ability to push me just a little bit out of my comfort zone. Karen Marie, your careful reading and constructive input has lifted this work, and your confidence in me has lifted my spirit many times. Haldis, I have greatly appreciated our discussions on theory and the enthusiasm you have shown for this project. Last, but not at all least, prof. Joseph, this work would not have been possible without you. I am forever thankful for your gentle way of guiding me through the difficult task of

working on sensitive issues. You have taught me a lot about raising difficult questions in polite ways. I greatly appreciate our many talks along the way.

The University of Zambia, School of Public Health, has served as my academic home away from home. I am immensely thankful to its Dean, Professor Charles Michelo, for welcoming me. Moreover, I am grateful to Maureen Mupeta Kombe for practical assistance and to Margarate Munakampe, Adam Silumbwe and Natasha Chilundika for providing friendship and good discussions during my stays in Lusaka. All the members of the SAFEZT project group in Ethiopia, Tanzania, Zambia and Norway deserve special thanks for their input along the way. Our academic discussions and long dinners with song and dance have meant a lot to me throughout the project period.

I am grateful to CISMAC and the Centre for International Health for providing me with an academic environment that has allowed me to develop and grow as a researcher and a medical anthropologist. Thank you Bente Moen and all members of staff for providing such an environment. I would like to thank Halvor Sommerfelt for his confidence in me and for our interdisciplinary discussions along the way and Ingvild Sandøy for her encouraging nudges and words. A special thanks to the research group for Global Health Anthropology for providing a safe and interesting space for trying out analysis and ideas. I am also grateful to my fellow young scholars for making long hours at the office more tolerable.

The long process of producing a PhD would be unbearable without good friends and colleagues. Among these, I am particularly grateful to Lisa Gullbransson, Nick Grinstead and Hugo for opening their hearts and Lusaka home to a fieldworker in need. I plan to be a life-long guest at the G&G rest house. Andrea Melberg, Kristine Onarheim, Emily McClean and Hanne Keyser Hegdahl have been excellent sources of encouragement and energy along the way, and our academic and non-academic discussions have been of great help. Oda Maraire, Kajsa Amundsen, Malin Kleppe and Erik Sandvik deserve a big thanks for listening to my long accounts of joys and frustrations over the last few years

and Nora Haukali and Ane Straume for the excellent combination of friendship and necessary social pressure to write. I am also grateful to Ingvild Hope for our never-ending chats and laughs and to Kine Skogås Fristad for always being just a phone call away. Thanks to Aldo Dyrvik for both helpful and hard reminders that life is about more than a PhD. Kajsa and Oda also deserve a special thanks for getting me through the hardest moments and pushing me over the finish line.

Lastly, thanks to my parents, Inger and Svein, for always supporting me no matter what I want to do or where I want to go. And a big thanks to my sister, Gry, for believing in me and for always providing the right advice at the right time.

Summaries

Abstract

Every year, as many as 25 million women are estimated to resort to unsafe abortion worldwide. Many of these abortions lead to severe complications and death. Nevertheless, abortion remains a contentious issue that is commonly left out of discussion in global health. When addressed in international fora, abortion is often treated primarily as a legal question, and liberal abortion laws are taken as proxies for girls' and women's access to safe and legal abortion services. Zambia is internationally known to have a relatively permissive abortion law. Nonetheless safe abortions are difficult to access and unsafe abortion remains a considerable health and societal problem, contributing to the high maternal mortality statistics in the country. The inconsistency between Zambia's abortion legislation and the lack of legal abortion services is not well understood, and is the starting point for this study that examines the complex relationship between abortion law, policy implementation and practice.

The aim of this dissertation is to generate knowledge on how articulations between policy, legislation and sociocultural conditions shape women's reproductive possibilities. The study draws on 11 months of multi-sited ethnographic fieldwork that took the Zambian abortion policy as its main object of study and followed its movements across different layers of the Zambian society and health system. The findings reveal that the restrictive elements of the abortion law - which were in focus when it was developed in the early 1970s - resonate strongly with current interpretations of the law, further strengthened by the declaration of Zambia as a Christian nation. Examining the processes involved in translating abortion policy from paperwork to practice, the study reveals unfolding discursive disputes and subtle power mechanisms. Centrally located policy actors in the health bureaucracy are key in these processes that shape and constrain girls' and women's access to safe abortion services. The dissertation argues that strategic use of knowledge and 'ignorance' are core mechanisms for the ways in which the politics of abortion is played

out. The study further investigates the everyday reproductive politics of abortion as it unfolds at the local community level and reveals a tolerance of abortions that are kept out of the public domain, while abortions that become known to the public are made subject to loud condemnation. Informed by Fassin's conceptualization of moral economy, the dissertation discusses how public opposition to abortion serves to preserve the moral self and to strengthen social ties in the community.

Morgan and Roberts' concept of 'reproductive governance' is located centrally in this inquiry of Zambian abortion politics. The concept facilitates an analysis of how abortion governance plays out across social and bureaucratic layers in subtle ways that shape or even impede the abortion policy's on-the-ground implementation. As such, this study goes beyond the common focus on the legal status of abortion and contributes to the literature on how reproductive practices, such as abortion, are shaped by structures of power that operate through a set of visible and less visible tools.

Sammendrag

På verdensbasis er det estimert at 25 millioner kvinner tyr til utrygge aborter hvert år. Mange av disse fører til alvorlige komplikasjoner og dødsfall. Likevel er abort fremdeles et omstridt tema som vanligvis utelates fra diskusjoner om global helse. Når abort tas opp som tema i internasjonale fora behandles det ofte som et juridisk spørsmål om hvorvidt abort er lovlig eller kriminalisert. Liberale abortlover sees dermed som ensbetydende med tilgang til trygge og lovlige aborttjenester for jenter og kvinner. Zambia er kjent for sin relativt liberale abortlov. Likevel er det vanskelig å få tilgang til trygge aborttjenester og utrygge aborter utgjør både et helseproblem og et mer gjennomgripende samfunnsproblem. Utrygge aborter bidrar dermed til Zambias høye mødredødelighet. Det finnes lite kunnskap om hva som fører til diskrepansen mellom Zambias abortlov og fravær av lovlige aborttjenester i landet. Denne studien tar utgangspunkt i denne diskrepansen og utforsker det komplekse forholdet mellom abortlov, implementering av abortpolitikk og praksis.

Formålet med denne avhandlingen er å frembringe kunnskap om hvordan politiske føringer, lovgivning og sosiokulturelle forhold sammen former kvinners reproduktive handlingsrom. Studien bygger på 11 måneders etnografisk feltarbeid som ble gjennomført på flere ulike steder. Feltarbeidet tok utgangspunkt i den zambiske abortpolitikken og fulgte dens bevegelser gjennom ulike lag av det zambiske samfunn og helsesystem.

Studien viser at de restriktive elementene i abortloven, som sto sentralt da den ble vedtatt i 1972, resonerer med dagens tolkninger av loven som ytterligere forsterkes av at Zambia har erklært seg som et kristent land. Videre utforsker studien hva som skjer når abortpolitikk omformes fra dokumenter til praksis og ser på hvordan pågående diskursive kamper og subtile maktmekanismer påvirker disse prosessene som former jenter og kvinners tilgang til trygge aborter. Helsebyråkrater plassert i sentrale posisjoner har stor innvirkning og avhandlingen argumenterer for at deres strategiske bruk av kunnskap og ignoranse er sentrale mekanismer i det subtile politiske spillet rundt abort. Studien utforsker også hvordan reproduktiv politikk utspiller seg i hverdagslivet på lokalsamfunnsnivå. Den finner at aborter som holdes utenfor den offentlige sfæren langt på vei tolereres, mens aborter som blir offentlig kjent møtes med høylytt kollektiv fordømmelse. Ved hjelp av Fassins konseptualisering av begrepet 'moralsk økonomi', drøfter avhandlingen hvordan fordømmelse av abort fungerer som et verktøy for å bevare et moralsk selv og å styrke sosiale bånd til lokalsamfunnet.

Morgan og Roberts sitt begrep 'reproduktiv styring' (reproductive governance) står sentralt i denne analysen av zambisk abortpolitikk. Konseptet tillater en forståelse av hvordan politisk spill rundt abort finner sted på tvers av sosiale og byråkratiske nivå, på subtile måter som former eller til og med hindrer implementering av politiske føringer for abort. Studien går dermed lenger enn å fokusere på abort som et spørsmål om hva loven tillater og bidrar til litteraturen om hvordan reproduktive praksiser som abort formes av maktstrukturer som virker gjennom et stort sett av synlige og mindre synlige virkemidler.

List of Publications

The following three articles form the basis of this dissertation. Hereafter, these articles will be referred to as Papers I-III.

Paper I

Haaland, M. E. S., Haukanes, H., Zulu, J. M., Moland, K. M., Michelo, C., Munakampe, M. N., & Blystad, A. 2019. Shaping the abortion policy – competing discourses on the Zambian termination of pregnancy act. *International Journal for Equity in Health* 18(1), 20.

Paper II

Haaland, M. E. S., Haukanes, H., Zulu, J. M., Moland, K. M., & Blystad, A. (2020). Silent politics and unknown numbers: Rural health bureaucrats and Zambian abortion policy. *Social Science & Medicine*, 251, 112909.

Paper III

Haaland, M. E. S., Mumba Zulu, J., Moland, K. M., Haukanes, H., & Blystad, A. (2020). When abortion becomes public - Everyday politics of reproduction in rural Zambia. *Social Science & Medicine*, 265, 113502.

1. Introduction

I'm not sure whether there really is an abortion policy in Zambia or not. The reality is that people are asking for abortion services. We have people who are coming to the hospital for that service and we cannot just tell them 'no', they will still go and do it for themselves.

— Manager of a rural district hospital in Zambia

Worldwide, as many as 25 million women are estimated to resort to unsafe abortions annually (Ganatra et al., 2017). Many of these go on to suffer complications that cause considerable lesions or even death. As such, abortion is not only an important issue of gender inequity, public health and women's rights, but also a field in which these dimensions come together and intersect. Abortion nonetheless remains highly contentious and politicised in global health fora and is often left out of priorities and agendas (Austveg, 2011; Suh, 2015). When abortion is addressed, it is commonly discussed in terms of legalisation or criminalisation, and permissive abortion laws are often equated to easy access to abortion services. In this dissertation, I question and problematise this assumption through a study of the relationship between law, policy and practice in Zambia, where abortion has been legal on broad grounds since 1972 (GRZ, 1972).

The epigraph illustrates the confusing and ambiguous scenario the Zambian abortion law represents. The hospital manager, who shared his doubts on whether there really is an abortion policy in Zambia, had seen legal abortion services offered in a city hospital where he had previously worked. His doubt came from a series of mixed signals he had received when asking district and provincial health authorities about how to go about offering legal abortions to girls and women requesting the service in his rural hospital. The case points to the obscure nature of Zambian policy that seems to both allow and disallow induced abortion at the same time. How such obscurity comes about, what it does to the processes of translating policies to actual provision of services and how it shapes and influences girls' and women's actual reproductive possibilities are some of the underlying questions that I address in this dissertation.

The present study has been motivated by a key interest in the complex entanglements between reproductive health and politics. The discrepancy between Zambia's abortion legislation and the apparent lack of abortion services provided in Zambian hospitals, evidenced by considerable numbers of girls and women with complications after unsafe abortions (GRZ, 2017b), thus provided a point in case to explore why a seemingly liberal law is not enough to secure girls and women access to abortion services.

In the following section, I outline the contextual backdrop relevant for this study. I situate the study within a wider context of global abortion politics (Sections 1.1 and 1.2) before turning to the Zambian context (Section 1.3). In subsequent sections, I describe the study's rationale and objectives (Section 2), outline and discuss key theoretical perspectives (Section 3) and describe and reflect on the study's methodological approaches (Section 4) before summarising and discussing the study's main findings (Sections 5-8).

1.1 Abortion in Global Health

In 1994, more than 25 years after the International Conference of Population and Development (ICPD) placed women's health and rights at the core of global policies for sexual and reproductive health (SRH), SRH remains politicised and contentious. Unsafe abortions still make up a considerable part of the worldwide levels of maternal mortality estimated to cause between 4.7% to 13.1% (Say et al., 2014) of the annual 295,000 maternal deaths (World Health Organisation, 2019). However, abortion is a topic that continues to be excluded from the global health governance agenda (Austveg, 2011; Barot, 2011), marginalising women's SRH and rights (SRHR) (Grimes et al., 2006; Kumar et al., 2009; Suh, 2015, 2019b).

Following a series of global international conferences on population control in the 1970s and 1980s, the ICPD represented an attempt to remove gendered ideals about women as primarily mothers and to look beyond motherhood when granting women reproductive rights and services; it is mainly maternal health that has been made subject to global priority setting and political significance (Storeng and Béhague, 2014, 2017; Suh, 2015; Wendland, 2016). Maternal health, and specifically maternal deaths, was

given due attention both in the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) agenda. However, with the exception of Ethiopia (Blystad et al., 2019), few countries have made explicit efforts to reduce maternal morality caused by unsafe abortions by facilitating access to safe and legal abortion services (Austveg, 2011; Barot, 2011; Blystad et al., 2020).

1.1.1 Counting (Un)Safe Abortions

Global health governance is increasingly focused on numbers and counting (Adams, 2016) through mechanisms such as demographic health surveys and sustainable development indicators. However, abortion is a phenomenon that is often left uncounted and is, as an example, not addressed in the indicator framework for the SDGs (United Nations Statistics Division, 2017). Creating an indicator means granting it status as a problem to be solved (Merry, 2016), a form of political visibility that is up for contestation when it comes to abortion (Suh, 2019). Abortion thus emerges as a field in which we can readily see how social and political conditions determine what should and should not be counted (Suh, 2018, 2019a, b).

The WHO periodically publishes worldwide abortion estimates (Ganatra et al., 2017; Sedgh et al., 2016; Shah et al., 2010; WHO, 2011). Until recently, these estimates operated with the binary distinction between safe and unsafe abortions, and estimates of unsafe abortions were generated based on the legal status of abortion in a given country, assuming that all illegal abortions were equally unsafe. This assumption was related to the WHO's definition of unsafe abortion, which was described as an abortion carried out by someone without the required skills or in settings without a minimum of hygienic and medical standards (World Health Organization, 1993:3). Owing to important difficulties in measuring abortions according to these criteria, unsafe abortions were operationalised as those that are carried out illegally (Ganatra et al., 2017).

The risks involved in abortions, however, run along a continuum, and as medical abortion (with misoprostol and mifepristone, or misoprostol alone) has become increasingly available outside of health systems, many clandestine abortions have less

severe complications. Ganatra and colleagues (2017) have thus suggested a more nuanced understanding of safety and proposed a threefold classification that distinguished between safe abortions, less safe abortions and least safe abortions.

Owing to the moral and political questions abortion raises in a given context, women who seek post-abortion care (PAC) after complications often fear stigma or other social sanctions and report their complications to be from miscarriages instead of induced abortion (Suh, 2014, 2019a). As a consequence, numerical data on abortion are fraught with uncertainty. Suh (2014, 2019b) has documented how health workers further add to the uncertainty by classifying abortion cases as miscarriages, even when there are abundant indications to the contrary, thereby avoiding unwanted attention to high rates of illegally induced abortions may create (Suh, 2014, 2019a, b). PAC thus seems to imply a process of producing some abortion-related knowledge and the silencing of others. A careful scrutiny of how and whether PAC is documented and reported thus creates insights into how political visibility through numbers is granted to some reproductive issues over others (Suh, 2019b), ascribing them different meanings and values within a moral regime of reproduction (Morgan and Roberts, 2012).

1.1.2 Post Abortion Care – Harm Reduction and Public Health

While the global population conferences of the 1970s, 1980s and 1990s largely succeeded in finding common ground and a shared language to discuss family planning, abortion became a key dividing issue (Crane, 1994) on which major fronts were formed. This politization of abortion posed a challenge to efforts to efficiently combat mortality and morbidity caused by unsafe abortion and led central international organisations, such as the United Nations Population Fund (UNFPA), to not push for increased access to safe abortions (Crane, 1994). In the 1990s, international non-governmental organizations (INGOS) working on abortion issues proposed PAC as a strategy to address the considerable problem of women with complications from unsafe abortions in contexts where abortions were not legal (Corbett and Turner, 2003).

PAC is a package of essential services that include (1) the emergency treatment of complications from spontaneous or induced abortions, (2) postabortion family planning counselling and services and (3) linkages between emergency care and other reproductive health services (Rasch 2011). An important premise for PAC is that women who have unlawful abortions should be able to seek help without facing legal repercussions (Storeng and Ouattara, 2014). As a strategy, PAC frames unsafe abortions as a major concern for public health, and discursively moves away from abortion as an issue of women's rights. Considered less controversial than working for increased access to safe abortion services, PAC was increasingly included in global SRH policies, such as the ICDP action plan, and has been rolled out since the end of the 1990s in countries where clandestine and unsafe abortions are common (Corbett and Turner, 2003; Storeng and Ouattara, 2014; Suh, 2019b).

Although PAC has been a successful strategy to overcome some political lines of conflict over the abortion issue and has allowed countries to address some of the problems caused by unsafe abortions, it has not come without important unintended consequences. Storeng and Ouattara (2014) argued that the underlying framing of abortion as an issue of public health, which is inherent in PAC as a harm-reduction strategy, also works to undermine public debate about the need to expand access to safe abortion services. This concern resonates with Suh's (2014, 2018, 2019a, b) findings from Senegal, where PAC services and the metrical data they produce serve to obscure the very real challenges caused by unsafe abortions in a legally restrictive setting.

1.1.3 United States Agency for International Development (USAID) and Abortions in Sub-Saharan Africa

PAC emerged as a way to address abortion-related mortality and morbidity in the wake of the United States' (US) turn towards a more restrictive foreign policy for reproductive health (Corbett and Turner, 2003). As the world's largest funder of global health, the US, through its foreign aid agency USAID, holds considerable power in the field of reproductive health (Brooks et al., 2019; The Lancet, 2019). In sub-Saharan Africa, USAID is the main funder of family planning, funding more than

a quarter of all contraceptive services (Kates et al., 2014). This position makes sub-Saharan African countries vulnerable to shifts in US policies for reproductive health.

Over the last few decades, it has become evident that the US foreign policy for reproductive health is increasingly entangled in domestic disputes over abortion and the symbolic role it plays in political power at large (Andaya and Mishtal, 2017; Brooks et al., 2019; Morgan, 2019). While starting out as a progressive champion for family planning and reproductive health, US foreign policy took a more restrictive turn with the introduction of the Helms amendment in 1973, which prohibited the use of US funds for direct abortion-related activities (Corbett and Turner, 2003). The US was a central actor of global abortion politics when they, at the Second International Population Conference in Mexico City in 1984, were key in passing a declaration that stated that governments should 'take appropriate steps to help women avoid abortion, which in no way should be promoted as a method of family planning' (Crane, 1994:243; United Nations, 1984). The statement placed efforts to increase access to safe abortion services firmly on the outside of global consensus. The declaration was in line with policy put in place by the newly elected Reagan administration that withdrew USAID funding to organisations that offered abortion services and abortion counselling, even if those services were not funded through USAID (Hawkes and Buse, 2017). The policy quickly led to the withdrawal of funds from organisations such as the International Planned Parenthood Federation and even UNFPA (Crane, 1994). As the first clear expression of the policy was made during a summit in Mexico City, it later became known as the Mexico City Policy.

Following its introduction by a republican administration, the Mexico City Policy has been lifted by every Democratic US president, and reinstated by every Republican president, revealing its entanglement in internal US politics (Brooks et al., 2019). The organisations affected by the Mexico City Policy are core actors in other areas of SRH, such as the distribution of contraceptives and HIV-related services. As such, organisations that refuse to sign an agreement with USAID legally binding them to not in any way work towards access to safe abortions will get considerable cuts in funding that affect basic services unrelated to abortion. These shifts have not gone

unnoticed in sub-Saharan Africa, augmenting barriers to contraceptives and other SRH services. In fact, recent studies have documented that the Mexico City Policy may have the unintended consequence of increasing the number of abortions in countries that are exposed to the policy through major changes in USAID's funding to family planning and SRH when the policy is in place (Brooks et al., 2019). When the Trump administration reinstated the policy in 2017, they specified that the policy applied not only to funds from USIAD, but also to global health assistance furnished by all departments and agencies (Greer and Rominski, 2017). This expansion of the policy substantially increased the number of partners affected and is expected to have considerable consequences for HIV-related services since it now also applies to projects funded through the President's Emergency Plan for HIV/AIDS Relief (Sherwood et al., 2018).

Access to SRH services is shaped through complex entanglements between social, political and cultural factors in each of the countries where the Mexico City Policy takes effect (Zulu and Haaland, 2019). As such, girls' and women's reproductive possibilities are conditioned by more than US policies for sub-Saharan Africa. In the wake of the last reinstatement of the Mexico City policy in 2017, a group of European governments raised funds to compensate for the expected implications of the policy (Government of the Netherlands, 2017). While it remains unclear whether these efforts have been effective in ensuring that girls and women have sufficient access to quality SRH services across sub-Saharan Africa, it is evident that many sub-Saharan countries are left vulnerable to such shifts and fluctuations in global reproductive politics.

1.1.4 Abortion as Sexual and Reproductive Health and Rights

The ICPD agenda from 1994 marked a discursive shift from talking about SRH issues as problems of population control to framing SRH as an aspect of women's rights and thereby also human rights (Austveg, 2011). Since the 1990s, stakeholders working to expand access to safe abortion services have actively strived to frame abortion as a right under the larger umbrella of SRHR, situating abortion within the rhetorical context of human rights (Morgan, 2018). As a discursive strategy, the move has been

highly successful and has driven processes of decriminalisation and liberalisation of abortion laws in a series of settings, including Argentina, Ireland, Uruguay, Spain (Morgan, 2018) and South Africa (Berro Pizzarossa and Durojaye, 2019).

The approach, which has been called 'rights-talk' (Merry, 2003; Morgan, 2018), draws on the established legitimacy of the human rights framework to achieve its goals and is a strategy that can be employed by all parties. Vaggione (2005) noted how religious organisations, such as the Catholic Church, increasingly use secular reasoning and language, often including scientific and legal references. The strategy that Vaggione calls 'strategic secularism' allows religious organisations to employ a rights-based approach to achieve anti-abortion goals by, for example, referring to the rights of the unborn embryo or foetus or the right to religious freedom to make use of conscientious objection to refrain from taking part in abortion services. Framing abortion as an issue of SRHR thus raises questions about how rights are made and sustained over time, and warrants attention to the processes through which abortion rights are continuously redefined, challenged, contested and implemented (Morgan, 2018; Shore et al., 2011), of which legal frameworks only make up a small part.

1.2 Abortion Laws and Policies

With the framing of abortion as an issue of SRHR and ultimately human rights comes a focus on abortion as primarily a question of law and legal frameworks. Global actors such as INGOs and research organisations that work on analysing or advocating for increased access to abortion often discuss abortion in terms of processes of legalisation or criminalisation (Boland and Katzive, 2008; Centre for Reproductive Rights, 2014; Rahman et al., 1998; World Health Organization, 2018). The Centre for Reproductive Rights, for example, publishes regular overviews on the legal status for abortion across the world, and the WHO has launched a database for abortion policies. While these overviews create valuable information and opportunities to raise attention to areas where abortion is prohibited or restricted, the narrow focus on legal status obscures more nuanced understandings of girls' and women's access to safe and legal abortion services. Such a focus may easily lead to

the assumption that abortion services are in fact accessible in countries where abortion is considered legal, which, as this dissertation will show, is not necessarily the case. It is, however, well established that restrictive abortion laws do not in and of themselves lead to a reduction in the number of abortion cases, but rather push girls and women towards unsafe or less safe methods to terminate pregnancies (Bearak et al., 2020; Singh et al., 2018). This link between restrictive abortion laws and unsafe abortions makes it necessary and important to maintain an overview of how legal conditions for abortion change and develop across countries.

1.2.1 Abortion Laws in Africa

Women in African countries suffer disproportionally from complications of unsafe abortion, a situation that should also be understood within the context of the legal status of abortion in many African countries. It is estimated that about two-thirds of the world's maternal deaths (World Health Organization and UNICEF, 2015) and more than 60% of all global abortion-related mortality (World Health Organization, 2011) occur in sub-Saharan Africa despite decades of family planning programmes and safe motherhood policies (Jaffré and Suh, 2016). Restrictive abortion laws contribute to these alarming figures (Berer, 2017; Ngwena, 2014).

The majority of African countries have legal frameworks for abortion that were introduced by colonial powers (Ngwena, 2014). Both the English Offences Against the Person Act and the European Napoleon penal codes that were included in national legislation on the African continent considered abortions as crimes that warranted severe punishments (Ngwena, 2014:section II). While most African countries still have versions of these codes in place, many have been modified to include provisions allowing abortion in cases of rape and incest or to save the life and health of the woman (Guttmacher Institute, 2018). Of the continent's 54 states, only Tunisia, South Africa, Cape Verde and Mozambique have abortion laws that allow abortion on the pregnant woman's request. Zambia's Termination of Pregnancy (ToP) Act from 1976 does not allow abortion on demand, but it is considered liberal in the African context as it opens up for abortion on socioeconomic grounds, which makes Zambian abortion legislation an exceptional case in the African context.

Ethiopia constitutes another noteworthy case in terms of abortion legislation in Africa. The country has no specific abortion law, but abortion is regulated by the criminal code that was revised in 2005. Under the revised code, abortion is decriminalised in cases of rape or incest, if the woman has any disabilities, to save the life of the pregnant woman, in cases of foetal malformation or if the woman is a minor (FDRE, 2005). These provisions are not, by themselves, unique to Ethiopia, but the specification that the woman's statement is sufficient to prove that a pregnancy is a result of rape has opened the door to legal abortions for a considerable number of women (Blystad et al., 2019; McLean et al., 2019). As such, Ethiopia serves as an exceptional case in which access to abortion was liberalised without the political processes involved in passing a specific law on abortion (Tadele et al., 2019).

1.2.2 The Maputo Protocol

While abortion remains criminalised and culturally controversial across many African countries, there are regional-level policies and treaties that are among the most progressive in the world and that go far in re-affirming abortion as a question of human rights (African Union Assembly, 2003; Ngwena and Durojaye, 2014; Ngwena, 2014). When the African Union passed the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol, it was applauded by women's rights advocates for setting the standard for new and innovative ways to conceptualise women's rights (Ngwena, 2010b). Critics, however, have considered the protocol problematic, and it has remained controversial.

In particular, the protocol's explicit stands on abortion have caused both praise and controversy. The protocol's article 14 (2)(c) states that

> State parties shall take all appropriate measures to (…) (c) Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. (African Union Assembly, 2003)

While the article does not open for abortion on the pregnant woman's wish, nor ensures abortion on socioeconomic grounds, it is progressive in the context of

widespread criminalisation of abortion in most African countries. Ngwena (2010a) argued that the protocol has considerable normative potential that can give states legal justifications for liberalising their abortion legalisations. The protocol has been signed and ratified by two-thirds of the African Union's member states (Ngwena, 2014). Nevertheless, it has so far had limited implications for national abortion laws across the continent.

1.2.3 Zambia's Legal Framework for Abortion

While Zambia has signed the Maputo Protocol, it has had little direct effect on abortion policies in the country. The legal framework for abortion in Zambia consists of a set of laws and guidelines that together regulate when and how abortions are allowed to be induced. The most relevant regulations that shape abortion services in Zambia are the ToP Act (GRZ, 1972), the Penal Code (GRZ, 2005) and the Standards and Guidelines for Comprehensive Abortion Care (GRZ, 2009, 2017b). All of these regulations are grounded in the Zambian constitution, which ultimately makes up part of the legal framework for abortion.

Termination of Pregnancy Act

When the ToP Act was passed in 1972, it stood out as one of the African continent's most liberal abortion laws. Before it was enacted, abortion was primarily regulated by the Penal Code (Ngwena, 2014). When the ToP Act was proposed as a Bill in 1972, it was done suddenly and without much public debate (see Paper I for more information). Little is known about why the Ministry of Health (MoH) decided to introduce a specific law on abortion, but there are indications that it came as a reaction to a controversial court case in which three renowned doctors were charged under the Penal Code for unlawfully providing an abortion (Ngwena, 2014). The case in which the three doctors were absolved caused turmoil and confusion around the legality of abortion and made apparent the need for a specific law on abortion, according to policymakers involved in the process (Ngwena, 2014) see Paper I).

Even though the Zambian ToP Act was introduced eight years after independence, its wording is almost identical to the British Abortion Act from 1967 (United Kingdom

Government, 1967). It does not open for abortion on demand, but states that legal abortions can be provided based on the following criteria:

> (a) that the continuance of the pregnancy would involve (i) risk to the life of the pregnant woman; or (ii) risk of injury to the physical or mental health of the pregnant woman; or (iii) risk of injury to the physical or mental health of any existing children of the pregnant woman; greater than if the pregnancy were terminated; or (b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped (GRZ, 1972).

The criteria are broad enough to allow for wide use of discretion and can be used to provide abortion to almost any girl or woman who seeks it. The criterion on the mental health of the woman's already existing children represents socioeconomic status as a valid ground for abortion. This is further enforced in the law that also states that 'in determining whether the continuance of a pregnancy would involve such risk as is mentioned in paragraph (a) of subsection (1), account may be taken of the pregnant woman's actual or reasonably foreseeable environment or of her age' (GRZ, 1972).

The ToP Act also spells out important restrictions about when abortions are allowed. The Act specifies that legal abortions should be carried out in a hospital by registered health personnel and requires the signature from three medical doctors, of whom one must be a specialist (GRZ, 1972). On this requirement, the Zambian ToP Act is stricter than the British Act, which asks for approval from two medical doctors (United Kingdom Government, 1967). Moreover, the ToP act allows medical practitioners to employ their conscientious objection to refrain from partaking in abortion services (Freeman and Coast, 2019; GRZ, 1972).

