Perceptions of Abortion in Contemporary Urban Botswana

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Abstract

The complications of unsafe, illegal abortion are a significant cause of maternal mortality in Botswana. The stigma attached to abortion leads some women to seek clandestine procedures, or alternatively, to carry the foetus to term and abandon the infant at birth. I conducted research into perceptions of abortion in urban Botswana in order to understand the social and cultural obstacles to women's reproductive autonomy, focusing particularly on attitudes to terminating a pregnancy. I carried out 21 qualitative, semi-structured interviews with female and male urban adult Batswana. Further research is required to examine perceptions of abortion in rural areas. Restrictive laws must eventually be abolished to allow women access to safe, timely abortions. However, my findings suggested that socio-cultural factors, not punitive laws, present the greatest barriers to women seeking to terminate an unwanted pregnancy. These factors must be addressed so that effective local solutions to unsafe abortion can be generated.

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Statement of originality

I certify that this dissertation is my own original work, except where due acknowledgement has been made to another person in accordance with standard referencing practice.

Chapter One: Introduction

Botswana is a Sub-Saharan African country, bordered by Namibia, Angola, South Africa, Zambia and Zimbabwe. It has maintained a multi-party democracy since independence in 1966, and has remained politically stable. The economy has experienced rapid growth since the discovery of mineral deposits. Botswana is the only African country deemed one of the world's 13 'economic miracles' (The World Bank, 2010: viii). Botswana has invested its diamond wealth in education, health, employment and infrastructure with notable results. The population estimate for 2011 was 2,065,398 (CIA World Factbook, 2011). The 2001 census showed 72% of Batswana identified themselves as Christian, less than one percent was Muslim, and 21% stated no religious affiliation (The World Bank, 2010). The national language is Setswana and the official language is English. People from Botswana are collectively referred to as *Batswana*, and individually as *Motswana.*

I lived in Botswana's capital, Gaborone, working as a volunteer teacher for 16 months in 2010-2011. During that time I witnessed several indicators of problems for women's reproductive choice, which appeared out of alignment with a rapidly modernising society.[1] I met women who had been compelled to surrender their personal aspirations because they were unable to terminate an unwanted pregnancy either as a result of social or familial pressures, or because abortion on request was not available in Botswana. I encountered a small number of women who were being forced to track down clandestine providers, and many more who had made the expensive and time-consuming journey to South Africa to procure an abortion in a legal setting. In addition to these encounters, I read numerous newspaper reports about women who had been caught being involved in abortion and were being prosecuted; the suicides of pregnant teenagers; deaths caused by dangerous 'backyard' abortions; and babies and foetuses being found abandoned or buried (some examples are: Ontebetse, 2010; Disang, 2011; Gosalamang, 2011; Moroka, 2011; Oniro, 2011). I was struck by the implication of these incidents; that there is an unmet need for safe, legal and accessible abortion in Botswana.

I searched academic journals, library books, and government reports for information about abortion in Botswana, and found very little. I felt compelled to research the issue myself, hoping to build an understanding of the meaning behind these circumstances by conducting interviews. At that stage I was not enrolled on an academic programme, and to embark on research would mean foregoing supervision throughout the process. I was entirely inexperienced in research methods, and my resources were limited.

[1] 'Modernisation' and 'development' encompass a range of meanings. In my essay they will be used

The circumstances were not ideal, but I went ahead with the project. I was aware of my privileged position; having lived in the community for some time I knew many people who would be willing to participate.[2] I felt confident I would be able to elicit honest responses, and was uncertain that this would remain the case if I attempted the research after having left Botswana. In addition, I would be financially unable to return after commencing postgraduate study. To compensate for the pitfalls of conducting research outside of academe, I consulted a wide variety of literature regarding research methodology and practice. I sought guidance from a professional academic friend who had conducted similar work, and who advised me generously. Aware of the potential ethical dilemmas of my project, I avoided raising personal experiences with abortion when I questioned my participants. I conducted interviews with 21 Batswana, questioning how they feel about abortion and other related issues.

This dissertation will begin with an introduction to the contextual setting of my research and a review of the literature (Chapter One), followed by a methodology chapter (Chapter Two). I will evaluate data from my interviews, and my analysis will be divided into three key sections. The interview data will be my primary source, although I shall draw on contemporary articles from a selection of local newspapers. In Chapter Three I will examine the ways one might procure an abortion in an illegal setting. I shall discuss 'backyard' abortion, illegal medical abortion, travelling abroad, and the phenomenon of 'baby-dumping' as a way of avoiding childrearing whilst circumventing abortion. Chapter Four will discuss why abortion is a difficult topic in Botswana. I will illustrate how social, cultural, religious and legal factors affect the way abortion is perceived as problematic. In Chapter Five I shall focus on the circumstances in which abortion might be considered permissible. I will present my conclusions in Chapter Six.

The situation of women in Botswana must be appreciated in order to understand the problem of unsafe abortion. There is notable tension between traditional culture and the new values accompanying development. 'Cultures resistant to women's equality with men have unselfconsciously perpetuated women's subordination and powerlessness as a "natural" condition of family life and social order so profoundly as often to render women's disadvantage invisible' (Cook and Dickens, 2003: 59). This quote is pertinent in the case of Botswana where the notion of submissive obedience for women has permeated socialisation to the extent that it can be difficult to recognise (Kinsman, 1983; Datta, 2004: 261). In the gender-related development index Botswana ranks 109 out of 157, illustrating

[2] For a detailed discussion of the 'insider/outsider' dynamics of my situation, and other methodological issues, see Chapter Two.

that gender inequalities remain an issue (The World Bank, 2011). Whilst some women have begun to live relatively independent lives, they 'continue to negotiate their gender identities against a background of internalised cultural values' (Mookodi, 2004: 127).

Many women in Botswana today live simultaneously modern and traditional lifestyles. They share their time between their rural home and their city workplace, increasing their independence and yet continuing to operate within the customary patriarchal system. An NGO study (BONELA, 2007) found that young people in Botswana expect women in rural communities to be subservient, yet view women in the city as determined to seize their independence. The boundaries of patriarchy in Botswana are becoming increasingly fluid as women begin to move away from their traditional gender roles (BONELA, 2009). I shall examine the prominence of traditional views about women's reproductive autonomy among my urban interviewees.

Traditionally, the *Lobola* (bride price) system represented the purchase of a woman's reproductive function, moving it from her family to her husband's family. Having paid this, the new husband was entitled to total sexual and physical control over his wife under customary law (Schapera, 1984; Maharaj, 2001). Customary law operates alongside common law today, but is ring-fenced and thus not subject to constitutional obligations which protect women's rights. The historical practice of *lobola* persists.[3] Women's ability to resist a situation where they have little or no bodily autonomy continues to be undermined by their economic dependence on men (Phaladze and Tlou, 2006). Whilst employment in the formal sector is beginning to open up for women, it is limited and positions reserved for women are low-paid; most women are low-income domestic workers (ibid.). This situation supports the continuation of unequal marriages, and pushes unmarried women into exploitative interactions with older men who can supply them with the goods and services they require. Within these relationships women's reproductive decision-making powers are likely to be compromised by their subordinate position, which is both culturally perpetuated and economically necessary for their material survival (Phaladze and Tlou, 2006).

Gendered rules of behaviour mean that if a woman is raped she was 'asking for it' by acting inappropriately (Mathangwane, 2001). STDs are generally perceived to be women's diseases; some believe HIV can only be contracted from a woman (Phaladze and Tlou, 1996). This belief system extends to holding women culpable for unintended

[3] The practice is beginning to fade in young, urban generations. However, the belief system behind it has proven durable and the historical exchange of cattle for a wife has, arguably, been replaced by a more nuanced 'payment' in the form of cash and material goods over a period of time.

pregnancies; it is thought that they risk pregnancy by choosing to have sexual intercourse. To have an abortion is hence viewed as avoidance of responsibility; the woman must bear a child as punishment for her lascivious behaviour (Cook and Dickens, 2003). In a nation where men generally dominate sexual decision-making, this punitive approach has especially vicious consequences for women's health rights. Holding women at fault for negative aspects of sexual health and behaviour is a theme which I shall discuss in my analysis of attitudes to abortion.

Botswana has seen great social change since independence, although the benefits of modernisation have unevenly favoured men. The unemployment rate for women is consistently higher than that for men (Mookodi, 2004) and there is no space for women to participate genuinely and effectively in law or politics (Dow and Kidd, 2007). Botswana's system is inherently contradictory; a modern, democratic state, proclaiming the equal rights of all citizens; it is still fundamentally patriarchal (ibid.). Current restrictive abortion laws, high levels of domestic violence against women, and increasing incidence of rape would suggest that society's gravitation towards individualistic, autonomous lifestyles has not extended into the realm of women's bodily autonomy. I shall explore this idea in my examination of attitudes to abortion; and this will function as a lens through which to view developments in women's sexual empowerment, be they actual or perceived changes.

The government of Botswana, aided by NGOs and donor agencies, has made some important commitments to establishing women's rights (Datta, 2004). These include the formation of the Women's Affairs Division and the accompanying National Gender Framework; Vision 2016, which is rooted in national principles of democracy, equality and autonomy; the Platform for Action following the 1995 Beijing World Conference on Women; the signing of international instruments for gender equality, including the UN Convention on the Elimination of All Form of Discrimination Against Women (CEDAW), the Southern African Development Community (SADC) Declaration on Gender and Development and the Protocol to the African Charter on the Rights of Women; Millennium Development Goals; the Declaration of the International Conference on Population and Development; the Constitution; National Development Plan 9 (NDP9); and the instigation of a comprehensive review of gender-discriminatory laws which has resulted in numerous reforms (Datta, 2004; Women's Affairs Dept., 2004). Despite this impressive inventory of programmes aimed at eradicating gender inequality and advocating women's health rights, women continue to be socialised into subservient, dependent roles, unable to participate in sexual-decision making and thus made vulnerable to rape, forced pregnancy and unsafe

abortion. 'Tradition' is invoked all too often as a defence against the gendered roles that hinder women's autonomy (Women's Affairs Department, 2000).

The government claims it is committed to revising all discriminatory laws, and altering the damaging cultural attitudes that currently prevent women from making full use of healthcare and family planning resources. Botswana is signatory to international instruments that specify the importance of women's sexual and reproductive health and rights. This includes CEDAW, which states that withholding medical services needed only by women, such as abortion, is discriminatory (General Recommendation 24). Yet, the Abortion Act has not been included in the State's otherwise extensive legal reforms. Failure to acknowledge that a restrictive abortion law damages women's health contradicts the government's pledge to address gender equality in the law. My research will address people's perceptions of the legal status of abortion in an attempt to uncover the meaning behind this inconsistency.

Botswana's healthcare system is funded by 18% of the total budget (The World Bank, 2010), and resources are distributed throughout rural areas via an outreach system. The country has witnessed rapid fertility decline, from 7.1 in 1981 to 2.9 in 2007 (The World Bank, 2011), and 2.5 in 2011 at the time of my research (CIA World Factbook, 2011). Fertility according to education level shows marked disparity. The fertility rate for women with no formal education is 5.8. For university-educated women it is 2.7 The fertility transition is partially a result of the family planning programme in Botswana, deemed the most effective in Africa; it is incorporated into maternal and child health services and is free and accessible (The World Bank, 2010). By 2007 95% of the population lived within 8km of a healthcare facility and 90-99% of births were assisted by skilled birth attendants. In 2010 only 1% of births did not take place in a clinic or hospital (Central Statistics Office, 2011). 94% of women receive antenatal care (The World Bank, 2011).

Despite improvements in reproductive health, maternal mortality remains very high and its causes must be addressed (Government of Botswana and the National Preparatory Committee for the Regional and World Conferences on Women, 1995).[4] The MDG target 5A is a reduction of the maternal mortality ratio by three quarters between 1990 and 2015. A lack of baseline data has resulted in imprecise measurement,[5] although varying data

[4] There are no available data on maternal morbidity in Botswana which limits discussion of this aspect of reproductive health, but it must be kept in mind that for every maternal death, many more women suffer from non-fatal complications of pregnancy, abortion and childbirth.

[5] Maternal death was classified as a notifiable event in 2006 (The World Bank, 2010), resulting in more comprehensive data collection from clinics and hospitals. However, 'unknown' causes still

sources give an impression of the situation. Figures vary from 163 to 800, although 200 to 300 is the most frequently cited range (Women's Affairs Dept., 1995; Emang Basadi, 1996; CIA World Factbook, 2008; Central Statistics Office, 2011). Botswana's MDG target for 2015 is 21 (The World Bank, 2011). Set against this goal, even the lowest figures for maternal mortality suggest inadequate progress.

A significant cause of maternal mortality in Botswana is unsafe, illegal abortion. This seems to have been increasing since the 1990s, which could be a result of the desire for smaller families (Henshaw et al, 1999). 3,700 women were officially treated for complications of unsafe abortion in 1992 (UN, n.d.), which amounts to around 3% of the 1992 population. In 2007, 16% of maternal deaths were attributed to septic abortion (The World Bank, 2010). In 2010, deaths from abortion complications were the leading cause of maternal mortality at 13.4% (Central Statistics Office, 2011).[6] It must be noted that some women suffering from the medical consequences of unsafe abortion may present with miscarriages or unknown causes to protect themselves from the law; many more women will not receive treatment at all. Under-reporting is the likely result.

The total annual cost of post-abortion care in Sub-Saharan Africa is between $80m and $145m, and this would be doubled or more if all the women who needed such care actually received it (Vlassoff et al, 2009). The psychological and personal costs for women are great. Depression, confusion and guilt often follow abortion (Paxman et al, 1993). Suicide associated with the turmoil of unwanted pregnancy and abortion is yet another cost (Barreto et al, 1992).[7] Vlassoff et al (2009) call attention to indirect costs to households and society. Inter-generational productivity is affected by maternal deaths or morbidity in the family and this has repercussions for the economy.

Abortion was illegal in Botswana until 1991, when amendments were made under the Penal Code (Amendment) Bill. Pregnancy could be legally terminated within 16 weeks of conception under the following conditions: if the pregnancy was caused by rape or incest, to save the life of the mother, or in the instance of foetal impairment. The UN (n.d.) warns that despite this liberalisation of the abortion law, dangerous, illegal procedures occur regularly in Botswana. Bureaucratic delays, lack of clearly defined protocol, attitudes of health facility staff, shortage of sites where the procedure may be carried out, shortage

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constitute 6.1% of deaths (Statistics Botswana, 2010) and no account is taken of non-institutional deaths.

[6] After abortion-related deaths, the biggest known causes were respiratory diseases (11%). HIV-related causes (9.8%), protozoal diseases (8.6%) and eclampsia (7.3%) (Statistics Botswana, 2011).

[7] The study by Barreto et al (1992) is based in Latin America, but I have drawn on it here for the parallel incidents of suicide related to unwanted pregnancy in Botswana, as reported in local newspapers.

of doctors and women's lack of knowledge of their rights under the law, all contribute to denying access to the procedure even where it would be legal.

Abortion outside of the permitted circumstances is illegal. The sentence for aiding an abortion carries a maximum of seven years imprisonment. A woman who attempts the procedure herself is liable to three years imprisonment. Criminalising abortion contributes to economic injustice in developing countries (Henshaw et al, 1999; Benson, 2005). Access to safe abortion and/or quality aftercare is usually restricted to women who have access to funds. Those without such means become the victims of dangerous clandestine procedures (Paxman et al, 1993). This is applicable to Botswana where those with sufficient finances and freedom of movement can procure safer illegal services from a qualified practitioner, or travel to neighbouring South Africa to access legal abortion. However, most women needing abortions are restricted to 'backyard' services.

While police and newspaper reports must be treated with caution, they strongly suggest that 'backyard abortion', 'foetus-dumping' and 'baby-dumping' occur regularly. In the local context, backyard abortion is a common term for unsafe abortion. This is defined by the WHO as a 'procedure for terminating an unwanted pregnancy done by persons who may lack the necessary skills or conducted in an environment that lacks the minimal medical standards, or both' (cited in Benson, 2005: 189). Foetus-dumping refers to the concealment of a foetus following an abortion, usually buried in pit-latrines or flushed down toilets. Baby-dumping is closely linked with infanticide, and involves the abandonment of a new-born child. In some cases the child is killed and the body is hidden, in others the child is left alive in a public place such as a hospital. It is important that this effect of criminalising abortion is acknowledged and monitored as far as possible. It is likely that incidences of baby-dumping would be dramatically reduced if abortion was legal and accessible. One aim of my research is to contribute to creating a dialogue around this issue.

The 'pro-life' (anti-abortion) argument is commonly grounded in the idea that termination of the foetus is tantamount to murder. The debate surrounding the Penal Code (Amendment) Bill gave voice to vigorous disagreement from the Botswana Christian Council who took this approach (Mogwe, 1992). However, the Penal Code states, 'a child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother.' Botswana's law does not appear to have any legitimate base in the pro-life paradigm, and the government's pro-active approach to revising gender-discriminatory laws implies that it is not simply an outdated piece of colonial legislation. Rather, there are contemporary grounds for denying abortion on demand. In the context of Botswana's notable democratic record, it is reasonable to expect that the law reflects the values of

society. This prompted me to explore attitudes to abortion, in order to find out if there are socio-cultural explanations for the criminal status of abortion.

Understanding the conception of motherhood in Botswana will aid my analysis of the way abortion is perceived. Motherhood is rooted in traditional culture as a vital indicator of womanhood. This has not diminished with modernisation. Childless women are treated with suspicion and suffer harsh consequences (Gage-Brandon and Meekers, 1993; Phaladze and Tlou, 2006). Schapera (1984) emphasises how having and raising children is the cornerstone of the family and society in Tswana culture. Sexual and social practices are deliberately created to maximise reproductivity. The primary reason for marriage is the production of offspring. Children are seen as key sources of labour and they help strengthen important family ties (Dow and Kidd, 2007). A woman becomes an adult on becoming a mother; women are re-named in relation to their first child (for example 'Mma Kgosi', meaning 'Mother of Kgosi'). Being able to bear children continues to be central to women's identity, and a point of great personal pride. To be perceived as infertile 'is to risk characterisation as an individual who is not seen as a Motswana' (Upton, 2001). Traditionally, the blame for infertility was placed on witchcraft or a past abortion (Schapera, 1984). Today it is still widely considered that a man cannot be infertile; the responsibility for childlessness must fall upon the woman (Upton, 2001).[8] In this context, perceptions of abortion are inextricable from perceptions of motherhood; to terminate a pregnancy is to deny child-birth.