Considering the severe lack of health personnel in Zambia, particularly in rural areas, the need for approval from three medical doctors, including a specialist, represents an important legal barrier for girls and women seeking legal abortion services. The barrier is further strengthened by medical doctors making use of their right to conscientious objection (see Papers I and II).

Penal Code

Abortion is criminalised in Zambia with punishments of up to 14 years of imprisonment for abortions that are not carried out according to the ToP Act (GRZ, 2005). The Code contemplates three abortion-related felonies: carrying out an abortion on someone, having the abortion, and assisting someone to have an abortion. The latter two are more severely punished (up to 14 years) than the former (up to seven years). In 2005, the Penal Code was revised to specify that pregnancies that were the result of incest or the rape of underage girls were not criminalised and should be granted abortions under the ToP Act (GRZ, 2005, 2009, 2017b).

While the Zambian ToP Act does not indicate the gestational timeframe within which abortions are allowed, the Penal Code establishes a distinction between the felonies of abortion (a felony when procured outside of the parameters established by the ToP Act) and child destruction. This distinction provides some insight into how moral understandings of abortion are contemplated legally in Zambia. The Penal Code describes the felony of child destruction as the act of causing 'a child to die before it has an existence independent of its mother' (GRZ, 2005:§221) and sets 28 weeks of gestational age as *prima facie* proof that the foetus was capable of being born alive. The felony of child destruction thus indicates 28 weeks of gestation as an upper limit for abortions and creates a legal category between abortion on the one hand and murder on the other.

Standards and Guidelines for Comprehensive Abortion Care

In 2009, the Zambian MoH developed the first set of standards and guidelines to facilitate interpretation and implementation of the ToP Act and the Penal Code (GRZ, 2009). The document called 'Standards and Guidelines for Reducing Unsafe Abortion Mortality and Morbidity' was developed in close collaboration with the INGO IPAS. The document aimed to improve access to abortion services by specifying that first trimester abortions can be carried out by trained mid-level providers and that in emergency situations, the need for signatures from medical practitioners can be reduced from three to one' (GRZ, 2009)'.

A new set of standards and guidelines were published and officially dated in 2017, though they remained within the MoH and were not publicly launched before 2018. The document now called 'Standards and Guidelines for Comprehensive Abortion Care in Zambia' was drafted by an entity named the Safe Abortion Advisory Group, a coalition of international and national NGOs working on abortion issues, and was revised and finally approved by the MoH (GRZ, 2017b). The document incorporates new WHO guidelines on the use of medical abortion, as opposed to surgical methods. On some accounts, this revised document goes even further in facilitating access to abortion services and specifies that medical doctors' conscientious objections should not compromise the patient's right to information and access to abortion services (GRZ, 2017b:24). Moreover, the revised document states that public hospitals are legally obliged to provide abortion services and that in situations where there is only medical doctor available to approve an abortion, it should be handled similarly to emergency situations, where the signature of a single doctor is sufficient (GRZ, 2017b:28).

Both documents show efforts made to clarify the legal framework for abortion in a way that seeks to facilitate and increase girls' and women's possibilities of accessing safe and legal abortion services. As such, they are progressive documents well suited for providing health personnel with the necessary support to provide the services the ToP Act regulates. However, their distribution across the country has been limited. In facilities that are not directly supported by one of the organisations that are represented in the Safe Abortion Advisory Group, it is rare to find the guidelines. None of the hospitals I visited in the study province had the guidelines present, and few health workers, including those providing PAC, were aware of the existence of the 2009 document, let alone the revised 2017 version.

Constitutional Reform and the Bill of Rights

The Zambian constitution currently opens for abortions that are carried out within the conditions of the law (GRZ, 2017b:20). In the last few years, however, this situation has been challenged. Zambia has gone through a process of constitutional review in several rounds. In the years preceding 2016, a new and progressive Bill of Rights was

developed as part of the constitutional reform. The Bill was developed through extensive consultation with civil society and professional organisations that led to the development of a progressive document that went far in ensuring social rights. However, in the very last hour of developing the Bill, a clause was introduced stating that the right to life begins at conception (Blystad et al., 2019). The late introduction of the clause gave policy actors advocating for broader access to abortion no opportunity to remove the clause that put the Zambian abortion law at the risk of becoming unconstitutional. The Bill, which could have had devastating effects on the legal status of abortion in Zambia, was sent to a referendum that coincided with the 2016 presidential election. Because of a low turnout of voters, however, the referendum was unsuccessful and the Zambian ToP Act remains in line with the constitution (Electoral Comission of Zambia, 2016).

For a few months in 2016, the constitutional reform thus placed abortion on the explicit political agenda, with some organisations working to improve access to abortion services and others working to restrict such action mobilised efforts (Blystad et al., 2019) (see Paper I). Following the failed referendum, however, no new efforts have been made to re-introduce the Bill of Rights. While the ToP Act thus remains well within the frame of the Zambian constitution, the Bill of Rights referendum came close to removing it altogether, demonstrating the vulnerable position of girls' and women's rights to safe and legal abortion services.

1.3 Zambia

This dissertation explores abortion policy and politics through the case of Zambia, a landlocked country in southern Africa. The 752,618 square kilometres of Zambian territory is spread out across a plateau with an average of about 1,100 metres above sea level (Central Intelligence Agency, 2020). The country enjoys a tropical climate, somewhat modified by its altitude, with a rainy season expected to last between October and April. The population is rapidly growing and is currently estimated to be about 17.8 million inhabitants (The World Bank, 2020). About 40% of the population

live in areas surrounding major urban centres such as Lusaka, Ndola, Kitwe and Livingstone. The territory is divided into 10 provinces.

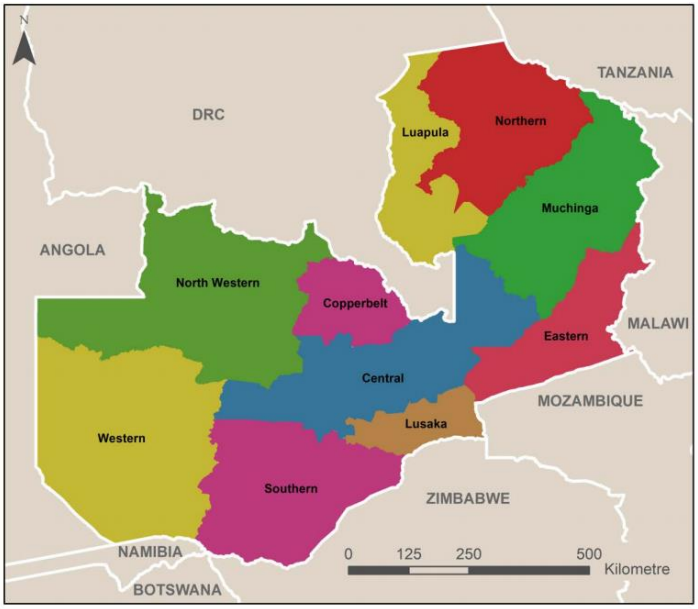

Figure 1: Map of Zambia from, reproduced from the Zambian Demographic and Health Survey 2018 (Central Statistical Office of Zambia, 2018).

1.3.1 Colonial History

Located between two Portuguese colonies, Angola and Mozambique, Portuguese explorers were the first Europeans to visit Zambian territory. Nevertheless, it was the British Empire that claimed most of the territory in what is known as the 'Scramble for Africa'. In the late 1880s, Cecil Rhodes' British South African Company was given administrative authority to claim land on behalf of British territory, which was done in negotiations with other European powers, and to a lesser degree through agreements between Rhodes and local chiefs (Williams et al., 2020).

The British South African Company ruled the territory north of the Zambezi in two parts, but North Eastern and North Western Rhodesia were united into Northern Rhodesia in 1911 (Williams et al., 2020). The company mainly used Zambian territory to recruit labour to gold mines in Southern Rhodesia (today Zimbabwe) and for transportation by railroad from copper mines in Belgian Congo and the port of

Beira in Mozambique (Williams et al., 2020). After a few incidents of rebellion and opposition, the British South African Company gave up its administration of Zambian territory to the British Colonial Office, which made Northern Rhodesia a protectorate with a legislative council of five members elected by the small white population of 4,000 (Williams et al., 2020). The Colonial Office distributed land rights to fertile land along the railroad to Europeans and created reserves for Africans around these areas. The reserves quickly became overcrowded, leading to food shortages (Williams et al., 2020). From the 1930s, the copper mining industry dominated the protectorate's economy, to little advantage for workers whose wages were kept to a minimum (Williams et al., 2020). Poor working conditions led to strikes and protests, and by the 1940s, labour unions had become important political organisations.

In 1953, the protectorates of Northern Rhodesia (now Zambia) and Nyasaland (now Malawi) and the colony of Southern Rhodesia (today Zimbabwe) were united in the Federation of Rhodesia and Nyasaland to great public protests (Williams et al., 2020). The federation remained unpopular in Northern Rhodesia, which found that resources were drained towards Southern Rhodesia. A fall in copper prices that threw many workers into unemployment and poverty created momentum for a new generation of African leaders from the African National Congress that later became the United National Independence Party. Led by Kenneth Kaunda, the party worked towards independence from the federation and from British rule through campaigns of civil disobedience while agreeing to partake in elections that gave them parliamentary majority. The federation with Southern Rhodesia and Nyasaland was dissolved towards the end of 1963, and on October 24, 1964, Zambia declared its independence, led by the republic's first president, Kenneth Kaunda (Williams et al., 2020).

1.3.2 Ethnicity and Language

Zambia was populated in several rounds of Bantu migrations largely from the Niger-Congo branches and the vast majority of the country's over 70 languages and recognised dialects belonging to the Niger-Congo Bantu language family (Williams et al., 2020). As such, Zambia is a country with important linguistic and cultural

diversity. Bemba, spoken by a fifth of Zambians, predominantly in northern and central areas, is the largest Zambian language, followed by Tonga, which is widely spoken in southern Zambia. Nyanja (also called Chichewa) is widely spoken in eastern Zambia and Lusaka, and Lozi is mostly spoken in western Zambia.

While languages are important for ethnic identities in Zambia, a one-to-one relationship does not exist between ethnic groups and languages (Marten and Kula, 2008). In Lusaka, Nyanja is widely used as a lingua franca, independent of the mother tongue. English is Zambia's only official language, but Bemba, Tonga, Nyanja, Lozi, Kaonde, Luvale and Lunda all have status as national languages. While these languages are increasingly used in schools, English remains the main teaching language and is the only language used by the written press and in government documents (Marten and Kula, 2008). The Zambian population is mobile and increasingly urban, which means that while particular language and ethnic groups predominate in respective regions of the country, urban populations are often ethnically and linguistically heterogenous.

During the colonial period, English was the language of power and administration. Marten and Kula argued that English gained an even stronger position after breaking free from the Federation of Rhodesia and Nyasaland in 1964 (Marten and Kula, 2008). After independence, it became increasingly important to establish a common national identity, and language was an essential part of this task. Under the motto 'One Zambia, One Nation', which remains Zambia's national slogan today, the first president, Kennet Kaunda, made English the only official language, with underlying preconceptions about English being the alternative to ethnic, linguistic and subsequent political fragmentation (Marten and Kula, 2008).

In the current socio-political atmosphere, the national languages have gained status within the Zambian state and are increasingly being used by political candidates and state representatives. While ethnic identity remains somewhat politically sensitive, Marten and Kula (2008) argued that the ability to speak several of the national

languages and code-switching between them according to the social situation at hand has become a part of enacting Zambian citizenship.

1.3.3 Economy and Livelihoods

The majority of Zambians engage in agricultural activities as a means to sustain their livelihoods. Nevertheless, only a sixth of the country's arable land is cultivated (Williams et al., 2020). While the agricultural sector varies from small household farms to large commercial farming enterprises, most people work on their own household plots. Maize, a key ingredient of the widely consumed dish *nshima*, is the most cultivated crop, but crops such as cassava, sorghum, millet and ground nuts are also used. Large commercial farms are mostly found around the railway that runs northbound from Livingstone, a pattern related to colonial rule that gave fertile land around the railway to European settlers, forcing the local population to either take up work in the developing mines or cultivate land in less fertile areas (Williams et al., 2020).

Since colonial rule, mining, particularly copper mines, has been the driving force of the Zambian economy, leaving the country highly vulnerable to fluctuations in copper prices. After independence, President Kaunda's government worked to nationalise the mining industry by acquiring equity holdings in several foreign mining companies. When copper prices severely dropped in the 1970s, the Zambian government took up considerable debt with the International Monetary Fund, which subjected the country to a long series of privatisation and restructuration reforms in the 1980s and 1990s. Today, the mining industry is still largely privatised with substantial foreign ownership (Williams et al., 2020). Over the last few decades, efforts have been made to diversify, but the Zambian economy remains vulnerable to drops in copper prices. Like other African countries, China has become a major creditor in the Zambian economy and is heavily involved in the development of infrastructure (Servant, 2019).

1.3.4 Religion, Ideology and Citizenship

Religion, particularly Christianity, is a central part of public life and politics in Zambia (Haynes, 2015b, 2017; Hinfelaar, 2008; van Klinken, 2018). Zambian postcolonial history is commonly divided into three distinct periods called the first, second and third republics. The first republic refers to the initial years after independence under Kenneth Kaunda's presidency. The second republic refers to the period from 1972 to 1990 when Kaunda installed a one-party electoral system (Larmer, 2008). The third republic describes the period that started with the instalment of a multi-party system and the election of Zambia's second president Frederic Chiluba. While religion has played an explicit role in the third republic, religious institutions were also key political actors and shaped politics in the first and second republic (Hinfelaar, 2008, 2011).

Zambian Humanism

The Zambian abortion law was enacted just as Zambia was transitioning from the first to the second republic. In his eight years as president of the first republic, Kaunda had ample time to develop his ideological project called 'Zambian Humanism', which was adopted by the ruling party UNIP as Zambia's state ideology (Larmer, 2008; van Klinken, 2018). Zambian Humanism has been described as a mix of a variety of elements, including socialism, liberalism, Christian morality and an idealisation of communal values and the precolonial past (Vaughan, 1998). While Zambian Humanisms' impact on current Zambian society is debated (Hinfelaar, 2008; Vaughan, 1998:178), it provides insight into how the political elite of the time envisioned the ideal moral and political citizen (Gordon, 2012; van Klinken, 2018:160).

Despite its rhetorical association with socialism, references to a wide set of religious beliefs, and at times secular undertones, Zambian Humanism held conservative views on questions of sexuality, heavily influenced by Christian moral teachings (van Klinken, 2018). In 1975, UNIP published a moral code with specific instructions on the moral conduct of the ideal Zambian citizen. The code displayed patriarchal views on the female body with restrictive views on women's right to make active decisions

in sexual relationships and specific instructions on the appropriate length of a woman's skirt (van Klinken, 2018). Kaunda and UNIP's writings on gender and sexuality within Zambian Humanism thus demonstrate that conservative views on women's bodily autonomy have been part and parcel of the political elite's ideals of citizenship since the onset of Zambia's postcolonial history.

A Christian Nation

When Zambia's second president Frederick Chiluba came to power as Zambia moved into multi-party democracy, he brought with him a political rhetoric that borrowed heavily from Pentecostal language and symbolism (Haynes, 2015b). In a speech in 1991, the newly elected president unexpectedly declared that Zambia was Christian Nation in a covenant with God, a declaration that was included in the preamble to the national constitution in 1996 (Cheyeka, 2008; Haynes, 2015b). Since then, the declaration has been further enforced by the introduction of a series of religious state ceremonies (Haynes, 2018). While Zambia continues to have religious freedom, demonstrated by an increasing number of mosques in Lusaka, the declaration sets the starting point for what can be called Zambian Christian nationalism (van Klinken, 2018). The vast majority of Zambians today define themselves as Christians (87%) (Haynes, 2018), belonging to a variety of different denominations. Churches and religious communities make up important social areas in many Zambians' everyday lives.

The declaration of Zambia as a Christian nation has had important implications for discourses around sexuality and reproduction (van Klinken, 2014), including abortion (Blystad et al., 2019; Zulu and Haaland, 2019). It is often brought up as a final and moral argument in public debates on issues such as pornography, appropriate dress codes for women or the distribution of contraceptives. Recently, the declaration was actively evoked in a fierce debate about Zambia's programme for Comprehensive Sexuality Education (CSE) (see Section 2.4.2). Scholars have noted how speaking of personal morality has become a characteristic of political rhetoric in Zambia, and references to the Christian Nation readily allow for establishing a nexus between person and politics (Chan, 2013; Cheyeka et al., 2014). As such, the declaration of

Zambia as a Christian Nation demonstrates the entangled relationship between politics, religion and personal moral integrity.

1.3.5 Zambia's Place in the Field of Anthropology

A note is warranted on the unique position of Zambia in anthropological literature. Former home to the Rhodes-Livingstone Institute, Zambia holds a particular place in the history of anthropology and has been subject to a series of both classical and more modern influential anthropological works (Englund, 2013). Central figures of structural functionalism made Zambian communities key empirical sites for classical anthropological works, such as Audrey Richards' study of Chisungu, a Bemba rite of passage for girls (Richards, 1956) and Max Gluckman's foundational work in legal anthropology from Barotseland (today the Western part of Zambia) (Gluckman, 1955). However, studies from Zambia were also influential in breaking with the static view on society that characterised structural functionalisms, moving towards process thinking and studies of social drama and situational analysis (Englund, 2013; van Velsen, 1967).

An overwhelming number of anthropologists belonging to the Manchester school carried out fieldwork in Zambia (Colson, 1958; Mitchell, 1956; Turner, 1968; Werbner, 1984). The rapid process of urbanisation on the Copperbelt made Zambia a well-suited place to embark on what would become the field of urban anthropology (Englund, 2013; Epstein, 1958) and to develop defining theories on ethnic, class and national identities (Englund, 2013; Kapferer, 1972; Mitchell, 1956). When Zambia went through a radical process of structural adjustment imposed by the International Monetary Fund, scholarship on Zambia turned to topics of globalisation and neo-liberalism, with Ferguson's (1999) influential monography *Expectations of Modernity: Myths and Meanings of Urban Life on the Zambian Copperbelt* at the forefront. As the geographical centre of the Zambian mining industry and therefore also of important social, economic and demographic changes, substantial parts of anthropological literature from Zambia is empirically concerned with the Copperbelt, leaving little attention to other areas of the country.

In recent years, religion and Christianity have been prominent topics for anthropological studies in Zambia. Haynes' (2015b, 2017, 2018) studies of Pentecostal churches and social mobility on the Copperbelt provide an analysis of the way Pentecostal theology is shaping social life and politics. Another example is Van Klinken's (2013, 2014, 2017, 2018) work on intersections between gender, Christianity, LGBT and politics from the perspective of religious studies.

1.3.6 Health and Demography

Nearly half of the Zambian population is under the age of 15 (Williams et al., 2020). The young population is related to the fairly high fertility rate of 4.7 children per woman (Central Statistical Office of Zambia, 2018). The Zambian Demographic and Health Survey (ZDHS) from 2018 shows a considerable difference in fertility between urban and rural areas, with a fertility rate of 3.7 in urban areas and 5.6 in rural (Central Statistical Office of Zambia, 2018). Moreover, the ZDHS finds the rural population to be significantly poorer than the urban population, despite huge levels of poverty in urban shanty towns. Over 70% of urban houses have electricity, compared to only about 8% of the rural population.

The general health situation for the Zambian population is still heavily shaped by HIV/AIDS. Of Zambians aged between 15 and 49 years, 11.1% are HIV positive, and women are particularly hit by the HIV pandemic (Central Statistical Office of Zambia, 2018). As anti-retro viral treatment is widely rolled out, Zambians are increasingly living with HIV as a chronic condition. The HIV prevalence is considerably higher in urban areas compared to rural areas (Central Statistical Office of Zambia, 2018).

Child mortality and maternal mortality figures provide fragmented glimpses into the general health status of a country. During the last few decades, Zambia has seen considerable drops in child mortality, from 152 per 100,000 live births in 2000 to 61 in 2019 (UNICEF, 2020). When it comes to maternal mortality, however, Zambia is facing serious challenges, and in the past few years, there has been a small increase in the maternal mortality ratio, which is currently estimated at 258 deaths per 100,000

live births (Central Statistical Office of Zambia, 2018). As a key development indicator in the MDG and SDG framework, maternal mortality has become increasingly politicised and performing poorly comes at certain political cost for governments (Bevan et al., 2019; Evans, 2018). This cost may be part of the reason why the current president in 2019 declared a public health emergency of maternal and perinatal deaths (Bwalya, 2019).

Zambia's young population warrants special attention to adolescents' health. Early pregnancies are a re-occurring issue in the public health literature from Zambia, with estimations indicating that a third of all girls have been pregnant by the time they reach 19 years of age. Early childbearing is found to be more common among poor populations (Zuilkowski et al., 2019).

1.3.7 Health System

Traditional Healers

The Zambian health system is complex and consists of various actors placed in the formal and informal sectors. The informal health sector, particularly with traditional healers, referred to as *ng'angas* in some of the local languages, remains important and widely used (Sugishita, 2009). Traditional healers were recognised as part of the broader health system after independence, and efforts were made to integrate them into the formal health system on specific issues related to psychosomatic symptoms and chronic illness. However, the efforts were not widely successful, and the traditional healers today have an ambiguous and somewhat problematic relationship with the formal health sector. It has been estimated that there are around 40,000 traditional healers in Zambia, making them a lot more accessible than medical doctors (Sugishita, 2009).

The Formal Health System

Biomedical healthcare is provided in the formal health sector that consists of three main actors: the Zambian government, faith-based health institutions, and private healthcare, which includes mining companies' health services to employees. Over

90% of patients seeking help in the formal health system do so in government-funded public facilities (GRZ, 2017c).

Zambia is divided into 10 administrative provinces and an increasing number of districts (117 at the time of the study), which make up the organising units for the health system. While the central governments run a few third-level hospitals, including the University Teaching Hospital in Lusaka, most healthcare delivery is organised through provincial health offices and district health offices. At the national level, the MoH works on overall coordination, policy formulation, planning and funding (GRZ, 2017c).

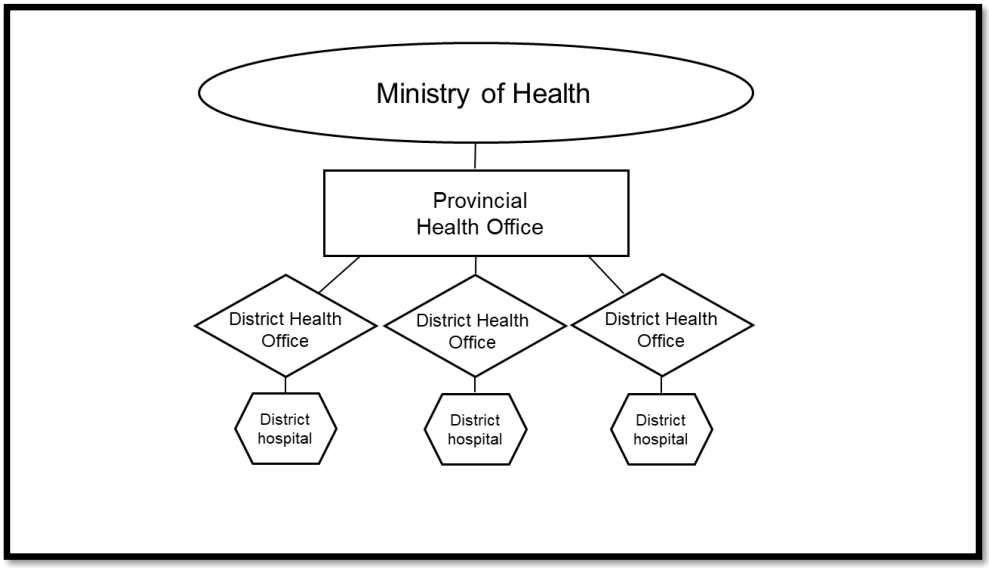

Figure 2: Administrative structures of the Zambian health system (Haaland et al., 2020:3).

The district health offices, led by a district health director, are in charge of coordinating first-level healthcare delivery. While all districts are meant to have a hospital, this is not necessarily the case. However, all district health directors are set to coordinate a series of clinics and health posts providing primary healthcare and are charged with implementing multiple health programmes within reproductive and maternal health. District health offices report to the provincial health office that

coordinates health services within the province and are set to instruct and monitor service delivery at the district level (GRZ, 2017c). Over the last decade, efforts have been made to decentralise the Zambian health system, shifting responsibilities from the national MoH to provincial and district health offices. This shift has made regional- and local-level health bureaucrats central actors in the Zambian health system key in the implementation of health policy.

Health Personnel

The Zambian health system is facing a severe challenge in terms of recruitment and deployment of skilled health personnel. In 2017, the Zambian government estimated a shortage of almost 15,000 medical doctors, nurses and midwives and projected the shortage to increase further in the coming decades as the population continues to grow (GRZ, 2017a). At the time of the study, Zambia had 1,514 medical doctors employed, making the country one of the 25 African countries with fewer than one medical doctor per 10,000 inhabitants. About 60% of the population lives in rural areas where the lack of qualified health personnel is particularly severe. Despite a system of deployment to rural areas, rural hospitals and clinics face high rates of turnover and can be severely understaffed (GRZ, 2017a). Lack of qualified health personnel has had general consequences for the quality of the healthcare provided, with particular consequences for girls' and women's access to legal abortion services.

1.4 Reproductive Health and Abortion in Zambia

1.4.1 Abortions and Post-abortion Care

Numerical data on abortion and PAC remains scarce in Zambia. There are no official statistics estimating either the number of legal abortion services provided or how many cases of PAC are attended to in public hospitals. Nevertheless, there is reason to believe that abortion-related cases constitute an important challenge to the Zambian health system. The most recent and relevant policy document states that abortion causes 30%-50% of all acute gynaecological admissions and the deaths of six per thousand women of reproductive age (GRZ, 2017b). It has also been

estimated that Zambia spends US$1.4 million on PAC for unsafe abortion cases, a cost that could be considerably reduced by facilitating access to safe and legal services (Parmar et al., 2017).

The discrepancy between the seemingly liberal abortion law and the number of girls and women in need of PAC indicates that access to abortion services remains a challenge (Owolabi et al., 2017). Research on abortion in Zambia has documented that knowledge of the legal status of abortion is limited in the Zambian population (Coast and Murray, 2016; Cresswell et al., 2016), turning girls and women to clandestine abortions that are costly and often unsafe (Leone et al., 2016). Such lack of knowledge also extends to health workers who may turn abortion-seeking girls and women away (Geary et al., 2012; Macha et al., 2014). Moreover, the risk of compromising privacy and social integrity adds to the barriers girls and women face when seeking abortions (Chemlal and Russo, 2019).

1.4.2 Adolescents' Sexuality and Reproduction

Abortion and abortion policy needs to be understood within the wider cultural context in which they take place (Kumar et al., 2009). Even though Zambia is a culturally heterogeneous country, there is a common public conversation going on about youth and sexuality (Rasing, 2002:121) that speaks to a shared cultural and political context. This context is particularly relevant for a broader understanding of girls' and women's reproductive possibilities, including abortion.

The public discourse on sexuality is shaped by the condemnation of premarital sex and normative restrictions on discussing sexuality between parents and children (Rasing, 2002; Zulu et al., 2019:121). My ethnographic material is rich in examples of inter-generational tension related to how and whether to provide youth with information about sex. Beliefs about causal links between providing adolescents with information about sex and sexuality and promiscuous and immoral behaviour figures strongly in my material as in the literature (Rasing, 2002:121; Zulu et al., 2019).

Such perspectives on youth and sexuality can be seen in relation to the practice of female initiation ceremonies that form part of a cultural heritage across most of

Zambia (Haynes, 2015a; Jules-Rosette, 1980; Rasing, 2002). In these ceremonies, girls are commonly secluded and receive instructions on the responsibilities of adult life, including messages about sexual practices, from grandmothers or other elder female relatives. While female initiation ceremonies have either been abandoned or are practiced in shorter versions (Moore and Vaughan, 1994; Rasing, 2002), the idea about grandparents or other older relatives being the ones allowed to provide information about sex and sexuality still remains strong (Zulu et al., 2019).

Comprehensive Sexuality Education

In 2014, the Zambian Ministry of Education rolled out a progressive curriculum of CSE for children and adolescents in grades 5-12. Zambia has signed 'The Eastern and Southern African Ministerial Commitment on CSE and SRH services for adolescents and young people' (Birungi et al., 2015) and developed a curriculum that is meant to address disparities in access to SRH knowledge in close collaboration with UNSECO (Zulu et al., 2019). The CSE programme is designed to be integrated into the ordinary teaching of other subjects, such as science or social sciences, and is to be implemented by teachers. Its successful implementation rests heavily on the will and discretion of the teachers, who may not be well prepared to discuss what are considered controversial topics with students. This means that even though CSE has been rolled out, its actual implementation varies from school to school and teacher to teacher (Zulu et al., 2019). In addition to providing basic information about biological processes of reproduction, the curriculum covers gender relations, sexual behaviour and contraceptive methods as well as reflections on values, attitudes and development of life-skills (Zulu et al., 2019).

The CSE curriculum is substantially informed by UNESCO's International Technical Guidance on Sexuality Education, which situates CSE within a human rights discourse and draws heavily from the ICPD agenda (UNESCO, 2009; Zulu et al., 2019). While there were rounds of stakeholder consultation and engagement in development and roll out of the programme, it has been documented that critical actors, such as key religious leaders, parent groups and youths, were left without

sufficient influence, leaving the programme vulnerable to critical voices (UNESCO, 2016; Zulu et al., 2019).

Since its introduction, CSE has been subject to public debate in newspapers and television, often with criticism about it being incompatible with Zambia's status as a constitutionally declared Christian nation and with public opinion about age appropriateness for discussing sexuality. In September and October 2020, such debates re-emerged and gained enormous force as a petition was circled by influential religious organisations to remove CSE from Zambian schools (Phiri, 2020). The petition and subsequent controversy led the vice president to announce the suspension of the programme until a committee including all relevant stakeholders had examined its content (Mwebantu editor, 2020). There are strong indications that the petition was initiated in close collaboration with the US-based right-wing organisation called Family Watch International (Family Watch International, 2021), which lobbies against UN initiatives on sexuality education (Mwebantu editor, 2020). As such, the ongoing debate speaks to how Zambian reproductive politics are closely linked to ongoing global disputes and power struggles.

Other SRH Policies Targeting Adolescents

Apart from CSE, two more policies shape adolescent Zambians SRH: the re-entry policy that allows girls to return to schools after giving birth, and the firm stand on keeping the distribution of condoms or other contraceptives out of schools. Similar to the CSE programme, the re-entry policy is progressive on paper but is implemented differently across districts and schools (Zuilkowski et al., 2019). Only 38% of girls who get pregnant in primary school and 65% of girls who get pregnant in secondary school make use of the policy and re-enrol a year after giving birth. In rural areas, the numbers are considerably lower (Zuilkowski et al., 2019). Contradicting the sentiments of the CSE and the re-entry policy, the Zambian Ministry of General Education has repeatedly taken a firm stance to not allow the distribution of condoms in schools (Chongo, 2017).

2. Rationale and Research Objectives

2.1 Rationale

This study has been motivated by a key interest in the complex entanglements between reproductive health and politics. Access to abortion is commonly discussed in terms of questions of legalisation or criminalisation, but little attention is paid to the processes of translating liberal abortion laws from policy to practice. The discrepancy between Zambia's abortion legislation and the apparent lack of abortion services provided, evidenced by considerable numbers of girls and women with complications after unsafe abortions (GRZ, 2017b), thus provided a particular opportunity to explore why a seemingly liberal law is not enough to secure girls and women access to abortion services.

2.2 Objectives

This study aimed to generate knowledge on how articulations between policy, legislation and sociocultural conditions shape women's reproductive possibilities. Specifically, this study has

- Explored how historical, political and discursive elements shape the continuous development of Zambian abortion policy (Paper I);
- Examined the processes involved in translating abortion policy from paperwork to practice and explored the gaps between knowledge, policy and practice in reproductive health (Paper II); and
- Investigated the everyday reproductive politics through mapping out local dynamics of moral judgements of abortion to increase understanding of what is socially at stake for abortion-seeking girls and women (Paper III).

3. Theorising Abortion Politics

3.1 Politics of Reproduction – Anthropological Perspectives

With a particular interest in kinship and its significance for political alliances anthropology has a long history of studying questions of reproduction and power across a variety of settings. In classical works, however, the link between the two is often rather subtle or indirect. Rapp (2001) noted that what used to be the 'invisible centrality' of reproduction to social life seems to have become more explicit and visible, giving force to a growing body of literature on the politics of reproduction within anthropology over the last few decades (Andaya, 2014; Andaya and Mishtal, 2017; De Zordo et al., 2017; Franklin, 1997; Franklin and Ginsburg, 2019; Mishtal, 2017; Morgan and Roberts, 2012; Suh, 2015, 2018, 2019b). As such Ginsburg and Rapp's (1995) collected volume *Conceiving the New World Order: The Global Politics of Reproduction*, which includes sections such as 'The Politics of Birth Control', 'Stratified Reproduction' and 'What's Political about Reproduction?', represents a shift in anthropological attention to reproductive politics.

In an essay on feminist perspectives of reproduction in medical anthropology, Rapp (2001:466) notes that 'When reproduction becomes problematic it provides a lens through which cultural norms, struggles, and transformation can be viewed'. The topic of induced abortions causes controversy and debate both on the level of global health politics and between neighbours and family members on the ground. Studies of abortion and abortion policies thus readily lend themselves to analyses of the nexus between reproduction and power and the intertwined relationship between bodies and national and global politics.

The scope of this study encompasses abortion politics across scales and domains. It considers its local expressions in people's everyday lives, tracing it up and down through bureaucratic levels of health administration, national-level policymakers and their interconnectedness to global discourses on abortion and reproductive health. Such a broad scope warrants a combination of an overarching theoretical framework

that facilitates such tracing and more specific theoretical intakes that are helpful for understanding specific mechanisms and interactions. This dissertation draws on Morgan and Roberts' (2012b) notion of *reproductive governance* to theoretically frame and inform the analysis. Moreover, it has taken Shore and Wright's (Shore and Wright, 1997; Shore et al., 2011) thinking about anthropology of policies and Fassin's (2014) conceptualisation of moral economy to gain further understanding of the many subtle mechanisms at play.

3.2 Reproductive Governance

In their paper 'Reproductive governance in Latin America', Lynn Morgan and Elizabeth Roberts (2012:241) introduced the concept of reproductive governance to be used as a tool for 'for tracing the shifting political rationalities directed towards reproduction'. Their paper was written to make sense of the increased politicisation of sexual and reproductive practices through emerging moral regimes and rights claims in Latin America. They wanted to address the need for an analytical concept that could encompass the variety of ways in which reproduction is placed at the centre of politics. As an analytical tool, the concept of reproductive governance allows us to consider the ways in which 'reproduction is mobilized and activated in particular historical moments' (Morgan, 2019:113). This enables a focus on both the historical and political conditions underlying specific reproductive policies, while also considering the overarching international, structural and financial factors conditioning reproduction across country borders.

Reproductive governance emerged as a relevant tool for gaining a deeper understanding of the specific dynamics that make abortion politically contentious in Zambia. In particular, it is the ability of the concept to cut across the political and administrative scales and of tying together 'embodied and biological moral regimes, national political strategies, and global economic logics' (Morgan and Roberts, 2012:244) that makes it both appealing and relevant.

Morgan and Roberts' (2012) conceptualisation of reproductive governance draws significantly on Foucault's writing about power/knowledge, governance and the history of sexuality. In their 2012 paper, the authors explicitly refer to his ideas about regimes of truth (Foucault, 2008) and about the distinction between sovereign power and biopower (Foucault, 1998). Morgan and Roberts (2012) are also concerned with Foucault's ideas about sex and sexuality and their place in exercising biopower. In his work, Foucault (1977, 1980, 1994, 1998, 2008) describes the intricate and overlapping relationship between knowledge and power and the specific forms in which they have created certain rationalities for governance in modern Western societies. His analysis is broadly concerned with sketching out a genealogy of the way power/knowledge came to be used in processes of domination, subjugation and governance. At times, he touches upon how such processes of governance gave place to the rise of racism and imperial power, although this was not his primary concern.

In *The History of Sexuality, Vol. 1,* Foucault (1998) builds upon his own writings in *Discipline and Punish: The Birth of the Prison* (1977)*,* where he outlined a transition from the sovereign power displayed through the spectacle of infliction of bodily pain to a governmental power that puts fomenting of life at the core. He further develops this idea when he briefly introduces biopolitics as a rationality of governance, which he does by pointing out that while under sovereign power, the sovereign had the right to take life as he pleased; this right has now been diffused and transformed into a right to kill only those who represented a kind of biological danger to others (Foucault, 1998). The right to take life or let live was replaced by a right to promote life or 'disallow it to the point of death' (Foucault, 1998:138).

Furthermore, Foucault (1998) described how this new biopower, or power to foster life, took place both on the level of the individual body (anatomo-politics) and the species body, or population, through biopolitics. Here, he introduces the increased focus on the administration of populations through supervision of 'births, mortality, the level of health, life expectancy and longevity' and other regulatory controls (1998:138). If the management and administration of the population is located at the centre of political power, it is not difficult to see how reproduction takes on a key

position. Foucault (1998) further develops this aspect of biopower when he writes about the central role of sexuality. This is a part of his writing that particularly concerns Morgan and Roberts (2012:243) when they state that 'according to Foucault, sex was one of the exemplary sites for the deployment of biopower in modern European nation states'. Following Foucault (1998:146), sex is granted this status since it is an area of life where power accesses both the life of the individual body and the life of the entire species. Considering the governing logics of managing and administrating populations, we can see how a link is created between individual sexual and reproductive practices and politics. Though Morgan and Roberts (2012:244) specified that biopower can be used to analyse other realms of society, such as race, it is the link between individual practice and politics of a nation that Morgan and Roberts build upon when theorising reproductive governance.

Despite this clear influence from Foucault, reproductive governance goes beyond the mere pointing to how the dynamics of governance through knowledge/power are constructed. The concept also includes an element of the content of the governance that is carried out, which becomes clear in the way Morgan and Roberts draw upon Fassin's (2007, 2009a) notion of the politics of life. Fassin (2007:500) calls for increased focus on processes of differentiation among human lives when he defines the politics of life as politics that 'give specific value and meaning to human life'. He draws upon Foucault, but criticises him for avoiding both meaning and value in the practice of government (Fassin, 2009a:46). Moreover, Fassin (2007:500-501) differentiates his politics of life from biopower in highlighting that the former is not concerned with technologies of power or ways of governance, but rather with 'the evaluation of human beings and the meaning of their existence'. Fassin's project is to study the moral economies through which inequalities are produced and accepted and to understand why society seems to accept that some human lives have more value than others (see section 3.4). He suggests replacing Foucault's biopower with the concept of biolegitimacy that allows for emphasis on 'the construction and meaning and values of life instead of the exercise of forces and strategies to control it'(Fassin, 2009a:52). He goes on to say that 'considering politics beyond governmentality is similarly to insist on the issues involved in the way human beings are treated and

their lives are evaluated more than on the technologies at work in these processes' (Fassin, 2009a:52).

It is, in particular, through what Morgan and Roberts (2012) call *moral regimes*, that the influence of Fassin's politics of life is important. They describe moral regimes as 'the privileged standards of morality that are used to govern intimate behaviours, ethical judgements and their public manifestations' (Morgan and Roberts, 2012:242). The notion is inspired by the concept of *regimes of truth* which Foucault (1980:131) describes as a general politics of truth that includes the types of discourses that are accepted and operationalised as truth, the mechanisms involved in distinguishing what is true and false, and the means of sanctioning true and false statements. Furthermore, it is the element of evaluation of human beings through a moral economy that produces inequalities and differentiation that is at the core of moral regimes, as described by Morgan and Roberts (2012b: 242) when they say, 'With moral regimes of reproduction, the focus becomes the evaluation of actions and ideologies related to generation, perpetuation and human continuity. Moral regimes are often evaluated in relation to other, supposedly immoral and irrational activities'. This perspective thus allows for an analysis of how reproductive practices are evaluated and differentiated from each other in a particular context. It enables the question of how some reproductive practices, such as the use of modern contraceptives, are allowed and even encouraged, while others, such as abortion, even when legal, are left on the outside of the moral demarcations.

3.3 Anthropology of Policy

This study places the Zambian abortion policy at its core and seeks to trace its origin and its articulations with global reproductive politics and follow its movements towards implementation in the Zambian health system. In doing so, this study builds on Shore and Wright's thinking about policies from an anthropological perspective (Shore and Wright, 1997; Shore et al., 2011; Wedel et al., 2005). At the core of Shore and Wright's thinking is an understanding of policies as continuously contested and

reshaped, rather than constant and fixed, as they often appear in policy literature. They highlight that 'policies are not simply external, generalized or constraining forces, nor are they confined to text. Rather they are productive, performative and continually contested' (Shore and Wright, 2011:1).

Policies take on many forms, including laws, regulations and actions of a wide range of state officials and first-line workers and civil servants. Borrowing from Appaduarai's (1986) *The Social Life of Things*, Shore and Wright (2011:3) highlight the flexible and productive nature of polices and stress that 'a key quality of policies is that, once created, they often migrate into new contexts and settings, and acquire a life of their own that has consequences that go beyond their intentions'. This perspective is helpful for analysing how Zambian abortion policy is contested and re-interpreted and shaping ideas about what a legal abortion is, as it moves through the administrative layers of the Zambian health system on its way to implementation in rural hospitals.

Shore and Wright's (1997, 2011) thinking makes room for a more in-depth interpretation of the intricate and complex processes involved in translating policies from paperwork to on-the-ground practice. Through their perspective, the variety of actors, including law-makers, mid-level bureaucrats and health personnel, are brought to light as policy actors (Bierschenk and Sardan, 2014; Goetz, 1997) and are actively involved in shaping policies and their implementation. Elaborating on bureaucrats as policy actors, Bierschenk (Bierschenk, 2014) noted how lower-level bureaucrats navigate complex moral and political landscapes with contradicting and shifting instructions and a series of informal and often locally produced norms. Lower-level bureaucrats are thus positioned in the interfaces between higher-level state authorities and more locally produced norms and values (Bierschenk, 2014:238-239), which makes them interesting focal points for understanding the social lives of policies, providing insights into how policies are conditioned by broader social and political factors. Perspectives from anthropology of policy are helpful when aiming for a better understanding of why the Zambian ToP Act is not sufficient to ensure that girls and women have access to safe and legal abortion services.

3.4 Moral Economies

To better understand the everyday politics of abortion as it plays out on people's lives, including how moral judgement of abortion comes about and circulates, the study borrows from Fassin's (2014) thinking of moral economy. As an analytical concept, moral economy was first introduced by the historian Edward P. Thompson in his study of the emergence of the English working class (Götz, 2015; Palomera and Vetta, 2016; Thompson, 1971). Thompson (1971) used the term 'moral economy' to understand how riots and protests came about, not only because of the dire situation of poverty and despair of the working class, but also because of moral concerns about the capitalist system (Fassin, 2014; Thompson, 1971). The concept was further made popular by James Scott (1976), who used it to describe peasant mobilisations in Burma and Vietnam and their entanglements with larger economic and political processes, colonial state formation and expansion of capitalism (Palomera and Vetta, 2016). Moral economy was thus a term that put emphasis on how economic systems caused moral concerns, which in turn mobilised resistance and riots grounded in ideas about legitimate norms and practices for work and exchange of commodities.

Fassin's (2014) understanding of moral economy represents a different way of using the term. He thinks of moral economy as the 'production, distribution, circulation and use of affects and values in the social space' (Fassin, 2014:157) and thus puts more weight on 'moral', such as affects and values, than on 'economy' (Fassin, 2009b; Götz, 2015:157). As such, Fassin forms part of a turn in anthropology that seeks to move away from bleak studies of harsh consequences of neoliberalism towards increased focus on what makes up good lives, including anthropological studies of morality and ethics (Fassin and Lézé, 2014; Ortner, 2016; Zigon, 2007:59-60).

Fassin's (2014) use of the term has been criticised for overlooking the role of class, capital and economic system (Palomera and Vetta, 2016). While such a criticism may be valid, Fassin's understanding of moral economy, which grasps the processes of how affects and values come about and are exchanged and circulated to maintain or

increase a state of moral integrity, makes a helpful analytical tool when seeking to understand the everyday politics of abortion.

The theoretical foundations of these theses thus combine the concept of reproductive governance and moral economy with thinking inspired by anthropology of policy. Together, these three perspectives provide a theoretical scope that enables a broad analysis of both the mechanisms and content of abortion politics in Zambia and beyond.

4. Methodology and Methods

4.1 Ethnography of Abortion Politics

4.1.1 Epistemological Foundations

This study was conceptualised and carried out as an ethnographic study. Despite being firmly rooted within anthropological research traditions (Hammersley and Atkinson, 2007), ethnography is a term that is used to describe methods and methodological approaches across a series of disciplines (O'Reilly, 2012:3). The diverse use and application of ethnography comes with a great variety of definitions and connotations attached. It follows that simply calling a study 'ethnographic' is not sufficient and does not fully portray how a study was conceptualised, carried out, analysed and written. Striving for much needed methodological transparency, it is necessary to reflect on the epistemological positions underlying this study before outlining the specific methodological choices that were made.

As a study of politics and policy of abortion and their implications for people's ordinary lives, this study operates across several scales. It is concerned with historical lines of moral politics and reproductive rights, people's and policy actors' opinions and conceptualisations of abortion, and with the articulations between these. As such, it is grounded in an epistemology that contemplates a balance between agency and structure and seeks to understand social life from two simultaneous and intertwined perspectives: through people's thoughts and feelings in their everyday lives, and through the wider structural contexts within which these lives take place. Willis and Tronman (2002:395) have described the ontological foundations of such an epistemological position as one that sees human beings as 'part objects and part subject', revealing a theoretical affinity with Bourdieu's (1977) practice theory that sought to overcome the gap between agency and structure.

Moreover, this study was conceptualised from a critical position, seeking to not only understand, but also expose hidden or subtle injustices and power dynamics with the

ultimate goal of social change (Thomas, 1993). This does not mean that the study aimed to produce any specific intervention or to interfere with Zambian abortion politics, but rather that it sprung out of the thought that social research should produce and provide knowledge on imbalances of power and possibilities that can add to the knowledge base on which social change can form.

Based on these underlying premises, this study was conceptualised as an ethnographic study in the broader sense of the word. While common traits of ethnography, such as long-term fieldwork, participation in everyday activities and engagement in informal conversations as well as formal interviews, were all key elements of this study (O'Reilly, 2012), these are not the only elements that make this study ethnographic. It is the commitment to a methodology that is iterative, flexible and sensitive to context, that strives to achieve and sustain social contact with relevant agents and to richly describe interaction with them that is at the core of this study's methodological grounding together with a careful contemplation of my own role as a researcher (O'Reilly, 2012; Willis and Trondman, 2002: 3).

4.1.2 Outline of the Study

The study set out to increase understanding of the interplay between policy, legislation and sociocultural conditions that shape women's reproductive possibilities, taking Zambian abortion policy as a case. Using the apparent gap between a seemingly liberal ToP Act (GRZ, 1972) and the sustained problem of complications from unsafe abortions (Coast and Murray, 2016; GRZ, 2017b) as a starting point, I took Zambian abortion policy as the object of study and employed a multi-sited approach to inquiry (Marcus, 1995) that aimed to follow the policy across different sites and actors within the Zambian health system.

The study can broadly be divided into two distinct phases and three interconnected and overlapping 'sites'. From August to December 2017, I spent the initial phase of fieldwork in Lusaka, where I collected archival material from the Zambian National Archives and the Parliamentary library about the law-making processes involved in making the ToP Act. In Lusaka, I also mapped out and interviewed the relevant actors

involved in disputing or influencing Zambia's abortion policy or who were in other ways engaged in public debates on reproductive health issues. Taken together, the archival material and the interviews with national-level stakeholders are concerned with how Zambian abortion policy and politics play out at the national level, with a focus on situating the current policy within Zambian postcolonial history. Paper I presents the major findings from this part of the fieldwork.

The second phase of the study started in January 2018 when I relocated to a town in one of Zambia's predominantly rural provinces. To protect the anonymity and integrity of informants, I have chosen not to include the name of the study province and town (see Section 4.5). Originally, the idea was to take part in the daily activities of a local NGO working on SRHR issues to explore the relevance and understanding of the abortion policy at the community level. However, after a few initial interviews, I became attentive to the central role of health bureaucrats responsible for implementing a series of SRHR policies, including those related to abortion. This led to the inclusion of a focus on the health bureaucrat's role as policy actors central to the complex process of turning health policy from paperwork to practice.

District- and provincial-level health bureaucrats and hospital managers in the study province thus represent another 'site' in which it is conceptually possible to examine how abortion policy is contested, reinterpreted and redefined as it moves through the layers of the Zambian health system. Through contact with the provincial health office and collaboration with the local NGO working on SHR issues, I participated in four health management and policy meetings where issues of SRH were discussed. These included a regional Maternal Death Surveillance and Response meeting that specifically touched upon abortion. Moreover, I interviewed district health directors and maternal health coordinators, hospital managers and provincial-level health bureaucrats about their responsibilities, knowledge of and opinions on SRH issues with a particular focus on abortion, and I explored their role in implementing the Zambian abortion law. Paper II presents the main findings from this 'site'.

Throughout my stay in the study province, I worked closely with a semi-rural clinic that provided SRH services to adults and adolescents. I took part in daily activities of the clinic's youth-friendly corner run by a group of young peer educators, and I followed the work of the maternal and child health nurses who provided SRH services at the clinic and in the community. Through the clinic's community health workers, I was introduced to the neighbourhoods surrounding the clinic where I participated in daily life activities such as church going or market hangouts. Participant observation at the clinic and in the community, interviews and group conversations (see below) with neighbours, health workers and community health workers make up the empirical core of this third 'site' of Zambian abortion politics examined in this study. Paper III presents the main findings from this site.

4.1.3 Constructing the Field of Abortion Policy – A Multi-sited Approach

When Marcus introduced the term multi-sited ethnography in 1995, he was naming an emerging approach to ethnographic research that was gaining increasing force. While ethnography is conventionally associated with long-term fieldwork dominated by participant observation within a defined community that makes up a study 'site', another more mobile way of doing ethnographic research emerged with the post-modernist turn of anthropology in the 1980s and 1990s (Falzon, 2016; Marcus, 1995). As its name indicates, multi-sited ethnography takes on and moves between several social and geographical 'sites', but also includes a somewhat different conceptualisation of what is to be studied (Candea, 2016). It replaces inherent assumptions about field sites as containers of social relations that can holistically be studied, explored (Falzon, 2016) and situated within larger 'world systems' (Marcus, 1995). Instead, it proposes strategies of 'following' or 'tracking' social phenomena, relationships and connections as they unfold across scales and geographical boundaries (Candea, 2016 ; Falzon, 2016). As such, Marcus (1995) held that multi-sited ethnographies became closer to studies *of* world systems than studies situated *within* them.

Since the 1990s, multi-sited ethnography has been subject to a lot of methodological debate (Candea, 2016 ; Hage, 2005; Horst, 2016). Some scholars argue that the approach is not qualitatively different from other ethnographic strategies (Falzon, 2016:2; Hannerz, 2003:202-203), while others have argued that multi-sited ethnography rarely manages to get the depth of insights that ethnographic research strives to obtain (Falzon, 2016; Horst, 2016). These debates all raise questions about the meaning of place and location in anthropological research and lead to reflections and deconstructions of what makes up the 'field' in fieldwork (Gupta and Ferguson, 1997). Located at the core of such understandings of the 'field' is the notion that all 'sites' are constructed in the sense that the ethnographer makes decisions about what to include and exclude in their definition of the field (Gupta and Ferguson, 1997). Candea (2016) contends that multi-sited ethnographies and their focus on mobility and flow to a greater extent obscure the practice of choosing what 'makes the cut' when researchers define the boundaries of what makes up their area of study (geographical or social).

More than the number of 'sites', it is the epistemological focus and conceptualisation of the field that underlies the decision to describe this study as multi-sited. Using the label of multi-sited is meant to reflect a commitment to Marcus's (1995) metaphors of following and tracking, in this case Zambian abortion policy, rather than a mechanical decision to carry out fieldwork in several physical locations. Inspired by Appadurai (1986) and Shore and Wright's anthropology of policies (Shore and Wright, 1997; Shore et al., 2011), the study conceptualised Zambian abortion policy as the main object of study and aimed to track its relationship to the wider context of global reproductive politics and follow its movement through the different layers of the Zambian health system.

With Candea's (2016) warning about multi-sited studies in mind, some reflections on how this study's 'field' was constructed as a 'field of abortion politics' are required. When conceptualising and planning the study, the intention was to explore the relationship between national abortion politics, including influence from global reproductive health governance and on-the-ground conceptions about abortion and

the relevance of abortion policy. During the first few months of fieldwork, however, the immense discrepancy between how the Zambian ToP Act was disputed by key stakeholders at the national level and the apparent lack of implementation of the law in the study province forged the emergence of more relevant questions such as 'What happens to an abortion law on its way from paperwork to actual implementation?' and 'How do political processes intervene with reproductive rights, such as the right to access safe abortion services, when they are ensured in the legal framework?' From these questions, a broader understanding of the field of Zambian abortion politics emerged. Following abortion policy, as a political device, became the leading methodological principle, allowing me to tie together abortion policy across multiple scales. Such a conceptualisation has enabled an analysis that ranges from national abortion politics situated within systems of global governance of reproductive health to everyday politics of abortion as it is played out between neighbours in rural Zambia.

4.2 The Research Process

4.2.1 Accessing Abortion Politics

The question of access is at the methodological core of all ethnographic research. The ethnographer depends on gaining access to the social arenas relevant to the topic of study (O'Reilly, 2012:87). With the exception of classical anecdotal prefaces about how the ethnographer arrived in 'the field' (Marcus, 2006), the ethnographic literature does not commonly pay much attention to the often continuous process of negotiating access throughout a period of fieldwork (O'Reilly, 2012:89; Sixsmith et al., 2003:578). For this particular project, the relevant arenas to access were those where abortion politics manifested. I was interested in any social space where efforts were made to influence the making of abortion policies or how they were implemented, or where everyday abortion politics played out in interactions between neighbours. The three different 'sites' of this study (national-level political stakeholders, regional-level health bureaucrats and community interactions) presented different challenges in terms of access.

Accessing National Abortion Disputes

The first social space I attempted to access was the one where national-level political stakeholders, such as (I)NGOS, major churches, religious organisations and professional organisations made strategies and engaged in disputes to influence how (and if) the Zambian abortion law was to be interpreted and implemented. When conceptualising the study, I aimed to gain access to the offices of such organisations. The intention was to carry out participant observation by contributing with office chores or report writing while learning the field of Zambian abortion politics by seeing them develop strategies of advocacy. While all of these organisations welcomed me to interview them and many pointed to other possible stakeholders, none of them were interested in allowing me access to their everyday office lives.

(I)NGOs are known to be protective of their integrity and reputation and are particularly reluctant to grant access to their inner workings (Sridhar, 2008:9). The sensitive and politicised nature of abortion made (I)NGOs and other organisations particularly protective of their positions, further challenging access to their work. Through interviews and other interactions, I came to know about the 'Safe Abortion Action group', a meeting place for (I)NGOS and the MoH. The group discussed abortion policy and was active in proposing changes to the 'Standards and guidelines for reducing unsafe abortion morbidity and mortality in Zambia' (GRZ, 2009). Despite continuous attempts to be invited to take part in meetings, I was never informed about when they took place and was never allowed to attend one.

Ever since the 1970s, anthropologists have increasingly expanded their analytical interest to move beyond a focus on marginalised groups and focus on the powerful and influential (Nader, 1974). This pertinent turn, however, is not without its methodological challenges. In her iconic essay 'Up the Anthropologist-Perspectives from Studying Up', in which Nader (1974) encourages studies on social elites, she points to access as one of the obstacles standing in the way. This challenge to 'studying up' is further dealt with by Gusterson (1997), when he reflects 25 years later on Nader's call. While strong organisations and corporations may be willing to allow interviews and insight into documents, Gusterson (1997:115) notes how access

to do participant observation is particularly challenging when studying up and goes as far as stating that 'participant observation is a research technique that does not travel well up the social structure'. The method was developed for research in small communities dominated by face-to-face interaction and not to study people who may put their careers at stake or risk compromising their organisations' interests (Gusterson, 1997:115).

Attempting to circumvent the challenge of access related to participant observation when studying up, Gusterson (1997:116) suggests 'polymorphous engagement', a strategy that fittingly describes my activities in Lusaka. This strategy entails efforts to achieve repeated interactions with key interlocutors across different sites and a broader intake of the question by also including elements such as careful reading of the media and reviewing relevant political documents. During my fieldwork period in Lusaka, I carried out a series of interviews with relevant stakeholders, such as policymakers, religious leaders and NGO employees. I also took on an archival investigation about the origin of Zambian abortion law and policy, mapped out media attention on abortion issues and interacted with relevant stakeholders at conferences. Moreover, I found reasons to stay in contact with the ones I had interviewed for follow-up questions or additional information about what was going on in the field of abortion politics. This strategy enabled me to collect what I perceive to be a comprehensive set of materials about the current national disputes over abortion in Zambia, despite the challenges of access.

Accessing Health Bureaucracies

As I relocated to the study province and tried to access situations where health bureaucrats discussed SRH and abortion, I encountered some of the same challenges to access as in Lusaka. Much like representatives of national-level political stakeholders, the bureaucrats represented a strong organisation (in this case the MoH) with a particular set of interests and codes that posed certain challenges to access. While located towards the bottom of the administrative hierarchy of the Zambian health system (see Figure 1), rural health bureaucrats such as district health directors

and maternal health coordinators represent another group of influential social agents relevant for studies of abortion.

Interactions with health bureaucrats started with the process of seeking the necessary research permits from the Provincial Health Office. The bureaucratic and cumbersome process of seeking research permits from national (see Appendix 6), regional and local authorities became central to the continuous process of negotiating access. When approaching the provincial health office to get approval, collaboration was established with the office's public health specialist, who remained a key contact person and interlocutor throughout the fieldwork period. This first meeting quickly moved beyond the necessary signature and started a conversation about the status of abortion services in the province that pointed me to a few of the province's districts with particular problems of unsafe abortions. My contact at the provincial health office moreover introduced me to some of the NGOs working on SRH issues (but not abortion) and facilitated my initial interview with the province's only gynaecologist.

Despite allowing me access to attend, the provincial health office did not actively invite me to the health management meetings that became a central part of my ethnographic research. To know about these meetings, I was dependent on using my broader network. Some of these meetings were brought to my attention through my collaboration with a local NGO (see below), and others through contacts in Lusaka with knowledge about provincial health policy management within maternal and reproductive health. When learning about a meeting, I asked my main contact at the provincial health office for permission to participate as a researcher.

Accessing Everyday Politics of Abortion

At the community level, my strategies to access were many and diverse. Before moving to the study province, I made contact with a local youth-led NGO (operating only in the province) that worked on adolescent SRH issues. Initially, my idea had been to follow their activities to learn more about how abortion was perceived and understood and to better understand the relevance of the Zambian abortion policy. In contrast to my experience in Lusaka, this organisation warmly welcomed me, and for

the first weeks in the study province, I spent countless hours in their small office space. The organisation, however, was going through a shift in leadership and a decline in funding that led to a decrease in their level of activities, which made them a less suitable entry point to the town's neighbourhoods and communities. Nevertheless, the NGO was central to my access to relevant social arenas in several ways.