Literature review

Mogwe (1992) outlines the key points of debate that surrounded the Penal Code (Amendment) Bill of 1991. The Catholic Church, backed by the leading opposition party, actively resisted the reforms. The bill was finally passed as a result of pressure from the medical profession seeking to protect themselves from the law, rather than from public demand for women's rights. Mogwe challenges the extent to which abortion law reform has actually increased women's bodily autonomy in Botswana; she argues that the extent to which the law enables women to procure abortions is dubious, particularly as they must secure a conviction through the courts to receive an abortion on grounds of rape or incest.

Notwithstanding Mogwe's article, there is little academic work that discusses abortion specifically in the context of Botswana. I have been able to gain a limited

[8] Women have deployed covert devices to negotiate problems arising from uncertain fecundity in their husband. Narratives of 'sleeping foetuses' to explain how a woman became pregnant while her migrant worker husband was away, is just one example (Upton, 2001). Despite such evidence of women's agency, the literature is weighted towards the devastating impact of infertility on women.

understanding of the situation by reading more widely around issues of women's health in Africa. The literature on aspects of Botswana's culture, society and history has helped me to situate my own research in a wider context. In addition, official publications from the government of Botswana and its partners in policy-making provide some useful information on women's reproductive health and rights.

Kinsman (1983), Schapera (1984), Suggs (1987), Maharaj (2001), Datta (2004), Mookodi (2004), Mogobe (2005), Phaladze and Tlou (2006) and Dow and Kidd (2007) have extensively explored the position of women in traditional Tswana culture. They highlight the gender imbalances created by a patriarchal socialisation process. Women are expected to be subservient not only to their husbands and fathers, but to all men. Schapera (1984) and Maharaj (2001) have given the customary-law practice of *lobola* ('bride price') substantial attention, as it underscores women's situation with regards to their bodily autonomy. Understanding the dynamics of *lobola* is useful for investigating contemporary issues of sexual and reproductive choice, potentially illuminating perceptions of abortion.

The capital Gaborone, where my study is based, is beginning to witness changing norms in family structure, including increases in cohabitation and extra-marital pregnancy. Mookodi (2004) attributes this to a greater desire for autonomy in the face of new education and employment opportunities for women. However, the belief that 'motherhood is rather a mandate and not an option' (Mogobe, 2005: 33) prevails, severely limiting women's prospects for control over reproductive decisions. Researchers (Schapera, 1984; Gage-Brandon and Meekers, 1993; Upton, 2001; Mogobe, 2005; Phaladze and Tlou, 2006; Dow and Kidd, 2007; Main, 2007) have explored the meaning of motherhood in Tswana culture, emphasizing that bearing a child is tantamount to womanhood. Contributing to my understanding of motherhood in Botswana, Mogobe (2005) details the multiple ways in which being perceived as infertile can destroy a woman's social standing and identity. Peters (1983) calls for further investigation into interactions between women and men in the context of developmental changes; my research into the socio-cultural aspects of abortion in urban Botswana will add to this. I will use others' research on attitudes to child-bearing and infertility to help me reflect on how termination of pregnancy is viewed by the Batswana interviewed in my study.

Barreto et al (1992), Gage-Brandon and Meekers (1993), Henshaw et al (1999), Teklehaimanot (2002), Brookman-Amissah (2004), Hord and Wold (2004), Benson (2005) and Vlassof et al (2009) have discussed abortion in the African context. Where Botswana is mentioned it tends to be grouped with the Sub-Saharan region as a whole. These studies shed light on the general dynamics of abortion, but merging one nation into a regional

compound is problematic. Countries in Sub-Saharan Africa differ significantly from one another in terms of their culture, political stability, economy and social structure, and do not share a common history. This compromises the efficacy of this grouping for discussion of sexual and reproductive health matters. I will focus singularly on Botswana; how perceptions of abortion are shaped by its culture and society, and how the procedure can be accessed there despite legal restrictions.

Coeytaux (1988), Paxman et al (1993), Henshaw et al (1999), Potts and Marks (2001), Teklehaimanot (2002), Brookman-Amissah (2004), Hord and Wold (2004) and Vlassoff et al (2009) have examined the costs of unsafe abortion. They focus heavily on health-care system costs. Whilst the cost of illegal abortion is a strong argument to present to policymakers in a campaign for law reform, it is not my key focus. Rights to bodily integrity are of equal importance and my analysis will be weighted towards this paradigm. Teklehaimanot (2002), Sai (2004) and Benson (2005) have discussed the possibilities for a human rights approach to abortion law reform, emphasizing that reproductive autonomy is a basic right, regardless of the legal context (Benson, 2005). However, until we begin to develop a localised understanding of how unsafe abortion is constructed and dealt with, attempts at generating effective solutions will be limited.

To some extent, inferences about the socio-cultural aspects of abortion can be drawn from literature that explores identity, family planning, motherhood, teenage pregnancy, infertility, HIV/AIDS, rape, domestic violence, and the status of women in Botswana. However, Coeytaux (1988), Barreto et al (1992), Paxman et al (1993) and Brookman-Amissah (2004) have called for qualitative work which addresses the absence of socio-cultural research focusing specifically on abortion. NGO Emang Basadi has called for studies which investigate the beliefs and attitudes of men and women in regard to family planning (1996).[9] My study is a contribution to this effect.

The literature on unsafe abortion in developing countries focuses on maternal mortality and morbidity. It emphasizes that 'It is the number of maternal deaths, not abortions, that is most affected by legal codes' (Jacobson, cited in Paxman et al, 1993: 218). This signifies that rather than reducing the number of abortions taking place, legal restrictions on the procedure serve to create a market for unsafe, clandestine services, increasing the risk of complications and resulting maternal deaths. Hord and Wold (2004) discuss how dangerous problems such as infection, haemorrhage, perforation, infertility and pelvic inflammatory disease are almost totally preventable if procedures are done

[9] *Emang Basadi* translates as 'Stand Up Women!' in Setswana.

safely, and yet resources directed at reducing complications from unsafe abortion are too minimal to be effective. They blame this situation on the stigma surrounding sexual and reproductive concerns in Africa, which my interviews suggests is a legitimate claim in the case of Botswana. Mogobe et al (2007) examine the situation in Botswana; sexual and reproductive services are supplied free in government clinics and hospitals, and yet alarming maternal mortality levels persist. In agreement with Hord and Wold, they attribute the high number of abortion-related deaths to the cultural stigma which prevents women from seeking medical attention for complications of unsafe procedures, and to Botswana's restrictive law pushing women to clandestine providers.

The official 'Policy on Women in Development' declares the State's dedication to promoting reproductive health rights (1995). We see this pledge repeated in multiple reports and publications. In these papers, discussions of rape, contraception, family planning, teenage pregnancy, HIV/AIDS, maternal mortality and other related issues are extensive. Abortion is given only a cursory mention as one cause of maternal mortality and is not investigated further. The government of Botswana and UNICEF (1989) acknowledged the tragic consequences of an increase in backstreet abortion in the late 1980s, yet only six lines are reserved for this issue within a 253-page publication. The government (2001) has continued to confirm that illegal, unsafe abortion is a regular occurrence in Botswana.

Official reports are somewhat useful for my research, in that they outline the country's goals, achievements and strategies in the arena of women's health and rights. This allows me to gauge the extent to which abortion-related concerns support or contradict the perceived stage of development in these issues. However, they are limited in that they only state what ought to be happening, what improvements have been attempted and the statistical impact of these changes. They cannot be said to represent lived experience or attitudes; people's voices are not heard through numerical data. It is imperative that investigations of beliefs and knowledges are carried out so that we can gain an understanding of the context of unsafe abortion, which may help pave the way for a thorough investigation of the problem.

Among the literature I reviewed a small number of studies were based on the voices of the Batswana rather than on statistical data (Upton, 2001; Datta, 2004; Mogobe, 2005; Ritsema, 2008). Datta's research on gender and development involved interviews being conducted with official representatives in government and NGOs, as well as focus group discussions with groups of men. Ritsema's illuminating study on HIV/AIDS in the context of rapid urban growth in Botswana presents a similar methodological framework as my own research, in that it is comprised of opportunistic selection of interview

respondents. Mogobe's study of infertility was based on interviews with people living in Gaborone and encompassing a range of demographic attributes. Whilst there are some important methodological differences, I can draw significant parallels from my work to the valuable research discussed above, specifically in the use of my interview data. These studies will be utilised both for content and method.

In this chapter I have introduced my research project and provided general and topical background information on the country in which I conducted the study. I have examined the existing literature that is relevant to my work and situated my own research within it. In the following chapter I will discuss the methods I used to generate data, and the practical and ethical issues I encountered in the process.

Chapter Two: Methodology

In this chapter I will outline the methods I used to conduct my study and the theoretical and practical justifications behind them. I will discuss my ethical considerations at each stage of the process, the problems I encountered throughout and the effects they had on the research. Qualitative research is vital for 'understanding the cultural and social context of abortion and its social epidemiology' (Coeytaux, 1988: 188), and is the only appropriate technique for investigating illegal activity (ibid.) Attitudes to abortion are fraught with ambiguity; a qualitative approach was the best method for gathering data on a topic that is embedded in subjective experience. Qualitative research aims to develop an understanding of certain complexities within the views of individuals (Rubin and Rubin, 1995). I used qualitative interviews to explore how individual people think about abortion and the meanings they create in doing so (Ambert et al., 1995). As a secondary data source, I used local newspaper articles from *The Daily News, Botswana Gazette, Mmegi* and *Sunday Standard* to help situate interview content within the contemporary context of abortion in Botswana.[10] I accessed these articles using a keyword-search in online archives, specifying the same date range (1990-2011) and used the same key-words (abortion, foetus-dumping, baby-dumping, infanticide, and pregnancy) for each newspaper to aid consistency.

I was committed to a feminist focus in my research. This meant exploring abortion in Botswana as an issue of concern for women that is shaped by their oppression, as 'abortion behavior is inextricably connected with issues of women's roles and opportunities' (Coeytaux, 1988: 189). The gender equality movement in Botswana is progressing at a slow pace and women remain marginalized. Their inferior social status is most apparent in the domain of sexual and reproductive issues, and the taboo surrounding sex has restricted the creation of conditions in which women can be heard on these matters. In my research I aimed to access the views of a group of individuals whose voices would otherwise remain unarticulated (Hesse-Bieber, 2007). I acted to minimise the possible objectification and exploitation of participants by acknowledging my responsibility to them at all stages of the research (Acker at al., 1983; Forbat and Henderson, 2005). In line with feminist methodology, I maintained an awareness of my positionality, reflecting on how my 'specific social, economic and political context affect[ed] the process at all levels' (Hesse-Bieber, 2007: 129). This affected the way I interacted with my participants, how I formulated interview questions and my approach to the analysis process. The

[10] *The Daily News* is a government-produced newspaper. The other publications are considered to be politically 'neutral'.

feminist methods I employed and my reflexive analysis will be discussed at length in this chapter.

My research site was Gaborone, the capital city of Botswana. I chose my research site for a combination of theoretical and practical reasons. Urban society in Botswana is in a constant state of flux as a result of rapid economic development since 1966. Western influences are abundant. Attitudes are transforming from conservative, community-based, religious world views, towards a liberal, secular, individualistic and material lifestyle. However, traditional Tswana culture is by no means obsolete, and many people live simultaneously 'modern' and traditional lifestyles. The primary aim of my study was to investigate socio-cultural views surrounding abortion. The socio-cultural transformations being experienced in the city at the time of my research (2011) offered a complex and dynamic research site. The decision to conduct interviews with people living or working in Gaborone was compounded by practical considerations. I did not have access to my own vehicle, and public transport to other areas of the country was unreliable, unsafe and time-consuming.

I attempted to use snowball sampling to recruit participants for my research. Snowball sampling is a useful method in situations where access is difficult, such as when researching a sensitive topic (Brown, 2005; Cohen et al., 2007). My rationale for choosing this method was the sensitive nature of abortion in Botswana, both as a cultural taboo and as an illegal activity. A certain level of trust is therefore required to discuss this topic. For this reason I would have struggled to enrol total strangers in my study. A relationship or connection with the interviewee aids communication by encouraging empathy (Ambert et al., 1995),[11] and snowball sampling allows for friends of friends to ask questions about the researcher and the interview process (Brown, 2005). For example, one of my respondents reported back to me that when discussing my study with her friends, they had reacted with suspicion which was neutralised after my respondent's assurances about me as a person (Masego, *personal communication*, 2011). I asked respondents at the end of each interview to name people they thought would be willing to participate.

I had some success with this method and accessed two thirds of my sample this way. Whilst the snowball sampling technique was useful in later stages of data gathering, the reliability of the method was weakened by the absence of a randomly chosen initial sample. My social and work network in Botswana was small, limited by my 'particular

[11] Brown (2005) writes that people may prefer to talk about taboo subjects with somebody they will have no further contact with. On the contrary, I found that the participants that I had the strongest relationships with were the most 'open' in their interviews.

components of class, gender and culture' (Fleishmann, 1996: 355). This resulted in entirely opportunistic recruitment of the initial group. Around one third of the interviewees were members of my personal group of friends and acquaintances, selected for ease of access (Heckathorn, 1997). For this reason, my sample is exploratory rather than representative. Snowball and opportunistic sampling gives credence to the individual worth of one's participants (Holstein and Gubrium, 1995), and 'may complicate description of culture and experience writ large, but enables and encourages representations of diverse and complex experience' (ibid: 25-26).

Because of the social nature of the interview, 'bias is often inevitable and needs to be recognised and controlled. One way of doing this is by having a range of interviews with different biases' (Cohen et al., 2007). Whilst this was not my primary aim in sampling, this approach informed the process. I selected participants with varying relationships to myself and to the research topic. Although respondents were from a small social network and therefore shared key demographic characteristics, I was able to secure some variation across the sample.[12] This helped to prevent one form of bias from dominating the research. It enabled me to make some connections between what participants said about abortion, and their age, sex, education level, family background, religious affiliation and where they were from. Where small numbers are involved, aiming to select a representative sample of all 'types' of people would be to assume that one or two individuals can speak for all others of the same attributes, e.g. mothers, young people, or educated people (Brown, 2005).

I made initial contact with most of my interviewees in person, or otherwise by telephone or email. Reactions to my requests for interviews were mixed. In traditional African culture social research may be treated with suspicion as a result of historical experiences of exploitation, and perceived as an alien western activity. Some people were suspicious of my motives, asking 'why do you want to know about that?' in a defensive or confused tone. Those of very traditional backgrounds responded with uncertainty and a small number were hostile to the idea. However, the majority of the people I approached showed an eagerness to be interviewed, even before I had explained the subject matter. This may reflect the abundance of 'celebrity culture' in Gaborone, where interviews are a mainstay of popular gossip magazines and television shows and have come to be considered as a legitimate form of gathering information.

Arranging interviews was the most practically difficult part of the process. In Botswana plans are rarely made in advance, and even pre-arranged meetings are regarded

[12] See Appendix I for tabulations of the demographic attributes of my sample.

as flexible. Trying to arrange a meeting often resulted in the response 'oh, just find me when you want to do it'. Of course, as all of my sample were busy, mobile people, this was rarely possible. I missed out on interviewing two people who had agreed to take part, due to them repeatedly rescheduling until it was too late. However, most of the participants were keen for their interviews to happen, and I was able to secure meetings after a number of attempts to confirm details.

In addition to the 19 respondents who participated in the study, I interviewed two individual women who have had professional involvement with the issues raised by abortion in Botswana. I hoped to acquire information about these matters from a different perspective than that of the interviewees with no professional interest in abortion or women's rights. I interviewed a human rights lawyer who has published research concerning abortion in Botswana (Mogwe, 1992), and through the snowball sampling technique I was put into contact with a former obstetrician who now specialises in women's health research. While I used a standard (albeit flexible) interview guide for the majority of the participants,[13] I tailored my interviews with these professionals to make the most of their unique knowledge base. Both women were Motswana, living and working in Gaborone. Their demographic attributes were therefore not at odds with the sample, enabling cross-comparison of data between respondents and professional informants. Selecting professional informants can minimise bias by 'reduc[ing] the tendency to exaggerate socially acceptable behaviour and understate disreputable behaviour' (Heckathorn, 1997: 175). However, as both informants proclaimed a belief in legal and social reform in Botswana, I was aware of the potential biases of a vested interest in my research.[14]

There were many practical restrictions on my participant recruitment, including my lack of transport, negligible financial resources and time. Language was perhaps the greatest barrier as I did not speak fluent Setswana. While most Batswana speak some English (it is an official national language), it is usually only middle and upper classes that are fluent. I considered working with a translator, but concluded that the time demand on the translator would be too heavy. In addition, Setswana is a language steeped in metaphor and symbolism and much of what might be said would be impossible to translate directly. I could lose nuances of meaning as a result and impair the interview analysis. Having decided to limit my sample to fluent English speakers, I was simultaneously limiting my sample to

[13] See appendix IV.

[14] Whilst the professional nature of key informants' potential vested interest warrants concern, this issue was not absent from the rest of my sample, who may also have had a vested interest in the research as a result of being strongly pro-abortion or anti-abortion on a personal level.

the well-educated, middle-class, urban dwellers. Consequently, my sample is not generalisable to the population of Botswana, 61% of whom are rural dwellers (CIA World Factbook, 2010).

My sampling method resulted in an uneven distribution of demographic attributes across the participants. The total number of participants was 21. All of the participants were black and citizens of Botswana by birth. 17 were women, four were men. A high number of interviewees worked in the domain of education, either as teachers or students. It is difficult to know how far this represents the labour force of Botswana as there are no data for the occupation of residents. However, I did not anticipate job type to have a notable influence on the interviewees' perceptions. Only one participant was over 50 years of age, and the 31-40 years category had the most members. The available data on the age distribution of the population are presented in categories too large to be comparable with my own. However, they show that Botswana's population, like my sample, is relatively young.[15] Despite this, it would have been preferable to secure interviews with more people of older generations for the sake of cross-comparison of their views with younger people.

No respondent had more than three children and many had no children. While that may be comparable with the population at large whose average fertility rate is 2.5 (CIA World Factbook, 2011), it could be detrimental to my analysis as it can be expected that high fertility might be of some significance in shaping opinions about abortion. Most interviewees defined themselves as Christians, which corresponds to the national figure of 71.6% Christian affiliation (CIA World Factbook, 2001). All of the interviewees possessed a minimum of GSCE (or equivalent) education, which places them above the national average education level of 12 years of age (CIA World Factbook, 2007). They all lived and worked in Gaborone; some were raised in rural villages before moving to the city and some were born in urban areas. This is not representative of Botswana's population where 61% live in rural areas (CIA World Factbook, 2010).

As I aimed to conduct feminist research, I focused on interviewing women. However, many of these women said 'why don't you ask the men?', and stated strongly that men should have to answer questions about a problem that men were perceived to be responsible for (unwanted pregnancy). In addition, as my focus was on opinions rather than experience, I thought the views of men could be important in assessing the way abortion is

[15] Estimated figures in 2011: 0-14 years: 33.9%, 15-64 years: 62.2%, 65 years and over: 3.9% (CIA World Factbook, 2011).

socially constructed and how it relates to women's autonomy. Whilst the men provided some interesting insights into the underlying gender relations at play, I soon realised that their perceptions lay outside the boundaries of my commitment to feminist research, and I intentionally limited the number of men I spoke to so that their inclusion would be an additional dimension, rather than a core to my research.

Qualitative, open-ended interviews encourage gaining an insight into the world-view of the individual (Cohen et al. 2007), and are suitable for eliciting respondents' opinions about abortion as a personal and sensitive issue. Holstein and Gubrium (1995) explain that 'with increasing deprivatization of personal experience, and development of the interview society, interviewing is increasingly becoming a naturally occurring occasion for articulating experience' (18). Feminists assert that structured interviews reinforce a traditionally hierarchical relationship between researcher and researched by allowing the participant little control over the process. However, interpreting and answering questions that are completely open-ended can be confusing and put interviewees under pressure (Silverman, 1993). Using semi-structured interviews in research balances these concerns by allowing the researcher to generate the data required to cover her domains of enquiry, whilst still creating space for the participant to talk about what they feel is important (Hesse-Bieber, 2007). Whilst I aimed to explore pre-established areas of enquiry, I began the interviews with only vague theoretical ideas, allowing concepts to emerge from the meaning-making process of interviewing (Ambert et al. 1995).

Ethical considerations were paramount to the research process. I took care to ensure consent was informed and voluntary. I verbally explained the purpose of the study on initial contact, and again at the beginning of the interview. I gave an information sheet in advance of meeting with subjects.[16] This contained details of the reasons for my project, my own background, all potential uses of the interview data and my full contact details. It clearly stated that information would be kept confidential, that anonymity would be assured through the use of a pseudonym when quoting the data, and that no information that could be used to identify the participant would be made public. It outlined the right of the participant to decline any question they preferred not to answer and to stop the interview at any time. It indicated how the interviews would be conducted and that they would be digitally recorded. All informants signed a consent form at the beginning of the interview.[17] In doing so, they agreed that they understood the purpose and procedures of the study and the interview; that they were free to withdraw consent and discontinue

[16] See Appendix II.
[17] See Appendix III.

participation in the study at any time; that the interview would be digitally recorded and transcribed in full; that they permitted their words to be quoted directly under a pseudonym to protect their anonymity; that I might publish documents containing quotations by them and that they granted copyright permission to the researcher for the purpose of publication.

I conducted interviews with colleagues in a spare room at our mutual workplace. Others I visited in their office or home. My personal safety was not compromised at any point. All interviewees were known people, and I was accompanied in instances where I travelled outside of my workplace to conduct interviews. When visiting people in their homes I took biscuits as a gesture of gratitude. However, in only three instances did I carry out an interview in respondents' homes, as it is generally considered intrusive unless one knows that person very well. When meeting at my home or elsewhere I made tea, coffee and biscuits available wherever possible to create a welcoming atmosphere.

There were a number of interruptions throughout my interviews. These included children, husbands, household staff or colleagues entering the room. There was one incident in which a fire alarm sounded repeatedly. In another incident I had no choice but to interview a respondent during her work shift at the library, in between her signing out books for customers. I didn't find these interruptions to be damaging to the interview process; rather, they acted as an effective ice-breaker in some instances. Throughout my interviews respondents were cooperative and interviews were taken seriously. The given responses didn't always correspond to specific focus of the question (Fleischmann, 1996). In many cases, I perceived that interviewees were presenting a culturally-defined moral stance, rather than exploring strictly personal feelings and ambiguities around the issue of abortion. This was indicated by heavy use of the modal verbs 'should' and 'must', and distancing techniques, such as referring to Batswana as 'they' rather than 'us'.

My inexperience in interviewing caused several problems, particularly in earlier interviews. The most salient were that I talked too much and failed to follow up on important points. There were many instances where I paid too much attention to covering everything in my interview guide, and not enough to what the speaker was trying to say. 'The artfulness of doing that in-depth interview is to know when to follow up on what a person is saying in the moment' (Karp, D., cited in Hesse-Bieber, 2007: 122). There were occasions where a respondent made an interesting and unexpected point, and I missed out on rich information by failing to encourage elaboration or ask follow-up questions:

> *Researcher*: So, if a woman became pregnant in any unfavourable circumstances as far as she was concerned, or her family, who would usually be involved in the decision about whether or not she would have an abortion? Who would it rest with? Who would be involved? Who would get the final say?
> *Masego*: I think probably the man.

In the above instance the respondent said something that was potentially very rich in meaning, such as her reasons for suggesting that the man would have the decision-making power in this situation. However, after clarifying that she was referring to the father of the baby, I moved on to other questions. This problem became less acute as I progressed through the interviews, gained in confidence and experience, and reflected on my mistakes throughout the process. I adjusted my interview guide after every interview, changing the order, adding questions and re-wording, and found the improvements effective. As new themes emerged from the interviews and I increased the number of questions, I returned to participants I had interviewed early in the study to ask them follow-up questions based on the emergent concepts. This method was met with varying success. Those whom I was able to contact responded thoroughly, but I was unable to contact many people due to it being the school holidays, a time when people working in the city often visit family in rural areas.

I was eager to ensure that the respondent understood what I was trying to ask, and misinterpreted their pauses as uncertainty about the question. In such cases I would immediately offer a clarifying example rather than allowing the interviewee time to think. In spontaneously creating examples to explain a concept, I outlined situations which were ontologically weighted and imbued with my own value judgements. Such behaviour may have been directional. At times I summarised the speakers' point too early, potentially cutting them off or missing the true meaning of what they were trying to say. As the interviews progressed I became more adept at holding back and allowing the participant to direct the interview. I used 'neutral' and silent prompts to encourage the speaker to continue, such as 'ok', 'yeah', a smile or nod of the head, rather than interrupting them. This was more effective in giving the participant room to speak.

The length of the interviews varied from 19 minutes to 52 minutes. All of the longer interviews were those with personal friends, suggesting that a relationship with the interviewee was conducive to respondents talking for longer and answering questions in more detail than those with whom I was not so well acquainted. I was concerned that some

interviews were shorter than I had expected. This implies a reluctance to talk about the topic, or to being interviewed in general. A recurring problem was that many respondents wanted to meet at their workplace immediately after they had finished for the day, and so they may have been eager to get home. This could have contributed to answers being kept brief. Other factors influenced the level of detail that respondents went into when answering questions. Unintentionally brief interviews could have resulted from the structure of the questions. I had aimed to use open-ended questions that would encourage the participant to explore their ideas. However, I often received overly concise answers which suggests that questions might have been more effectively designed. Alternatively, respondents may have been uncertain of what constituted 'appropriate' interview behaviour, being more familiar with questionnaires than interviews. I attempted to clarify the nature of open-ended interviews in advance, to which participants responded with surprise. I explicitly invited them to talk freely about whatever came to mind when thinking about abortion, but in practice this was not always achieved and I was unable to draw out detailed answers:

> *Researcher*: Does your, um, Setswana culture affect your feelings about abortion in any way?
> *Laone*: Yes, they do.
> *Researcher*: in what ways?
> *Laone*: To, I mean our culture it's not, it's not acceptable to do abortion.
> *Researcher*: Why is that?
> *Laone*: I mean it's our culture it's not allowed, it's not allowed at all.

I encountered other problems with my interview guide and the questions I had formulated. As I was inexperienced in formulating questions, I sometimes unintentionally prevented the interviewee from responding outside of my frame of reference. Arguably the most regrettable aspect of the interviews was that I avoided encouraging respondents to discuss their personal experiences of abortion, stating in the information sheet that I would not be asking questions about personal experience. I was undertaking the study prior to enrolling in an academic programme,[18] and therefore without the approval of an ethics board. In this situation I was acutely aware of the possibilities of breaching ethical protocol that standard social research practice might dictate. I acted to minimise all risk to

[18] For an explanation of these circumstances, see Chapter One of this dissertation.

participants by avoiding any possibility of causing them distress through enquiring about potentially traumatic and painful experiences. However, I could have found methods for coping with this concern. My decision to circumvent asking about personal experiences altogether demonstrated the disproportionate sensitivity referred to by Platt (1981):

> There is perhaps a danger in showing excessive ethical sensitivity, both in applying absolute standards rather than in attempting to calculate a risk-benefit ratio, and in defining as unacceptable in sociological research behaviour that is quite acceptable in everyday interaction. (87)

Despite relinquishing potentially rich data, I was able to gather useful and interesting information about abortion through participants' articulation of their views and attitudes. This enabled me to begin to formulate an understanding of how abortion is socially and culturally constructed, and how it is perceived in the context of women's empowerment in Botswana.

In feminist research, reflexivity is important for engaging with power relations between researcher and researched. My positionality was unfixed and remained susceptible to both external and internal influences. The identity dynamics and related distribution of power between me and the participants was constantly created and transformed during the research process (Mullings, 1999). The interview is a social situation (Holstein and Gubrium, 1995). Its dynamic can change throughout according to the exchange between researcher and researched, and to the questions asked (ibid.). Participants may alter how they think and what they say in response. However, as explained by Ithiel de Sola Pool (cited in Holstein and Gubrium, 1995), 'these variations in expression cannot be viewed as mere deviations from some underlying "true" opinion, for there is no neutral, non-social, uninfluential situation to provide that baseline' (14). As an unavoidable element of social research my identity effected participant responses. This was both beneficial and damaging to my data. Here I will discuss aspects of my positionality that were most significant during my study, and the consequent affects.

I was perceived, both myself and by others, to be both an 'insider' and an 'outsider'. Whether I was viewed as one or the other was situational and conditional (Mullings, 1999). When I carried out the research I was a foreign individual who had lived in Gaborone for over a year before beginning the project. I worked alongside Batswana in an international school (over 65% of students were Batswana), I lived with a Motswana man with whom I was in a relationship, and all of my close friendships were with Batswana. I

spoke basic Setswana, ate the local cuisine every day and dressed from the local clothing stores. In these aspects, then, I was integrated into the community. However, my physical appearance and accent were permanent markers of my identity as a white British expatriate. My Setswana was by no means fluent, and not advanced enough to conduct interviews in the local language. I was a volunteer teacher, which set me aside somewhat from the paid staff, and it was widely known that I was a short-term member of Botswana society; my stay would not exceed 18 months. There were marked benefits to being perceived as both an insider and an outsider. In Botswana all matters relating to sex are taboo, and abortion is highly controversial. As a foreigner I was not considered to be subject to the same code of taboo as Batswana. I avoided being viewed as disrespectful or inappropriate in asking questions about a sensitive matter. As an outsider, I may have been assumed to be less biased and more trusted (Hesse-Bieber, 2007). Simultaneously, had I not been accepted as a partial insider by my respondents, all of whom were part of my social network, it is unlikely that I would have been trusted enough to be given information.[19]

My identity as a woman contributed to the more successful aspects of my data collection when interviewing people of my age group. Oakley (1989) claims that a 'feminist interviewing women is by definition [...] "inside" the culture' (57). Women participants with whom I had a relationship appeared most comfortable speaking with me about abortion. Some commented after the interviews that they had enjoyed the experience and the opportunity to explore their feelings on the topic. I believe this was a result of shared experience of gendered socialisation. When interviewer and participant have aspects of culture in common the participant may feel more comfortable giving information (Rubin and Rubin, 1995). Whilst socialisation of girls and women in Botswana is more explicitly gendered than in England, it rests on the same fundamental assumptions of female inferiority and male dominance. I suspect that my identity as a woman affected my interviews with men. In traditional Tswana culture, it is considered improper for intimate matters to be discussed between the sexes. Whilst the men in my study defined themselves as 'modern', it is not inconceivable that their cultural heritage may have caused some discomfort when talking about abortion with a woman researcher. In addition, they may have been wary of offending me when responding to questions about women's bodily

[19] The ethical and methodological concerns that arose when interviewing friends are discussed below.

autonomy, and answers could have been shaped to represent a stance more favourable to women than was perhaps the case in reality.[20]

I was acutely aware of my white, 'western' identity. In Botswana the term western is often synonymous with white. Botswana's history as a voluntary protectorate of Great Britain means there is little racial tension in society (relative to neighbouring Angola, Namibia, South Africa, Zambia and Zimbabwe). However, cross-cultural tension resulting from a colonial past is unavoidable, and I believe some of the participants felt uneasy portraying 'the west' in a negative light for this reason. In questioning participants on whether they perceived legal abortion to be an unwelcome western imposition, I was given the impression that some of them might have responded differently had I not been a 'westerner' myself. Whilst admitting they believed that the pro-choice paradigm originated overseas, they were eager to assure me that this was neither unwelcome nor an imposition. Despite this assertion, they made clear that they did not support the pro-choice movement elsewhere in the interview. This suggests that their responses to questioning about the western world were affected by my western identity.

My feminist, pro-choice attitude towards abortion was markedly different from many of those whom I interviewed, and raised concerns over reciprocity in research. Sharing your own beliefs and experiences can help create a balance of power between interviewer and interviewee by increasing 'reciprocity and rapport' (Hesse-Bieber, 2007: 128). However, being entirely open can give a false impression of equality, and can contribute to participants feeling obliged to disclose more intimate information than they might ordinarily have done (Stacey, cited in ibid.). Having taken both of these views into account, I decided not to provide full disclosure about my own beliefs. To reveal my feminist stance could have made participants who did not agree with abortion feel attacked, causing them distress or offence. It could have damaged the data by biasing participant responses in reaction to my world view, either through them wishing to appear in agreement, or by feeling they needed to defend their position. This choice raises ethical issues over reciprocity and openness in research. I hoped to minimise this dilemma by being clear about the purposes of the study at all times, and by answering any questions from the respondents honestly. In many cases, once the audio recorder was switched off, the interviewee entered into a discussion with me about abortion. In these instances I was open about my personal position, but made clear that there was no judgement involved in

[20] This is not to assume that the men I interviewed were against women having control over their bodies, only that men (who were also my acquaintances) may have been reluctant to discuss the issue from a perspective which they may have thought would offend me.

the research. However, despite the highly controversial nature of abortion, no respondents with whom I did enter into a post-interview discussion on the topic appeared to be in any way offended or unsettled, and were content to continue their participation.

There is a danger of exploitation and manipulation when interviewing friends, and an 'unarticulated tension between friendship and the goals of research' (Acker at al., 1983: 428). Everybody in my sample was a friend, acquaintance or colleague, or a friend or spouse of my personal contacts. Several issues arose as a result of me using my social networking to establish a sample. I found it difficult to refrain from 'joining in' the discussion when interviewing peers and commenting on things they had said. In this example, where the respondent was a close friend, the dialogue is aligned more closely to a discussion between friends than to a social research interview:

> *Keletso:* I mean there's people in the western world that get pregnant unexpectedly and still keep the child even though they have the option of not keeping the child.
> *Researcher*: Mm, definitely and certainly not all of the western world is pro-choice either.
> *Keletso:* Exactly, mm.

I encountered some awkward moments when respondents would refer to what they perceived to be a common understanding between us. They would expect me to respond in accordance with the norms of our personal relationship rather than in the manner of a social research interview. I struggled to answer in a manner which both prevented confusion for the respondent and avoided biasing or directing what was said. A further issue with interviewing friends arose when I would miss out on clear and explicit data because both myself and the participant assumed mutual understanding about a particular point and therefore neither of us elaborated on it (Platt, 1981). Again, my inexperience in interviewing was problematic here as I failed to illicit the 'whole story' in these instances. For example, Masego said: 'the family structure is very complicated! (laughter) very very complicated! (laughter)'. I knew from observation and personal experience that families in Botswana are large and complex; assuming too much knowledge, I moved onto the next question without fully ascertaining precisely what Masego was trying to say about families, and how that related to abortion.

A level of embarrassment ensues when breaching normal social interaction by 'manipulat[ing] or dominat[ing] an equal, claiming the right to define the situation for him'

(Platt, 1981: 80). This was significant when interviewing people in my social network, particularly those who I had a close friendship with. The shift from casual chat to research interview was not always smooth. Most respondents understood the need for a different approach, but I was uncomfortable with the responsibility of initiating the transition because of the imbalance of power this implied. Another concern was that of interviewees holding back for fear of offending me,[21] which was related to my positionality and is discussed above.