First, they facilitated contact with the local traditional court in charge of the area in which I was working. Traditional leaders are highly respected, and they are important community leaders in Zambia in general and in the study province in particular. Asking for their permission can be crucial for gaining access, and particularly for a project that deals with what is considered a particularly sensitive and controversial topic. Navigating the system of traditional leadership and taking the necessary steps to obtain acceptance of the research project is challenging for a foreign ethnographer, and I was dependent on the local NGO to take me through both the bureaucratic process and the cultural and ritual codes involved. Assisted by the NGO, I was received by five of the chief's advisors in a session of the traditional court. After hearing a presentation of the project and receiving the appropriate and mandatory gifts to the community, the court members gave their blessings to the project and wished me luck. This made a lot of difference when I later approached reluctant community members to talk about reproduction and abortion-related issues.

The local NGO was also central in introducing me to the semi-rural clinic, which became a central starting point for my participant observation at the community level. The clinic manager showed a particular interest in my research project and introduced me to the young peer-educators who worked at the youth-friendly corner and allowed me to use a spare room at the clinic as a location to conduct interviews when needed. In return, I promised to write a report about my main findings and to facilitate some of the clinic's outreach activities. I kept my end of the agreement by organising meetings between the peer-educators who volunteered at the youth-friendly corner and adolescents who lived some distance from the clinic. In an attempt to avoid being too closely associated with the clinic, these meetings took place towards the end of

my fieldwork period, and my participation was limited to providing logistical support. I also wrote a report with key findings that was delivered to the clinic in February 2020.

The clinic head also put me in contact with its community health workers. While several of the community health workers became key interlocutors, I developed a close relationship with one of them who became central to my access to ordinary neighbourhood activities (O'Reilly, 2012:91). Christine (pseudonym) was not only a respected community member chosen to represent the community in their communication with the clinic, but also owned a humble restaurant at the local market that was a meeting point for many neighbours. This became a starting point for my access to everyday community life.

After acknowledging that all strategies for access have unavoidable consequences for the findings of any qualitative research project, Sixsmith and colleagues (2003) encouraged researchers to make use of multiple strategies when negotiating access and acceptance for a research project. In addition to common strategies like using gatekeepers or introductory surveys, the authors stressed the importance of long-term presence and 'being there', which is typical in anthropological research, as key to gaining community members' trust and willingness to discuss controversial or sensitive topics (Sixsmith et al., 2003). 'Being there' became central to my own possibility to access everyday life in the community as well as settings where SRH issues were discussed. However, I employed a series of strategies to find natural reasons for 'being there' that ranged from carrying out simple house chores for elderly women who lived alone in the neighbourhood (that had been severely stuck by HIV-related mortality in the early 2000s, leaving many old women without children to care for them) to hanging out in the market or taking part in church-organised women's groups and women's saving groups.

4.2.2 Events as Methodological Tools

Detailed outlines of events and situations have been a central element in both classical (Geertz, 1980; Gluckman, 1940; Mitchell, 1956; Sahlins, 1981) and more

recent anthropological literature (Das, 1995; Kapferer, 2010; Sahlins, 1981). Events have been used either as telling exemplifications or illustrations of norms and patterns that are believed to be typical, or as happenings that seem to constitute a contradiction or paradox that the ethnographer can further make sense of through analysis (Kapferer, 2010). Kapferer (2010) encourages scholars to not take events as static examples of social relations or norms but to focus on what goes in extraordinary and uncommon public situations. He urges anthropologists to no longer use 'events as case studies' but rather take unusual events as dynamic situations that open new possibilities in which social elements are cast together in new and often unexpected ways (Kapferer, 2010). As such, events constitute helpful analytical tools to gain deeper understandings of dynamic and continuously changing societies. While this is also true in this study (see Paper III), I have found that events may also constitute a methodological opportunity in addition to an analytical tool.

Paper III is focused around an event that took place outside the clinic after a neighbour discovered an aborted foetus that a dog was pulling it into his yard. He called the police and notified all of his neighbours who spontaneously gathered by the clinic to express their disgust and moral judgement of what had taken place. The paper takes the rally of neighbours as an analytical starting point to explore the everyday politics of abortion embedded in questions of morality and social ties to the community. While in the field, however, the event played a much more practical and methodological role.

Before the rally at the clinic and about six weeks into my fieldwork in the study province, people were generally reluctant to talk about abortion. Health workers at the clinic referred to what PAC cases they had seen as students in the bigger cities, but never discussed local experiences with abortion issues. Neighbours often held that they did not know anything about abortion. Interviews and conversations were cut short when abortion-related issues were brought up, and abortion was not a topic that came up easily without me introducing it. Considering the monthly numbers of 40-50 girls and women coming in for PAC in the referral hospital in town, I was aware that abortions were, after all, fairly common, but I was running out of appropriate ways to

approach the topic and gentle ways to ask about it. The event described in Paper III turned this situation around. In the weeks that followed the rally at the clinic, it became clear that it had been experienced as dramatic for all parties and had enforced the social ties among those present during the event, including me. The rally, and the abortion that sparked it, repeatedly came up in conversations, interviews and social gatherings, without the need to ask specific questions about it.

The fact that I had been present at the clinic when the rally took place seemed to give legitimacy to my questions about abortion issues. I could notice how some became more open to talk about abortion-related issues as they realised that I had also been present at the clinic on the day of the event. One possible explanation for this openness could be related to the event as a public, and to some degree collective, expression of moral condemnation towards abortion. Neighbours who might have questioned my intentions for asking questions about uncomfortable issues about sexuality, contraceptives and abortions might have considered my presence at the clinic an expression of my own personal moral condemnation. What most neighbours did not know, of course, was that I had already spent a few hours at the clinic prior to the event and that my presence was quite unrelated to the aborted foetus.

Methodologically, the event that took place outside the clinic thus served as a gateway for access to conversations and discussions about abortion that would have been a lot more difficult in other circumstances. Being present when unusual or socially significant events occur thus seems to add to the value of 'being there' (Sixsmith et al., 2003).

4.2.3 Methods

Participant Observation

Employing ethnography as an overarching methodological approach allows for a range of options and great flexibility in terms of methods for data collection (O'Reilly, 2012). Participant observation, however, makes up a central method in most ethnographic studies, including the present. As described above, some areas of

Zambian abortion politics remained inaccessible for participant observation (though approachable through other methods), while others were more available.

Participant observation in health policy and management meetings was key in gaining insight into how politics and subtle power mechanisms were at play at provincial and district levels of Zambian health administration, with wide-ranging consequences for interpretation and implementation of Zambian abortion policy. Without taking part in and witnessing social interactions between health bureaucrats at different levels, when discussing abortion-related cases, it would not have been possible to begin to understand the gap between Zambia's seemingly liberal abortion law in paper and its lack of implementation at rural hospitals in the study province.

Moreover, participant observation in everyday activities in the communities surrounding the study clinic was indispensable for gaining insights into how abortion is understood and discussed in everyday life. By hanging out at the marketplace or attending church services and engaging in conversations about everyday activities such as agriculture or childcare, I learned about conditions for social life that provided the essential contextual information needed to interpret findings around issues of SRH and abortion. Moreover, participant observation gave me insights into how issues of sexuality and reproduction, including abortion, were conceptualised and handled at the community level.

As indicated by its name, participation is an important part of participant observation, but striking a balance between participating and observing can be challenging. O'Reilly (2012:105) contended that the unique value of participant observation lies in the dialectic relationship between the two actions that works to 'produce new outcomes unattainable by each approach alone'. I engaged in participant observation across two major areas: in health policy and management meetings on the one hand and everyday activities at the clinic and the community it served on the other. The balance between participation and observation varied substantially from setting to setting. In the health policy and management meetings, my role was a lot more an observer than a participant since my participation was limited to introductory

statements about my role in the meeting and the nature of my project and to small talk with meeting participants during breaks. On these occasions, observation played a more important role, allowing me to be more attentive to what was going on and pay close attention to interactions between meeting participants. My activities in the community involved a higher degree of participation, which allowed me to understand life in the neighbourhood from a different perspective.

I documented participant observation in detailed field notes that I wrote on a daily basis. While all field notes involve a selection (O'Reilly, 2012-102), I strived to write in as much detail as possible about any observations directly related to abortion and as much as possible about other issues of reproductive health.

Interviews

In ethnographic research, asking questions and listening to answers go on continuously, and the distinction between interviews and participant observation can be quite fluid (O'Reilly, 2012:118). Throughout the fieldwork period, I registered 83 clearly defined interviews with a variety of relevant actors, ranging from adolescent girls in the community to high-level MoH policymakers. The interviews varied both in length and in structure from on-the-spot semi-formal interviews that resembled somewhat structured conversations to very formal interviews with MoH representatives or other policymakers that flexibly followed an interview guide. Independent of how formal the interview setting was or whether a flexible interview guide was used, all interviews can be characterised as open-ended, where the aim was to allow the interviewee to speak as freely as possible about the topic of interest.

Formal interviews with national-level political stakeholders, particularly ministry employees and representatives from religious organisations, often started with a thorough introduction of the rationale for the study and the purpose of the interview. Considering my position as a European woman, automatically perceived as having a positive attitude to liberalising abortions, this was particularly necessary in interviews with ministry employees or with leaders of religious organisations to establish trust that the project did not have a pre-established agenda that did not align with their

position towards abortion. These interviews most often took place in the offices of the NGO, ministry or church following the interviewee's wishes. Occasionally, interviews took place in the interviewee's home or at a public place like cafés or hotel lobbies. Interviews with this group were centred on topics such as the organisation's assessment of the Zambian abortion law, the problem of unsafe abortion in Zambia and their ongoing work to influence interpretation and implementation of abortion law and policy. In many cases, however, interviewees spoke widely about broader topics such as poverty, SRH more generally or gender equality.

Interviews with national-level political stakeholders, rural health bureaucrats, hospital and clinic managers and health workers also started with a thorough introduction to the purpose of the research. This introduction included all the formal bureaucratic steps I had taken to obtain research permits from all relevant instances before asking to interview them, as I learned that this made a difference for interviewees' ability to accept and speak freely during the interview. These interviews focused on questions about the interviewees' tasks and responsibilities, their knowledge and perceptions of SRH in general and abortion-related issues more specifically, as well as their knowledge and experience with the abortion law and its implementation. The interviews could also branch off to related topics such as contraceptive use, maternity care or adolescents' health.

When interviewing girls, women or other community members, more time was spent on introductory small talk about topics such as schooling, the harvest or the weather conditions before introducing the purposes of the interviews. These interviews varied greatly in both length and the interviewee's ability to speak freely. Depending on the interviewee, these interviews would start with talking about 'safer' SRH issues such as contraceptive use or appropriate age for first pregnancy before moving onto more sensitive abortion-related issues if the interviewee seemed comfortable. In many cases, abortion-related questions remained difficult to introduce or were answered only very briefly when asked. However, as described above, a noteworthy change took place in community members' openness to discuss abortion-related issues after

the ‘event’ at the clinic took place (see more under Section 9.2.2 Events as methodological tools).

Interviews with national-level political stakeholders, rural health bureaucrats, hospital managers, health workers and most community health workers took place in English, Zambia’s only official language and working language within the health system. These interviews were transcribed verbatim by me or by an experienced research assistant in Lusaka. Most interviews with neighbours were carried out in the vernacular language, assisted by a locally recruited female assistant (for more information about language and use of interpreters, see Section 4.4.2). These interviews were transcribed verbatim and translated into English. The translation process included discussions about terminology and cross-cheeking between two different research assistants fluent in the vernacular language.

Group Discussions

Ethnographic research recognises that people’s knowledge and feelings do not come about in isolation but are formed through interactions with others (O'Reilly, 2012:135). There are several ways for an ethnographer to capture group dynamics. While participant observation often provides opportunities to take part in and observe how people interact in groups, it is also possible to make more active use of group dynamics by introducing certain topics for conversation when groups are gathered or by inviting people to take part in more formal group discussions.

During fieldwork in the study province, I took part in, and sometimes led, a series of group discussions that make up an important chunk of my collected material. These group discussions were not part of my initial plans but came about through my efforts to gain access to everyday life activities in the community. After participating in a woman’s saving group meeting with one of the elderly women I was visiting regularly, I was asked to come back the following week so that we could discuss ‘the things you are researching’. This became the first of many group discussions about SRH issues and, whenever possible, abortion. A similar thing happened after I took part in a woman’s group meeting of the neighbourhood’s United Church of Zambia

congregation. After the meeting, some of the women invited me to go to their house the following week to discuss the topics they knew were of my interest.

After these two initial group discussions, word seemed to spread that women could organise group meetings and invite me to their house. I received a lot of invitations from groups of women who lived close to each other that grouped together to invite me. Women who knew me approached me directly with an invitation, and women who had not yet talked to me asked around at the clinic or asked Christine (the community health worker I spent a lot of time with) to set it up. For several months, I had between two and four weekly group discussions with groups of all sizes and ages. Most commonly, I found only women in the groups when I arrived, but some groups consisted of both men and women, and occasionally, groups of men invited me to discuss with them.

I have had some difficulty finding a good methodological label for these group conversations. Focus group discussion is the term commonly used to describe group discussions that are a lot more structured than these groups (O'Reilly, 2012:134). As I had not set them up myself, I had no control over the gender (through they were mostly only women), age or social status of the participants in each group discussion. O'Reilly (2012) used the terms opportunistic group interviews and planned group interviews to describe a less structured approach to group discussions. The former refers to ethnographers using the opportunity to introduce certain topics or ask certain questions when a group of people is already gathered (O'Reilly, 2012). Considering that the group discussions I refer to took place in groups that got together specifically to have a discussion with me, this term is not a good fit. While planned group interviews may thus be a more suitable label, it should be noted that most of the planning was done by the person who invited me to their homes and not by me as a researcher.

I find that 'guided discussions' may be a more adequate term to describe these groups. When I was invited to people's homes for group meetings, there was an expectation that I would start the discussions with a question or two about the topics

of my research. I would start gently and ask about people's opinions and attitudes towards child spacing and contraceptive use and their relationship with the clinic in these areas. This would usually be enough to set off a discussion about any related topic, such as appropriate age for marriage, adolescents' sexual morals, challenges of raising teenagers, adolescent pregnancies, relationship between schooling and sexual promiscuity and women's negotiating power within a marriage. After the abortion-related event took place at the clinic, it would very often come up in these discussions, providing an opportunity for me to ask more about the phenomena of abortion. If discussions came to a standstill, I would ask another question to hopefully start another discussion. As such, there was certainly an element of guiding involved, but to a much lesser degree than in a focus group discussion, and only if and when participants did not guide themselves.

The methodological literature has documented how group discussions can provide valuable insights difficult to obtain in one-to-one interactions (Kamberlis and Dimitriadis, 2011; Krueger and Casey, 2000; Morgan, 1997:5). Group-based methods are, however, generally not recommended in research on sensitive issues where the presumption is that personal stories will be more difficult to share in a group than in a one-to-one conversation. When invitations to group discussions at people's homes started coming, I was excited that the neighbourhood's women showed that kind of interest in my research, but I did not expect these discussions to provide substantial information about abortion-related issues that I believed to be too sensitive to take up in these semi-public/semi-private settings. I was therefore surprised when I experienced that for some, talking about abortion issues appeared to be easier than in more private conversations.

The group discussions not only allowed participants to engage in a collective process of meaning-making around certain topics through bouncing ideas off each other (O'Reilly, 2012), but they also enabled what appeared to be some sort of protection against suspicion. My presumption about abortion being a topic fraught with secrecy and taboos was quite right, but maybe for that reason, it was particularly important not to be taken for a person who had secrets about abortion and who only discussed

them in one-to-one conversations with me. Discussing abortion thus appeared to be more feasible in a group where suspicion of secrecy was avoided.

I captured the first few group discussions in field notes that were taken during and immediately after the meetings. It took me a few rounds to realise that these meetings were not part of my ordinary participant observation activities but were what I now call 'guided discussions' that could be audiotaped to capture more details and rich descriptions. After the first few discussions, I started asking each and every participant for permission to audiotape the discussion and took them through a process of informed consent. When all participants gave their permission, the discussions were audiotaped and later transcribed verbatim and translated into English by the research assistant.

Document Analysis

Document analysis made up a significant part of the first phase of fieldwork that took place in Lusaka. As I was carrying out interviews with political stakeholders about the Zambian abortion policy, it appeared increasingly difficult to understand how the ToP Act had been drafted and passed in 1972, something that seemed unthinkable in the contemporary political climate. Looking for answers, I collected two types of archival documents: the 1972 Speaker of the Parliament Robinson Nabulyato's personal correspondence with Zambia's first president Kenneth Kaunda, and the records of parliamentary debates leading up to the enactment of the abortion law and the 2005 amendment of the Penal Code that decriminalised abortions in cases of rape and defilement.

Prior (2003) cautioned social researchers who engage in document analysis to focus not only on the content of the documents but also on the 'processes and circumstances' under which they were produced, and how they function and are used beyond their production. Following her advice, it became important to consider the two sets of documents separately, one produced as personal correspondence between two high-ranking politicians in power, and the other produced as a public record of parliamentary debates.

I accessed the Zambian National Archives and consulted the private collection of Mr. Robinson Nabulyato. The collection contained copies of the letters he had sent to President Kaunda in response to the Catholic Churches' protests of the parliaments passing of the law. In these letters, Mr. Nabulyato urges the President to refrain from giving assent, which would effectively make it law. In my interpretation of these documents, it became important to consider that they were written as part of a 'behind the scenes' political negotiation. As Speaker of the Parliament, Mr. Nabulyato wrote in defence of the decision made by the institution he represented. As such, they are written with a certain amount of affect warning the president about the consequences of allowing the Catholic Church to interfere with an institution of the state.

The parliamentary debates, on the other hand, are rather frontstage documents as open public records of political negotiation. In my interpretation of these documents, it was important to keep in mind that I did not have direct access to any 'behind the scenes' negotiations that most likely took place. I therefore tried to locate and interview some of the policymakers that had been involved in the process. Considering that the debates took place over 40 years ago, many of the relevant actors had either passed away or were difficult to locate today, but I managed to interview one of the key policymakers who provided supplementary information to the parliamentary records.

4.3 Analysis and Interpretation

In ethnographic research, analysis is a continuous iterative process that starts while in the field (O'Reilly, 2012:180-181). While a more intensive period of analysis took place after I ended the fieldwork, important parts of the analysis were done during the fieldwork, including in afternoons and evenings as I was processing the information gathered.

The (nearly) daily writing of ethnographic field notes was not only an important way to capture and document observations, but it was also a continuous way of making sense of the information I recorded, with implications for the way to move the

research forward. An important methodological decision that was made through such iterative circles between analysis and collection of data material was the decision to focus on rural health bureaucrats and their role in translating abortion policy into practice. This decision was made as I was writing field notes from a visit to a rural district hospital that faced serious problems with the number of PAC cases but had received confusing advice from their district health office. In addition to these daily hours of note taking, I wrote small fieldwork reports to my supervisors in Norway on a bimonthly basis. These small reports served as excellent opportunities to re-assess my activities, highlight what emerged as more important and find gaps in my understanding.

Similarly, the process of transcribing interviews was also key in the analytical process. Independent of whether I was transcribing myself or carefully reading and checking transcripts carried out by the research assistant, I would note down new thoughts and questions that came to mind in the process. Particularly important were discussions with the research assistant about vernacular words or different possible interpretations. When spending time in the communities surrounding the clinic, I similarly discussed my preliminary thoughts and understanding with key interlocutors to have their feedback and adjust depending on their assessment of my interpretation.

After concluding the main fieldwork, a more concentrated period of analysis and writing started. During this period, I used NVivo11 and NVivo12 as a way to organise the material. The material that consisted of field notes, transcribed interviews and group discussions, and relevant historical and political documents was read and re-read to gain familiarity before it was inductively coded and clustered into categories and themes. During this process, I made attempts to shift between emic and etic categories. Moreover, I strived to move between more actor-oriented (Geertz, 1973:14) analysis closer to people's life worlds and a more theory-sensitive analysis paying closer attention to the wider context in which a situation occurs (Fangen, 2010:213), looking for wider patterns. In this iterative process, much of the final analysis that shaped the overall narratives that were selected and presented in the paper was done at what Braun and Clark (2006:84) have called a latent level,

focusing on underlying assumptions and conceptualisations that shape the semantic content captured in the interviews.

From conceptualisation to writing, the study has been informed by theory. While theoretical perspectives on gender (Moore, 1994) and discursive power (Foucault, 1980) were central to the conceptualisation of the study, the theoretical focus shifted during the iterative process of fieldwork and analysis in a way that created a fruitful relationship between findings and theory. While the process of coding and categorisation was not directly driven by theory, theoretical concepts like reproductive governance (Morgan and Roberts, 2012) and moral economy (Fassin, 2014) informed the overall thinking during analysis and writing.

Just as it is difficult to draw a clear distinction between fieldwork and the process of analysis, there is no clear boundary between analysis and writing. While the process of writing a manuscript starts with a plan for what arguments to make and how to sustain them with empirical examples, the writing process involves selection of quotes and ethnographic episodes that best conveyed the content of the identified themes.

4.4 Methodological Reflections

4.4.1 Positions In (and Out of) the Field

In ethnographic research, the researcher uses themselves as the main instrument in a way that unavoidably has consequences for how knowledge is produced and written. Since the 'reflexive turn' (Foley, 2002) in the social sciences, increased attention has been granted to the researcher's background and position towards the topic of research and vis-à-vis interlocutors. Drawing upon lessons from feminist studies and postcolonial thinking, anthropology acknowledges that knowledge can never be separated from the knower and takes the epistemological position that a complete 'outside' perspective is impossible. With such a position comes the need for the researcher to reflect on how their biography and social position may have influenced how research questioned were asked, interlocutors responded, analysis was carried out and theoretical inclinations came about.

Making the decision to enter into a research endeavour about the politics of abortion came out of a longer scientific and personal interest in SRH issues and health inequities. After completing a master's thesis in social anthropology about migrant women's access to antenatal care in Norway and working as a research administrator for the Centre for Intervention Science in Maternal and Child Health at the University of Bergen, the opportunity to join a study team that focused on abortion politics was an excellent fit. As such, the present study allowed me to further develop my interest in the nexus between health, gender and politics. My academic experiences and my situation as a Norwegian woman in her early thirties have shaped the conceptualisation of the study and its research objectives.

My position as a European female researcher interested in Zambian abortion politics did not come without its challenges. Despite starting fieldwork being well aware of the controversy of the study topic, I was still caught by surprise by the extent to which my interlocutors and interviewees would ascribe me positions and political opinions before our conversations had started. One of my first interviews in Lusaka with a gynaecologist at the University Teaching Hospital started with a 45-minute conversation about the motives of my study before I was allowed to ask questions. While not all interviews and interactions started out with this level of suspicion and presumption, I often heard statements such as, 'It is not like in your country where you can just get an abortion' or similar, signalling what interlocutors assumed about my views on abortion. Notably, such statements were more common among health bureaucrats or national-level political actors than among interlocutors that I got to know in the study province communities. Such perceptions are, of course, likely to have influenced interlocutors' and interviewees' ways of answering my questions. While some interlocutors may have aligned their answers somewhat to make them fit with their perceptions of my opinions, others appeared deliberately to mark their distance from what they believed to be typical and overly progressive European standpoints.

A note is therefore warranted about my personal opinions and positions with regards to abortion-related issues. Within the Norwegian context, I have been vocal about

access to safe and legal abortion services as both an issue of public health and a question of women's bodily autonomy. I have defended the Norwegian abortion law that allows abortion on demand up to week 12 of gestational age, and under a broad set of criteria until week 18. While this position will unavoidably have influenced my interpretations and writing, I have made continuous efforts to bracket them out as much as possible during fieldwork and build relationships with interlocutors with a variety of viewpoints on whether and when girls and women should be able to access safe and legal abortion services.

Viewpoints on abortion are, however, not the only relevant factor that may have influenced my interactions with interlocutors. In Lusaka, when working on gaining access to national-level political actors, I experienced how my age as an adult researcher, somewhat older than the typical student collecting data for their projects, could work both for and against me. Young age can be a methodological advantage during ethnographic fieldwork, as you may be perceived to be less of a threat and more in need of being 'educated' on your topic of interest (Fangen, 2010:147; Goffman, 1989:128). I benefitted from this perception, as some people I approached assumed I was younger than my age of 31 years at the time of fieldwork. Among neighbours in the communities I worked in the study province, this assumption was aided by the fact that I am not married and do not have children. However, on other occasions, particularly when approaching high-level policymakers or health bureaucrats, I would benefit from talking about my several years of experience as an employee of a university, increasing my credibility and legitimacy as a researcher in ways that could grant me access to certain interviewees or meetings.

A reflective process also includes situating oneself and one's research historically, and for this study, that means recognising the postcolonial context the research unavoidably is positioned within. Tamale (2011) pointed out the important imbalance in research on issues related to sex and sexuality, where vast numbers of researchers from the global North do studies in African countries but almost none the other way around. Such projects cannot, of course, avoid historical legacies of inequality and prejudice (Tamale, 2011:27). This position has been uneasy for me throughout the

research process and has taken many rounds of doubt, reflection and discussion with my collaborating partners at the University of Zambia. As such, I have strived to follow Tamale's (2011:27) advice about employing a critical and reflexive lens throughout the research project, which includes a particular scrutiny of the actual research practices and the politics of research and writing.

As a researcher from the global North researching a topic like abortion that is highly sensitive on a personal and a political level, Tamale's (2014) advice was helpful, though it did not make my task any easier, as it involved the constant and careful scrutiny of my position in the academic and empirical field and on the possible political implications of my writing. Throughout the fieldwork period, my interlocutors continuously reminded me of my position. Considering the ongoing political power struggles over the question of abortion in Zambia (covered in Paper I), this position in the field came with some consequences for my writing. Many of my interlocutors, especially NGO workers and health bureaucrats, were requesting to read my work, and some even hoped to include my published papers in the literature on which they base their political advocacy. This situation left me both aware and somewhat uneasy about the politics of my writing, including the political dimensions of the theory I choose to draw upon. While the process of thought that went into writing this dissertation has allowed me to engage in a thorough process of scrutiny and critical reflections about the postcolonial dimensions of my research, it has not completely removed the feeling of unease. Along with the expectations from my interlocutors, this unease has kept me on my toes and helped me to employ a (self)-critical and reflexive lens throughout the research and writing process.

4.4.2 Reflections on Methodological Quality

The flexible nature of qualitative research has led to much debate on how to determine appropriate criteria for assessing its quality (Green and Thorogood, 2014:265-266; Hammersley, 1992; Malterud, 2001:224-225; Mays and Pope, 1995; O'Reilly, 2012). In these debates, ethnography has been considered particularly challenging to pin down using a set of formal criteria for assessment (Green and Thorogood, 2014:265). In part, such discussions revolve around the underlying

ontological assumptions about the nature of reality and epistemological questions of how it is possible to know anything about it (Hammersley, 1992:68). Hammersley (1992:68) suggested a position that he calls subtle realism, which holds that there is a reality to know something about, but that we as researchers can only aim to achieve a selective representation of it rather than an actual reproduction of it. Within such a paradigm, researchers can never manage to make claims that are completely accurate, but rather selective and partial representations of a reality. Nevertheless, Hammersley (1992) believes that it is possible for readers to critically assess the claims made in ethnographic research and suggests the criteria of validity and relevance for doing so.

Validity

As a criterion, validity deals with the extent to which the claims we make are accurate representations of the phenomenon it aims to describe, explain or theorise (Hammersley, 1992). However, since it is not possible to access the complete reality of the phenomenon, we can only assess the validity of claims by evaluating the quality of evidence that is presented to support them (Hammersley, 1992:68). This study has strived to achieve validity through several strategies that include prolonged engagement in the field, triangulation of methods and of sources, reflections on the role of the researcher and methods, the inclusion of rich contextual information and engagement with theory throughout the research process.

In qualitative research, triangulation between different methods, such as interviews and participant observation, is often used as a means to ensure methodological strength. However, such evaluations imply the assumption that the weaknesses of one method (i.e. interviews) is compensated by the strength of another method (i.e. participant observation). Mays and Pope (2000) argued that triangulation is better understood as a way to ensure comprehensiveness. In this study, I moved between multiple methods (participant observation, interviews, group discussions and document analysis) and sources (actors and social arenas that are differently positioned towards abortion in Zambia at different administrative and political levels). When exploring the role of rural health bureaucrats, for example, it proved

fruitful to move between interviews and participant observation in health policy and management meetings where issues of SRH were discussed. Such a triangulation of methods provided opportunities for obtaining a more comprehensive understanding of how the Zambian abortion policy was understood and acted upon.

Moreover, throughout the study, efforts have been made to ensure transparency and clarity about how the study was carried out and analysed. Methodological choices and analytical approaches have been described in all three papers and further expanded in the present dissertation. Such descriptions and reflections are important to allow readers to evaluate the relationship between the interpretations presented and the methods and analytical strategies employed (Mays and Pope, 2000). In addition to a continuous reflective process about the relationship between my own position and background and its possible implications for the study, clarity of methods contributes to ensuring validity.

Mays and Pope (2000) also proposed attention to negative cases and fair dealing as techniques that strengthen the validity of a study. The principle of fair dealing relates to designing the research in such a way that gives opportunities to a variety of different interlocutor perspectives, so that no single group or position dominates the accounts presented. Considering the contentious and political nature of the question of abortion in Zambia, this was particularly important. From the early planning phase, efforts were made to include the voices of both those working to increase access to legal abortions in Zambia and those working to restrict such access. Ensuring such a variety also provided opportunities for learning about situations that did not align with the general patterns and that brought out the contradictions and complexities of Zambian abortion politics.

A Note on Language

When discussing validity, a note must be made about language and translation. While English is Zambia's only official language, Zambians use one of the country's 70 different languages in their everyday interactions. When embarking on fieldwork, I had no final decision about to where I would move after my initial months in Lusaka,

as that depended on where I would manage to negotiate the best access to arenas where issues of SRH and abortion were discussed. I started a process of learning Bemba, one of Zambia's major languages, and worked towards gaining access to a Bemba-speaking area. During my fieldwork, however, I gained more contacts in a province where Bemba is not widely spoken (due to questions of confidentiality described below, I cannot provide information about what language was spoken in the area where I carried out the second phase of fieldwork). As I relocated to the study province, I made efforts to learn the vernacular language, but due to time restrictions, I did not manage to reach a level where I could actively partake in conversations.