Holstein and Gubrium (1995) state that interviewers should make themselves aware of 'the material, cultural, and interpretive circumstances to which respondents might orient', and familiarise themselves with localised vocabulary and manners of expression to 'cultivate a shared awareness' with interviewees and encourage active interviewing (77). Having lived in Gaborone for over a year prior to beginning the interviews I was well-versed in the local phraseology and familiar with participants' contextual framework. This was invaluable during the interviews and in my analysis of the transcripts, as I was able to understand certain nuances of meaning in phrases that might otherwise have read as nonsensical. I transcribed all of my interview recordings in full. I used a simple word processing programme and typed out all words and sounds as faithfully as possible. I used basic punctuation and formatting to demonstrate pauses, unclear words, emphasis and laughter, and added details of external interruptions in parentheses. I did not time the length of pauses or try to show the accents of interviewees. This system was adequate for my analytical requirements. I did not explicitly offer to share the transcripts with my participants. I thought that my respondents might be alarmed by the ungrammatical style of their speech. This could have caused harm by embarrassing them (Henderson and Forbat, 2005; Karnieli-Miller et al., 2009). Respondents might have requested that I alter their transcripts to make them grammatically correct. This would have been impractical due to time constraints, and I would have risked damaging the data by losing nuances of meaning in translating the words from spoken to written form. I would not have refused a respondent's request to view her or his own transcript, out of respect for their ownership of the data. However, my participants showed little interest in the results of the study and nobody contacted me for further information or to request transcripts after the interviews.

Deciding whether to involve participants in the process of analysis was an ethical dilemma. Including interviewees in this manner can limit objectification and empower them by giving them some control over the way they are represented. However, it can also

[21] This problem is not unique to interviewing known people. It is well documented that respondents often wish to 'please' the researcher (Cohen et al. 2007; Silverman, 2010).

contradict the fundamental ethical considerations of confidentiality and avoiding causing any harm. Sharing analysis with participants who were recruited from the same social network would have risked breaching their anonymity. The disjunction between my 'feminist frame of reference and their interpretation of their own lives' might have been difficult to reconcile with participants' views, especially when my perspective is 'not only different but potentially threatening and disruptive to the subject's view of the world' (Acker et al., 1983: 428). My views on women's bodily autonomy and right to make their own reproductive decisions could have been interpreted as confrontational and offensive to Tswana culture. As I had decided not to share my analysis with the participants, the decisions over how to represent them lay with me. The power distribution at this stage was entirely imbalanced and so ethical issues were of great significance (Karnieli-Miller et al., 2009). To examine the socio-cultural context of abortion from a feminist perspective, it was necessary for me to view interviewees' accounts as resulting in part from an underlying gendered social structure (Acker at al., 1983). However, I was cautious not to discount participants' individual agency and autonomy of thought, and I took care to conduct non-judgemental analysis.

My analysis was thematic and based primarily on content. In a preliminary reading of the transcripts I pulled out key themes and noted all concepts that arose. I coded information which supported or contradicted each theme. I abandoned ideas for which I did not have substantive data. I conducted a more detailed analysis of the data within each category, comparing and contrasting what was said about a theme across different interviews. Here I took account of the demographic attributes of the respondents, noting any apparent relationships between this information and the interview content. Once I had carried out a thorough exploration of each thematic category, I began to examine concepts across categories to find connections between them. Here a grid system was useful to enable cross-checking. Through this process, I was also able to identify important areas where further data collection would be required to generate a more comprehensive understanding of abortion in Botswana.

The clandestine nature of abortion in a country where it is restricted by law means it is difficult to ascertain 'facts' about its occurrence. Whilst I did question respondents about the means of procuring the service in Botswana, their answers were mostly based on rumour and assumption. I did not ask them directly about their personal experiences of abortion for ethical reasons (discussed above), and focused on views and attitudes instead. For these reasons, my analysis will necessarily be weighted towards the 'pursuit of a

different, “narrated” reality in which the “situated”, or locally produced, nature of accounts is to the fore’ (Silverman, 2010: 225).

I made several mistakes throughout the process, particularly during the interviews I conducted. This caused me to generate avoidable bias in some instances, and to miss out on important information. However, these problems were not unique to me and resulted from inexperience in social research. Despite the difficulties I encountered, I was able to generate rich, interesting and unexpected data about people’s views of abortion in Botswana, data which challenged my innate assumptions and allowed me to gain some insight into views different from my own. The following three chapters are the result of my interview analysis.

Chapter Three: Procuring an abortion: Possibilities and constraints in the Botswana context

This chapter is concerned with the knowledge shown by the interviewees regarding how one might procure an abortion in Botswana where it is restricted by law (see below). I will explain the circumstances under which it is possible for a woman to legally terminate her pregnancy, and examine the level of knowledge that the participants demonstrated about these options. I will analyse the information interviewees provided about alternative means: 'backstreet' abortion; home-methods; illegal services from the medical profession; crossing the border to South Africa where abortion is legal; and 'baby-dumping'. I will conclude with a discussion of who would be involved in the decision of whether or not to terminate a pregnancy, and the extent to which the pregnant woman would be allowed the freedom to make that decision.

Abortion was comprehensively illegal in Botswana until 1991. The medical profession sought to protect themselves from the law in instances where an abortion might be necessary on medical grounds (Mogwe, 1992). They pressured the government for changes, and amendments to the law were passed. Following the bill, abortion was allowed during the first 16 weeks of pregnancy under the following circumstances:

a) 'Where the practitioner carrying out the operation is satisfied, by acceptable evidence, that the pregnancy is the result of rape, defilement or incest.'
b) 'Where the continuance of the pregnancy would involve risk to the life of the pregnant women or injury to her physical or mental health.'
c) 'Where established evidence shows that there is a substantial risk that, if the child were born, it would suffer from or later develop such serious physical or mental abnormality or disease as to be seriously handicapped.' (*Penal Code*, (n.d.): section 160)

According to Mogwe (1992), the effectiveness of the amendments in terms of practical application and access is negligible. To procure an abortion on medical grounds, one must secure the signatures of two doctors. In an under-funded and inefficient healthcare system this can be a long bureaucratic process. An additional complication arises in the instance of abortion on grounds of foetal impairment, where no definition of 'seriously handicapped' is provided in the code. For abortion to be granted in the instance of rape, a conviction must be secured through the courts. Most rapes in Botswana go unreported, the legal process is

slow and convictions are rare (Mathangwane, 2001). In addition, it is the remit of the examining doctor to decide whether or not the woman has been raped, not the woman herself. A further barrier to usage is the lack of public knowledge about the circumstances in which abortion is legally permitted.

This unawareness was apparent in my interview data. When asked if they were aware of the legal status of abortion is Botswana, 14 respondents answered that it was illegal with no exceptions: 'it's not allowed. It's illegal. Period' (Mabedi: 4). Many of those expressed uncertainty: 'I think it's illegal, I'm not very sure but yeah' (Linda: 5). Just six respondents maintained that abortion was available for medical reasons; three of them were men and two of them were women with professional knowledge of the law.[22] The men appeared unsure: 'I think I know that it's illegal, unless it's, um, on medical grounds' (Kgosi: 7). Except for one woman, none of the remaining interviewees displayed an understanding of the legally permissible circumstances for abortion. It is not possible to know whether respondents knew more about the abortion law than they said. The interviews suggest that either they did not possess such knowledge, or that they wished to present themselves as such. That more men than women showed a (partial) understanding of the law could indicate that reproductive decision-making power lies with men; hence they are aware of the options for procuring an abortion legally.[23] Alternatively, it may be culturally acceptable for men, but not women, to portray themselves as knowledgeable about the law and matters relating to sex. In a country where abortion remains legally circumscribed and is highly taboo, it could be considered inappropriate to possess detailed knowledge about the law that would allow one to procure a legal abortion. It may also be related to the complex issue of discussing one's own country with a foreign researcher. To claim that abortion in Botswana is 'illegal and that's it' (Masego: 7) may suggest two different dispositions, depending on the respondent's stance on abortion. By suggesting that the law is highly restrictive, Botswana is presented as either morally upstanding or unduly repressive.

That the amendments to the law did not come from women's rights activists, but from the medical profession, implies that there is little outspoken pro-choice sentiment in

[22] One woman was a former obstetrician and current lead physicist of a women's healthcare programme, the other was a human rights lawyer. Due to the nature of their work, is to be expected that they would be aware of the stipulations of the abortion law.

[23] The data concerning the politics of reproductive decision-making will be examined at the end of this chapter.

Botswana and thus barely any public awareness of the reforms.[24] However, to understand the significance of this, further research is needed to ascertain how well the law is understood generally. Certainly the new less restrictive statute was not widely publicised. Doctors may be unaware of the circumstances under which abortion is legally permissible, or they may hold an anti-abortion stance and prefer to withhold such information from patients (Rahman et al., 1998). This has often been the case in South Africa, where abortion is legal on demand in the first 13 weeks of pregnancy and yet many women continue to use backstreet providers or self-induce. One study (Jewkes et al., 2005: 112) found that 54% of participants who had presented with an incomplete abortion had not used legal services because of a lack of knowledge of the law. The study also found that some women had attended clinics and had not been told about the law or had not been referred to a doctor who would perform the abortion (ibid.). That only the professional participants in my study and one other individual spoke of pregnancy caused by rape as an allowable reason for legal termination is indicative of both lack of legal knowledge, and the low-profile status of rape in Botswana. Rape is common but is barely spoken of; most rapes go unreported and convictions are unusual (Mathangwane, 2001). A combination of the above factors might have contributed to the apparent lack of public understanding of the abortion law that was suggested in my interviews.

Respondents spoke of several alternative means of terminating a pregnancy in a setting where abortion is restricted by law. 'Backstreet' abortion emerged as the most commonly known and responses were relatively uniform, showing no relation to the demographic attributes of the speaker. When asked, 'can you tell me anything about backstreet abortion?', respondents gave two definitions. The majority of interviewees defined the practice as a termination provided by a rural woman for a fee, usually involving the pregnant woman being given a herbal concoction to drink to cause miscarriage, or having an instrument of some kind inserted into the womb to destroy the foetus. Others explained that illegal abortionists would sell information about how to terminate a pregnancy, rather than risk committing the abortion themselves. The 'remedies' mentioned included: bleach (Jessica: 4; Keletso: 5; Kgosi: 6; Masego: 8); coffee granules (Jessica: 4); furniture polish and oil (Fingi: 5); vinegar (Boitumelo: 5); methylated spirits and laxatives (Jason: 4); tubes from pens (Fingi: 5); and wire coat hangers (Masego: 8, Oratile: 3). Two respondents mentioned pharmaceutical drugs (Keletso: 5; Laone: 4). They may have been referring to Cyotec (or Misoprostol), an arthritis treatment drug which was reported to

[24] The absence of a visible pro-choice sentiment may be a result of the taboo status of abortion. This will be discussed in the following two chapters of this dissertation.

have been sold 'underground' as an abortifacient (Ontebetse, 2010). In South Africa, Misoprostol is often given to women seeking abortions by nurses, pharmacists or doctors (Jewkes et al., 2005). In Botswana, other 'home methods' reported in the media include potassium, reported to have been used by secondary school children (Odubeng and Phala, 2005) and sticks from a *mokhure* plant (Ngakane and Rantsimako, 2005).

There was ambiguity in the data surrounding the qualifications of these abortion providers. Six respondents held that the providers were traditional healers. Traditional healers are a significant source of health care and advice in Southern Africa. For example, even where abortion is legally available in clinics in South Africa, 24% of women in a recent study had procured an abortion from a traditional healer while only 11% had used a doctor's services (Jewkes et al., 2005: 112). However, 15 of my respondents portrayed backstreet providers as just 'some random person' (Jason: 3) who is untrained: 'I think it's just a woman, you know someone, just anybody' (Michelle: 6). Those who asserted that it is traditional healers who provide backstreet abortions did not report that they were adequately trained or equipped to offer a safe service. It is important not to dismiss the legitimacy of medical practice simply because it is not part of standardised 'western medicine'. However, the interviewees overwhelmingly portrayed backstreet providers in a negative light. They were described as 'shady' (Siriol: 4), 'charlatans' (Kgosi: 6), and their service as a 'scam' (Keletso: 5). 12 interviewees spoke directly of the danger surrounding backstreet abortion: 'They die, people have died' (Banyana: 3). Others implied it with their tone of voice when describing the methods used: 'Of course no-one knows what she's putting in what you're drinking' (Fingi: 5). There was one exception to the interviewees' negative perceptions of backstreet providers: Mabedi (3) described them as 'quite trained and experienced' in traditional medicine. However, her view came into alignment with the majority of responses as she went on to explain the techniques she had heard of, 'they use some kind of a string, try and attach it to the uterus or something, I don't know. Urgh, some scary [method]'.

Interviewees reported that the system of backstreet abortion relies almost exclusively on women. Most of the providers are women (although one interviewee referred to a male abortionist). The process of finding an illegal practitioner and accessing the service operates through a women-only system of information: 'You'll always find someone who knows someone who can help you. Yeah, it's always like that' (Siriol: 4). While it appeared that men were the more knowledgeable about procuring an abortion legally, the data suggests that backstreet abortion as described above rarely involved men:

Researcher: It is men and women?

Laone: Women! (laughter) (4)

Laone's laughter suggests that the idea of men being party to finding and using a backstreet abortionist is nonsensical. Most interviewees spoke of a female network; none asserted that men might be involved (other than Oratile, who implies below that the abortionist could be male). This could simply be a result of women being more likely to know about an issue which directly concerns their own bodies, and the accompanying belief from both women and men that abortion is 'women's stuff' (Fingi: 6); that women 'don't talk about abortion with men' (Barati: 4). It could also indicate that women have created among themselves a network of information and services in order to secure some control over their reproduction, decisions over which are traditionally reserved for men. Former obstetrician Oratile illustrated this possibility through a personal anecdote:

> It's in the grapevine, patients do know who to go to, who will do the backyard, you know, they, I mean I remember seeing a patient in Juaneng, and one of the things was that [the abortionist] scraped the uterus inside and you can scrape all of the lining, such that when it heals it actually causes scarring [...] and this woman had that. [...] I said to her, you know, have you had any scraping? No. [...] And eventually she said, yes I did. And I said will you tell me who? Of course she wouldn't tell you, 'cause she's like, this is the guy who helps so many women. (4)

This story demonstrates two key points. Firstly, there are cases in which women who have suffered from the complications of backstreet abortion will not report the abortionist. Rather, the victim remains silent to ensure that the service continues to be available. Secondly, women presenting with unwanted pregnancies know, through the 'grapevine', how to procure a backstreet termination. My other interviews support this. All of the female respondents demonstrated knowledge of backstreet abortion. Whether this is due to personal experience or to media coverage is difficult to know. Some interviewees were initially evasive when asked if they could tell me about backstreet abortion. However, they proceeded to describe it in detail. Michelle (6) responded: 'Oh I don't know anything about that', after which she told me about her close friend who had died from the complications of a backstreet abortion. Such distancing is not unexpected when discussing a clandestine

and dangerous activity, particularly if culture dictates that women ought not to know about ways to terminate a pregnancy.

Backstreet abortion as discussed by my interviewees is not unique to Botswana. For example, there are notable similarities with the practice in Victorian and Edwardian Britain where it was probably the most common method of regulating fertility used among the working class (Knight, 1977). Local women (who were probably untrained) carried out abortions by inserting instruments, or by selling various abortifacient remedies for unwanted pregnancy (ibid.). Home methods were circulated by these providers, and by female family and friends. In comparison with Botswana, it appears that men were rarely involved in abortions (ibid.).

A minority of my interviewees mentioned GPs, gynaecologists and nurses, who provide illegal abortions in Botswana for a high fee. In contrast with the widespread understanding of backstreet abortion among my participants, knowledge of illegal terminations provided by members of the medical profession appeared to be minimal. Very little detail was revealed:

> I wouldn't want to suggest anything here, because it's not legal. So to be honest I, I, I, I cannot say anything about it because I am also very much against [abortion]. But I've heard people do it behind closed doors with certain doctors. (Dineo: 4)

The only interviewees who gave any detail about abortion services provided illegally by the medical profession were my professional informants, and two participants who admitted to having sought out such services themselves. The general absence of detailed information on this practice has several implications. Illegal medical abortions might happen less often than backstreet services, possibly because they cost more: 'You can get gynaecologists that can do it for you here, but it's *expensive'* (Michelle: 5).[25] Alternatively, it may be reported in the media less frequently and thus less known by the public: 'No. No qualified person have I ever heard who does backstreet abortion' (Nicole: 4). An examination of the relevant newspaper articles demonstrated that an abortion usually becomes public only when a maternal fatality or a found foetus draws media attention (Ganetsang, 2007; Kologwe, 2009; Madibana, 2010; Seitshiro, 2010; Disang, 2011). It is likely that terminations provided by trained medical professionals would result in fewer fatalities and more thorough

[25] For a discussion of the relationship between personal wealth and access to abortion services, see Francome (2004: 15).

concealment of the foetal remains than in cases of backstreet abortion, therefore remaining secret. However, there is data to contradict this suggestion. When asked if illegal medical are abortions are a safer option, Oratile commented:

> Well, we don't know. Because we don't know what they use [...] because it's illegal, and it's all done under very dubious circumstances, 'cause if then this woman bleeds, what does the doctor do? [...] you know a doctor did that, and this woman bled so much she, I think he ended up putting the woman in the back of his car, and by the time they got to the hospital the woman was dead. (3)

Notwithstanding Oratile's concerns, the data generally portrayed doctors who commit illegal abortion in a more positive light than backstreet providers. Perhaps this is due to the perception that medical abortions are safer:

> *Michelle*: No, usually it's done in a safe kind of, um environment. 'Cause like, when I went, I didn't just go, I asked. I asked them what you gonna do, how you gonna do it?
> *Researcher*: At the gynaecologist?
> *Michelle*: At the gynaecologist. So it's safe. It's safe. (5)

That detailed information was rarely given in interviews could also suggest that some participants hold doctors in high esteem, and would not wish to link the profession with criminal activity. Evidence of the respect held for doctors was shown by interviewees who did not present themselves as pro-choice, but maintained that abortion was acceptable if a medical professional believed it to be necessary:[26]

> Suddenly because it's almost removed from, really a decision that the mother is making. So for example if there was a medical recommendation you know, if one or two doctors or whatever [...] somehow I find myself thinking that it would be [...] if it's necessary, and yeah, so that's the strange thing. If someone else with some sort of relevant knowledge is saying, yeah. [...] I doubt it's

[26] There are further implications of this attitude than those discussed here. The reasons abortion might be considered to be acceptable, including on medical grounds, will be examined at length in Chapter Five.

> something that we will ever welcome. I don't think anyone really does. But I think people, we'd understand. (Fingi: 2)

After expressing general anti-abortion sentiments throughout the interview, Fingi found that 'suddenly' her opinion changed when considering a scenario in which the decision to terminate the pregnancy came from somebody who was not the mother, and particularly from a doctor. She extended this idea outwards to include society at large, demonstrating that this is a culturally acceptable stance to take.

An option for procuring an abortion legally is to cross the border to neighbouring South Africa, where abortion is legal on demand within 13 weeks of conception, and under certain circumstances later in the gestational period. With only seven respondents mentioning this alternative, it was the least cited of all the means to terminate a pregnancy.[27] Crossing the border to procure an abortion was portrayed by those who did mention it as simple and common (2):

> *Michelle:* Abortion is totally legal in South Africa. So it's a matter of people just crossing the border.
> *Researcher:* And people do that?
> *Michelle:* People do that *a lot*. I almost did that. yeah, I almost, I went to South Africa for an abortion [...] people do. A lot of people that I know [...] it's just a matter of if you have the money just cross the border, you have a passport so go, have an abortion, couple of days you back!

Mabedi (4) explained that this is what 'our Batswana women do, they simply cross the border now.' Six respondents used the plural form in this way when describing the process of obtaining abortion services in South Africa, indicating that they thought it happens often. The terms they used were general, such as 'they' and 'people'; no sense was given of a particular sub-group who might choose this option. Moreover, the participants who described it possessed no unifying demographic characteristics. The richness of my data is especially limited in this area, and further investigation of Batswana use of South African medical abortion services is required. Travelling to foreign countries to procure an abortion is not unique to Batswana women. This pattern has been seen worldwide. Francome (2004)

[27] As my research was known to concern 'abortion in Botswana', and my questions did not refer directly to South Africa, it could be that respondents did not perceive this activity to be relevant to the interview.

gives the recent example of Irish women who came to Britain in the year 2000 to terminate their pregnancies. 80.5 per cent of all non-residents who had an abortion in the UK in that year were from Ireland (42).

All respondents showed knowledge of a form of infanticide, or concealment of birth, known locally as 'baby-dumping'. This refers to a scenario where a pregnancy is concealed until birth, after which the infant is abandoned, buried or otherwise hidden. Most respondents believed this takes place as a consequence of abortion being restricted by law and condemned in traditional culture: 'It's so shunned upon in our community for them to have an abortion, so they keep, so they have the child, either leave them at the hospital, or dump them. Yeah' (Siriol: 4). The majority of respondents held that they thought baby-dumping would decrease if abortion was legalised, regardless of their stance on abortion. This suggests that infanticide is commonly viewed as a direct alternative to termination.

Unlike descriptions of crossing the border to procure an abortion, considerable detail was provided in relation to those who were thought to commit infanticide. Most interviewees maintained that the perpetrators were economically disadvantaged and under-educated young women in desperate situations. Such women were said to find themselves pregnant with no financial means to raise a new child, and nobody to support them in doing so. It is important to note that the participants in my study were of the middle classes; by describing these women as being from 'ghettos' (Linda: 5) and 'the poor neighbourhoods of town' (Keletso: 5), the participants distanced themselves from the phenomenon. Some interviewees asserted that it is not Batswana, but Zimbabweans who resort to infanticide. These distancing techniques indicate that baby-dumping is considered deplorable. Some respondents were explicit on this point: 'Very unacceptable isn't it. That is *so* unacceptable, I mean, that is *really* gruesome' (Mabedi: 3).

That certain aspects of this phenomenon, such as the demographic characteristics of perpetrators, are repeated by multiple respondents could be a result of related media reports that are so common as to be an almost daily occurrence. Newspaper articles covering such incidents are plentiful (Seitshiro, 2010; Disang, 2011; Kologwe, 2011; Gosalamang, 2011; Pinielo, 2011). Summerfield (2005) explains how local phenomena are collected and presented in a 'generalised form in popular culture' and 'it becomes difficult to speak outside it' (59). All of my respondents lived and worked in the city, where media formats of collective information are easily accessible. It is difficult to separate my

interviews which represent knowledge drawn from this 'cultural circuit' from information gleaned from other forms of experience (Summerfield, 2005: 59).[28]

I asked interviewees who would be involved in the decision of whether or not to terminate a pregnancy, and who would ultimately decide the outcome. Responses were far from uniform and many participants displayed uncertainty in their answers: 'That one is hard to, I don't know, I can't answer that really' (Banyana: 3). This indicates that reproductive decision-making is a complex area where the boundaries of power are not always drawn clearly. That responses were so varied, both in content and in degree of assertiveness, demonstrates that social rules operate differently from one context to another. Certain thoughts were shared by individuals of diverse demographic sets, while others reflected similarities between the views of a particular 'category', notably age groups.

It was in the analysis of the information regarding reproductive-decision making that my assumptions were most challenged. Traditional Tswana culture dictates that men are in control of such matters. This cultural context is more strongly maintained in the older generations and in rural areas. I had presumed, then, that the young, urban women of my sample would be more likely to assert that women were or should be gaining bodily autonomy. On the contrary, respondents from a range of age groups claimed that men make reproductive decisions on behalf of women. This included the two youngest participants: 'In reality the man usually comes out stronger. Yeah, insists that the mother has a baby' (Linda: 4). That many of the younger respondents made similar claims might be due to a stronger awareness of gendered processes (4):

> *Researcher*: Would she have the final say in the matter?
> *Michelle*: She should have, but probably not.

However, other interviews contradicted this and implied agreement with gendered reproductive decision-making: 'It would be unfair for the mother to be insistent on having the abortion. Because it's not her baby' (Linda: 4). Masego explained why children are not considered to belong to their mother:

> The man is very very important in, in the family, and it's almost like his, he has the last word on things. Um he, you know when you get married, and a man

[28] This concern is relevant to all of the knowledge shown by my participants. However, it is more salient in a discussion of baby-dumping because this phenomenon is so frequently reported.

> says to you he would like to have lots and lots of children, and he says he would like to have four kids, and maybe you only wanted two, you almost feel obliged to have the extra two [...] you hear the old ladies in the village talking about, when are you going to give your husband children? Not when are you going to have kids or, when are you gonna give your husband children. (6)

Barati's comments further clarify the reason that men are given control over family and reproductive decisions. Her use of 'apparently' implies that she disagrees somewhat with the *status quo* she is describing:

> Well because sex is eh, ehh, a domain, a *male* domain. You know it's men who control when and how to have sex. You know it's men who enjoy sex apparently, so women basically, you know, ehh, go along with the needs of men. And men as well they, they decide when to have kids, you know, yeah, yeah, so basically reproduction is a decision that men make. You know, yeah. (1)

Not all respondents thought that men would decide all reproductive matters within the family. Interviewees frequently claimed that the woman would decide whether or not to terminate her pregnancy simply because she would keep the whole process secret:

> It's still a very lonely decision to make for women [...] it's the desperate woman who has no-one to turn to for advice [...] and they go it alone. (Kgosi: 5)

Kgosi went on to reiterate the isolation of women in this situation, and this was strongly supported by other interview data. Many respondents held that if a woman wanted to terminate her pregnancy she would have to seek an abortion in private. They assumed that if the father or the mother's family were to discover that she was pregnant, the choice would cease to be hers. Jessica's statement on this was all the more assertive through repetition:

> *Jessica*: Usually it's only the mother and it's in secret. Yes.
> *Researcher*: If a woman decided that she wanted to have an abortion, but her family knew about it or the man knew about the pregnancy and it went against their wishes, who would have the final say?

> *Jessica*: Not the mother. Not the mother at all. I think the mother would have to um, get, live with the pregnancy, give birth to the child. It wouldn't be the mother. Yeah. (3)

Jessica initially answers that the mother would make the choice in private. However, if anybody discerned the woman's intention there would be no doubt that her control would cease. Most respondents answered in a similar vein, stating that it would be 'a very very private decision' (Barati: 3) for the woman, unless her family became involved, in which case 'I doubt if she would get the decision [...] they speak against it, it would be very difficult for me to go ahead and say look, this is what I've decided to do, yeah' (ibid.). This indicates that women's bodily autonomy is far from established. Yet, that women will find a means to have an abortion, albeit in secret, points to a level of control not publicly acknowledged.

A minority of interviewees answered that rather than make the decision privately, 'it would be a family decision. Definitely would' (Keletso: 4). Keletso continued to explain that in a traditional setting, the final choice would belong to the head of the family, whereas in a modern setting, the woman might get more say in the matter. Siriol also held that the family would be included in the decision-making process, although her assertion of parental control was more rigid: 'It's never the child's choice. You tell your parents, they talk amongst themselves about what you should do, and they decide if you keep it or you lose it. It's never, it's never your choice.'(3) As one of the youngest participants, this explanation could be affected by her age and the relationship younger people might have with their parents. However, when I asked if one's parents would have such control regardless of the woman's age, Masego (aged 31-40) explained: 'Yeah, yeah. 'Cause it matters a lot what they think, and how they feel about things' (6).

Three interviewees thought that the decision to terminate or not would unquestionably be the pregnant woman's choice. They were in the 41-50 age group, and one was male.[29] A further male participant agreed, but held that it was conditional on her relationship status: 'If they're not that close or they're not in marriage or they're not talking enough, then the woman can do whatever she wants' (Jason: 3). Jason's statement implies that women would have a choice only if men were not involved. Four participants said that the decision would be made through a process of discussion and compromise between the

[29] My positionality as female researcher and acquaintance with the interviewee makes the analysis of the views of male participants on the issue of women's autonomy problematic. Consequently, I have omitted discussion of their answers in this section. This, and other concerns raised by my positionality are examined in the methodology chapter of this dissertation (see above).

two parents of the unborn child. Three of them were in the 31-40 and 41-50 age groups. It is interesting that those women who claimed that the pregnant woman would be allowed a level of genuine bodily autonomy were mostly of the older generations. This could indicate a thread of matriarchy which is connected to age: as a woman grows older she is imbued with more decision-making power in the family.[30]

The concept of matriarchy was mentioned elsewhere in the data in explanations of how the extended family would make the decision on behalf of a female member: 'your grandmas, your aunts [...] women of the family [...] whatever they would decide really [...] and it would be either, you know, the matriarch or patriarch of the family, whoever the strong opinion is coming from, is usually what would happen' (Keletso: 4). In contrast to the uncertainty displayed by many participants discussing this issue, those older interviewees who maintained that women would be allowed to make reproductive choices answered assertively: 'It should come from you, I don't think anyone should have the right to tell you what to do [...] the pregnant woman will, has to have the final say. That's how I feel' (Faith: 3). This worked to emphasize that they strongly thought this ought to be the case and were confident in their knowledge of reproductive decision-making. The concept of female power within a patriarchal society arose from some of my interviews but was not a pre-selected topic for exploration. As such, my data is minimal and more research needs to be done to examine this important theme.

In this chapter I have shown that my interviewees were aware of several options for procuring an abortion in Botswana, where it is restricted by law. I examined the data regarding these services, including medical termination where it is allowed by law; backstreet abortion; home methods; illegal medical abortion and crossing the border to South Africa where termination is legal. I discussed a form of infanticide known locally as 'baby-dumping', as a means by which to deny a pregnancy in circumstances where abortion was inaccessible. I moved on to consider who in a woman's life would decide whether she could terminate her pregnancy. The interviews revealed that all forms of illegal abortion operated in a clandestine manner; often concealed both from the law and from the pregnant woman's family or partner. In the following chapter I will investigate the reasons behind this apparent need for secrecy, examining what makes the concept of abortion problematic in Botswana.

[30] This late acquisition of power for women may not result directly from age in itself. Rather, from the status gained through childbearing over the course of one's life. For a discussion of the meanings of motherhood in Botswana, see Schapera (1984).

Chapter Four: What makes abortion problematic in Botswana?

In the previous chapter I outlined the options for procuring an abortion in Botswana where abortion is legally circumscribed. In this chapter I shall examine social and cultural factors which contribute to abortion being perceived as 'problematic' by my participants. These include the significance of motherhood, the patriarchal structure of society, and the extended-family support system. I shall investigate the impact of religion on the interviewees' opinions, and the extent to which they employed a 'pro-life' argument. I shall discuss the taboo surrounding abortion and where this originates from, as well as the extent to which participants viewed abortion as an imposition of 'western' ideas.

The participants explained that abortion was perceived as 'a shameful deed' (Linda: 1) in Tswana culture. Part of this originates from the nature and role of women in a conservative patriarchal society, where 'certain aspects of Setswana culture' are 'basically oppressive' (Emang Basadi Manifesto, 1999, cited in Van Allen, 2010: 111). To be able to control one's own fertility represented an unacceptable level of autonomy in a culture where traditionally, 'women were not supposed to have any words [...] You can't stand on your own feet, you can't defend yourself' (Michelle: 2). Michelle further described this social attitude:

> There are some discussions on the radio, the TV, they usually have these discussions. About why women's rights and whatever, it's just making women bigger than they should be. That's what they say. Bigger than they should be, and they're just trying to make women into men. (2)

Michelle's words suggest that for women to be allowed rights is viewed as seemingly equivalent to gendering them male; autonomy for women *as women* is not a possibility. The interviews indicated that both men and women accept this situation, for 'women are raised to become a certain way and believe in their own inferiority' (Bokang: 9) and there is 'a level of comfort in having restrictions' (Masego: 10). Barati was pro-choice herself, but explained the social role of women as an obstacle to the social acceptance of abortion: 'Women emancipation ideologies, you know. It's just [seen as] women refusing to look after babies, yeah' (5). She said that information about abortion was withheld from women to prevent them from considering it: 'They try to make it seem like it's illegal. You know it's not something that women are taught about at all' (2). This indicates that while there are some possibilities for legal abortion in Botswana, cultural barriers thwart the dissemination

of facts that could contribute to empowering women in terms of their reproductive autonomy. Barati, who was an advocate for sex workers, used the example of the Domestic Violence Act to illustrate how legal protection is not always useful for women:[31]

> It's a very good act that protects women from being beaten by boyfriends, husbands and so on and so forth, but Batswana don't *use* it, women don't use it. Why, because it's not disseminated, you know. We still think that the law is something that we don't have access to. (5)

Research has supported Barati's suggestion that women do not tend to benefit from the law. This has been demonstrated in reference to multiple issues in addition to abortion and domestic violence. Changes to the law mean that women can vote, instigate court cases and claim land from the district land board (Brown, 1983). However, women's inferior social and economic position results in them being 'excluded from exercising their rights fully' (ibid.: 376). For example, while women may apply for land, their applications are unlikely to be treated equally to those of men, and they commonly lack the resources to utilise the land in a way that will bring them economic independence (Brown, 1983). The law fails women in other ways; although rape is illegal it is rarely reported, and most rapes that are reported do not make it to court (Mathangwane, 2001). Single mothers face social and bureaucratic obstacles to securing maintenance from their children's father, and most never receive payment even if a court has ruled in her favour (Brown, 1983; Mookodi, 2001). These examples illustrate the ineffectiveness of legal rights for women, and this raises questions about the socio-cultural, bureaucratic and economic obstacles women face in accessing the law which must be addressed through further research.

Some interviewees suggested that abortion conflicts with the meaning of womanhood. One participant said that terminating a pregnancy would deny one's female identity altogether:

> *Researcher*: Can you tell me what you think about a woman having an abortion?
> *Dineo*: Um, I don't think they are women. Because as a woman you should feel compassionate. (1)

[31] Some examples of research on women and the law in Botswana include Dow and Kidd (1994) and Banda (2006).

This suggests that women are expected to possess particular personality traits, such as empathy, in order to be accepted as women in Tswana culture. It also points to the perception of abortion as an act lacking in compassion. It appears that this compassion is reserved for the foetus and excludes the pregnant woman, for 'when you're a Motswana woman [...] you will have children [...] if you dare mention that you're not interested in having children, whoa! What!!' (Masego: 2). The concept of child-bearing as a compulsory act of womanhood in was articulated repeatedly in my interviews: 'Having an abortion, it's not supposed to be *done* in our culture. If we get pregnant then you're pregnant, you're gonna have that baby' (Michelle: 1). My interviews strengthened Mogobe's (2005) claim that in Botswana, 'motherhood is rather a mandate and not an option' (33). In fact, the significance of women's role as reproducers is indicated by the meaning of their polite term of address – 'Mma', which translates to 'Mother' (Van Allen, 2010).

The interviews indicated that the significance of children in Tswana culture is an important factor regarding abortion, and reflects the common pronatalist culture found across Africa (Braam and Hessini, 2004). Braam and Hessini (2004) attribute the historical problematic of abortion in Africa to this pronatalist perspective, in which children bestow social standing on their parents, are used for labour and for financial support later in life, and allow for the continuation of family lineage. These functions were not often mentioned explicitly by my interviewees, possibly out of concern for offending the sentimental conception of children often found in the west and perhaps assumed to be my own. However, 15 respondents asserted that 'Batswana believe that children are a blessing' (Boitumelo: 1). The view of children as a precious gift to be welcomed regardless of your life circumstances was very common. Many participants pointed to the sense of pride and respect to be achieved through child-bearing. The more children a family has, the higher their status within the community. This is because 'having a number of children is also a kind, some sort of, *richness* in the family' (Tlamelo: 1).

To be infertile or to choose not to have children was to 'sort of deny who you are' (Keletso: 2). Jessica spoke of the Setswana proverbs which paint images of children as one's pillars, explaining how 'your success is counted, or it surfaces when it's from your children [...] your children are what you are, and who you are' (1). This implies that the only way for women to overcome their inferior position in society is to bear as many children as possible (Schapera, 1984; Gage-Brandon and Meekers, 1993; Upton, 2001; Phaladze and Tlou, 2006; Dow and Kidd, 2007). In the light of these circumstances, respondents viewed abortion as unnatural: 'It's weird. It's strange. How can a human being, a woman, not want children?' (Barati: 5). Braam and Hessini (2004) explain that in a male-dominated culture, women can

only gain personal power through their assigned role as mother. They point out that motherhood is seen as a 'natural' life event which women should not try to control or change, putting them under incredible pressure to bear children (ibid.). Several of my interviewees asserted that to be 'virile and fertile' (Bokang) is fundamental to one's identity. They thought it was unacceptable (or was seen to be by society at large) to terminate a pregnancy when you could give the child away to somebody 'unlucky' enough to be infertile. This view is repeated in literature that examines the damaging impact of infertility on women in Tswana culture (Schapera, 1984; Gage-Brandon and Meekers, 1993; Upton, 2001; Phaladze and Tlou, 2006; Dow and Kidd, 2007).