Lack of language skills had important implications for interactions in the field. For my participation in everyday activities, such as spending time at the marketplace or attending church services, I made sure to go with an interlocutor with proficiency in English who could help me when needed. Interviews with policymakers, health bureaucrats, health workers and others with education levels beyond primary school were carried out in English. While all of these groups of interlocutors were proficient English speakers, I have often contemplated how our interactions may have been shaped by the fact that none of us was speaking our first language. For interviews and group discussions, I worked with a female research assistant. She interpreted my questions from English to the vernacular and interpreted the answers from vernacular to English. When reading translated transcripts of the interviews, I could see how I had missed out on nuances and details in interviewees' answers that I could have further explored.

Since the research assistant who helped me with interpretation did not have regular access to a computer, I needed a different research assistant to transcribe and translate interviews. As a consequence, the assistant who transcribed and translated may have missed out on the tacit understanding of a phrase or a statement that one gets from observing body language and facial expressions. However, being aided by two different assistants in the process of interpreting, transcribing and translating was also beneficial. The assistant who transcribed and translated would point out situations

where something may have been misunderstood by the interpreter, and the interpreter would assist me in checking the quality of translations from the transcriber and translator. Both assistants facilitated the overall interpretation of the findings by engaging in discussions about cultural meaning.

The presence of an interpreter also has implications for the social dynamics that emerge in the field. On some occasions, I felt how establishing trust and rapport with an interviewee was challenged by the presence of a third person in the room. In other situations, the research assistant provided helpful advice about how to rephrase my questions in ways that would make them easier to answer and thus contributed to the relationships established in the interview situation.

Relevance

Hamersley (1992) suggested answering two main questions to determine the relevance of a research project: (1) Is the topic of research of sufficient importance to the intended audience? (2) Does it add something to the existing knowledge on the topic? (Hammersley, 2008:6). As a study that forms the basis of a PhD dissertation, the academic community with an interest in SRH and policy are part of the audience for this research. The dissertation has been written as a contribution to the wider academic debates on abortion and SRH policies, which means that I have made efforts to situate the research within wider debates on the politics of reproduction and abortion and to draw on relevant social theory, aiming to contribute to its nuancing and development. For this audience, I believe the overarching topic of mechanisms of interplay between reproductive health policies, abortion legislation and sociocultural conditions in the permissive legal context of Zambia is of interest as it challenges established conceptions about the role of abortion legislation.

While the study was carried out with particular emphasis on anthropological literature, I have strived to write in a way that can be accessible and relevant across disciplines. For example, I hope that Papers I and II that deal with how abortion policy is continuously renegotiated and reshaped on its way to implementation can be relevant for both an academic audience and an audience with a more practical interest

in policy. I have had the opportunity to present findings from this study to practitioners and policymakers from the Zambian MoH, which has created opportunities for the exchange of ideas that I hope the study can also contribute to in the future.

Adding to Hammersley's (2008) two questions to assess relevance, it is important to carry out and write up the study in a way that makes it possible to assess the study's relevance to other settings. Providing information on the context of the study, both in terms of the historical and geographical setting, and the legal, political and social conditions has been important. Such information can allow others to draw upon this study to compare its findings with those from other countries with liberal abortion laws and persistently high prevalence of unsafe abortions.

4.5 Ethical Considerations

A research project about a sensitive topic like abortion warrants particular ethical considerations (Fangen, 2010:189). While there are established procedures to ensure ethical research, research ethics is also a continuous process of reflection and negotiation of a series of key principles such as informed consent, confidentiality, doing no harm and respect for personal integrity. This study has clearances from the Regional Ethical Committee Western Norway (2017/1191) and the University of Zambia Biomedical Research Ethics Committee (009–07-17) (see Appendices 4-5). It also has authorisation from the National Health Research Authority in Zambia (MH/101/23/10/1) and the Zambian Ministry of Home Affairs (see Appendices 6-7). With these approvals came commitments to following procedures for informed consent and confidentiality that were helpful guides throughout the project. However, the ethical committees could not anticipate or cover the dilemmas that arose as the project was carried out (MacClancy and Fuentes, 2013:3). Below, I outline some ethical dilemmas I faced and reflect on the choices made.

4.5.1 Confidentiality

Confidentiality is a key principle of research ethics (NESH, 2016; World Medical Association, 2013). When asking someone to share their stories that include personal and sometimes sensitive information, the researcher promises them that the information will not be shared with others in a way that can be traced back to them. In the information sheet I used when asking interlocutors for informed consent, I followed the commitments made when receiving ethical clearance and promised my interlocutors that the information they shared with me would be kept confidential and only be used for the purpose of this research project (see the information sheet in Appendix 8). This promise came to represent more of a dilemma than anticipated.

When I relocated to the study province, it was important to me to understand the specifics of how the Zambian abortion policy was understood, interpreted and implemented. One of the particularities of the Zambian abortion law is that it requires approval signatures from three medical doctors, of which one needs to be a specialist, for an abortion to take place within the legal framework. The lack of medical doctors is severe in Zambia, and particularly so in rural areas. Finding medical specialists in rural areas is even more difficult, but due to a recent policy and considerable political will, the MoH has, over the past few years, managed to ensure the presence of at least one specialist in each of the country's 10 provinces. The study province was in the situation that they quite recently had employed their very first specialist in the provincial hospital and he happened to be an obstetrician and gynaecologist.

When mapping out how legal abortions were (or were not) carried out in the province, the specialist became a key interlocutor, and throughout the fieldwork period I had contact with him on several occasions. On our first meeting, when I interviewed him, he was informed in detail about my study, both through the information sheet and my explanations. I promised him, as everyone else, that the information he shared with me would be kept confidential. However, when I started the process of writing up my findings, the promise posed a dilemma. As the province only has one specialist, I struggled to find a way to write about the information he

shared with me without compromising the principle of confidentiality and his right to privacy and personal integrity.

The solution I eventually opted for was not to specify in which province I had carried out the rural part of my fieldwork. However, this was not an easy decision to make. As discussed above, detailed descriptions of context are important to ensure the validity and relevance of the research, allowing the reader to get an understanding of the wider social context of the findings. The decision to exclude references to the study provinces also meant excluding the rich and detailed descriptions of language, ethnic groups, livelihoods and other specific traits of the study province. As such, it meant compromising the possibility for others to properly assess the quality of my work.

Principles of research ethics are made to balance out the power the research situation grants the researcher over their participants (MacClancy and Fuentes, 2013). As anthropologists increasingly engage in 'studying up', new questions related to research ethics and writing emerge (Mosse, 2006; Storeng and Palmer, 2019). Mosse (2006:938) noted how codes for research ethics were drawn up to protect the less powerful and when applied to research that critically scrutinises the powerful may grant them even more power. This is a concern I have had with regards to my decision not to reveal the study province. In the case of the specialist, the principle of confidentiality balances out some of the power I, as a researcher, have to expose and criticise his positions and actions and their consequences. As described in Paper II, the specialist in question had chosen to make use of his right to conscientious objection and refrained from signing off on any abortion procedures. Effectively, this deprived all girls and women of the study province of the possibility of having a legal and safe abortion within the public health system. While the ethics employed in this research protect the specialist as my interlocutor, it does not protect the less powerful girls and women seeking legal abortions, who may have benefited from exposure to the specialist's use of contentious objection.

4.5.2 Do No Harm

'Do no harm' has been the mantra of research ethics within anthropology for decades (American Anthropological Association, 2014 (2012); MacClancy and Fuentes, 2013:11; NESH, 2016). While it has been criticised for overshadowing other ethical principles, it remains an important part of codes for ethical research within health and social sciences, including anthropology. As a principle, 'do no harm' is both vague and specific. It appears self-evident that a researcher should not inflict harm on others, but what exactly it means to inflict harm and who these others are is not always clear. These were questions that repeatedly came to mind during fieldwork and the writing process of this study.

In the case presented in Paper III, which deals with what happened when an aborted foetus was discovered in the community, I found the principle of doing no harm particularly difficult to manage. As neighbours started rallying together outside the clinic, I was concluding a difficult conversation with a girl of 17 years who had, with a trembling voice, told me the story of how her grandmother last week helped her abort using herbal medicine. As we all stepped out the room the clinic had allowed us to use and together saw people's aggressive reactions to a case of abortion they had just learned about, I could see that the girl became increasingly nervous and uncomfortable. Unintentionally, I felt that I had, indeed, caused the girl harm simply by meeting with her at the clinic on the day when community members' harsh reactions to another abortion were being manifested so strongly. While the girl in question went home and her story was not exposed in the community, the event clearly demonstrated what she had risked by sharing it with me and made me increasingly wary about putting anyone at risk of suffering the social sanctions of insults and shaming I witnessed during the event.

As described above, the community member's collective and public condemnation of an abortion case came up time and time again in conversations with neighbours about reproduction or abortion. It quickly came to occupy a central part of my field notes and interview transcripts. I realised how valuable it would be to get the other perspective: the story of the girl who was suspected and arrested for having aborted

the foetus that was found. However, this raised a series of ethical dilemmas. With my experience of seeing how the event had caused anxiety and nerves in another girl who had aborted, I felt extremely reluctant to add to the enormous burden the arrested girl was carrying. I felt that asking her to relate to me as a researcher with immense curiosity about her personal tragedy was incompatible with the principle of doing no harm. At the same time, I questioned the ethics of getting just one side of the story and not allowing the victim of the public outrage to voice her story and share her experience.

In practical terms, approaching the arrested girl would mean interviewing her inside the prison facility where she remained until the end of my fieldwork period. This raised new ethical concerns about coercion and informed consent that made me refrain from attempting such contact. While I have not regretted this choice, it created a new series of doubts when writing Paper III. I struggled with finding a way to write about the event without writing about the girl and questioned whether it was at all possible. The solution became to remove focus and emphasis from how and why the abortion had taken place and rather place focus on the perceptions and experiences of those who participated in the event.

The event represents one of those situations that is difficult to predict and plan for. As such, it serves as an example of how research ethics demands continuous reflection on what is the right way forward and what it really means to ‘do no harm’.

5. Findings

5.1 Synopsis of Paper I

Paper I explores how the Zambian abortion law is continuously disputed and negotiated and takes the internationally prevailing idea of Zambia having a liberal legal framework for abortion as a starting point. It situates the Zambian abortion law in a historical and political context and traces how narratives about the law have been influenced by political and religious shifts and continuous disputes over its interpretation and implementation. The paper presents findings from archival investigations of the law-making process of the Zambian ToP Act and interviews with current stakeholders involved in abortion-related advocacy work. Both in private correspondence between President Kaunda and the speaker of the parliament, and in the public records of the parliamentary debates over the ToP Bill in 1972, the focus was on the restrictive elements of the law, rather than the liberal criteria for abortion it introduced. The paper sees the law-making process in the context of the president's wider ideological project of Zambian Humanism, which combined progressive socialist perspectives and communal values with conservative Christian morality and patriarchal views on women's position in society. The restrictive elements of the law, including signatures from two medical doctors and a specialist, were increasingly emphasised when Zambian politics became increasingly influenced by Pentecostal rhetoric as Zambia president Chiluba came to power and declared Zambia a Christian Nation in the 1990s. With the declaration came a shift in public discourse that seemed to further challenge health workers' willingness to provide abortion services. The narrative of a restrictive Zambian abortion law can be readily recognised in the contemporary abortion debates that take place in Zambia. This narrative contradicts the internationally known image of the liberal Zambian abortion law. Moreover, the study finds that there is no consensus in Zambia on whether the abortion policy is liberal, restrictive or neither of the two. Stakeholders who are differently positioned towards the abortion issue also differ in whether they describe the law as liberal or restrictive. Such differences in characterizations of the law are possible because the law is ambiguous enough to justify these two very different narratives. The study finds that the abortion law is continuously disputed by strategically employing labels

like liberal or restrictive to advocate for either further restrictions or further liberalisations in how the law is implemented. When considered together, the lack of knowledge about the Zambian abortion law, the ambiguity of the law and the discursive dispute about it may work to reduce girls' and women's access to abortion services. The findings of this paper thus shed light on how historical, political and religious contexts are key to understanding the relationship between abortion legislation and actual access to abortion services.

5.2 Synopsis of Paper II

Paper II follows the Zambian abortion policy as it moves through the administrative layers of the Zambian health system and explores how it is understood and implemented by health bureaucrats in a rural Zambian province. Rural health bureaucrats, such as district or provincial health directors, are centrally positioned in the processes of translating abortion policy into practice. They are responsible for administrating and implementing a vast number of SRH policies, including abortion policies. This paper examines how these bureaucrats handle abortion-related cases they come across in their work and uncovers a complex field of entangled reproductive health policies and politics. While the district- and provincial-level health bureaucrats had knowledge about the Zambian abortion policy, the policy was not implemented in their districts, and none of the hospitals in the study province offered legal abortion services. Drawing on Morgan and Roberts' (2012) thinking about reproductive governance, the paper explores this gap between knowledge, policy and practice. It finds that abortion issues are easily bypassed or silenced in health policy meetings or other more public settings. There are several possible reasons for this phenomenon. While many SRH policies are subject to detailed upwards reporting with corresponding national and global political pressure, there are few, if any, measures in place to report on abortion-related issues, including PAC. The paper describes how bureaucrats find themselves in situations of double-bind where they are given conflicting instructions and subtle signals from supervisors and authorities within the hierarchical system of the Zambian health system. Moreover, the rural context, where the lack of medical doctors is severe, provides further

challenges for the implementation of the ToP Act. The findings presented in this paper raise questions related to how political factors not only influence processes of policy making but also the complex processes of turning policy from paperwork to on-the-ground implementation.

5.3 Synopsis of Paper III

This paper takes the mob-like reaction of community members to the discovery of an aborted foetus as a starting point to explore the everyday politics of reproduction in a rural Zambian town. It examines how public expressions of abortion opposition come about and looks at why some cases are publicly denounced while others are silently tolerated or even supported. By analysing the community reaction to an abortion case as an anthropological *event,* this paper examines the local dynamics of abortion opposition and uncovers how conceptions of abortion are intimately tied to gendered structures and power dynamics, but it also explores how these conceptions are contextually dependent and vary from case to case. While abortions that avoid public attention may be silently tolerated, abortions that become openly known are harshly condemned. This distinction between different abortion cases brings up questions of how gendered ideals shape everyday reproductive politics. In the event that was analysed it became clear that once abortion was brought into the public sphere, it set in motion a harsh public reaction that mobilised a series of affects and values. The paper draws on Fassin's (2014) concept of moral economy to grasp how values like motherhood, sexual morals and protection of life were evoked, circulated and shared among community members in what resembles a system of economic exchange. Participation in the public expression of abortion condemnation allowed community members to maintain and accumulate their personal moral integrity and strengthen moral and social ties to the community. The paper thus outlines what is morally and socially at stake for girls and women seeking abortions and community members reacting to abortions they get to know about.

6. Discussion

This study set out to generate knowledge on how articulations between policy, legislation and sociocultural conditions shape women's reproductive possibilities. To do so, the study has investigated abortion politics across several overlapping and intertwined scales. The findings underline how access to safe and legal abortion services depends on a lot more than a permissive abortion law. They document how political stakeholders engage in discursive disputes over how the Zambian abortion policy should be defined and interpreted, and how subtle power mechanisms shape or even impede the policy's on-the-ground implementation. The study also casts light on how public opposition to abortion serves the purpose of moral self-preservation and strengthens social ties at the community level. Running across the findings is how abortion seems impossible to separate from politics, understood as strategies, actions and mechanisms that allow one to achieve or maintain power. In what follows, I discuss two distinct but entangled aspects that emerge as central to abortion politics: (1) the strategic use of knowledge and ignorance and (2) the role of affects and values. I then reflect on the interplay between these two aspects and its implication for a wider understanding of what is at stake when abortion is disputed.

6.1 Silence, Knowledge and Ignorance

The three papers that make up this dissertation are in different ways concerned with mechanisms that shape and constrain abortion as a reproductive practice. Morgan and Roberts (2012) pointed out a variety of mechanisms that govern reproduction, such as 'legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices' (Morgan and Roberts, 2012).

While legislative controls or direct coercion constitute hard measures that are readily visible, others, such as moral injunctions and ethical incitements, are more elusive and may be difficult to pinpoint. This study has documented how such mechanisms may be conflicting and contradictory.

In the case of Zambia, most of the hard mechanisms, such as the abortion law (GRZ, 1972) or the guideline documents that have been developed (GRZ, 2009, 2017b), go far in allowing access to abortion. The study casts light on how soft and often silent mechanisms, such as subtle power dynamics among health bureaucrats or discursive disputes over the abortion law, may indirectly be just as decisive for girls' and women's access to abortion services. The study thus exemplifies how biopolitical mechanisms of self-governance shape reproductive possibilities (Foucault, 1998; Morgan and Roberts, 2012). Papers I and II, for example, bring out how the notion of Zambia as a Christian nation in subtle ways provides ideas about the ideal public servant, citizen or policymaker (van Klinken, 2018) in indirect ways that shape how and whether abortion services are offered. Zambian abortion politics thus seems to unfold largely behind the scenes (Storeng et al., 2019) rather than in the public eye.

6.1.1 Working in Silence

Even when abortion is regulated through public channels, it is often done in ways that aim to reduce public attention. Paper I describes how the Zambian ToP Act was passed quickly and without much public debate. Considering the controversy the abortion issue often raises (Kumar, 2018; Kumar et al., 2009), keeping changes to abortion laws and policies out of the public realm may be an effective strategy.

The changes made to the Ethiopian abortion policy in 2005 are a particularly clear example of keeping abortion-related policy changes discrete (Blystad et al., 2019; Tadele et al., 2019). Seeking to reduce abortion-related maternal mortality, efforts were made to increase access to abortion services, without antagonising the orthodox church that holds considerable moral and political power among Ethiopians. The answer became a silent approach in which changes were made to the Ethiopian Penal Code in a way that decriminalised abortion for underage girls or in cases of rape, and with guidelines that specifically state that the word of the abortion-seeking woman is sufficient to document age or sexual abuse. After experiencing loud debates in the media as the policy change was suggested, policy actors working to increase access to abortion made strategic efforts to keep a low profile as the policy was rolled out (Tadele et al., 2019).

While successful in achieving a policy change, the silent efforts to obtain a more liberal abortion policy in Ethiopia were not unproblematic. Abortion remains contentious and stigmatised, and girls and women are often unaware of the changes made to the law (Kebede et al., 2014; McLean et al., 2019; Zenebe and Haukanes, 2019). Health workers find it ethically and morally challenging to meet abortion-seeking patients in the new legal context that McLean and colleagues (2019) have called 'slightly open' for abortion. More than before, it is left to health workers to guide the women on how to make use of the possibilities the revised policy grants them to access legal abortions. This situation has placed health workers in an uneasy position in which they experience ethical challenges and moral distress in addition to abortion-related stigma (McLean et al., 2019).

In an article about how the United Kingdom Department for International Development and other major funders seek to influence policy making on abortion in countries where they work, Storeng et al. (2019) pointed to how they make use of strategies that diffuse attention away from themselves. By engaging INGOs to carry out behind-the-scenes campaigns and concealment strategies, major funders work to achieve policy changes in concealed ways. The authors argued that such strategies for achieving policy changes are found across many fields, but particularly so in issues related to SRH, 'where strong political sensitivities at both global, national and local levels, mean that INGOs often choose to work "behind the scenes" or "under the radar"' (Storeng et al., 2019, 557).

6.1.2 Lack of Knowledge

An important implication of avoiding public debate about abortion laws and policies is that few people become aware of their existence. The most significant challenge to this approach is lack of knowledge. A law has limited value for girls' and women's access to safe abortion services if they do not know about it. In Zambia, it has been well documented that few people are aware of the legal status of abortion, something that prevents girls and women from turning to a public facility when they seek abortion services (Coast and Murray, 2016). Paper I describes how the ambiguity of the Zambian ToP Act, opening up for abortions on broad socioeconomic grounds on

the one hand, while severely restricting access by requiring signatures from three medical doctors on the other, further generates confusion and lack of knowledge about the legal status of abortion.

The apparent lack of knowledge among health workers (Geary et al., 2012; Macha et al., 2014) who may turn abortion-seeking women away if they are unaware of the women's right to abortion is even more concerning. The introductory quote to this dissertation, where a hospital manager expresses his profound doubt over whether abortion services are legal in Zambia, speaks to the implications that confusion and ambiguity may have on girls' and women's access to abortion services. If hospital managers are insecure about the legal status of abortions, hospitals will not offer such services within the terms established by the law, and girls and women may resort to less safe measures.

Similar scenarios have been described in other settings where abortion laws are considered liberal, but the sociocultural context for abortion is not permissive. Studies from South Africa, where abortion was legalised in 1996, show that clandestine abortions remain common partly because few women are aware that they are legal (Bloomer and Pierson, 2018:62-67; Hodes, 2016; Jewkes et al., 2005). In her study from India, where abortion has been legal on broad grounds since 1971, Nandagiri (2019) found a considerable lack of knowledge of the legal status of abortion among community health workers tasked with assisting and guiding women in SRH issues. She relates this lack of knowledge to modules on abortion being skipped in community health workers' training. As a consequence, community health workers guide women following the wider moral understanding of abortion in the community, rather than according to the legal rights of women (Nandagiri, 2019).

6.1.3 Social Construction of Ignorance

Lack of knowledge, or ignorance, is commonly understood as a mere void to be filled with knowledge. Moreover, knowledge is closely associated with power (Foucault, 1980, 1998), which leads to the assumption that lack of knowledge creates a vulnerable position and should be avoided. While anthropologists have long paid

attention to unequal distribution of knowledge, the last few decades have seen an increasing interest in ignorance as being socially constructed as something more than just a gap in knowledge (Geissler, 2013; High et al., 2012; McGoey, 2012; Proctor and Schiebinger, 2008; Sanabria, 2016). It has been pointed out that lack of knowledge can also be actively produced (Proctor and Schiebinger, 2008) as a strategic asset to be actively or passively employed at convenience (McGoey, 2012). In her essay on what she calls strategic ignorance, McGoey (2012) argues that contrary to what is assumed, organisations and institutions do not always strive to achieve knowledge to strengthen their position, but may choose to remain ignorant on certain topics. Drawing on Taussig's (1999:6) argument about the inherent social power that lies in 'knowing what not to know', McGoey (2012) theorises ignorance as a tool for governance in need of further investigation. She points to how knowledge comes with accountability, and in consequence, institutions or organisations may in some cases strategically benefit from not knowing uncomfortable facts, counting on not being responsible for what they do not know (McGoey, 2012).

McGoey's (2012) concept of strategic ignorance adds a useful perspective to this study. The ambiguous nature of the Zambian ToP act, both liberal in permitting abortions and restrictive in constraining access, has created a scenario that opens for doubt and ignorance about the actual legal status of abortion in Zambia, making its implementation across the country difficult. I have found that abortion-related statistics in Zambia are not subject to the same routines of upwards reporting as other SRH services, such as the distribution of contraceptives or skilled attendance at birth. This leaves abortion-related statistics strategically unknown to the rural health bureaucrats tasked with monitoring and implementing SRH policies as well as to the MoH. Moreover, Paper II demonstrates how health bureaucrats seem to make use of the ambiguity surrounding the abortion policy to selectively make known and employ their knowledge of it, depending on the context at hand.

In a paper on public secrets in demographic surveillance areas and other transnational medical 'field sites' on the African continent, Geissler (2013:13) argues that

ignorance or 'unknowing' does not specifically deny or suppress knowledge, but is 'actively produced through linguistic conventions, irony or and differentiation between places of knowledge and ignorance'. Inherent to the logic of ignorance is thus being able to switch between the known and the unknown according to the context and situation. While Geissler (2013) was describing global health actors involved in medical research in Africa, such switching between knowledge and productive or strategic ignorance helps to understand the Zambian rural health bureaucrats silencing of their abortion-related knowledge and the gap between the knowledge, policy and practice of the Zambian abortion policy.

6.1.4 Knowing and Unknowing in Reproductive Governance

Attention to how knowledge and ignorance is constructed and distributed is helpful when aiming to understand how reproductive practices, such as abortion, are governed. The papers that make up this dissertation all attempt to reveal how knowledge and ignorance are shared or withheld, voiced or silenced, sought or avoided, depending on the social and political situation at hand in ways that shape and constrain reproductive possibilities. Inspired by Foucault (1980, 1994, 1998), the concept of reproductive governance encompasses the inseparable relationships between knowledge and power. However, little attention has been paid to how ignorance or lack of knowledge make up powerful tools for reproductive governance, with the exception of Suh's (2018, 2019a, b) work on PAC in Senegal.

National abortion politics cannot be understood without situating them within the global context of reproductive governance. Following Merry's (2011, 2016, 2019), influential and critical work on metrics Suh (2014, 2018, 2019a, b) pointed to how systems of metrics for PAC create incentives for health workers to register abortions as miscarriages and treatment outcomes as 'survival'. This practice obscures the magnitude of unsafely induced abortions and establishes mere survival as sufficient quality of care. When PAC metrics are reported upwards, they contribute to a construction on abortion-related ignorance in key fora for global health. Suh's (2018, 2019a, b) findings resonate with reporting practices and knowledge gaps this study encountered at the district level where abortion-related numbers remained in

hospitals, while other SRH metrics were rigorously reported to provincial and national health authorities as they were subject to international attention through systems of global health metrics. In consequence, health bureaucrats across all levels of administration were allowed to remain ignorant about the actual magnitude of abortion cases and not held accountable for the consequences of clandestine and unsafe abortions suffered by girls and women within their districts.

McGoey (2012:559) argued that the power inherent in ignorance as a tool for governance is the challenge of determining whether someone is actually ignorant or willingly choosing to be so. This juxtaposition poses a particular challenge to scholars seeking to 'prove the existence of something for which the very ability to evade detection is a key criterion for success' (McGoey, 2012:559), and it has certainly been a challenge in this study that has tried to make sense of the gap between knowledge, policy and practice of abortion in Zambia. It remains difficult to pinpoint exactly whether and when ignorance is strategic. Nevertheless, I find that the ethnographic approach and anthropological tradition, which allows the researcher to take a step back and 'connect the dots' (Morgan, 2019), is uniquely suitable for such a task of indicating patterns and pointing to the intangible.

6.2 Politics of Affects and Values

In the present study, I have strived to elucidate some of the less tangible dynamics of abortion politics that shape girls' and women's SRH. While Papers I and II describe and discuss how the Zambian abortion policy is continuously reshaped and disputed according to dominant discourses, political priorities and subtle power dynamics, Paper III takes on a different perspective when it looks closer at what is at stake for community members who engage in abortion opposition. As such, Paper III opens a wider discussion of how abortion politics, while certainly entangled in wider structures of power, cannot be properly understood without paying attention to the role of affects and values that cut across the field of reproductive politics (Kumar, 2018). Inspired by Fassin's (2007, 2009a) politics of life, Morgan and Roberts (2012) called for scholars to move beyond mechanisms of governance and consider the

content of governance. Such content includes moral evaluations and differentiation between people and practices that are accepted and others that are not. Considering the content of abortion politics means grappling with questions of meaning, affects and values that are set in motion when abortion is disputed.

6.2.1 Politics of (Religious) Values

It is difficult to discuss affects and values in abortion politics without considering the role of religion. Across the world, there are examples of abortion disputes entangled in questions of religion's role in society. In Poland, for example, the central role of the Catholic Church has been essential to the impositions of restrictive abortion policies over the last few decades (Mishtal, 2015), and public discourse on abortion in the US has since the 1980s been characterised by religious symbolism and undertones (Holland, 2020:83-87). Also in the Norwegian context, the abortion debate is entangled with questions of religion. When the Norwegian abortion law was put into political play in 2018, it was because the Christian Democrats suddenly found themselves in a strategic political position that they used to negotiate changes to the abortion law. While minor, they constituted the first change in the law in over 40 years (Haaland, 2019). Operating at a transnational level, the Vatican state and Catholic Church have been greatly successful in influencing abortion politics since Pope John Paul II made reproductive issues a key concern of his papacy (Crane, 1994).

The political role of religion in Zambia is undeniable (Blystad et al., 2019; Cheyeka, 2008; Gewald, 2008; Haynes, 2015b, 2018; Hinfelaar, 2008, 2011; van Klinken, 2018). This study has shown how the notion of Zambia as a Christian nation has indirect, yet substantial, implications for access to safe and legal abortion services. The notion was continuously and actively evoked by those seeking to influence abortion policy and restrict its implementation. To my surprise, however, religious arguments were seldom used by interlocutors explaining their personal views on abortion. Abortion was rarely categorised as a sin; instead, statements like 'it's like killing' or 'it's wrong' were commonly used. In other words, when reasoning around

personal stands on abortion, arguments would commonly use a more humanistic rhetoric, rather than a religious one.

In Paper III, we see how a series of values such as motherhood, sexual morality and protection of life were evoked and circulated, but without references to religious terminology. I further found that it was not Zambia's status as a Christian nation that prompted community members to attend the mob-like rally that condemned a particular abortion case, but rather a community-level narrative about moral standards void of religious references. This poses a question about exactly how religion and religious values make a difference for girls' and women's access to abortion services. It appears as though religion as state ideology may be more important for shaping how and whether the Zambian abortion policy is implemented than religion as a personal moral compass in everyday life.

Religion and religious values thus seem to have at least three important ways to shape abortion politics and subsequently access abortion services: through state ideology or religiously founded nationalism (Bloomer and Pierson, 2018:52-54), through community-level moral narratives, or through personal religiously informed moral stands. Without making the distinction between the three, one runs the risk of conflating many forms of abortion opposition into 'religion', which in turn can lead to poor understanding of articulations between religion and abortion politics. Kumar (2013:e329) underscored the need for researchers to be more precise in their understanding of abortion stigma 'so that we can carry out better research to understand and measure it'. Her point, however, is relevant not only to abortion stigma, but also in the wider context of abortion politics, and should be considered when researching and theorising abortion politics as it plays out globally.