An aspect of traditional Tswana culture is the importance of wider kinship networks for child-rearing. My interviewees suggested that the support of one's kin network eliminates the need for abortion. While a pregnancy might be unwanted by the mother, 'you cannot have no home for a child in Botswana' (Banyana: 3). The transfer of children between family members, or from one family to another, appeared to be a common and acceptable occurrence. The interviews suggested that a pregnancy was always wanted by somebody as long as there was a community available to provide care for the baby: 'I mean with the support structures now, as an extended family we sometimes just don't really have to deal with [unwanted pregnancy]' (Keletso: 4). Respondents of all demographic characteristics spoke of the extended family support system, indicating that the practice is widespread. This is similar to evidence found in other parts of the world. Research suggests that the extended family is more important for child-rearing among black communities than among white communities, where the nuclear family tends to take primary responsibility for the socialisation of its children (Hays and Mindel, 1973; Uttal, 1999).

The interviewees discussed the various types of kinship support available for child-rearing. The extended family might aid the mother practically or financially: 'When I was pregnant, I was totally broke. But then, I was sure that my mother would help in any way that I needed' (Michelle: 2). This kind of help is usually from mothers, aunts or grandmothers, and 'tends to put a lot of weight on the other women in your family' (Fingi: 3). However, men might also be involved in the maintenance of the extended family's children: 'Even my father, when I was born, was taking care of seven people' (Fingi: 6). Financial help might be given in the form of cash, food and school fees: 'Mom would pay the school fees or something, you get some kind of assistance from extended family' (Masego: 3). Fingi spoke of the sense of obligation involved: 'If you happen to be the successful one, then you have to [take care of the child]' (6).

In some cases, the child might be sent to live with other family members during periods of particular difficulty for the parents:

> In Tswana culture, when someone is not able to maintain their family, uh we help one another [...] like I am doing with my cousin, the son of my uncle. So I decided to because uh, there are now nine in the family, and you know [...] life is too difficult for them and both parents are not working, so in a Tswana culture we have that covered for. (Dineo: 2)

Alternatively, the infant might be (unofficially) adopted by a family member in the village to be raised as their own child, as described in Masego's anecdote:

> I remember going to um, to a friend's village with her. [...] she was telling me that one of her little cousins, one of the kids running around is, um, some auntie or other's um, child. The child doesn't know that that's the mother. The mother has given this child to another relative in the family and this child calls her real mother auntie such-and-such, and the mom is momma. (8)

In a similar scenario, the pregnant woman's family might raise the infant as a sibling alongside its birth mother in the same home: 'They (the family) kind of raise them (your child) and they think you're their cousin, or you're their older sister or brother' (Keletso: 4). The cost, effort and creativity demonstrated by these familial solutions to an unwanted pregnancy point to the value the community places on the birth of a child. This suggests that kinship groups are willing to go to significant lengths to avoid any member opting for abortion. While this could be related to the illegal status of most abortions in Botswana, the availability and apparently wide use of clandestine providers suggests this is instead a result of anti-abortion sentiment among the community.[32] One aspect of this could be the function of children as a financial resource where government welfare is minimal and not comprehensive. Children offer a future source of income and economic security, particularly as the parents reach old age. Abortion, then, might be considered to be financially disadvantageous.

[32] There are no figures estimating the incidence of illegal abortion in Botswana. However, for official statistics for the number of maternal deaths caused by abortion complications, see Chapter One. For a discussion of the range of options for terminating a pregnancy, see Chapter Three.

My interviewees' discussions of kinship support lacked any acknowledgement of the complexities of a woman's experience of these alternative child-rearing options. Rather, it was assumed that if a pregnancy was not desired then familial support for the child would be an ideal solution for everybody involved, including the birth mother. The overarching concern appeared to be with the birth and wellbeing of the child, rather than with mother's mental and physical health. Further research is required to help understand women's experiences of raising an unwanted child with family support, giving one's child away temporarily or permanently, or adopting a different kin relationship to the child other than that of mother.

Abortion and infanticide have historically been connected with witchcraft and other such superstitious beliefs in Botswana (Schapera, 1984), and the Southern African region as a whole. For example, despite the fact that the abortion law in South Africa has been liberalised and that advertisements for abortion providers can be found on lampposts and in newspapers, a recent project found that abortion was the third greatest taboo of the 37 studied (Madu et al., 2002).[33] During my recruitment for this study I found many people were uncomfortable speaking about abortion. Most of my interviewees, regardless of their age or sex, agreed that abortion is taboo and that 'people still hold back from talking about it 'cause it's, it's pretty awkward' (Jessica: 1). By their agreement to participate in my study, respondents proclaimed themselves willing to talk about abortion to some extent. The greater taboo was implied not by my respondents, but by those who do not acknowledge abortion at all. Despite statistical and anecdotal evidence to the contrary, the reality of induced abortion is often denied completely in Botswana: 'Culturally just, abortion is like a, Setswana [sic] would say it doesn't happen' (Bokang: 1). A potential interviewee refused participation on the forceful assertion that there was nothing to discuss, because 'we do not have abortion in Botswana'.

In Setswana there is no exact term for abortion, but the phrase used is '*go senya mpa'*. This translates as 'to spoil/destroy the stomach' (Fingi, *personal communication*, 2011). Discussion of abortion is thus only accommodated by the cultural language of Botswana as a destructive act. I asked my interviewees whether the termination of pregnancy is something that people are willing to discuss, and they explained several factors which contribute to the taboo surrounding abortion. It was primarily attributed to the association of abortion with sexual intercourse: 'So sex and everything else, it's not spoken about. So immediately when there's a child then it shows that you've been in an

[33] The first was homosexuality, the second was tattoos and piercings (Madu et al., 2002).

act' (Bokang). Avoiding talking about sex might be a result of childhood socialisation patterns which are continued into adulthood. Kgosi explained:

> In terms of Tswana culture there's a lot of respect and issues of status and if you're younger than someone you need to respect them more, and so you don't get those sort of conversations happening between generations [...] So there's a lot of issues relating to power, status, respect [...], what sort of topics are out of bounds [...]. So that's probably why issues of sex are taboo, including abortion. (1)

One participant claimed that 'part of the reason why people don't, don't talk about it is because government doesn't deal with it' (Masego: 7). That there is little political or public debate surrounding abortion was mentioned by several respondents, who recognised that 'there's been no conversation, there's been no dialogue, other than, you know, you read the occasional paper' (Fingi: 6). Another reason given for the taboo on termination was that: 'It's about killing isn't it. Like capital punishment, no one wants to talk about it' (Jason: 1). Throughout the interviews participants regularly connected abortion with killing; I shall discuss this in relation to religiosity below.

17 of my participants aligned themselves with an organised religious group.[34] The correlation between religiosity and lack of support for abortion is well established (Petersen and Mauss, 1976; Rhodes, 1985; Francome, 2004), and this was reflected in my interviews:

> *Linda*: [...] I'd like things to be done God's way. So if God hates something, I tend to also be against it as well.
> *Researcher*: Ok, so you feel that God, God would hate abortion?
> *Linda*: Yeah. (1)

13 people claimed that religiosity influenced how they thought about abortion. The majority (14) of interviewees defined themselves as Christian or Catholic. [35] It is widely assumed that the resistance to abortion by Catholic doctrine results from the idea that the soul enters the body at conception, thus becoming a person worthy of God's protection (Petersen and Mauss, 1976). The pro-life school of thought asserts that life begins when the

[34] See Appendix One.
[35] I lack sufficient demographic data to determine whether the Christian participants were Catholic or another form of Christianity. However, Christianity in Botswana is generally conservative, and follows much of Roman Catholic belief and practice.

ovum is fertilised, and that aborting the resulting foetus amounts to the murder of a child (Pro Life, 2012). This argument can be secular, attending to the medical grey area of when life is said to begin. Non-religious pro-life supporters tend to view the foetus as a medically viable life, referring to it as a baby or child. For example, atheist Kgosi explained that 'speaking for the baby, I don't think that's reason enough [to have an abortion]' (4). However, the pro-life idea is usually combined with religious beliefs (Francome, 2004), for example: 'My religion says abortion is, it's, it's killing. It's killing a person, because, no matter how many weeks or days or months pregnant you are, it's still a person. So my religion says its killing and it's a sin you are not supposed to kill a person' (Michelle: 1). Here the verb 'to kill' is repeated four times in just a few lines, indicating a strong belief. However, Michelle mentioned elsewhere in the interview that she had considered having an abortion herself, and that she thought it should be legalised. This suggests a personal conflict between religious or pro-life values and self-determination, a source of ambiguity shown by other participants too.[36]

The pro-life argument has been mobilized fervently in many anti-abortion campaigns, particularly in the United States (Francome, 2004), and appeared to be a common principle among my participants: 'I believe that everybody has a right to life. And if um, that is the case, god created us all to be on earth and to live, and nobody really has a right to take someone else's life' (Tlamelo: 1). When asked 'what's the first thing that comes to mind when you think of abortion?', nine people said that their first thoughts were in line with 'killing an unborn baby' (Linda: 1) or 'taking away a life' (Kagiso: 5). Others expressed pro-life sentiments at different stages of the interview, giving a clear overall picture of the significance of this particular stance on abortion. This was not affected by demographic characteristics; participants from every age group, education level, and family background emphasized that 'Christianity, it doesn't allow you to think, to even think about abortion, let alone do it' (Dineo: 1). In her interview, Mabedi's general view of abortion was that it is sometimes necessary, and that it should be legalised. However, invoking her Christian identity altered her thoughts, demonstrating the influence of religion on her beliefs: 'Well, you know as a Christian, I do have reservations. We can't just go around killing' (Mabedi: 1). She said that religion has a similar influence for society at large:

> *Researcher*: Ok, um, so [abortion is] restricted by law in Botswana, why do you think this might be?

[36] The ambiguity surrounding perceptions of abortion will be further explored in Chapter Five.

Mabedi: We are a Christian country. I think that explains it all. (4)

Mabedi's thoughts were echoed by two thirds of the respondents, regardless of their religious affiliation or views on termination. This suggests that a significant aspect of the problematic of abortion stems from a conservative Christian attitude towards it, and that this was widely recognised by my participants.

Harris and Mills (1985) claim that the correlation between religion and attitudes to pregnancy termination might be due to the weight that American religious teaching gives to taking responsibility for others (rather than on living a self-determined lifestyle). While my questions about the impact of religion on abortion were too limited to allow for a detailed conceptualisation of that relationship, the emphasis placed on the extended family and community values in other areas of the interviews implies that Harris and Mills' theory may apply to Botswana. Further research is required to examine the exact nature of the impact of religion on abortion attitudes in Botswana, investigating the effect of denomination, attendance, intensity of religiosity and other factors.

A further challenge for the acceptance of abortion in Botswana is the widely-held perception of unwanted pregnancy as a result of irresponsible sexual behaviour. Over half of the respondents attributed the need for abortion to unacceptable promiscuity on women's part: 'If you've committed abortion you're dirty, you're careless, you are all sorts of things' (Banyana: 4). When asked if they thought abortion should be legalised, many interviewees expressed concern that permissiveness would be equivalent to declaring a 'free-for-all' (Jason: 4) in which 'many people will just go around sleeping around knowing that they'll terminate the thing' (Faith: 3). The root of this fear was double-edged, originating from an apprehension of widespread immoral conduct and from concerns that HIV infection rates would soar as a result of increased sexual freedom.[37] Jason and Kagiso demonstrated this apprehension around these two issues:

> you can't make it legal for people to abort, because one, you compromise a lot of, you know, a lot of education that goes into trying to stop teenage pregnancies and trying to stop a lot of uh, extra-marital affairs and out-of-wedlock uh, you know that sort of thing. (Jason: 4)

[37] Botswana has one of the highest HIV infection rates in the world, at 24.8% (CIA World Factbook, 2009).

> In the country we are trying to fight HIV and AIDS [...] you know people have to change their ways, you know, the government, everyone is trying to get people to change their ways, like, sexual patterns and so on. (Kagiso: 4)

In the above quotes Jason and Kagiso implied that fears over sexual immorality and the spread of HIV were felt by both the government and the public, and that should abortion become legal these problems would be more difficult to resolve. Many stated that people would use abortion as birth control if it was more easily available. Jason and Kagiso were both male, but such an outlook was not limited to the male participants. In fact, the views of the women I interviewed were more punitive. Women of different generations held similar views in this respect. 18-20 year old Jessica asserted: 'If you do something wrong you should take responsibility' (6), referring to becoming pregnant accidentally. Faith, of the 41-50 group, echoed this view: 'If you get sexually active at any age then you must live with the consequences. Yeah' (2). This conservative view of abortion is similar to that of anti-abortion activists in twentieth-century UK and USA, who viewed abortion as 'a "prop" to irresponsibility in sexual relationships'[38] (Francome, 2004).

In discussing the problems associated with abortion in Botswana, the age of participants appeared to have little impact on their views. However, the majority of respondents thought that views about termination of pregnancy were changing with each new generation. Only one interviewee said that feelings 'haven't changed at all' (Barati: 1). Respondents of all age groups claimed that the younger generations were beginning to be open to the need for abortion, but 'you can forget about the older generation' (Mabedi: 4) shifting their beliefs. Some of the older interviewees appeared to be resentful of this change: 'The younger generation, they don't see a problem with [abortion], 'cause they just see that you don't want the child, why not kill it' (Faith: 1). Others commented less emotively: 'Amongst youth, they seem to believe in it. That people do make mistakes' (Dineo: 1).

13 interviewees attributed this shift in belief to the influence of western culture in Botswana. Whether this was viewed as an unwelcome imposition or as a 'natural' result of globalisation varied between individuals. While the male participants did not express resistance to the influence of foreign values on a personal level, both they and the female interviewees agreed that men would be displeased with this change:

[38] This conservative viewpoint might also extend to an abhorrence of homosexuality as 'unnatural' and to capital punishment as the only appropriate response to murder (Francome, 2004), views also expressed by my interviewees both during and outside of the interviews.

> Men are like yeah but, you know, you're my wife, you need to do what I tell you, you know, you can't have an abortion, if I wanna have kids I wanna have kids, there's nothing you can say about it [...] so when you stand up for yourself it's like oh, it's because you're watching Oprah [...] it's because of like you know, what other people are saying in other parts of the world type thing. (Boitumelo: 2)

Older women tended to view western values as a negative influence, while younger women expressed a belief that non-traditional ideas could be a source of freedom. Michelle demonstrated this, implying that one must move to the urban areas of the country where values are less traditional in order to achieve greater autonomy:

> Traditional men will tell you, everything you need you have to ask from him. If you need pads you ask from him, if you need food you ask from him, if you want to buy food for the family you ask from him. Nothing ever happens without *his* permission. So, if you want that to change, you have to move to the city. Because if you are at the villages, people won't understand. (Michelle: 2)

While most interviewees accepted that views on termination (and women's autonomy in general) are starting to shift, they asserted that the process was very slow and restricted to urban areas. They explained that any change in values was limited in its scope:

> I think obviously now things are changing slowly. You're starting to get career women, focusing on their jobs, focusing on empowering themselves by different means. But women are, I mean children are still quite important to the idea of family. So women are still expected to marry, have kids, not as many kids as that used to happen but, it would be seen as relatively weird and unbecoming if a couple remains childless for a long time. (Kgosi: 2)

In this chapter we have seen that alongside the legally circumscribed status of abortion in Botswana, there are social and cultural factors which make it problematic. In a patriarchal society it is difficult for a woman to regulate her own fertility without challenging the male-centred power structure. It is viewed as a woman's role to bear children, to the extent that her identity is wholly entwined with her fertility. Thus, denying a pregnancy through abortion is to risk denying one's selfhood. I showed that children are

viewed as a blessing; a pregnancy is not to be rejected. Supportive kinship networks mean that there is always somebody available to raise or to help raise a child, thus seeming to eliminate the need to consider abortion as a solution to an unwanted pregnancy. I discussed the taboo surrounding abortion and the challenges involved in discussing it. Support for the pro-life argument was strong among my interviewees, with a number of individuals associating abortion with killing. Religious beliefs were also an important aspect of the problematic of abortion. The beliefs of many Batswana centre on a conservative Christian viewpoint, which does not permit abortion. While many participants claimed that anti-abortion views are beginning to show signs of changing, most pointed to abortion in Botswana as being highly problematic, constrained not only by law, but by culture, religion and language. In the following chapter I shall investigate the particular circumstances under which abortion might (or might not) be considered permissible.

Chapter Five: Under what circumstances might it be acceptable to have an abortion?

In the previous chapter I discussed the social, cultural, religious and legal factors that made the concept of abortion problematic in Botswana. In this chapter I will examine the attitudes my participants demonstrated in response to specific scenarios where abortion might be necessary. I outlined a number of scenarios in which a pregnancy might be considered problematic, such as when it would put the mother's health at risk or exacerbate financial difficulty.[39] After briefly describing each situation I asked the interviewees whether they thought abortion would be acceptable on those grounds. I will discuss their responses below, presenting each scenario in order from 'most agreed to', to 'least agreed to'.

Studies (Harris and Mills, 1985; Craig et al, 2002) have shown that ambivalence in abortion attitudes is common, and that agreement or disagreement with abortion is often context-specific. Harris and Mills (1985) claim that physical grounds for abortion tend to receive more support than social reasons.[40] This is attributed to a value conflict 'between '*responsibility for others,* on the one hand, and *freedom to determine one's own life*, on the other' (138-139). Self-determination is defined in part as being 'free to determine their own lives without coercion' (ibid: 139). Thus, when a physical or 'coercive' condition creates grounds for abortion, it is viewed as acceptable to terminate that pregnancy. Responsibility for others involves being 'responsible for the consequences of [one's] own action upon others' (ibid.); if the reasons for abortion are considered to be a matter of 'personal convenience', this is seen as antithetical to the selfless action required in the responsibility for others value system. Support for abortion for social reasons is therefore problematic. Craig et al (2002) illustrate a similar pattern in American society where:

> Those who usually oppose abortion tend to feel less comfortable doing so when the pregnancy is involuntary, or when either mother or child faces

[39] The scenarios I presented were not selected to represent a complete list of possible reasons why one might wish to terminate a pregnancy; rather, I chose them to represent a range of physical and social factors relevant to the Botswana context. In categorising reasons for abortion into 'physical' and 'social' groupings, I have drawn on Harris and Mills' (1985) study.

[40] The categories I used were not entirely discreet, given that certain situations could be considered as either social or physical, or both, depending on their context. For the sake of discussion the situations were loosely grouped into the following: social categories - being emotionally unprepared for a baby; an inconveniently-timed pregnancy; an extra-marital pregnancy and problems with the relationship with the father. Physical categories - rape or incest; woman's health risks; woman's age; financial problems and the mother being infected with HIV/AIDS.

> serious health problems; those who usually support a woman's right to choose tend to feel less comfortable doing so when the decision to abort is more of an economic or social choice than a medical one. (295)

Such an outlook was also evident in my interviews. Respondents often claimed to be comprehensively pro-choice or anti-abortion, yet when questioned about specific reasons to terminate a pregnancy, their opinions demonstrated seemingly inconsistent values. This suggests the principles applied by the participants were variable according to the circumstances of the pregnancy.

Abortion on the grounds of a pregnancy-related health risk to the mother was considered the most justified by the interviewees. Most of the participants thought that poor health was an acceptable reason to terminate, and two were uncertain. However, the interviewees' pro-abortion attitudes for this scenario were limited. It seemed that abortion was only considered a legitimate response to pregnancy during poor health if the health concerns were extreme enough to endanger the life of the mother: 'If at all there's a way of making sure that the giving birth is [...] not fatal to the mother then abortion could not be acceptable' (Jessica: 3). Others agreed with Jessica's view. Linda expressed strong pro-life sentiments during her interview, but acknowledged that the mother's (physical) life was equally worthy of protection: 'If there's going to be a life compromised when having a baby, then it's understandable to abort [...] you let it run full course, you might even lose the child or lose the mother at birth, then it's [ok]' (3). That abortion to prevent health risks caused by a pregnancy were supported by the participants correlates with the findings of a 1998 GSS survey in the United States, in which health concerns was the most supported reason for termination (Craig et al, 2002: 290).

However, poor health as defined and experienced by the sufferer was not always considered a defensible reason for abortion. Six people claimed that only when 'it can be proved medically' (Jason: 2) and 'the doctor says it's ok' (Laone: 2) was abortion warranted. Fingi was anti-abortion, yet in a situation where 'someone else with some sort of relevant knowledge' had recommended a termination then the decision would be legitimate in her view, because it had been 'removed from really a decision that the mother is making' (2). This indicates a belief that women are not capable of or should not on their own determine their own reproductive activity or even their general health status. Such a view was expressed by both men and women of all age groups, suggesting general prevalence. The professionalization of medicine and its undermining impact on women's knowledge of their

health is not unique to Botswana, and its effects have been widespread since the nineteenth and twentieth centuries (Morrow, 2007; Ehrenreich and English, 2005).

Some of the participants claimed that while they agreed with abortion if pregnancy put the health of the mother at risk, society at large would not find that position reasonable. This was attributed to the belief that 'you just have to be strong, as a woman you should want your child so much that you should be strong and you should go through it or, so here I don't think it would be an excuse' (Siriol: 2). Siriol's statement demonstrates an expectation that women be self-sacrificing in relation to motherhood, regardless of the physical risks they might incur through pregnancy and childbirth. Her use of the term 'excuse' in place of 'reason' was common among the participants, and implies a belief that abortion signifies selfish and irresponsible behaviour.

Terminating a pregnancy caused by rape was tolerated by most of the interviewees, and was the second-most permissible reason for abortion. When asked, 'in what circumstances would abortion be acceptable?', many of my respondents answered 'rape' without hesitation. This was usually the only scenario given as justified grounds for termination, indicating that while abortion was rarely supported generally, rape was widely considered as an exception. On being asked directly whether abortion was legitimate in the instance of rape, just one participant said no, and two were ambivalent. Support for abortion in these circumstances appeared to stem from the belief that the woman 'didn't consider engaging in sex' (Kgosi: 3), and so she 'hasn't been irresponsible, she hasn't asked for it' (Masego: 4). This line of argument indirectly strengthens the notion found throughout the interviews, that unwanted pregnancies were a result of a woman's promiscuous sexuality. Rape, then, provided a permissible reason to terminate because the 'decision' to become pregnant was explicitly out of the woman's control. This was also the result of the 1998 GSS survey, indicating commonalities between US views and those of my sample (Craig et al, 2002: 290).

Many of those participants who accepted abortion in rape cases were uncertain if 'society' would agree with their attitudes: 'I doubt in my culture, I would say that, maybe half, half of the population would agree to that [...] for others, it would not seem right.' (Dineo: 2) Barati thought that the law which allows abortion in rape cases, did not help women in reality. This was 'because it's not your decision as a woman [...] the family's considered [...] so it's in very rare circumstances that, you know, [an abortion] is done' (2). The woman's family might not automatically agree to a termination because of rape, and this social pressure would be likely to prevent her from procuring the service. This indicates that while participants claimed to support abortion in rape cases, they thought that a

general anti-abortion climate in Botswana would deny them agreement from their compatriots. Research on a larger and more diverse scale would be required to investigate this assumption.

Terminating a pregnancy because of a problematic financial situation divided participants' opinions. Ten people found it to be an acceptable reason to have an abortion, pointing out the difficulties of supporting a new child when financial resources are already stretched. For these participants, abortion was a clear solution. However, the same respondents expressed strong anti-abortion sentiments when presented with other scenarios, demonstrating the impact of 'coercive' conditions on people's attitudes. Several interviewees framed their response in terms of the extent of economic difficulty in the scenario presented, claiming that abortion was acceptable only in a 'dire, dire situation' (Jessica: 2). If 'the child wouldn't starve, [they would] figure something out' (Masego: 3). This implies that these respondents thought abortion ought only to be considered in extreme circumstances. That no interviewee mentioned the strain that poverty might place on the mother's quality of life suggests that consideration of the child's well-being was paramount. In discussing the effect of poverty on the decision over whether to bear a child, many participants pointed out that 'you always have the support of family, financial and otherwise' (Kgosi: 3). The kinship support system where, 'in Tswana culture, when someone is not able to maintain their family, uh, we help one another' (Dineo: 2), seemed to negate the need to consider abortion. A number of interviewees suggested that a pregnant woman in financial difficulty should 'give the child to somebody else, who can take care of the child' (Tlamelo: 1) or 'put a child up for adoption' (Jessica: 2), rather than terminate the pregnancy.

Some people claimed that abortion in circumstances of economic shortage was not a solution to the problem. On the contrary, bearing children might be a more effective answer to poverty. Children were viewed as a 'labour force, [...] the more you have, the more it helps' (Barati: 2). Where there is no state pension available, as in Botswana, raising many children can help to assure financial support in future years. A further consideration for those who did not agree to terminating a pregnancy because of economic difficulty was the assumption that women can, and should, find a way to support their children. This responsibility was placed primarily on the pregnant woman; the father was not mentioned: '[The] mother, she has got hands to work for her child' (Laone: 2). She 'should be working, and you know, should make a plan to work' (Siriol: 2). Bokang thought that 'having a child kind of motivates you to work hard' (2) and thus helps one escape the cycle of poverty. However, this view is not sustainable in the context of multiple factors which prohibit

women's ability to earn a reasonable living wage, such as low wages in the domestic sector where women are most likely to find employment, lack of employment opportunities for women generally (Phaladze and Tlou, 2006) and lack of time to work due to unpaid obligations in the home. Perhaps the scarce acknowledgment of such issues stems from my sample type, in which most were employed in better-paid, 'white collar' industries. None of my participants could be considered as part of the 30.3% of the population living under the poverty line (CIA World Factbook, 2003).

The majority of the interviewees thought that it was unwarranted to have an abortion because of a woman's age, whether she was considered by herself or others as 'too young' or 'too old' to have a baby. Bokang recognised the potential disruption caused by having a child at a young age: 'Cousins of mine, they had kids, under eighteen, and it's dramatically altered their lives [...] they don't actually become proper parents for the simple fact that they are still learning' (3). For this reason, he accepted abortion in a situation where the woman is young. However, while most interviewees acknowledged this disruption to a young mother's life, they did not think it was reasonable grounds to terminate a pregnancy: 'It's only that in youngsters like eh, primary school kids and junior secondary, that we are concerned about [pregnancy]. But again, abortion shouldn't be allowed. People should take measure of responsibility' (Dineo: 3). Dineo's statement indicates that it was only in children under the age of 16 that pregnancy was a cause for concern, and that she considered society at large would agree with her.[41] However, even where there was unease about the mother's age, abortion was still not acceptable. Her view seemed to stem from the conviction that unwanted pregnancy at any age represented sexual promiscuity; bearing the child is to accept the consequences of one's actions. This principle was articulated repeatedly throughout the interviews.

An anti-abortion perspective was also taken by the respondents in regards to a woman being considered 'too old' to have a baby. They asserted that it would 'definitely not' (Siriol: 3) be grounds to terminate, because 'in my culture there's nothing like too old. Um, as long as you can bear a child it's fine' (Dineo: 3). It appears that the worth placed on childbearing outweighs any concern for the potential problems caused by having a baby at a later stage of life. Bokang explained that 'it's actually a good thing [...] you're so old yet still you can have a child', because it portrays you as 'a youth, still fertile' (4). Kgosi gave a family example of this positive attitude towards childbearing at an older age: 'I have an

[41] In Botswana, primary school refers to children aged 7-13; junior secondary refers to children aged 14-16.

aunt who's like 55 or whatever, she just had a baby [...] and she was celebrated in fact' (5), suggesting that fertility at any age is valued as a symbol of virility in women.

When I asked the interviewees if a woman's age was a justifiable reason for abortion, I was referring to whether she might be socially considered as too young or too old to have a child. However, six respondents interpreted this question as an issue of health concerns, thus moving it from a social to a physical paradigm for discussion:

> *Jason:* That would be a medical issue.
> *Researcher:* Medical, ok, so if it was a social or cultural thing then it wouldn't be a reason [to abort]?
> *Jason:* Nah, it's not valid. (2)

This difference in interpretation implies divergent world views, and supports the assertion that abortion might only be considered by my sample in the case of physically challenging circumstances.

The pattern of greater support for physical than for social reasons to terminate a pregnancy applied to all of the categories except for HIV/AIDS infection. This was the only physical condition for which abortion received some but very limited support. While general poor health was considered by most of my sample to be a permissible reason to terminate a pregnancy, being infected with HIV/AIDS was not. Only four people thought that being HIV-positive was grounds for an abortion. Ten people asserted that it was not justifiable to terminate because one is HIV-positive: 'No, that's not an acceptable reason. 'Cause um, I think every child deserves a chance' (Jessica: 2).

It appears that HIV/AIDS was not widely viewed as constituting poor health in the same way as other illnesses might. This could be a result of the very high HIV prevalence rate in Botswana. At 24.8%, it holds the second-highest infection rate in the world (CIA World Factbook, 2009).[42] The government's education programme and provision of free antiretroviral drugs has meant that there are considerably more people living with HIV than there are dying from AIDS. In 2009 it was estimated that there were 320,000 people living with HIV, and 5,800 deaths (ibid.). Where so many HIV-positive people are living relatively long lives, being infected might not be considered extreme enough for abortion to be considered. Jason's minimizing response to my question demonstrated this concept:

[42] The highest HIV infection rate in the world is Swaziland, with 25.9% prevalence (CIA World Factbook, 2009).

Researcher: Ok and if the mother's infected with HIV or AIDS?

Jason: Just that?

The rhetoric employed by my participants suggested that the reality of HIV infection is something that many have become accustomed to. 19 interviewees pointed out the government's free prevention-of-mother-to-child-transmission programme (PMTCT) as a factor which prevented the need to consider abortion: 'That I don't think um, is an excuse, because we have medication for that' (Tlamelo: 2). The programme is highly accessible to women throughout the country, with 95% of pregnant women infected with HIV receiving PMTCT treatment (UNICEF, 2010).

Some of the participants implied that since the start of the PMTCT programme perceptions had changed. While abortion might previously have been acceptable in the case of HIV infection, it was no longer a legitimate option: 'No, that's not a valid enough reason now, not anymore. Maybe previously but not anymore' (Jason: 2). This apparently recent development in social attitudes towards HIV-positive women having babies could account for the high level of ambivalence among interviewees when asked if it was acceptable. HIV infection in the mother caused the most ambivalence of all scenarios presented; five participants were unable to give a definitive answer: 'So, that one I'm on the fence about just because I do know that now there is, there are the treatments you can take so it doesn't get passed on [...] it would depend on whether you had a plan' (Keletso: 3).

The participants' immediate association of a pregnant HIV-positive woman with PMTCT drugs implies that their key concern was whether the baby would contract the virus: 'If you are pregnant, there's these um, the, they call it PMCP [...]. And I don't think the child can be affected. I don't think there's a reason to abortion when you are HIV AIDS' [sic] (Laone: 2). Only three interviewees raised other concerns, namely that the baby might be left without a mother. None mentioned the physical and mental well-being of the mother herself, which illustrates the perseverance of a self-sacrificing, woman-as-mother ideal even in the face of long-term illness.

An inconveniently-timed pregnancy received little support as grounds for an abortion. This was defined in my interviews as situations in which pregnancy might be disruptive to the mother's career, education, or other life experiences. Only four participants agreed that it was permissible to terminate a pregnancy under such circumstances. One of these individuals showed comprehensive support for abortion in any given situation, and the other three displayed broadly pro-choice sentiments throughout

their interviews. This implies that terminating a foetus due to a poorly-timed pregnancy was only warranted for the most liberal of the interviewees, and supports the pattern of low acceptance of social reasons for abortion among my sample.

Of those who did not support abortion in the case of inconvenient timing, many considered it to be an 'excuse' (Tlamelo: 2) for a 'selfish' (Linda: 3) course of action; bearing a child should take precedence over every other aspect of one's life:

> *Researcher*: So things like, the mother is yet to finish her degree, or she has work commitments, those kind of things [...]?
> *Faith*: No. No no no.
> *Researcher*: Ok, no, so um, bearing the child should come before work, and study, everything?
> *Faith*: Yeah. (2)

Michelle reacted similarly: 'No. that's putting your career at a, before your child. Nobody should put their career before their child' (3). However, she openly discussed her attempts to procure an abortion at various stages during her interview, suggesting that Michelle's strong anti-abortion reaction here was context-specific. This is compatible with the reactions of the majority of the interviewees, only one of whom maintained a single line of argument against every scenario I presented.

Many interviewees interpreted the scenario of a poorly-timed pregnancy to refer specifically to schooling obligations, even where I explicitly mentioned careers or other commitments. This might be because of a lack of genuine career opportunities for women, particularly outside of the domestic sector. However, many of my sample were highly educated and had professional careers, yet still did not seem to prioritise this when presented with a scenario where a pregnancy would disrupt a woman's career. This is indicative of a socialisation pattern in which even those women who are able to secure a career outside of the home are expected to abandon that path should pregnancy occur.

Eight of the interviewees stated that abortion was not justified on the grounds of inconvenient timing because one 'can always go back to school' (Masego: 5). Participants appeared to assume that that 'going back' was a simple option: 'If you are writing an exam you can go to the hospital, have a baby, the next day come back and write an exam. Just go' (Michelle: 3). The disruption caused by having a child was scarcely acknowledged, perhaps indicating that that women are expected to perform childbearing with ease as part of their perceived role as 'natural' mothers. While some of the respondents were referring to

university when they spoke of school, many referred to senior secondary school, suggesting that a pregnancy might only be considered poorly-timed if the woman was still very young. This implies a low value placed on women's life commitments after she has reached what might be considered child-bearing age.

Educational policy in Botswana dictates that girls must leave their school immediately on becoming pregnant. Although they can apply to the Ministry of Education for re-admission once the child is born, it must be to a different school than the one they attended previously. Effectively, this means going to school in another village, which requires somebody to take care of the child while the mother is away. In reality, pregnancy prevents most girls from returning to school at all (Meekers and Ahmed, 1999). In fact, only 20% resume their education (Women's Affairs Dept., 1995). My participants seemed unaware of this actuality, perhaps because they had all gained above-average years in education and many of them did not have children, suggesting that they might not have experienced pregnancy while still at school. Their lack of acknowledgement of these difficulties might also be a result of their strong anti-abortion stance when confronted with the scenario of becoming pregnant while still in education: 'No, no not at all [...] that's not, for me, a good reason enough' (Mabedi: 2).

Two young women in my sample pointed out that they didn't think 'a pregnancy most of the time is ever really planned for' (Siriol: 2). The belief that 'the youth here, most of us, when we get pregnant it's not like it's planned. It just happens' (Michelle: 3) highlights numerous issues for further study, including sex education; attitudes to sex; STIs; pregnancy; and the usage and availability of contraceptives.[43] The interviewees implied that abortion should not be an option because unplanned pregnancy is the norm for young people. Life expectancy is relatively high at 67.1 years for women and 63.3 years for men (Women's Affairs Department, 1995), suggesting there is no biological need for childbearing at a very young age, thus adolescent pregnancy is an 'unnecessary' trend. In Botswana, over 90% of sexually active unmarried women know of one or more modern contraceptive method, but usage is low (Gage-Brandon and Meekers, 1993) and at least 85% of teenage births are unwanted (Women's Affairs Dept., 1995). This indicates socio-cultural pressures on young women and girls to have unprotected sex. As a result of this restrictive set of circumstances teenagers are often forced to resort to illegal abortion,[44] or as my participants suggested, abandon their education and raise unwanted children. That it

[43] Studies that have begun to examine some of these issues in Botswana include UNICEF (1989), Gage-Brandon and Meekers (1993) and The World Bank (2010; 2011).