6.2.2 Politics of Affects

When looking at how abortion rights are disputed across a variety of settings, one can readily see how affects and emotions often take up an important position. Feelings of anger, disgust or empathy and compassion are readily evoked and take centre stage in public protests, media campaigns and sometimes even legal rulings (Cahill, 2013;

DiIorio and Nusbaumer, 1993; Rivkin-Fish, 2018), be they for or against the right to abortion. Kumar (2018) has argued that emotions, and particularly the emotion of disgust (Cahill, 2013), are important components of abortion stigma and driving forces towards moral and political opposition to abortion rights. She calls for increased focus on emotions in abortion-related research when she states that 'a careful mapping of the role various emotions play in creating and perpetuating abortion stigma is needed to better understand abortion stigma and how to mitigate it' (Kumar, 2018:536).

Abortion politics is fraught with affects and emotions. When anti-abortion activists at certain times and places mobilise in the public sphere, such as in public marches or protests outside abortion clinics, emotions are activated and affects evoked through, for example, images of smiling foetuses or foetuses sucking their thumbs (Kumar, 2018). While these images appeal to feelings of compassion within the narrative of a personified foetus, other images appeal to disgust through the use of, for example, dismembered foetuses covered in blood (Cahill, 2013; Kumar, 2018). Activists advocating for increased access to abortion services also use affects and emotions in their strategies of communication. In the US, for example, the symbol of a coat hanger, often covered in blood, is used as a reference to unsafe abortions that took place before the supreme court's iconic ruling on the right to abortion in Row vs. Wade. In Norway, a knitting needle is used for the same communicative purpose. While less effective than grotesque images of foetuses, since it requires knowledge on the history of abortion (Condit, 1994), the coat hanger is meant to evoke feelings of disgust towards the peril abortion-seeking women face.

It may be difficult to pinpoint the exact emotions in play in the public reaction to the abortion described in Paper III, but it seems undeniable that the abortion case in question was met with affect in the community. The grotesque way the foetus was discovered may very well have caused immediate reactions of disgust, but sentiments quickly turned to rage and anger that were clearly expressed in the mob-like rally outside the clinic. Independent of the exact emotions, the case exemplifies how emotional reactions and affects, combined with local political dynamics and social

ties to the community, play important roles in shaping the everyday politics of abortion.

This study has considered the role of affects and values in abortion politics at the community level and has not looked at how these dynamics may play out when abortion is disputed in national or transnational fora. There is, however, no reason why emotions and affects may not be as important for national and transnational abortion politics as between neighbours at the outskirts of a rural Zambian town.

6.3 Towards a Moral Economy of Abortion

The two aspects of abortion politics discussed above – the strategic use of knowledge and ignorance, and the role of affects and values – may appear as conflicting and opposing to each other. On the one hand, silence and strategic ignorance about abortion appear as important political tools for shaping abortion policy, and on the other hand, abortion politics is fraught with strong affects that bring about turmoil and noise when it is publicly expressed. Abortion politics thus seem to be played out in a space created by the tension between these two aspects in which goals can be achieved when striking the right balance between emotions and values on the one hand and discreetness and silence on the other.

Abortion politics is certainly shaped by larger economic and social agendas (Morgan and Roberts, 2012), and embedded in diffuse and complex power structures that reach well beyond national contexts. However, it cannot be properly understood without considering the role of affects and values (Kumar et al., 2009; Morgan and Roberts, 2012). To refine and reach a more precise understanding of abortion politics, it is important to take into consideration the way affects and values are shared and circulate in the social space (Fassin, 2014). Despite the wide interest in reproductive politics and abortion within anthropology of the last few decades (Andaya, 2014; Andaya and Mishtal, 2017; De Zordo et al., 2017; Franklin, 1997; Franklin and Ginsburg, 2019; Mishtal, 2017; Morgan and Roberts, 2012; Suh, 2015, 2018, 2019b), the role of emotions and values remains understudied and undertheorised (Kumar,

2018). Fassin's (2014) conceptualisation of moral economy is not just a theoretical intake of community-level dynamics of moral judgement towards abortion but may be a helpful tool for theorising and refining our understanding of what is at stake when abortion is disputed by powerful actors within global reproductive health.

As a major funder of contraceptives worldwide, the US is one such global actor (Kates et al., 2014). The shift in US foreign policy of abortion through rescindment and reinstatement of the Mexico City Policy may constitute a suitable event to scrutinise in an effort to map out the contours of a global moral economy of abortion. When President Trump reinstated the policy in January 2017, it set in motion a series of actions and reactions among other global health actors and INGOS to make up for the loss of funding (Government of the Netherlands, 2017), which created a process that would be possible to explore ethnographically. By carefully following the actors who in different ways responded to the policy change, an ethnographer could investigate how affects and values are circulated between states and global actors. The predictability of the policy being reinstated by republican presidents and rescinded by democratic presidents allows researchers to plan for studies that could increase our understanding of global abortion politics. Such an understanding could go far in explaining how and why abortion remains a politicised and contentious element of global health discussions. Through such studies, it would be possible to start outlining a moral economy of abortion that could lead to a more nuanced understanding of abortion politics and reproductive governance.

7. Conclusions

The case of Zambia demonstrates that even in countries where abortion is permitted by law, women continue to suffer unnecessary complications and death caused by clandestine and unsafe abortions. Legal frameworks for abortion are important tools for ensuring girls' and women's right to make choices about their own lives, bodies and reproduction, but are not sufficient in and by themselves. This dissertation has explored the dynamics and contents of abortion politics as it plays out in the Zambian context, where abortion is legal on broad grounds but remains inaccessible. In doing so, it has moved beyond the legal framework for abortion and followed how abortion laws and policies are disputed, reinterpreted and redefined at different stages on their way to implementation.

While the empirical scope of this study has focused on arenas where politics unfold and the actors involved in disputing and shaping abortion policy, the underlying motivation has been about gaining insight into what shapes and constrains girls' and women's actual reproductive possibilities. The findings from this ethnography of abortion politics have revealed that discursive disputes and subtle power mechanisms among policy actors central to translating abortion policy into practice are important factors that shape and constrain girls' and women's access to services. Strategic use of knowledge and ignorance are some of the mechanisms involved in such a silent politics of abortion. An important context for these mechanisms is the global systems of reproductive governance that add political will and pressure to some SRH indicators over others, leading to an apparent knowledge gap when it comes to abortion-related services. Moreover, the study has documented how the everyday politics of abortion with silent tolerance of some abortions and loud public condemnation of others shape the scope of action available for girls and women with unwanted pregnancies and what is socially at stake for them.

Abortion politics unfolds across several scales and on many arenas, and this study speaks to the relevance of broadening the scope to include all relevant actors when seeking to understand why a liberal abortion law is not sufficient to ensure access to

abortion services. While the dissertation builds on ethnographic fieldwork in Zambia, the articulations between policy, legislation and sociocultural conditions that this study has scrutinised are not unique to the Zambian context. I believe that the findings and analysis presented here may be of relevance for other settings with similar gaps between abortion laws and actual access to legal abortion services and can inspire scholars and advocates to move beyond a narrow focus on legal frameworks for abortion.

8. List of Appendices

1. Paper I
2. Paper II
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4. Ethical approval Regional Committee for Medical and Health Research Ethics, Western Norway (REC Western Norway)
5. Ethical approval University of Zambia
6. Permit from the National Health Research Authority
7. Permit from Zambian Ministry of Home Affairs
8. Information sheet

9. References

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Haaland et al. International Journal for Equity in Health (2019) 18:20
https://doi.org/10.1186/s12939-018-0908-8

International Journal for Equity in Health

RESEARCH Open Access

Shaping the abortion policy – competing discourses on the Zambian termination of pregnancy act

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Abstract

Introduction: The Zambian Termination of Pregnancy Act permits abortion on socio-economic grounds, but access to safe abortion services is limited and this constitutes a considerable problem for rights to sexual and reproductive health. The case of Zambia provides an opportunity to explore the relationship between a legal framework that permits abortion on diverse grounds, the moral and political disputes around abortion and access to sexual and reproductive health services.

Methods: This paper draws upon eleven months of ethnographic fieldwork in Zambia. The fieldwork included 28 open-ended interviews with key stakeholders as well as the collection of archival material related to the origins of Zambia's legal framework for abortion. The archival material and the interview data were analyzed thematically, using theoretical perspectives on discourse and the anthropology of policies.

Results: The study findings show that the Zambian case is not easily placed into standard categories of liberal or restrictive abortion laws. The archival material reveals that restrictive elements were in focus when the Zambian Termination of Pregnancy Act was passed (1972). The restrictive aspects of the law were emphasized further when Zambia was later declared as a Christian nation. Some of these restrictive elements are still readily recognized in today's abortion debate. Currently there are multiple opinions on whether Zambian abortion policy is liberal, restrictive or neither. The law emerges as ambiguous, and this ambiguity is actively used by both those working to increase access to safe and legal abortion services, and those who work to limit such access. Coupled with a lack of knowledge about the law, its ambiguity may work to reduce access to safe abortion services on the grounds permitted by the law.

Conclusions: We argue that the Zambian Termination of Pregnancy Act is ambiguous and leaves much room for interpretation. This paper challenges the notion that the Zambian abortion law is liberal and opens up for further discussion on the relationship between how a law is described and perceived by the public, and the rights to health and services ensured by it.

Keywords: Sexual and reproductive health and rights, Abortion, Health policy

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Introduction

Since the Termination of Pregnancy Act was passed in 1972 [1], Zambia has been seen internationally as having a liberal legal framework for abortion [2, 3]. Less restrictive legal conditions are often coupled with lower estimates of illegal and unsafe abortions [4], but in Zambia, where complications from unsafe abortions are a considerable problem [5, 6], this does not seem to be the case. This apparent paradox allows us to explore the entangled relationship between the existence of a legal framework that permits abortion, the moral and political disputes associated with the topic of abortion, and the right to access sexual and reproductive health services.

When the Termination of Pregnancy Bill was proposed to the Zambian parliament in 1972, it was drafted on the basis of the United Kingdom Abortion Act of 1967 [1, 7]. The Zambian Act that was approved by parliament allows abortion to protect the physical or mental health of the pregnant woman or any of her existing children. It also allows abortion in the case of serious fetal malformation [1]. The law specifies that the pregnant woman's age and environment should be taken into consideration [1] and therefore allows for legal abortions on broad socio-economic grounds. Simultaneously, the law spells out some restrictions for access to legal abortion services. It specifies that abortions must only be provided in registered hospitals, and that three medical doctors - one of whom must be a specialist in the field in which the grounds for the legal abortion is being sought - must sign the form to allow the procedure to take place [1]. In cases of medical emergency, the signature of one medical doctor is sufficient. The law moreover permits conscientious objection, allowing health practitioners to abstain from providing abortion services on religious grounds, except in emergency situations [1]. Abortions are also regulated by the criminal code. The code establishes penalties of up to 7 years for those who illegally provide abortion services, and up to 14 years for women who procure illegal abortions or anyone who assists her [8]. It is only abortions that follow the procedures of the Termination of Pregnancy Act that are not criminalized. In 2005, the criminal code was amended to ensure that girls who are victims of rape can seek legal termination of pregnancy [8]. Zambia has ratified the Maputo protocol committing to provide comprehensive reproductive health services, including safe abortion [9]. Despite these legal commitments, abortion remains a controversial issue in Zambia. In 2015, a clause stating that "the right to life begins at conception", was included in a proposed new Bill of Rights of the Zambian constitution, implying a legal move in a more restrictive direction [10]. In August 2016, the Bill of Rights was sent to a referendum that was declared unsuccessful due to low turnout [11], but, with the proposition, abortion re-emerged on the Zambian political agenda as a contentious issue. In Zambia, religion and politics have been closely intertwined since independence and church bodies such as the Catholic Church (represented by the Zambian Episcopal Conference) and the protestant churches have had a great deal of political influence [12]. During the last decades, Pentecostal churches have also become more influential, and with the declaration of Zambia as a Christian Nation in 1991, the links between religion and politics became even more explicit [13]. This paper addresses the consequences this has had for the way the Zambian abortion policy has been contested and disputed since its introduction.

Zambian abortion policy cannot be understood separately from the structural conditions of the Zambian health system that is facing a crisis of human resources [14]. In 2016, there were only 1514 employed medical doctors in the country [14] for a population of 16.2 million [15]. This places Zambia among the 25 African Countries with less than 1 doctor per 10,000 inhabitants [16]. More than 60% of the population lives in rural areas where lack of qualified health personnel is particularly acute and facilities are often understaffed [14]. A newly revised set of standards and guidelines for comprehensive abortion care specifies that an abortion can be carried out with the signature of only one medical doctor if no other are available [17]. However, this new regulation has not been disseminated to health care workers across the country. Though mid-level providers such as midwives, nurses or clinical officers can carry out the abortion procedures, the law specifically requests the approval signatures from medical doctors. Lack of medical doctors, thus, continues to constitute an important barrier to accessing legal abortion services, that is unevenly distributed across the country.

In our examination of the history and current perceptions of Zambian abortion policy, we draw upon the work of Shore and Wright [18, 19] and their 'anthropology of policies'. Policies are manifested in many different ways, including, laws, regulations, and actions of state officials or civil servants. In this paper, we approach Zambian abortion policy through the Termination of Pregnancy Act. Paraphrasing Appadurai [20], Shore and Wright highlight the social 'lives' of policies [21] and point out how policies may appear as fixed, but are in fact, continuously contested and reshaped. As the context of a policy changes with time or space, its meaning also changes in ways that have consequences beyond its original intentions [21]. This perspective allows us to examine how diverging images of and narratives about the abortion policy travel through time and settings, and continuously reshape ideas of what a legal abortion is. The Foucauldian concept of discourse as a way of describing the complex relationship between power, truth

and right [22] is also central to the analysis. Discourse sets limits to how a topic can be addressed or conceived in a meaningful way and "the power embedded in discourse will determine what people consider to be true" [23]. These perspectives allow us to analyse how images created as notions of 'truths' about abortion policy have powerful implications for the range of actions available to girls and women making reproductive choices.

There is a general lack of data on the prevalence and characteristics of both legal and illegal abortions in Zambia [24]. The last official estimate from the Zambian authorities in 2017 asserts that 30–50% of all acute gynaecological admissions are abortion related and that six per thousand women die of abortion complications, most of them caused by unsafe abortions [17]. There are no official data on number and circumstances of legal abortions. Studies have found that, in Zambia, both knowledge about the legal status of abortion and access to abortion services are poor [2, 3, 24, 25]. To the best of our knowledge, however, no study has explored the history of abortion policy and how this history is entangled in current policy debates about abortion. This paper, therefore, examines historical, political and discursive elements of Zambian abortion policy and offers a new perspective on the legal framework for abortion in Zambia. The paper traces the moral and political context of 1972 to today and argues that Zambia's abortion law is inherently ambiguous and allows continuous contestations that shape abortion policy in ways that influence girls' and women's access to sexual and reproductive health services. In the process, the paper brings into question the international view of Zambian abortion law as being liberal.

Methods

This study is part of a multi-sited ethnographic study on the sociopolitical dimensions of access to fertility control and safe abortion in Zambia. It forms part of the comparative research project "Competing discourses impacting girls' and women's rights: Fertility control and safe abortion in Ethiopia, Zambia and Tanzania" funded by the Norwegian Research Council and the University of Bergen, Norway [26]. The umbrella project aims to explore the articulation between legal abortion frameworks, public discourses on abortion, and access to fertility control and safe abortion services in three African countries with different legal frameworks for abortion.

The present paper draws upon ethnographic fieldwork in Zambia between September 2017 and August 2018, which included the collection of media coverage on issues of sexual and reproductive health, collection of archival material, open-ended interviews with key actors as well as informal conversations with relevant stakeholders. Though informed by all of these sources, the findings presented in this paper are primarily based on the archival material and the open-ended interviews.

In October 2017, we accessed the Zambian National Archives and consulted the private collection of the Speaker of the Zambian parliament in 1972, Robinson Nabulyato. The collection included his correspondence with the first Zambian president Kenneth Kaunda on the Termination of Pregnancy Act. The library of the Zambian National Assembly was accessed in December 2017 to collect records of the parliamentary debates about the Termination of Pregnancy Bill in 1972, as well as the parliamentary debates about the amendment of the Penal Code in 2005. All the collected archival material was copied into text documents for analysis. To complement the archival material, we carried out an open-ended interview with a person employed as a high-ranking official in the Ministry of Health in 1972. The interviewee had participated in the preparation of the Termination of Pregnancy Bill and in the parliamentary process leading to its enactment.

We conducted 28 open-ended interviews with stakeholders who are influential in shaping Zambia's abortion policy or public opinion on reproductive health issues. The interviews covered topics about the interviewees' views about the abortion law and policy both today and historically, as well as their engagement and advocacy work with regards to sexual and reproductive health and rights in Zambia. Some interviews were conducted with two or more interviewees. When selecting potential interviewees, a list was made of ministries, NGOs (national and international), international agencies, religious bodies and professional health sector organizations who had been influential in abortion-related debates or that have political influence in other ways. We used snowball sampling to expand the list, and made efforts to secure interviews with a broad range of actors aiming to include different points of view [27]. The large majority of the stakeholders we approached for interviews accepted the invitation, but some declined arguing that the topic was not relevant to their area of work. A few never responded to our request. All interviews were conducted in English, the official language in Zambia, and were recorded with the informants' consent and transcribed verbatim. Most interviewees spoke at length about their views and opinions about Zambia's abortion policy giving examples from their own experience with the matter.

We analyzed the collected material through a critical and reflexive lens using a thematic approach. Both the interviews and the archival material were carefully read and re-read before they were imported into Nvivo11, which was used as a tool for inductively coding and clustering into categories of both types of data. Based on

rounds of careful review and categorizing, three pronounced themes were selected for further analysis. These were: the distinct focus on the restrictive elements of the law in 1972; the changing historical context of the law; and the current conflicting perceptions of the law. Shore and Wright's theoretical framework on policy [18, 21] was used to guide the analysis and writing processes. The quotes presented in the findings section to represent the major themes, derive from both the archival material and the interviews.

The paper could have been strengthened by findings from participant observation of the daily activities of one or more of the actors central in influencing the Zambian abortion policy. Due to barriers of access, this method was not possible to include in this part of the ethnographic study. Future papers from the same study will include findings from participant observation among regional and local level policy makers and daily life in communities of Zambia's Western Province. Nevertheless, the archival material and the interviews this paper builds upon are well suited for exploring the historical, political and discursive elements of the Zambian abortion policy that this paper addresses.

The University of Zambia Biomedical Research Ethics Committee (009–07-17) and the Regional Ethical Committee Western Norway (2017/1191), granted ethical approval for this study. All participants gave informed consent.

Findings

Making the termination of pregnancy act

The Zambian Termination of Pregnancy Act was passed in 1972, 8 years after Kenneth Kaunda became the first president of the independent Republic of Zambia in a time-period when the country was transitioning into a one party system [28]. President Kaunda's nation-building ideological project was named 'Zambian Humanism' and has been described as a mix of socialism, liberalism, Christian morality and idealized communal values of the pre-colonial past [29]. Whether Zambian Humanism was translated into politics and action has been questioned [29:160]. For the purpose of this paper, the ideological project provides insight into how the political elite at the time wished, ideologically and morally, to shape the interactions between the post-colonial Zambian state and its citizens [30, 31]. Zambian Humanism encompassed a conservative Christian morality combined with patriarchal perspectives on the female body and sexuality. The ruling party UNIP published a moral code in 1975 expressing conservative views on issues such as the length of women's skirts and women's limited rights over their own sexuality and body [31]. Against this contextual backdrop, we now turn to the debates leading up to the parliament's adoption of the Zambian Termination of Pregnancy Act.

Before the Termination of Pregnancy Bill became an act in 1972, the practice of abortion was regulated by the Penal Code that criminalized both the abortion-seeking woman, any of her helpers, and the abortion provider. The records from the parliamentary debate indicate that clandestine abortions were common in 1972. Nevertheless, addressing this phenomenon by increasing access to safe and legal abortion services was not explicitly on the agenda when the Bill was proposed. The Minister of Health who presented the Termination of Pregnancy Bill to the Members of Parliament rather argued that it was proposed as a simple clarification of the existing legal framework for abortion:

> *Mr Speaker, Sir, the purpose of this Bill is to amend and clarify the law relating to termination of pregnancy by registered medical practitioners. The bill provides for a stricter control of termination of pregnancy in that it requires two registered medical practitioners and a specialist in the branch of medicine in which the patient is specifically required to be examined before a conclusion is reached that the abortion should be recommended* (Zambian Parliamentary Library, Parliamentary Debates 1. August 1972).

The aim of clarifying the legal framework for abortion was repeated by the Minister throughout the parliamentary session. He also used public health arguments when presenting the Bill, arguing that the new law would remove doubts among medical practitioners about when abortions were indeed legal and therefore prevent unnecessary deaths from sepsis and bleeding caused by some unsafe clandestine abortions (Zambian Parliamentary Library, Parliamentary Debates 1. August 1972).

The Bill received some opposition during the debate, but it finally passed by 66 to 13 votes. The Members of Parliament who opposed the Bill used a range of different arguments, including that the new law would impede desired population growth and that it opposed Zambian cultural norms condemning abortion. Some also appealed to moral arguments either about the abortion itself or about undesired aspects of women's sexuality they believed the Bill would promote. A few argued that the law text would condone and increase the overall number of abortions. Nevertheless, the ideas and values expressed by most of the opposing Members of Parliament were not radically different from those expressed by the Minister of Health, as can be seen in the following statements by one of the opponents to the Bill:

> *I am not one of those extremists, Mr Speaker, Sir, who would add that under no circumstances should abortion (…) be authorised. That would be an*

*extreme case, and if this was the situation in this country that abortion was not allowed under whatever circumstances, I would have welcomed the Bill myself (*Zambian Parliamentary Library, Parliamentary Debates 1. August 1972).

This statement expresses a position on abortion as something to be restricted and strictly regulated, while also allowing it in a few and very exceptional cases. The disagreement between the supporters and opponents of the law was not mainly a discussion for or against women's general access to abortion services, but rather about the need for a specific law for abortion to allow it in such very specific situations. The Minister concluded the parliamentary debate by repeating the emphasis on the restrictive nature of the law stressing that it does "*not open the flood-gates for termination of pregnancy upon demand. There is nothing in the Bill which says so" (*Zambian Parliamentary Library, Parliamentary Debates 1. August 1972).

Reasons and reactions

After the Termination of Pregnancy Bill was approved in parliament and before President Kaunda gave his assent, turning it into law, the Catholic Church in Zambia protested against the Bill in a letter addressed to the Secretary General to the Cabinet (Letter from Secretary General of the Zambian Episcopal Conference to Secretary General to the Cabinet, 12.8.1972, Zambia's National Archives, Robinson Nabolyato's collection HM/79/PP/1/72/5). The letter used a variety of arguments to oppose the Bill, including criticism of its quick processing in parliament, the lack of public debate about the topic and the adoption of a UK law in a recently independent Zambia. The protest letter was discussed in personal correspondence between the Speaker of the Parliament and the President, casting further light on the intentions behind the law. The Speaker emphasized that the law was introduced to clarify an existing confusion about the abortion legislation provided in the penal code, adding to the President that*: "For somebody to think that it is a new law for terminating pregnancies on a wholesale basis is most irresponsible"* (Letter from Speaker Robinson Nabolyato to President Kenneth Kaunda, 24.8.1972, Zambia's National Archives, Robinson Nabolyato's collection HM/79/PP/1/72/5). He further stressed that the law was not intended to make abortion services available on request, a point that was made clearer when he wrote about the political consequences if the President should not approve the new legislative act with his assent. This, he argued, would allow the Catholic Church to influence decisions already made in Parliament. He claimed that:

Such action would be a highly expensive exercise involving and disturning the whole country while the Bill itself is meant to serve two to five people in twenty years or so.

The archival documents paint a picture of a process where the Termination of Pregnancy Act was introduced to clarify the legal status of abortion, not to liberalize it. Why the lawmakers chose to include socio-economic grounds for abortion remains unclear in the documents. An interview with a retired high-ranking official of the Ministry of Health involved in preparing the Bill in 1972 provided further insights into the law-making process. He expressed that the act was made:

(…) just to allow genuine cases, like say for instance where a mother has German measles or there is a risk to her mental health. But it is in our country, very limited circumstances under which a pregnancy would be terminated.

In line with what we found in the parliamentary debates, the former official argued that the main purpose of the law was for doctors to be able to perform abortions legally on medical grounds. He did not mention more directly socio-economic cases such as poverty among adult women. When asked about the rationale for introducing an abortion law that allows abortion beyond strictly medical grounds, he said that there were a few non-medical cases they had in mind, such as girl children who were victims of rape. This is an interesting observation since the Termination of Pregnancy Act makes no reference to rape. Only in 2005 was the penal code amended to allow abortions for rape victims.

Rather than aiming for liberalization, the retired policy maker referred to how they, in 1972, were concerned with restricting the practice of abortion. That is the reason he gave for including the requirement for three signatures from medical practitioners including a specialist. Reflecting on this measure, he stated: "*These things are very difficult to be precise about. To balance between* [what is] *fair, liberal, reasonable and too restrictive."* In retrospect, he seemed to be of the opinion that the wording of the Act may have been too permissive:

It was a progressive move, and even with the restrictions in the Termination of Pregnancy Act, there was the likelihood that there could be abuses. So in future, maybe we need to tighten the restrictions.

Abortion in a Christian nation

When Zambia's second president, Fredrick Chiluba, who identified as a born-again Christian, was elected in 1991,

he brought a set of Pentecostal symbols and rhetoric to the state house [13, 32]. Though the major churches and Christian morality had been influential during Kaunda's presidency from 1964 to 1991 [12, 31, 33], Christianity took a more explicit role in the 1990s that further influenced the relationship between citizens and the state. Only a few months into his presidency, Chiluba declared Zambia a Christian Nation, and in 1996 this declaration was included in the preamble to the national constitution. Much has been written about how the declaration of Zambia as a Christian Nation came about and what reactions it caused [13, 30, 32–35]. Particularly relevant to this paper is how the declaration came to shape dominant discourses on morality, sexuality and reproduction. Van Klinken [31] demonstrates how the declaration of Zambia as a Christian Nation is often used as a moral argument in public debates on issues such as pornography, sex work, women's dress codes and gay rights, but the declaration also affects the politics of abortion in Zambia.

An employee and activist in an NGO working with sexual and reproductive health and rights described the entangled relationship between morality, religion and politics in Zambia in the following manner:

> *I am sure you have already heard a thousand times that Zambia is a Christian Nation, so we* [Zambians] *tend to use that to not talk about what is considered taboo topics. (…) In terms of abortion, the moralistic view usually comes into play, and so whenever there is a conversation around abortion there is always a moralistic and religious argument that comes.*

The connection made between the Christian Nation and "moralistic religious arguments" is common. By referring to the Christian Nation, a person could readily take on a moral high-ground, and simultaneously silence diverging views on issues relating to sexual and reproductive morals, including abortion.

The discursive power of the 'Christian Nation' idiom goes beyond its use as an argument in debates. It also influences which laws and policies are conceivable and politically possible. On the question on whether the Termination of Pregnancy Act would have passed, had it been presented to parliament today rather than in 1972, several of the interviewees referred to the declaration as an impeding factor. One of the journalists interviewed phrased the point as follows:

> *I think the reason why it was easy to pass such a law in 1972 was because Zambia had not been declared a Christian Nation yet. But, from 1991 when this country was declared a Christian Nation, there has been this complication when it comes to such issues* [abortion], *because people feel we are a Christian Nation and we have to live by the Christian values.*

This statement shows the wide-ranging discursive and disciplining effects of the declaration of Zambia as a Christian nation. The Christian Nation idiom is tied to individuals' morality and way of life. It has been noted that speaking of politics as a question of personal morality is characteristic for the vernacular of politics in Zambia, and the use of the Christian Nation idiom seems to be particularly useful in creating such a nexus between person and politics in a way that shapes both public debates and political possibilities [36, 37].

The relationship between the Christian Nation and the actions of its citizens emerges clearly when discussing health practitioners' use of conscientious objection to abstain from taking part in terminations of pregnancies. As an Obstetrics and Gynaecology specialist in a private hospital explained:

> *There is also the aspect of the medical practitioners who are willing to do the legal termination* [of pregnancy]. *So, being a Christian Nation and being declared as such, very few would want to be identified as one who does legal termination* [of pregnancies].

An employee of an NGO and abortion rights advocate recalls how the situation at the gynaecological wards changed during her years working as a young nurse when President Chiluba came to power:

> *He declared Zambia as a Christian Nation and now everybody was saying 'why should we be terminating pregnancy when we are a Christian Nation?' (…) Then the doctors asked themselves 'Am I Christian? Should I continue?' So they would withdraw and say 'No, not my area,' but before it was politicized, they* [the doctors] *were signing* [forms authorizing abortions].

These statements show a connection between the declaration of Zambia as a Christian Nation and access to safe and legal abortion services. They underline the fact that the declaration may have influenced the willingness and ability of doctors to provide the necessary signatures for a legal abortion to be carried out. In this way, access to safe and legal abortion services was further restricted.

Talking about the law

Many of the interviewed stakeholders used the labels 'liberal' or 'restrictive' when characterizing the law. Interpreting the law in a way that would make it possible to grant legal and safe abortion services to a broad spectrum of abortion-seeking women emerged

as an important reason for representing the law as liberal. The employee of an NGO working with sexual and reproductive health and rights described how the grounds for legal abortion listed in the law leave room for interpretation and access to safe abortion as follows:

> *It* [the law] *is open to broader interpretation, (…) If I* [as an abortion-seeking woman] *explain my circumstances, you will see how they mostly connect to either one of those provisions* [allowing abortions], *so it* [the law] *is really broad and opens up for women's access.*

In other instances, the law was described as liberal in order to highlight the discrepancy between the broad grounds for legal abortions and the few women accessing safe and legal services. In the context of the number of illegal and unsafe termination of pregnancies, an advocate and provider of legal abortions told us the following:

> *Nobody should die from unsafe abortion and nobody should have an unsafe abortion in the environment where the law is very liberal.*

Other stakeholders would, in contrast, use the term 'restrictive' when characterizing the law. Some emphasized what they called the 'medical' aspects of the law, referring to the terminology of physical and mental health in the law and the requirement of three signatures from medical practitioners. A high-ranking representative from a religious organization commented upon the Termination of Pregnancy Act saying:

> *It is restrictive, and it has more to do with therapeutic* [abortions]. *Like in the case of losing a mother, the woman who is pregnant. It's not given like a norm, - it is for the exceptions*.

The emphasis on the medical aspects of the law was repeated by other actors, including national level bureaucrats and health professionals who based this view on the requirement for three medical signatures. A national level bureaucrat emphasized the necessity of doctors' signatures on a certificate for a legal abortion to take place when saying: *"I will start by saying that in Zambia abortion is illegal except when there is a certificate from a medical person."*

Interestingly, the grounds on which abortion is allowed seem to be used as a basis of the argument for both those stakeholders arguing that the law is liberal and for those arguing that it is restrictive. The law thus seems to be ambiguous enough to allow for two very different positions. The ambiguity of the law creates a somewhat confusing scenario. An NGO employee and advocate tried to explain people's confusion about the legal status of abortion in Zambia in the following terms:

> *They will tell you it is illegal because it has all these requirements* [for when an abortion is legal], *and if it is legal then it should not have requirements. But, I think that is the understanding and interpretation. That's partly why people are confused.*

The confusion surrounding the law was also expressed by a retired women's rights activist:

> *It was much later that I was actually fighting for a legal abortion law. Someone told me, 'you already have it', but at that point I didn't look at it that way. All I could see were so many don'ts and doctors and I said that is not good enough. (…) And there was lot of dependence on medical, - it had to be medical reasons.*

Some stakeholders argued that the Termination of Pregnancy Act was neither liberal nor restrictive, but that it rather strikes a balance between granting access to the services, without making it what they considered to be 'too widely accessible'. Answering a question on whether the Termination of Pregnancy Act would have been passed had it been presented today, a representative from a professional association answered:

> *I think it would have passed. Because it is not too restrictive and again it is not too liberal (…) Because I think any law should be able to provide checks and balances, if you make it very liberal the street corner* [practitioner] *can have an abortion service and I think it may not be best for the country.*

While not all stakeholders would use terms like 'liberal' and 'restrictive' to characterize the law, many argued that the law did not grant women access to safe and legal abortion services. Some described the law itself as the greatest impediment to access. A national level policy maker with expertise in maternal health described the challenge in the following manner:

> *I think the major obstacle today is the law because it does not provide abortion. You know there are all these requirements but when you look at the law itself it is not yet clear to say that actually a girl who falls pregnant can get access to the facility and be able to access safe abortion. The law is there, but accessibility and utilization are still limited.*

Discussion

Our findings reveal that the Zambian Termination of Pregnancy Act is an ambiguous law that leaves much room for interpretation. Though the law in 1972 appeared to be progressive, allowing abortions on socio-economic grounds, the archival material reveals that the restrictive elements of the law were in focus in the debates preceding its enactment. These same elements were further strengthened with the declaration of Zambia as a Christian Nation that had important consequences for health workers' will to be involved in legal abortion services. The restrictive elements of the law can readily be recognized in today's abortion debate in which the Zambian abortion policy is continuously contested.

In international fora, the notion that Zambia has a liberal abortion policy is widespread. The findings from our study reveal that there is no consensus about this representation of the law within Zambia itself. Global actors involved in analyzing or advocating for abortion rights worldwide are part of the process of presenting this image of Zambian abortion law. Researchers [38, 39], and international NGOs [40] have compiled and compared abortion-related legislation from different countries on several occasions and in such comparisons, Zambia is presented as having a liberal or permissive legal framework for abortions. However, when legal frameworks are compared, they are necessarily simplified and decontextualized. Commonly, comparisons of abortion laws are presented as tables where the grounds under which legal abortions are allowed are listed [38–40]. In such comparisons, the Zambian law will appear as liberal, as it permits legal abortions for more indications than most countries in Sub-Saharan Africa. However, this only paints part of the picture. The comparisons rarely take into account components of the legal framework that may have strongly restrictive implications, such as the requirement for signatures from two medical doctors and a medical specialist, or that legal abortions can only be carried out in registered hospitals [1]. By presenting the law in a decontextualized manner, and focusing only on one part of it, a partial picture that supports the image of a liberal abortion law in Zambia is allowed to prevail.

The history of the law presented in this paper tells a more nuanced story. The law text itself seemed progressive for its time as it opened up for legal abortion on more than only medical grounds. However, the archival material reveals that the restrictive elements of the law were just as important parts of the conceptualization when introducing and defending The Termination of Pregnancy Bill. The inherent contradiction of the law, allowing abortions on socio-economic grounds on the one hand, while seriously restricting access to abortion services on the other, can be understood as an attempt to balance the liberal aspects of the law with restrictions. Though the wording of the Termination of Pregnancy Act is very similar to the British Abortion Act of 1967, one important difference should be noted. Where the British law requires the approval of two medical practitioners for an abortion to be legal, the Zambian law requires the additional signature of a specialist within the field of medicine relevant to the ground under which abortion is requested. Considering the low ratio of medical specialists to inhabitants in Zambia, this constitutes a major restriction to accessing legal abortion [41] .

Examining the discourse surrounding how the Termination of Pregnancy Act became law enhances our understanding of how the law is perceived and practiced today. Shore and Wright argue that the passing of a law is a special moment in a continuous process of contestation, when one point of view succeeds in "making their versions authoritative and embedding it in the precepts and procedures of the state" [21] and effectively silencing others. Following this line of thought, the debates surrounding the Termination of Pregnancy Bill provide insight into what opinions and values became the dominant authoritative discourses on abortion in Zambia. When we scrutinize the views that were expressed by the advocates for the law in 1972, we find that they were indeed located fairly closely to the views of their opponents; both sides were arguing for a clear law that would regulate and restrict access to abortion services. Whether the supporters of the act strategically employed a discourse of restriction in order to increase the chances that the law would be approved remains unknown. The Speaker's estimation of cases eligible for legal abortion to 'between two and five in twenty years', seems so far from reality that it raises questions. Nevertheless, regardless of the policy makers' agenda, the imagery of a liberal abortion law intended to expand access to safe abortion services was not used and made authoritative during the process of enacting the abortion law. Instead, more conservative and restrictive imagery was used in which access to legal abortion was to be strictly regulated. This resonates with the dominating moral discourse of the time (1970s), which was characterized by conservative and patriarchal views on female sexuality and where special moral scrutiny was applied to the female body by the state as well as by the general public [31].

Who labels the law?

This study has revealed diverging opinions on whether the Zambian law is liberal or restrictive. The actors working to expand access to legal abortion services often used the term 'liberal' to highlight the contrast between a legal framework allowing abortions and girls and women's access to abortion services. Though they seldom would express their argument as a question of

rights, this emerged to be an underlying reasoning. Since the International Conference on Population and Development in Cairo, 1994, and the World Conference on Women in Beijing, 1995, abortion has been framed as a sexual and reproductive right and thereby an integral part of human rights, by abortion advocates across the world. The "rights-talk" strategy, though successful, is more fragile than it appears and has been contested by conservative and religious actors also framing anti-abortion messages in terms of human rights (rights to religious freedom, rights of the unborn child etc.) [42]. Nyanzi [43] has pointed out that framing sexual and reproductive rights as a human right can and has had important backlash effects in African contexts, especially in issues related to the situation of sexual minorities. This may explain why the actors working to expand access to safe abortion services avoid using the "rights" term, though their explanations and articulations of the topic often present it as such.

The actors working to limit access to abortion services often drew on the 'medical' elements of the law, such as the need of signature from medical doctors and the focus on physical and mental health in the wording of the allowed grounds for abortions. This way of reasoning resonates with a strong biomedical discourse around reproduction. Several anthropological studies of reproduction have described how presenting women's bodies, and reproductive processes as purely biomedical phenomena has worked to paint reproduction as something biomedical and scientific and thereby outside of what is considered political [44–47]. Emphasis on the 'medical' aspects of the law, discursively places abortion as something governed by the secular, scientific gaze of medical practitioners, and not by a woman making reproductive choices. Interestingly, this strategy, using primarily secular and scientific arguments, is most strongly employed by religious organizations, who limited their use of religious arguments considerably. Debating sexuality and reproduction in primarily secular terms, focusing on science and data instead of morals and religion, is a strategy employed by religious organizations on national and international levels across the world and has been given the name of strategic secularism [48].

When we consider who employs the different labels, an interesting pattern emerges. On the one hand, the actors who frequently label the abortion law 'liberal' are the same actors who criticize the law for not ensuring access to safe abortion services for those who need it, and hence indirectly argue that the current law is too restrictive. These actors include NGOs working on sexual and reproductive health issues and other advocates working for increased access to safe and legal abortions services. On the other hand, the major religious organizations who are in clear opposition to the idea of legal abortion outside of medical emergencies, label the law 'restrictive'. These same actors explicitly supported the inclusion of the clause in the proposed Bill of Rights in 2015 and 2016 stating that 'the right to life begins at conception'. With this clause, they worked towards making the Termination of Pregnancy Act unconstitutional, indirectly arguing that the current law which they call 'restrictive' is not restrictive enough. Labeling the law as either 'liberal' or 'restrictive' thus emerges as a discursive strategy that is selectively applied depending on the context at hand.

The way a policy is imagined or perceived carries great significance and may influence how the policy actually works in a particular context [19]. Shore and Wright argue that policies can be seen as contested narratives that define the problems they are addressing in a way as to "project only one viable pathway to its resolution" [19]. The diverging characterizations of the Termination of Pregnancy Act speak to such contestations over which image of the Zambian abortion policy should prevail in society at large. Arguably, by referring to the law as either 'liberal' or 'restrictive', the actors are engaged in a struggle to define the problem of access to legal abortions in a way that makes their own view the only one possible or acceptable. Considering that knowledge about the legal framework for abortion in Zambia is poor [25], also among health professionals [24], the imagery used to depict and describe the abortion policy carries great importance. If the image of the restrictive abortion law, presenting abortion as a practice meant for exceptional cases only, predominates, it is likely that a health worker, with little knowledge about the law, will not carry out abortions on socio-economic grounds, despite what is stated in the law text. In the same way that the notion of the Christian Nation has influenced health professionals' willingness to take part in legal abortion services, the notion of a restrictive abortion law can also shape girls' and women's access to safe and legal ways to terminate pregnancies.

If it is rather the imagery of a liberal abortion law, allowing abortion on broad socio-economic grounds, that predominates, it is likely that medical professionals will feel more secure and comfortable providing legal abortions, also on socio-economic grounds. However, the image of the abortion law as liberal may simultaneously move attention away from actual access to legal abortion services, as it places legality rather than access in focus. In consequence, the image of a liberal law may cause further confusion and distress among girls and women seeking abortion services. If a woman in a rural area, acts upon an impression that Zambia has a liberal abortion law and seeks legal abortion in a district hospital, she runs the risk of being turned away for multiple reasons. The professional she meets may believe the

service is illegal or has chosen to make use of his/ her conscientious objection, or the facility may simply not meet the required need for signatures. Confusion about the legal status of abortion emerged as a strong theme in our interviews, and health workers, activists and policy makers emphasized how they encounter confusion about the Termination of Pregnancy Act in their work. Discourses are powerful and determine what people consider to be true [23]. When the truths established by two contradicting discourses meet, on one hand the discourse of the liberal Zambian abortion law, and on the other, the discourse of the restrictive law, confusion is likely to prevail.

Concluding remarks

In this paper, we have argued that the Zambian Termination of Pregnancy Act is an ambiguous law that leaves much room for interpretation. Though the law in 1972 appeared to be progressive, allowing abortions on socio-economic grounds, it was the restrictive elements that were in focus in the debates preceding its enactment. These same elements were further emphasized with the declaration of Zambia as a Christian Nation, and can readily be recognized in today's abortion debate. The paper has discussed how key stakeholders engaged in disputes over the characterizations of the Zambian abortion law selectively apply discursive strategies. Drawing upon understandings from anthropology of policies, the paper argues that the imageries used to describe the law also contribute to the shaping of girls' and women's access to safe and legal ways to terminate pregnancies. The law is ambiguous enough to cater both for actors who want to expand and actors who want to further restrict access to safe and legal abortion. In its ambiguity it fails to provide strong and unequivocal rights to access to the services it permits and regulates. By highlighting how the Zambian abortion policy is contested by two competing discourses, we challenge the notion of a liberal Zambian abortion law and open up for further discussions on the relationship between the way a law is described and perceived by the public, and the rights to health and services to be ensured by it.

Acknowledgements

The authors would like to thank the participants interviewed for this study for their valuable contributions. MH is very grateful to Dr. Marja Hinfelaar for advice and guidance on the archival investigations that were part of this study and to Ms. Maureen Mupeta Kombe for administrative and logistical support.

Funding

This study is funded by the University of Bergen and the Norwegian Research Council through its Centre for Excellence scheme to the Centre for Intervention Science in Maternal and Child Health (CISMAC, project reference number 223269) and its NORGLBAL scheme (project number 249686). The funders had no influence on the design of the study or the collection, analysis and interpretation of the data or writing of the paper.

Availability of data and materiasl

The archival data used and analyzed for this study can be are available from the National Archives of Zambia and the library of the National Assembly of Zambia. The interview data generated and analyzed during the current study are not publicly available to protect the study participants' anonymity. The data is available from the corresponding author on reasonable request.

Authors' contributions

MH, AB, KMM and HH contributed to the design of the study. MH carried out the ethnographic fieldwork, including collection of archival material and the majority of the interviews. AB, KMM and HH actively participated in some of the interviews. MH carried out the analysis and drafted the manuscript. All the authors critically reviewed different version of the manuscripts, provided substantial contributions and approved its final version.

Ethics approval and consent to participate

Ethical approval for the study was obtained by the University of Zambia Biomedical Research Ethics Committee (009–07-17) and the Regional Ethical Committee Western Norway, Norway (2017/1191). Informed consent was given by all participants before being interviewed for the study.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

Publisher's Note

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Received: 21 September 2018 Accepted: 25 December 2018
Published online: 28 January 2019

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Social Science & Medicine 251 (2020) 112909

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

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

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ARTICLE INFO

Keywords:
Sexual and reproductive health
Health bureaucrats
Abortion
Zambia
Health policy

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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https://doi.org/10.1016/j.socscimed.2020.112909
Received 21 September 2019; Received in revised form 2 March 2020; Accepted 4 March 2020
Available online 10 March 2020

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

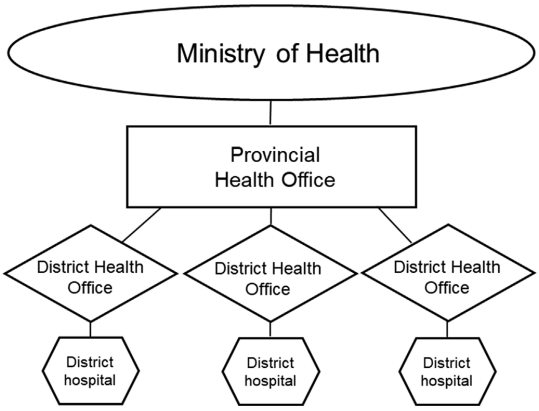

Fig. 1. Administrative structure of Zambian health system.

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.

Acknowledgements

The authors would like to thank all the health bureaucrats and hospital managers that took part in this study. We would also like to thank the three anonymous reviewers for their thoughtful comments to the manuscript. Moreover, we are grateful to The University of Zambia, School of Public Health for assistance and support during fieldwork. A special thanks to the Centre for Cultures of Reproduction, Technologies and Health and to professor Maya Unnithan for input during the analysis and writing process. Finally, we would like to thank the University of Bergen, the Norwegian Research Council (CISMAC, project reference number 223269) and the Meltzer Research Fund (2018/07/LMH) for funding the study and to the Global Health Anthropology Research Group (UoB) for continuous support and feedback.

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Social Science & Medicine 265 (2020) 113502

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: http://www.elsevier.com/locate/socscimed

When abortion becomes public - Everyday politics of reproduction in rural Zambia

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ARTICLE INFO

Keywords:
Sexual and reproductive health and rights
Abortion
Morality
Zambia

ABSTRACT

This article takes the public reaction to the discovery of an aborted foetus in a rural Zambian community as the empirical starting point for exploring the everyday politics of reproduction. It builds on eleven months of ethnographic fieldwork on abortion and abortion policy in Zambia in 2017 and 2018, including participant observation in the community where the episode took place and interviews with clinic staff and neighbours. The article explores local dynamics of abortion opposition in a country where abortion is legally permitted on broad grounds. By analysing this case as an anthropological *event,* it discusses how opposition to abortion is dynamic and changes depending on the situation at hand. While abortions that avoid public attention may be silently tolerated, abortions that become openly known are harshly condemned. Through scrutiny of a specific case of collective moral judgement of abortion, the article examines how values like responsible motherhood, sexual virtue and protection of life emerge and are shared, allowing participants to protect and accumulate their own integrity in a moral economy that forges stronger social ties within the community. The article argues that even the harshest expressions of opposition to abortion may not be as categorical as they first appear. It calls for increased attention to dynamics of moral and political opposition to abortion to understand what is socially at stake for those who engage in it.

1. The event

I was at the clinic and heard a lot of shouting and running outside. One of the nurses opened the door and said, *"You wanted to learn about abortions, right? Well, now we have one"*. Outside a crowd of neighbours had gathered. There were between 50 and 60 people, of all ages, shouting and running, clearly upset. "*They have found a baby, an aborted baby, in the community. People saw it as a dog was dragging it around*", the nurse told me. The owner of the dog had discovered the foetus in his yard and called the police before he alerted his neighbours to what had happened. As a group of outraged community members, they had moved to the clinic where they were discussing loudly among themselves and with the nurses. The police arrived only minutes later. Three male officers, two of them in uniform, came out of the vehicle and entered the clinic's main building. They came back out and walked through the upset crowd to a nearby house, only to come back a few minutes later, holding a girl between them. The crowd received them by shouting louder as the girl was brought towards them: "*Prostitute*" "*Baby murderer*" "*Witch*" "*Arrest her*".

This excerpt from the first author's (MH) field notes describes a case of strong collective reprehension of a specific abortion that took place on the outskirts of a town in one of Zambia's predominantly rural provinces. The incident gained a lot of attention. It was covered by local radio stations and in social media and was repeatedly discussed in the neighbourhood in the weeks and months that followed. This article takes the collective outrage expressed by community members as a starting point for exploring everyday reproductive politics and the moral economy of abortion.

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https://doi.org/10.1016/j.socscimed.2020.113502
Received in revised form 15 September 2020; Accepted 3 November 2020
Available online 5 November 2020

2. Introduction

Rapp (2001) has noted that "*when reproduction becomes problematic it provides a lens through which cultural norms, struggles, and transformation can be viewed*". Worldwide, abortion remains one of the most problematic and contentious reproductive issues (Kumar et al., 2009). Girls and women contemplating abortions are faced with a series of critical choices (Gammeltoft, 2002; Hoggart, 2019; Kebede et al., 2014; Schuster, 2005). Not only do they have to make tough decisions about their own lives and bodies, they also have to consider how their choices may be judged by others. It is well documented that both women who go through abortions as well as abortion providers may suffer considerable stigma (Coast et al., 2018; Kumar et al., 2009; Norris et al., 2011). But with few exceptions (Schuster, 2005), little attention has been paid to the moral reasoning and choices of those involved in inflicting moral judgements on others, or how abortion is situationally understood and responded to at community level.

Through studies of abortion, anthropologists have provided insight into a series of broader topics such as construction of personhood (Kaufman and Morgan, 2005; Morgan, 2006), new subjectivities (De Zordo, 2018) or sex and gender (Kasstan and Unnithan, 2020). The anthropological literature on abortion has also illuminated the inseparable relationship between politics and reproduction (Andaya and Mishtal, 2017; De Zordo et al., 2017; Ginsburg and Rapp, 1995; Haaland et al., 2020; Morgan and Roberts, 2012). These contributions have been important for situating reproductive health and rights within global political processes with wide-ranging consequences for girls and women. But abortion is also governed through community level social relations between neighbours and family members that make up the everyday politics of reproduction.

Drawing on Fassin's (2014) thinking about moral economies as production and circulation of affects and values, the article maps out local dynamics of moral judgement of abortions and seeks to understand what is socially at stake for abortion-seeking women and community members who surround them. Through an analysis of how abortion opposition comes about, is shared and understood by those who engage in it, we seek to contribute to an outline of a moral economy of abortion. We contend that a close examination of how abortion cases unfold in people's everyday lives enables insight into the micro-politics of reproduction and adds valuable knowledge on dynamics of abortion condemnation more widely.

2.1. Anthropology of events

In this article, we treat the rally of neighbours outside the clinic as a social event. Description of events as detailed case studies of particular scenes or situations have been central to both classical (Geertz, 1980; Gluckman, 1940) and more recent anthropological texts (Das, 1995; Sahlins, 1981). Events can be used either as illustrations of norms or patterns believed to be typical or as exceptional cases that ethnographic analysis can explain (Kapferer, 2010). Kapferer and colleagues have argued for the need to move beyond events as mere static examples of social relations or norms, to scrutinize extraordinary and untypical events. The aim is to expand the analysis of "*events as case studies"* and to look at events as *"opening to new potentialities on the formation of social realities*" (Kapferer, 2010:1). An event is thus a moment in which different social elements are put into play in new constellations, creating a space in which the social can emerge in new and unforeseen ways. This makes events avenues for change, political meaning and disputes. Events often take the form of public spectacles (Lewis, 2009) and are important for creating shared images and narratives that link the outer political world and the inner world of the self. Events *"therefore signal a form of "politics" beyond the formal political sphere"* (Lewis, 2009:127) and represent important avenues for everyday politics.

Inspired by Kapferer's and Lewis' thinking, this article treats the spontaneous rally of neighbours outside the clinic as an event and examines how affects and values towards sexuality, reproduction and abortion are put into play in particular ways. In doing so it uncovers how conceptions of abortion are intimately tied to gendered structures and power dynamics, but also how expressions of these conceptions vary with the circumstances at hand. While the gathering of neighbours was closely related to the discovery of a foetus, it is the community members' reaction to this incident that we treat as the event, and not the case of the abortion in itself. In order to analytically distinguish between the two phenomena, we will use the word 'incident' to refer to the abortion itself, while 'event' will be used about community member's public reaction to it outside of the clinic.

2.2. Abortion in Zambia

In Zambia, abortion has been legal on broad grounds since 1972 (GRZ, 1972). Nevertheless, access to abortion services is limited, both because of the restrictions spelled out in the law itself, as well as a set of political, bureaucratic and moral barriers that have to be overcome when seeking legal abortion (Haaland et al., 2019). The Zambian Termination of Pregnancy Act allows abortion to safeguard the life and health of the pregnant woman or that of her already existing children and in cases of severe foetal malformation (GRZ, 1972). Moreover, the law explicitly states that the pregnant woman's age and environment should be considered. In effect, the grounds allowing abortion are wide enough to accommodate the situation of almost every girl or woman seeking abortion services.

At the same time, the Termination of Pregnancy Act heavily restricts access to abortion services by specifying that abortions must take place in a registered hospital and be approved by three medical doctors, including a specialist. Given the significant lack of health personnel in Zambia (GRZ, 2017a), this represents an important barrier for access to legal abortion services, especially in rural areas. Abortions that do not comply with these requirements are still criminalized in the Zambian penal code with sentences of up to fourteen years of imprisonment (GRZ, 2017b). A set of standards and guidelines (GRZ, 2009; 2017b) to help health workers interpret and implement the Termination of Pregnancy Act was developed in 2009 and revised in 2017, but at the time of this study, neither document had been widely disseminated across the country. In addition to public hospitals, a handful of private clinics and (I)NGOs that operate in Zambia's major urban centres offer legal abortions. The (I)NGOs also work to increase implementation of the abortion law through advocacy and support to public abortion providers, but are primarily reaching urban areas. In the rural province that is in focus in this article, none of these organizations were present at the time of the study.

When the Zambian abortion law was passed in 1972, it was done quickly and without much public attention (Haaland et al., 2019). Lack of public debate around abortion may be one of the reasons why few Zambians, including health workers and law enforcers, are aware of the legal status of abortion (Cresswell et al., 2016; Macha et al., 2014). In Zambia, politics and religion are inseparably intertwined (Haaland et al., 2019). Since Zambia was declared a Christian nation in 1991, symbols of the state and of political power have become increasingly linked to religion (Haynes, 2015). Lack of dissemination about the legal status of abortion in Zambia, coupled with perceptions of a Christian state ideology, makes the idea of legal abortion difficult to imagine for abortion-seeking girls and women (Haaland et al., 2019).

When a clause stating that *"the right to life begins at conception"* was suggested in the proposed new Bill of Rights, abortion re-emerged on the political agenda. Both (I)NGOs and civil society organizations that work to increase access to safe abortion services, and churches and religious organizations that seek to limit access to abortion, mobilized efforts and became more explicit on the topic than before (Haaland et al., 2019). The proposed bill, which could have rendered the Termination of pregnancy Act unconstitutional, was sent to a referendum that was unsuccessful due to low voters turnout in 2016 (Zambia National

Broadcasting Corporation, 2016). Nevertheless, the proposal brought into light how Zambia's abortion law is subject to a subtle but continuous dispute over its interpretation and implementation (Haaland et al., 2019).

Notwithstanding, complications from unsafe abortions seem to persistently constitute a considerable problem of Zambian public health (Parmar et al., 2017). Studies from Zambia's urban areas have shown that girls and women's pathways to abortion vary greatly and may include seeking help from unsafe providers or accessing misoprostol for medical abortion through unofficial channels (Coast and Murray, 2016; Leone et al., 2016). Such cases are easily misclassified as miscarriages (Suh, 2014, 2019). However, little is known about abortion trajectories for girls and women living in rural Zambia today (Haaland et al., 2020).

Access to legal abortion is also conditioned by a series of sociocultural barriers (Kumar et al., 2009). Girls and women who seek abortion in Zambia, do so within a wider moral context in which womanhood is closely connected to motherhood (Manalula, 2009; Silva, 2009) and female sexuality is subject to both subtle and more overt mechanisms of control (van Klinken, 2018). This makes privacy a key concern for abortion seeking women, with consequences for where they seek assistance (Chemlal and Russo, 2019; Chiweshe and Macleod, 2018; Cresswell et al., 2016; Shellenberg et al., 2014). On a national level, data on both legal and clandestine abortions in Zambia is limited, but recent policy documents refer to a considerable number of girls and women admitted to public hospitals with severe complications after unsafe, clandestine abortions (GRZ, 2017b).

3. Methodology

This article draws upon eleven months of ethnographic fieldwork carried out by MH in Zambia in 2017 and 2018. It forms part of a larger study on the politics of abortion in Zambia that took on a multi-sited approach to inquiry (Marcus, 1995) to enhance our understanding of the gap between abortion policies and actual access to safe and legal abortion services. The study set out to follow the 'social life' (Appadurai, 1986) of the Zambian Termination of Pregnancy Act and followed the ways in which it is continuously disputed and reinterpreted (Shore and Wright, 1997) as it moves from national level policy makers to on-the-ground implementation in Zambia's rural areas. To do so, MH spent four months in the capital city of Lusaka before she relocated to the small town where she spent the remaining seven months. In Lusaka she investigated the origin of the Zambian abortion law and how it is perceived and disputed by national level political actors today (Haaland et al., 2019).

In a predominantly rural province, MH used a small clinic with a youth-friendly corner that provided sexual and reproductive health services to adolescents as a methodological starting point for access. She gained access to and familiarity with the community surrounding the clinic through taking part in daily life activities including church-going, market hangouts and performance of simple house chores for elderly women who lived alone. She moreover took part in meetings of women's saving groups and women's church groups that met on a regular basis. Participant observation in the community served to gain an understanding of how issues of morality and reproduction were talked about and handled in everyday situations such as in church activities, women's groups, at the market or the clinic. This allowed for increased understanding of the relevance of the Zambian abortion policy to people's everyday life. After gradually becoming more familiar with her research topic, several groups of women in the neighbourhood started to invite MH to their houses to discuss issues of sexuality and reproduction. In these meetings, the event described above was often brought up and discussed.

MH interviewed community health workers, clinic nurses and neighbours about issues of sexual and reproductive health and abortion, and representatives of the local and regional police force about how they followed up abortion cases reported to the police. After the event took place, she re-interviewed some of the participants who had actively taken part in the upheaval outside the clinic about their motivations for doing so and their thoughts about what had happened. All interviews were semi-structured, following a flexible interview guide. While this article draws upon the full ethnographic material, MH's engagement with the clinic staff, community health workers, neighbours and women's groups related to the event make up its empirical core.

Interviews and conversations with participants with education beyond primary school, took place in English, Zambia's official language. MH had rudimentary knowledge of the vernacular language, but in meetings with women's groups in the community she was assisted by a locally recruited female research assistant. Except for the interviews that specifically dealt with the event, MH made an effort not to add to the stigma suffered by the suspected girl, and did not ask about the case unless it was brought up by others. However, when talking about abortion, community members rarely failed to mention the event.

Interviews and group discussions were audiotaped with consent from all participants. These were either transcribed verbatim in English or transcribed and translated to English by a research assistant fluent in the vernacular language. In line with ethnographic tradition, the process of analysis started during fieldwork and continued into a concentrated phase of analysis and discussion between the authors once fieldwork was concluded. The collected material related to the event was read and re-read to gain overview and familiarity before MH engaged in a process of categorization using NVivo12 as a tool to organize the material. Codes and broader categories were discussed with the team of authors and a set of major themes were identified. The analysis focused on the latent level of underlying meaning and assumption (Braun and Clarke, 2006). After the major themes of visibility, motherhood, sexuality and gestational age had been identified, a more active engagement with theory took place by drawing on Kapferer's (2010) thinking about events and Fassin's (2014) concept of moral economy as a way to further interpret the findings before and during the drafting of the manuscript.

As a female European researcher with a special interest in issues related to gender and reproduction, MH's position in the field had bearings on her interactions with community members. On one hand, her status as a woman allowed her access into female social arenas, such as the women's saving groups. On the other hand, her European background and status as a researcher positioned her within larger historical as well as economic power asymmetries that unavoidably affected social dynamics between her and members of the community. Before the abortion-related event at the clinic took place, about six weeks into MH's fieldwork in the rural province, abortion had not been an easy topic to discuss in the community. The health workers at the clinic were reluctant to talk about it, and community members often just gave polite answers along the line of, *"Yes, it (abortion) happens sometimes, but I don't know much about it"*. This was, in no way, an indication of abortions being uncommon. At the referral hospital in town, there were records of the 40–50 monthly cases of girls and women admitted with complications from clandestine and unsafe abortions. Many of them were bound to be from the community where the event took place. It was rather an indication that abortions were not publicly discussed (though discreetly gossiped about), and maybe especially so, with a European researcher. In the period after the event, abortion repeatedly came up in conversations, interviews and social gatherings, and allowed MH to get insight into how abortions are commonly handled in the community, and what made this case different. The fact that MH was present during the event gave her questions more legitimacy, enabling community members to share their own views of what had happened, and why they reacted in the particular way they did.

The study has ethical clearance from the University of Zambia Biomedical Research Ethics Committee (009-07-17) and the Regional Committee for Medical and Health Research Ethics Western Norway (2017/1191). It was approved by the National Health Research Authority in Zambia (MH/101/23/10/1), the relevant provincial and district health offices and the Zambian Ministry of Home Affairs. Needless

to say the empirical core of this article, is of a particularly sensitive nature to some of the involved parties. To safeguard their integrity and anonymity, guided by the American Anthropological Association's ethical code (American Anthropological Association, 2014 (2012)), we have chosen not to reveal the town or the province where the event took place.

4. Findings

4.1. When abortions become public

When discussing the event in the weeks and months after it took place, it quickly became evident that while most people would argue that abortion is always a moral transgression using arguments like *"it is not right"* or *"it is like killing"*, all abortions were not considered equally immoral. The grotesque and public way that the foetus was discovered figured strongly in people's reasons for taking part in the rally at the clinic. Many were upset with the suspected girl, not only because of the abortion itself, but with the fact that it was so poorly hidden. Luyando, a woman in her 30s, described the participants' anger in these terms:

> *The neighbours are very much angry with her. In this community if you have the intention of aborting, then you better go somewhere else. They were angry,* [saying] *how could she abort here, in the community, and why could she not bury the baby?*

Most abortions are not reported to the police, but in the case that sparked this event, people were of the opinion that the dog owner who had discovered the foetus had no other option but to call the police. He needed to make sure everyone understood that the foetus he had found had nothing to do with him, relieving himself of possible gossip and social sanctions. A police officer set to handle abortion cases in the provincial headquarters described a similar motivation among the few who chose to report abortion cases to the police. In another case she was investigating, a father had approached a local police post to report that his daughter had aborted because her pregnancy had been very visible before the abortion took place:

> *He told the police station because she was very pregnant. She was showing a lot, so people knew. And when she was no longer pregnant, and her father, her parents saw blood in their house, they had to tell the police, to show that they did not know* [about her plans to abort]. *So he, her father, he reported it to the police.*

On the day of the event, people started gathering after the dog owner went around telling his neighbours what he had found and informing them that the police would arrive shortly. Some felt they had little choice but to take part in the public reproach at the clinic. Joyce, a woman in her 40s who lived near the clinic explained her motives for participating *"Because the dog was pulling on the baby everywhere, many people had seen it. It was not possible to keep quiet as if nothing had happened"*.

Many expressed similar feelings of obligation when reasoning about their actions, emphasising their need to avoid accusations. A young man later told MH that he had joined the crowd to avoid suspicion. He explained:

> *They may ask why you did not follow them or assume there is something else* [going on]. *They could point to me and say, 'Maybe he is also part of these things you know. Because how come* ***us*** *we are going to watch as the police come, and him, he is just there in his house?' Sometimes us men and boys, you find that we may not want to go there, but they will ask you why you didn't and say maybe you are the one who impregnated her? They will say that.*

The way in which this particular abortion case was discovered thus seems to play an important role in why people chose to express their judgement is such a public way. A community health worker who witnessed the event together with MH pointed to what she saw as a moral double standard among her neighbours who showed up at the clinic, *"Look at these people shouting at the girl for aborting, as if they have not aborted themselves!"*

Abortions are treated discreetly and with secrecy across many settings (Kumar et al., 2009), and in many places abortion cases have been described as *"open secrets"* that are not talked about, but still known (Rossier, 2007). Some of the participants of the event discussed later how they had, in other cases, privately tolerated, or sometimes even supported abortion-seeking girls or women. Grace, a woman in her 40s who was among the participants at the event, talked about abortion issues with MH in a women's groups meeting in which she described how she had reacted when she a few years back discovered that her daughter of 14 years was pregnant:

> Grace*: My child got pregnant in grade 7.*
>
> MH: *And what happened?*
>
> Grace*: Me and my husband, we were disturbed. We started thinking of ways to get rid of the pregnancy. I went to an herbalist and bought the medicine. Some people told me to be careful,- that she might die. But she was so young to have a baby. She drank the medicine and the pregnancy came out.*

This abortion had taken place discreetly. It had been handled as a private affair within the family, without much involvement of others. When Grace shared the story in the group, it sparked some discussion about her course of action, and some were of the opinion that the girl should have had the baby. Nevertheless, the case was discussed calmly and without hostile remarks.

The difference between the harsh public judgement that was expressed during the event and the calm discussion that took place after Grace told her story in her woman's group suggests that the level of visibility of the abortion made a considerable difference to people's reaction towards a particular abortion case. Throughout the fieldwork period, MH heard many stories about abortions that had become discreetly known to neighbours and friends, but none of them had been reported to the police, or sparked a mob-like situations like the event. Similarly, in his study of abortion in Ghana, Bleek found that an abortion is considered immoral and reprehensible unless it *"is successful and remains hidden"* (Bleek, 1981:203). He describes how people were quick to condemn abortions that became publicly known as immoral and foolish but kept quiet about or supported abortions they learnt about through more discreet channels.

An abortion that becomes exposed thus seems to create a situation where community members are cast as either for or against what is considered a morally debatable phenomenon, leaving out more nuanced positions. The aborted foetus brings into the public domain issues that are commonly dealt with in the private, revealing power dynamics at community level in which neighbours feel the need to mark their distance to what may be considered a moral transgression by publicly denouncing it.

4.2. (Ir)responsible motherhood

The concept of motherhood constituted a central element in people's anger displayed during the event. Inonge, a young woman of 22 explained her feelings about the case:

> We were just angry about the abortion. How could she abort the pregnancy while she has another child? For the first child, she kept it when she was I think 15 or 16 years. Now at the age of 18 or 19 how could she abort another child? We were angry!

Inonge's reflections resonated with those of many. Motherhood was often brought up as an aggravating factor. The clinic nurses e.g. expressed considerable disappointment with the suspected girl, since,

"She is supposed to know what to do [in terms of contraception,] *we were teaching her when she had her first baby"*. Mothers moreover appeared to be held to a higher moral standard, than young girls. The police officer assigned to work on abortion cases informed MH about another case that had been reported to the police:

> Officer: *It happened on Thursday. The suspect is a woman, age 24. She is a mother. She already has a son who is 4 years old. This is the second pregnancy, the one she aborted. Because she already has a son.*
>
> MH: *Ok*
>
> Officer*: She already has a son with the same man, and now she was pregnant again.*
>
> MH: *Were they married?*
>
> Officer: *No, not married. She, the girl, says that when she told the man about the pregnancy, he was the one who told her to abort it. He had told her he did not want it and that she should abort.*
>
> MH: *So what happened?*
>
> Officer: *Then she went to a woman … This woman, she is 34 years old. And she is a mother. She has four children … At this point, the girl was two months pregnant and the woman gave her some roots. She said it was lemon roots, soaked in water for a long time. So she drank that.*
>
> MH: *Lemon roots?*
>
> Officer: *Yes. And well, then, this past Thursday the pregnancy came out.*

Some of the participants who emphasized motherhood also made reference to the fact that the suspected girl was now older than when she had her first baby and may, therefore, have been referring to a more general notion of responsible adulthood. Age and adulthood, however, were mostly alluded to, and not directly held as an aggravating factor in the same way as motherhood. The fact that women may have abortions when they already have children seemed to be considered particularly immoral. This resonates with Tamale (2014) who contends that abortion is condemned, be it by law or social or religious norms, in ways that reflect particular gendered structures, that cast motherhood as the primary feminine ideal. Having an abortion when you already have children, thus seems to be an act that defies not only the pregnancy, but also the ideal of motherhood that one has already embodied (Kumar et al., 2009; Suh, 2014).

Since it was not clear at the onset who would be blamed for the aborted foetus, motherhood could not have figured among the main reasons for joining the public mobilization, but it certainly gained increasing force as the neighbours discussed the event in the following weeks. Notably, the conception of motherhood as an aggravating factor when judging a particular abortion case, resonates poorly with the Termination of Pregnancy Act (GRZ, 1972). The Zambian abortion law includes the health and wellbeing of existing children as a specific ground under which abortion is allowed, theoretically making abortion more accessible to mothers as the well-being of their children can be seen as a reason to grant a legal abortion.

4.3. Sexual (im)morality

Ideas about sexual morals appeared to be evoked when justifying one's own participation in the event. Participants seemed to consider abortion more of a transgression if the sexual morals of the abortion-seeking woman could be questioned. Mulenga, a 30-year-old man who took part in the event at the clinic, explained why people had reacted so strongly:

> *Because we knew that she used to go into town at night … you know these girls who go to town and what they do* [prostitution]. *Then again, we heard that the pregnancy belonged to a police officer, so when she went there the police officer told her, 'I used to see you in town* [as a prostitute]*' and he could not admit that he was the one who impregnated her so that it was his pregnancy. So that is why all that happened. We knew that she went to the bars in town and she just wanted to continue doing that.*

The same line of justifications was brought up by many of the participants of the event. When describing what had transpired, Sarah, a woman in her 50s, emphasized what she and others had been shouting at the suspected girl:

> *We were saying that she was the owner of the* [aborted] *pregnancy and she is a witch and also a prostitute. Because, you know, she goes into town during the night to night clubs.*

That abortion and prostitution was brought up in the same conversation was not unique to this event. Many of those who strongly opposed the idea of legal abortions evoked arguments of control of female sexuality. The leader of a rural district hospital in one of the neighboring towns, associated women requesting abortions at his hospital with infidelity:

> I think it has only happened a few times that a woman comes in and asks for an abortion at the hospital. You know, in such cases, the woman has cheated and doesn't want the husband to know. I don't think it's right.

As the event was going on, the participants did not know who would eventually be suspected and arrested for the abortion, so questions of sexual morals were not central to mobilizing people to come to the clinic. Rather, the sexual morals of the suspected girl were retrospectively constructed as a reason for the public and collective reprehension. Nevertheless, the local term for prostitute was one of the main insults shouted at the suspect at the time, suggesting a clear link between sexual morals and abortion as the event unfolded. Several authors have documented a conceptual link between control of female sexuality, and moral opposition towards abortion (Bleek, 1981; Norris et al., 2011). Kumar et al. (2009) go as far as stating that female sexuality is *"at the core of abortion stigma"* across the world.

4.4. Gestational age

During and after the event at the clinic, there was considerable uncertainty about the timing of the abortion and the gestational age of the foetus. It soon became clear that parts of the public condemnation were based on the fact that the foetus had been big enough to be clearly recognizable as a "baby". As the event was taking place, participants commented, "*They have found a baby*". In the aftermath, those who had seen the foetus had different estimates about its size and gestational age, but were quite consistent on describing it as *"big"*. Mainza, a woman in her 30s, said that; *"I think that baby was even seven or eight or six months, because you are able to see everything. Arms and legs and everything. It was all ready"*. While it is not known how the final police report established the gestational age, the health workers at the clinic who had assisted the police in collecting the foetus estimated that it was "*about seven months old*".

During the event, it became evident that the well-developed features of the foetus, combined with the grotesque way that it was discovered were decisive in why the neighbours rallied together at the clinic in anger. One of the young peer educators who worked at the youth-friendly corner and had seen the foetus before it was discovered by the dog owner, described how she had suspected the girl who was finally arrested because the foetus "*even resembled her mother*". While the actual gestational age of the foetus remains unknown, the event at the clinic uncovered timing of the abortion as an important aspect of abortion condemnation.

The developed features of the aborted foetus revealed a blurred line between abortions and infanticide. The participants at the event, who described what was going on, all referred to the transgression as an

abortion. But when describing what they thought had happened, some would hold that the suspected girl had given birth to a live baby and then buried it. Also this action was described as an abortion, though considered worse than an abortion at a younger gestational age. The event at the clinic and people's retrospective reflections thus uncover a continuum between abortions that can be silently or discreetly tolerated and abortions that warrant harsh public condemnation where gestational age and development play a role. While people who took part in the event did not make distinctions between abortions and infanticides, they did seem to agree that the more developed the foetus, the more of a moral transgression.

5. Discussion – towards a moral economy of abortion

While abortions were fairly common in the neighbourhood where the event took place, and many could tell stories about family members, neighbours or classmates who had aborted, few abortions caused the kind of public upheaval that took place at the clinic on the day of the event. Most abortions were silently tolerated, or discreetly gossiped about. In the distinction between reactions to different abortion cases we can begin to discern the contours of an everyday politics of reproduction in a rural Zambian community. As an event (Kapferer, 2010) and spectacle (Lewis, 2009), the upheaval at the clinic reveals how abortion opposition comes about through a dynamic process of disruption and reinforcement of established systems of gender and power.

Fassin's (2014) conceptualization of moral economy can broaden our understanding of what is socially at stake for both women deciding to undergo abortions and for community members acting in response to abortion cases they learn about. Fassin understands moral economy as *"the production, distribution, circulation and use of affects and values in the social space"* (Fassin, 2014:157) and foregrounds 'moral', understood as affects and values, over 'economy' (Götz, 2015:157). While this conceptualization has been criticized for leaving out aspects of class and capital (Palomera and Vetta, 2016), it enables a focus on the processes through which affects and values come about and are shared. The concept thus provides an analytical tool suitable for understanding everyday politics of abortion that played out in the event.

Affects played a central role in the event itself, through the harsh insults and angry faces of the participants. As people were contemplating what had happened, they brought up a set of values that gained force as the event unfolded. Motherhood, sexual morals, gestational age and how the abortion was discovered were all aspects that were considered by the participants. Among these, the public way in which the abortion was discovered seems to be the triggering element that put the event in motion. This resonates with studies of abortion across a variety of settings. Schuster (2005) found secrecy to be the decisive factor for how women choose abortion methods in Cameroon and in Bleek's iconic abortion study from Ghana (1981), abortions were widely accepted unless they became publicly known. As such, it seems that abortions that become visibly exposed in the public sphere are met with far harsher reactions than the ones that may be known about only as phenomena of the private sphere.

Explorations of divisions between the private and public have been central to the analysis of gendered structures and domains across many societies (Ortner, 1974; Rosaldo, 1974; Tamale, 2004). Feminist scholars have pointed out how social and biological reproduction often is associated with femininity and the private. From such perspectives, the public discovery of the aborted foetus thus represents a rupture of the division between the private and the public, bringing the private act of abortion into the public domain for discussion and scrutiny. Such a rupture, challenging established gendered power dynamics, may have been particularly provocative and key in setting the event in motion and mobilizing a series of values.

We find reflections of these values in the participants' reasoning about what took place For instance, in their retrospective justifications for taking part in the event, an ideal type of responsible motherhood was held up and used to morally assess the particular abortion case as worse than others. Motherhood thus emerges as a value that was put into play through the event. Similarly, participants' focus on sexual immorality points to the mobilization of sexual virtue as a value that became relevant both during and after the event. That abortion is cast as an act of defying the ideals of motherhood and sexual virtue is not unique and has been repeatedly noted across a range of settings (Beynon-Jones, 2013; De Zordo, 2018; Tamale, 2014). Together they point to a larger structure of gender roles that cast abortion as a transgression against the acceptable model of womanhood more broadly (Kumar et al., 2009; Norris et al., 2011; Tamale, 2014).

Participants' emphasis on the size of the foetus and insults such as "baby murderer" that were shouted during the event, reflects values related to protection of life that were mobilized in the collective public judgement expressed during the event. The fluid distinctions between acts such as abortion, infanticide or murder, raise questions about beginnings of life and personhood (Kaufman and Morgan, 2005; Onarheim et al., 2017; Scheper-Hughes, 1992) in which biomedical terminology distinguishing between embryo, foetus and full-born baby rarely concords with local understandings of pregnancy and pregnancy loss, including abortion (Morgan, 2006; van der Sijpt, 2018).

During the event and the weeks that followed, it was increasingly noticeable how the values that were being reflected were not constant, but shifted and gained more or less force in a way that, following Fassin (2014), could be seen as circulating and accumulating. As the event was taking place and people were eagerly discussing outside the clinic, the foetus was the main object of discussion, and its size and status as a baby were stressed. As the days went by, and people were no longer specifically gathered to discuss the case, the emphasis slowly moved away from the size of the foetus and towards sexual immorality and the status of motherhood of the suspected girl. In this process, it was notable how community members who shared few points of interaction, made similar shifts in their reasoning about the event, indicating that once mobilized, certain values gained force as they were shared between neighbours.

Moreover, the event uncovered a dynamic in which one's own moral integrity appeared as a commodity in need of protection and accumulation. In such a moral economy of abortion, mere bystanders or witnesses to an abortion, like the dog owner who found the foetus in his yard, or the neighbours he alerted, seemed to act in ways that maintained or increased their own moral integrity. When learning about the abortion, participants made evaluations about how their own reactions would be morally assessed, depending on the level of attention the abortion would get. Making the wrong choice could lead to suspicion and public outrage being turned against oneself as complicit to the morally debatable act of abortion. Participants' reasoning about whether to take part in the event thus point to a system of normative power that gained force as the event unfolded. Similar mechanisms of moral self-preservation among actors who find themselves close to abortion cases have been documented in studies of how health workers handle abortion-related cases (De Zordo and Mishtal, 2011; Freeman and Coast, 2019; Suh, 2014).

While actively involved in inflicting moral judgement on the suspected girl, participants' public expression of opposition to abortion constituted a pragmatic self-preservation from moral suspicion within a system of normative power that allowed them no middle ground. Simultaneously, it allowed the participants to enact a social identity as member of a moral community (Lewis, 2009) and strengthen social ties to neighbours and other community members. Yang et al. (2007) have encouraged researchers to move beyond the internalized and individual experiences of the stigmatized to focus on the social and moral experience of stigma of all involved parties, including the ones involved in stigmatizing. They have argued that to understand and address stigma as a social phenomenon, it is necessary to understand *"what is most at stake for actors in a local social world"* (Yang et al., 2007:1525) and pointed out that inflicting stigma on others is often a "*highly pragmatic, even tactical response to perceived threats, real dangers, and fear of the unknown*" (Yang

et al., 2007:1528). Through this lens, the strong moral judgement publicly expressed during the event suggests the presence of a shared everyday politics of reproduction in which a joint defence of threatened values, not only protects and increases personal moral integrity, but collectively reinforces social ties.

6. Concluding remarks

The event at the clinic allows us a snapshot of the micro-politics of reproduction in which even the harshest expressions of abortion condemnation may not be as categorical as they first appear. Through the analytical lens of events (Kapferer, 2010), this article has cast light on how gender and power relations may be challenged, reconfigured and reinforced as abortion becomes exposed in the public sphere. It has described how abortion condemnation comes about and is circulated, and has discussed how public expressions of judgments form part of a moral economy of abortion in which moral integrity and social ties to the community are at stake. While this article takes on a myopic view of abortion politics at community level, we believe that related mechanisms of a moral economy of abortion may be at play in abortion politics at national and global levels. We encourage increased attention to how and why moral opposition to abortion comes about and is circulated, also in the global moral community.

Author contribution

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

Acknowledgements

The authors would like to thank the clinic who allowed MH to follow their outreach activities and use their facilities when needed, community health workers who introduced her to the neighboring communities and all the community members who shared their thoughts and experiences about the event. We are also grateful to the research assistants who helped MH with interpretation and translation while in the field. Moreover, we thank the University of Zambia, School of Public Health for assistance and support during fieldwork and the Global Health Anthropology Research Group at the University of Bergen for interesting discussions about the article and continued support during the writing process. We are also grateful to the anonymous reviewers for taking the time to engage with the manuscript and help us fine-tune our analysis. Finally, we would like to thank the University of Bergen, the Norwegian Research Council (CISMAC, project reference number 223269) and the Meltzer Research Fund (2018/07/LMH) for funding the study.

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REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Øyvind Straume	55978497	21.09.2017	2017/1191/REK vest
			Deres dato:	Deres referanse:
			11.09.2017	

Vår referanse må oppgis ved alle henvendelser

Marte Haaland
Senter for internasjonal helse

2017/1191 Problematiske svangerskap: En etnografisk studie av de sosiopolitiske dimensjonene av prevensjon og trygg abort i Zambia

Institution responsible for the research: University of Bergen
Project leader: Marte Haaland
New project leader: Astrid Blystad

With reference to your application regarding the abovementioneded project. Chair of the Regional Committee for Medical and Health Research Ethics (REC Western Norway) reviewed the application and the response, pursuant to The Health Research Act § 10

Description of the project
The purpose of this study is to explore the scope of action available to policy makers who want to reduce the scale of unnecessary deaths related to unsafe abortions and to examine its implications for the lives of girls and young women. This will provide empirically founded knowledge about how social and political factors may influence the rates of maternal deaths caused by unsafe abortions. The study will beconducted as a multi-sited ethnographic study drawing upon a set of qualitative methods for data collection. The study will interview three groups: 1) policymakers, 2) opinion leaders and 3) women and girls from a rural community.

Ethical review

Response
The Committee asked for a response on the following:
1) How will the project group deal with any illegal activity that will be uncovered during the interviews?
2) The project leader must have a completed Phd or similar.
3) The role of the local co-supervisors must be explained.

REC Western Norway by Chair reviewed the response.

Ethical review
The response from the project group is satisfactory. The researchers will establish collaboration with an NGO working on sexual and reproductive health rights. The researchers are prepared to assist womenm if needed, to get in touch with the NGO. Any information on cases of illegal abortions will be coded anonymously and stored on a password protected hard disk.

Furthermore, Astrid Blystad will become project leader and the role of the local co-supervisors has been described in the protocol.

Decision
REC Western Norway approves the project in accordance with the applicaton and the response.

Further Information
A final report must be sent no later than 01.03.2023. The approval is based on the grounds that the project is implemented as described in the application and the protocol, as well as the guidelines stated in the Health Research Act. If amendments need to be made to the study, the project manager is required to submit these amendments for approval by REC via the amendment form.

The decision of the committee may be appealed to the National Committee for Research Ethics in Norway. The appeal should be sent to the Regional Committee for Research Ethics in Norway, West. The deadline for appeals is three weeks from the date on which you receive this letter.

Med vennlig hilsen

Marit Grønning
Prof. Dr. med.
Chair REC Western-norway

Øyvind Straume
Committee Secretary

Copy :post@uib.no; astrid.blystad@isf.uib.no

THE UNIVERSITY OF ZAMBIA

BIOMEDICAL RESEARCH ETHICS COMMITTEE

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IRB00001131 of IORG0000774

Ridgeway Campus
P.O. Box 50110
Lusaka, Zambia

28th August, 2017.

Your Ref: 009-07-17.

Ms. Marte Emillie Haaland,
C/o G. M. Munakampe,
University of Zambia,
Dept. of Mech. Engineering,
P.O Box 32379,
Lusaka.

Dear Ms. Haaland,

RE: RESUBMITTED RESEARCH PROPOSAL: "PROBLEMATIC PREGNANCIES-AN ETHNOGRAPHIC STUDY OF THE SOCIO-POLITICAL DIMENSIONS OF ACCESS TO FERTILITY CONTROL AND SAFE ABORTION IN ZAMBIA" (REF. No. 009-07-17)

The above-mentioned research proposal was presented to the Biomedical Research Ethics Committee on 21st August, 2017. The proposal is approved.

CONDITIONS:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported at once to this Committee.
- Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a Progress Report (Progress Report Forms can be obtained from the Secretariat).
- Apply in writing to National Health Research Authority for permission before you embark on the study.
- **Ensure that a final copy of the results is submitted to this Committee.**

Yours sincerely,

Dr. S. H Nzala PhD
VICE-CHAIRPERSON

Date of approval: 21st August, 2017. **Date of expiry**: 20th August, 2018.

THE NATIONAL HEALTH RESEARCH AUTHORITY
C/O Ministry of Health
Haile Selaisse Avenue,
Ndeke House
P.O. Box 30205
LUSAKA

MH/101/23/10/1

13 September 2017

Marte E.S. Haaland

University of Zambia

School of Public Health

P.O. Box 50110

Lusaka

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to conduct research titled **"Problematic pregnancies-An ethnographic study of the socio-political dimensions of access to fertility control and safe abortion in Zambia."**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been **approved** on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commencement of the study;
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, University leadership, and all key respondents.

Yours sincerely,

Sandra Chilengi-Sakala
For/Director
National Health Research Authority

UNIVERSITY OF BERGEN
Department of Global Public Health and Primary Care

THE UNIVERSITY OF ZAMBIA
SCHOOL OF PUBLIC HEALTH

Subject: Permission to conduct an ethnographic study on the topic of the socio-political dimensions of access to fertility control and safe abortion in Zambia

Reference is made to the above subject.

I am a doctoral student at the University of Bergen, Norway, and a guest student at the School of Public Health at the University of Zambia. Together with my supervisors Astrid Blystad, Karen Marie Moland, Haldis Haukanes and Joseph Zulu, I am conducting an ethnographic study that is exploring the socio-political dimensions of access to family planning and safe abortion services.

Currently I am based in Mongu, Western Province, where I am carrying out the community based component of my study. To better understand aspects related to abortions taking place in the communities, I would like to include members of the police force in Western Province in my study for interviews and information relevant to the focus of the study. I hereby apply for your permission to do so.

I would greatly appreciate if the request would be favourably considered as the study will contribute to the body of knowledge on the socio-political dimensions of access to fertility control and safe abortion.

Should there be any questions, please do not hesitate to contact me on e-mail marte.haaland@uib.no or phone +260 976 027 603

Yours sincerely,

Marte E. S. Haaland
PhD-Candidate
University of Bergen, Norway
Visiting-student at the School of Public Health
+260976027603

Attachement 1: Study protocol
Attachment 2: Approval from University of Zambia Biomedical Ethics Research Committee

cc. Dean Public Health, University of Zambia

Request for participation in the following research project:

Problematic pregnancies: An ethnographic study of the sociopolitical dimensions of access to fertility control and safe abortion in Zambia

The following information to be communicated to the potential informant:

Background and purpose of the study

This is a request for you to participate in a research study that intends to explore the topic of access to fertility control and safe abortion services in Zambia. There is today limited documentation on the social and political aspects related to access to fertility control and prevention of unwanted pregnancies in Zambia. The purpose of this study is to explore the scope of action available to policy makers who want to reduce the scale of unnecessary deaths related to pregnancy and childbirth and to examine its implications for the lives of girls and young women. This study is part of a research team that aims to explore dynamics between the law, policies and access to fertility control and safe abortion services in Ethiopia, Tanzania and Zambia. This is a collaborative project named *Competing discourses impacting girls' and women's rights: Fertility control and safe abortion in Ethiopia, Zambia and Tanzania* (SAFEZT) between the University of Zambia, The University of Addias Abeba (Ethiopia), the University of Dar es Salam (Tanzania) and the University of Bergen (Norway).

What does the study entail?

In the study we wish to conduct in-depth interviews and focus group discussions with the aim to explore how policy and legislation, together with social relations and norms influence girl's and women's reproductive health. The interviews and focus group discussions will be conducted in English, or in the relevant language spoken by the interviewee by myself and my collaborator.

The findings of the study will be used to write articles for scientific journals. The findings will also be presented at conferences and at meetings with local and national level policy makers in Zambia. It will not be possible to identify you in the findings of the study when they are published or presented

Potential advantages and disadvantages

Your participation in the research project will be valuable as it contributes to understanding how social and political factors may lead to higher number of women suffering the consequences of unintended pregnancies and unsafe abortions. This will make it possible to consider such factors when making policies that affect girls and women's reproductive health.

Potential disadvantages of your participation in the study include the time you will spend on the interview. A compensation for time and travel expenses will be provided.

What will happen to the information about you?
The interview will be tape recorded upon your consent, and notes will be taken during the interview. The information that is registered about you will only be used in accordance with the purpose of the study as described above. All the information will be processed without name, ID number or other directly recognizable type of information. A code links you to your data through a list of names. Only authorized project personnel will have access to the list of names and be able to identify you. It will not be possible to identify you in the results of the study when these are published

Voluntary participation
Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time without stating any particular reason. Withdrawal from the study will not have any implications for you. Anonymity and confidentiality will be ensured throughout the study.

If you wish to participate, please sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent. If you after the interview wish to withdraw your consent or have questions concerning the study, you may contact the project leader of this study: Marte E. S. Haaland on the following number xxxxxxxxxx.

If you have any other questions, you can contact the study leader or the University of Zambia School of Medicine Biomedical Research Ethics Committee (see contact information below).

Contact information:
Project leader of the study - Marte E. S. Haaland
Address: xxx, xxx, Lusaka Zambia
Phone: XXXXXXXX
E-mail: marte.haaland@uib.no

Consent for participation in the study *Problematic pregnancies: An ethnographic study of the sociopolitical dimensions of access to fertility control and safe abortion in Zambia*

I am willing to participate in the study.

(Signed by the project participant, date. NOTE: If the study participant is illiterate, he/she will give his/her oral consent, and the research collaborator will note the consent and date)

I confirm that I have given information about the study.

(Signed, role in the study, date)

Graphic design: Communication Division, UiB / Print: Skipnes Kommunikasjon AS

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ISBN: 9788230858660 (print)
9788230840054 (PDF)