[44] Further exploration of abortion among adolescents would illuminate this study. However, for ethical reasons people under the age of 18 were not included in my research.

is considered 'normal' for girls and women to desert their career or schooling to have babies suggests that there are social tools in place to deal with an inconveniently-timed birth, such as familial support and the acknowledgement that education and careers are secondary to motherhood: 'It's your responsibility, you have to raise the baby one way or another, you could quit [school or a job] and continue later' (Linda: 3). These social norms seemed to deny the option of abortion for a poorly-timed pregnancy; rather, 'you have a child that you did not plan for, but you need to take care of the child' (Tlamelo: 2).

I asked the participants whether it was reasonable to have an abortion because the pregnancy resulted from an extra-marital relationship. Some interpreted this to mean that the mother had become pregnant before marriage; others defined it as a pregnancy conceived during an extra-marital affair. However, this discrepancy in interpretations had no marked effect on the participants' attitudes, most of whom (all but three) did not support abortion in either set of circumstances. There was very little ambivalence in their responses, with only one person appearing to be conflicted about the issue. Most of the interviewees expressed strong anti-abortion opinions: 'No. Absolutely *no*. They have to keep the child [...] there is no way' (Laone: 2).

Some of the participants did not personally agree with abortion in such circumstances, but acknowledged the cultural possibility of having an abortion to conceal a pre- or extra-marital pregnancy. Siriol described the bearing of a child outside of a traditional marriage union as 'very shameful in our culture' (3). The family might therefore 'agree to [an abortion], but it would be very quiet' (Siriol: 3). However, others asserted that while there would be 'shame on the families' (Bokang: 3) if a child was born out of wedlock, it would bring greater disgrace to terminate the pregnancy and thus abortion would not be permissible. That extra-marital childbearing is preferable to abortion appeared to result primarily from distaste for abortion in general among the interviewees. However, it might also be attributed to the cultural maxim that a woman's 'procreative power should not be allowed to lie dormant' (Schapera, 1984: 157). Pre- or extra-marital pregnancy is considered objectionable, but is tolerated in Botswana as occasionally necessary for the vital task of childbearing (Phaladze and Tlou, 2006).

Both male and female participants expressed revulsion at women who become pregnant before marriage or as the result of an affair. They implied that this could only be the result of a woman's sexual promiscuity and if abortion were to become acceptable in these circumstances, 'it would be setting a bad example. She might think it's ok to just sleep around, get pregnant, and then go have an abortion' (Michelle: 3). Women and men expressed similar opinions: 'you make your own choice, you have to live with it [...]

abortion cannot be a solution' (Jason: 2). Masego's assertion that having an abortion in that situation would be 'too easy' (5) indicates a belief that women should be denied a straightforward solution to an unwanted pre- or extra-marital pregnancy because 'we all have to pay, or face the consequences of our actions' (Fingi: 3). This supports my other findings, in which women were considered sexually promiscuous should they conceive an unwanted pregnancy, and were held responsible for bearing and rearing the child as a penal measure against their perceived misconduct. However, even those who claimed to be pro-choice found it difficult to accept social reasons for an abortion:

> *Kgosi*: Speaking for the baby I don't think that's reason enough. Live with your deeds. [...] If a woman decides to jump out of her marriage [...] and have an affair, and if she's not careful enough and becomes pregnant, I don't [...] I don't think you're such a good person in my books [...] but if I'm pro-choice, surely every woman should be allowed to have an abortion for whatever reason?
> *Researcher*: So you're conflicted about that?
> *Kgosi*: I'm pretty conflicted about that. (4)

Here Kgosi appeared to be ambivalent about whether a woman should be entitled to an abortion if she had behaved 'unacceptably', despite his desire to support freedom of choice (or to present himself as such). This indicates that an approach to childbearing as a punitive measure against women's perceived promiscuity is ingrained, perhaps as a result of deeply patriarchal socialisation patterns.

One of the reasons for abortion which received the lowest agreement (two participants) was an unstable or otherwise problematic relationship; for instance, the relationship is new or casual, or the father has abdicated responsibility for the pregnancy. Two respondents compared having an abortion for this reason with killing a child later in life because the parents were to get divorced (Faith: 2; Jason: 2). This indicates that the foetus was perceived to be a child and thus abortion would not be justifiable, a belief demonstrated by many of the interviewees: 'It's a natural part of [relationships], abortion wouldn't really be fair to the child' (Jessica: 3). This pro-life argument whereby the foetus was deemed to be a person worthy of protection was employed by the participants in response to this scenario, particularly where they perceived relationship problems to be a social, rather than an economic concern. Six interviewees interpreted the scenario as an entirely economic problem: 'No. Because we have a system here [...] they can make direct debits from the father's salary towards the mother' (Fingi: 3). This suggests that the idea of

having an abortion because of a problematic relationship from a social perspective was not even to be considered. Like Fingi, other respondents stated that abortion is not permissible because of an absentee father or a difficult relationship because there is a child maintenance system available: 'They can always have the father be forced to support the child. So I don't think it's enough of a reason for women to take that measure' (Kgosi: 4).

The emphasis that the participants placed on the economic aspect of relationship problems implies that the mental and emotional stresses of single-parenthood for women were not widely recognised. Highlighting that there are 'many single mothers' (Michelle: 3), they explained that there are 'just responsibilities that the men don't take [...] the way society is shaped, it grooms men to be a certain way where they block out a lot of things' (Bokang: 3), and that men will 'get you pregnant and run away [...] most of the time he is not even going to be any help at all [...] so it might as well be he's not there' (Michelle: 3). These assumptions were held by both men and women of varying age groups, demonstrating an expectation of child-rearing as solely the mother's responsibility: 'If the father decides to dump the mother, um, then the mother should to some extent be in a position to look after the baby' (Dineo: 2). This overwhelming lack of support for an unstable relationship as grounds for abortion appears to stem from social and cultural norms in which men are not expected to participate in child-rearing. This might stem from Botswana's history of male labour migration. It is also supported by the high percentage (around 50%) of female-headed households, which suggests single-parenthood for women is common despite the value placed on the traditional marriage union (UN, 2002).

When I asked the participants whether being emotionally unprepared for a baby was a satisfactory reason to have an abortion,[45] their reactions highlighted confusion about the meaning of that concept. Some assumed that I was referring to the mother being very young:

> *Kgosi*: That's very difficult. Um, if she's not emotionally prepared, to have the baby?
>
> *Researcher*: Yeah.
>
> *Kgosi*: So she's like fourteen or fifteen? (4)

[45] Being emotionally unprepared for a baby was a scenario which I asked as part of a series of post-interview follow-up questions. Only half of the participants responded, and so my information is limited. However, the answers I received served to highlight and support emerging trends and so will be discussed here.

> *Jason*: Emotionally prepared. But how do you tell that? How do you determine that she's not emotionally prepared? Underage? Because underage... (2)

These reactions suggest that some interviewees felt ambiguous about the scenario because they weren't certain of the meaning of 'emotionally unprepared'. I defined emotionally unprepared as feeling one could not cope mentally with having a child, and feeling distressed about pregnancy for that reason. After I had clarified my meaning, Kgosi explained that psychological matters are neither understood nor accepted in Tswana society, and that claiming to be struggling mentally with a pregnancy would be viewed as the woman making excuses (4). Both of the above participants were male. The female respondents grasped the concept more easily, but were still unsupportive of this reason for abortion. They portrayed it as a selfish 'excuse' (Michelle: 7) and associated it with sexual irresponsibility: 'Why have unprotected sex if you are emotionally unprepared for a baby?' (Nicole: 6). Kagiso held that it was not viable because 'you cannot know if people are always telling the truth' (5). This implies that such a reason would be thought to be used untruthfully to conceal a less acceptable reason for termination. It also suggests that women might be expected to justify their reproductive decisions to others. In Masego's view it would only be permissible if the mother was traumatised by her pregnancy to the extent that it would harm the child (8). This perception of a mother's mental health as of secondary or little importance was seen repeatedly in my interviews.

In this chapter I have examined the participants' responses to particular scenarios resulting in unwanted pregnancy, and whether or not they considered such circumstances to provide acceptable grounds for abortion. I have shown that physical reasons to terminate a pregnancy generated more extensive support than the social scenarios that I presented to participants. For example, 17 people agreed that abortion was permissible if the mother's health was at risk. However, only two thought that a problematic relationship with the father was an acceptable reason to terminate a pregnancy. I surmised that the lack of support among my participants for social reasons stemmed from the belief that women become pregnant largely as a result of their own sexual irresponsibility. This was a view shared by 17 interviewees, suggesting a commonly held perception that an unplanned pregnancy happens because 'you weren't careful or you were promiscuous' (Fingi: 6), and that if 'you engage in sex you know the results' (Faith: 2) and must accept the consequences. I explained that physical grounds were often perceived as coercive

situations that fell outside of a woman's control. Therefore, having an abortion was more acceptable because it did not signify a 'selfish' response to 'carelessness'.

This chapter has shown that women's role remains aligned with traditional culture in the views of my participants. Despite important advancements in women's legal, economic and political rights since independence in 1966, they fundamentally remain submissive reproducers; their primary function being to bear and raise as many children as possible. In the following chapter I will draw together my findings from each of the analysis chapters of this dissertation, and relate them to the wider problematic of women's status in Botswana.

Chapter Six: Conclusions

In this dissertation I have first and foremost investigated the social and cultural construction of abortion. Secondly, I have used this as a lens through which to examine the status of women's reproductive autonomy in Botswana. My investigation was prompted in part by the reported high levels of maternal mortality caused by complications resulting from illegal terminations, and the government's failure to address this despite its strong developmental record in the arenas of health and women's rights. This raised questions over why the abortion issue had not been addressed; despite clear statistical and anecdotal evidence that dangerous and illegal abortion happens on a large scale. The government's inaction probably results specifically from political and legal concerns, but this was not the focus of my research. Rather, I set out to explore the underlying social and cultural reasons for neglecting the abortion problem, in the belief that these must be addressed before political or legal reform can be generated.

I sought to answer three main research questions: What are the possibilities and constraints for procuring an abortion? What makes abortion problematic? And, under what circumstances might it be considered permissible to have an abortion? To address these questions, I conducted 21 semi-structured qualitative interviews with Batswana. My sample was not representative of the population at large. Rather, I sought to draw out the views of a small group of women (and some men) and analyse their individual perspectives. This helped me to construct an image of some of the key issues surrounding abortion, and the way it was perceived by my urban Batswana interviewees.

In the Introduction (Chapter One) I outlined the context of my research. I provided a country profile and explained my connection with Botswana. I drew together secondary literature to illustrate the role and status of women in traditional Tswana culture. I focused particularly on the significance of motherhood, and the implications of the historical system of *lobola* (bride wealth). I described the ways in which society has begun to change as a result of rapid economic development, and the opportunities and limitations that these changes have represented for women. I explored the government's progress in advancing gender equality, and charted Botswana's commitments to national and international instruments for women's rights. I explained the country's restrictive abortion law and discussed the repercussion for women's health, focusing on clandestine and dangerous abortion as a primary cause of Botswana's exceptionally high maternal mortality ratio. While there is minimal literature concerning abortion in Botswana, I was able to situate my

research within existing work on Batswana women in culture, health, society and law, and to relate it to the substantial body of literature concerning illegal abortion worldwide.

In Chapter Two I discussed my methods, the methodology underlying my approach, and the ethical and practical concerns I encountered throughout my research. I reflected on my positionality as a young, white, foreign, feminist, female researcher, and how these attributes impacted on the interview process and my relationships with the participants. I examined the complexities of my insider/outsider status, and the issues that arose when interviewing friends and colleagues. I explored the tension between my desire to let the interviewees speak for themselves and my feminist approach to interpreting what they said, and I concluded that while my inexperience as a researcher and the practical and ethical constraints I encountered were somewhat limiting, my methods were generally effective. Through my interviews I was able to secure informative responses to questions surrounding a taboo topic, and gain a sense of the participants' attitudes towards it. In this conclusion I shall present my key findings from each of my analysis chapters (Chapters Three, Four and Five), and discuss the implications and limitations of those findings.

In Chapter Three I set out to investigate the nature of incidents of abortion by discussing the options for terminating a pregnancy. I discovered that the respondents' knowledge of the abortion law was weak; most thought abortion was illegal without exception. Amendments to the law in 1991 allowed for termination under certain circumstances, but knowledge of this was minimal even among my highly educated sample. That the abortion law is not widely understood suggests that in reality it is not useful for women suffering unwanted pregnancies. In investigating the various options for terminating a pregnancy I showed that 'backstreet' abortion was the most frequently described method, and that while such services were seen as dangerous, they were known to be common and easily available through a female network of information. I found that there are safer alternatives to backstreet abortion for those with financial means. These include procuring the services of a qualified medical practitioner, albeit illegally, and travelling to South Africa where abortion is legal on demand within 13 weeks of conception. Access to these alternatives is restricted to women who are able to secure the capital to pay for expensive services and the independence of movement to travel abroad. As such, it is likely that safer options for abortion are limited to a small percentage of the population. I demonstrated that my interviewees held common knowledge of infanticide and infant abandonment, locally known as 'baby-dumping'. The majority thought that such incidents would be reduced if abortion were to be legalised. This suggests that infanticide is viewed

as a resort for those who were denied access to abortion, and raises questions about the absence of an official adoption programme in Botswana.

I concluded Chapter Three by analysing the participants' responses to the question of who would decide whether or not to terminate an unwanted pregnancy. Many of the interviewees claimed that men would take control of reproductive decision-making. Others said the pregnant woman would choose whether to have an abortion, not because of publicly accepted power in that domain, but because she would keep it secret out of fear and shame. Some participants claimed the decision would be made by the woman's wider kin group. A minority of the sample claimed it would be the woman's choice. These were older women, implying that a woman's autonomy might increase with age, possibly as a result of multiple births and the social standing that this would bestow on her. I found that overall there was considerable ambiguity for individuals answering this question, suggesting that reproductive decision-making is complex, personal, and situational. In traditional culture men tend to make all family decisions, including when to have children (Schapera, 1984). That the interviewees spoke of alternatives to this pattern implies that cultural norms are unclear or are transforming, a notion which requires multi-directional investigations through future research.

In Chapter Four I discussed how diverse socio-cultural factors make the idea of abortion inherently problematic in Botswana. It appeared that the most important barrier to my participants' acceptance of abortion was that it was seen to conflict with the meaning of womanhood. This belief operated on multiple levels. In a culture where women's primary function is to bear and raise children it is difficult to justify terminating a pregnancy. The woman's physical, social, financial and emotional needs were considered secondary to her role as mother. The interviewees repeatedly emphasised the value of children, asserting that children are a blessing and that no pregnancy should be terminated. This was related to the cultural belief that a woman can only become whole once she has borne a child; the more children she bears, the greater her value in the eyes of the community. I found that women are socialised to believe that their worth is grounded in motherhood, the implication being that their sense of identity and pride increases with every child born. Such a construct of childbearing makes the acceptance of abortion difficult, in that it represents a denial of motherhood and the associated significance of childbearing for a woman.

My participants showed intolerance of a woman prioritising her personal requirements over motherhood, and associated abortion with selfishness. This was related to the widely-held belief that unwanted pregnancy is a result of a woman's promiscuous

sexuality; she must therefore accept child bearing as the consequence of her 'careless' actions. A further challenge for a woman wishing to terminate a pregnancy was the notion that for her to make reproductive decisions represented an unacceptable level of bodily autonomy. The majority of the interviewees claimed that reproductive decisions are made by men; a woman must act covertly if she is to circumvent their control over her body. In researching attitudes to women having abortions I found that while Botswana's patriarchal system has been somewhat weakened as a result of political, economic and legal changes, women's empowerment has not permeated the private realm of family and home. This is supported by evidence of increasing incidents of rape and domestic violence against women (Mathangwane, 2001; Mookodi, 2004).

In examining the participants' responses to scenarios that depicted an unwanted pregnancy under different sets of circumstances (Chapter Five), I discovered that the level of support for abortion was generally low, with only one person expressing consistently pro-choice beliefs. Many of the respondents defined themselves as anti-abortion. However, their reactions to specific scenarios suggested their stance was not resolute, but was instead determined by the context of the pregnancy. This reflects Harris and Mills' (1985) finding that 'multiple and mutually inconsistent principles (values, norms) are differently weighted according both to social location and to specific conditions' (139). 'Physical' grounds for abortion, such as rape, financial difficulty, or poor health, were more readily accepted than 'social' reasons, such as relationship problems or career commitments. I showed how this can be explained by the association of social grounds for abortion with a selfish and irresponsible lifestyle; terminating a pregnancy for social reasons was considered antithetical to communal Tswana culture. Physical reasons were more often perceived to be outside of the woman's control; she was not thought to have acted irresponsibly and thus abortion might be permissible. My findings suggest that mental or emotional grounds for terminating a pregnancy were among the least understood. The participants struggled with my interpretation of being emotionally unprepared for a baby and some thought that this could only mean that the mother was very young. In my analysis of this I showed that women were expected to be mentally ready for childbearing from an early age, and that a woman's emotional health was considered irrelevant for her reproductive activity.

In investigating the circumstances under which abortion might be acceptable, I found that the father's responsibility for the pregnancy was not generally a concern. This was articulated in various discussions. For example, parental-relationship problems were the least supported reason for abortion, and this was based on the assumption that single

parenthood for women is both conceivable and common. This was also shown in explanations of potential solutions to becoming pregnant at an inconvenient time; the woman should abandon her schooling or career commitments, receive childrearing help from a female relative, or give the child away. No respondent suggested paternal child care as the answer. The participants' interpretations of 'financial difficulty' as grounds for abortion usually consisted of an absentee father, the solution to which was to secure child maintenance through the courts;[46] or an unemployed mother, who must then prioritise finding employment to support her child. The interviewees interpreted 'financial difficulty' as being the woman's problem, not the parents' problem.

Through my analysis of factors such as those explained above, I demonstrated that pregnancy and child rearing are considered to be exclusively the mother's responsibility. This cultural expectation might stem from Botswana's history of male labour migration and high numbers of male deaths, which has resulted in a significant sector of the female population raising children as single mothers (Meekers and Ahmed, 1999). These female-headed households experience the lowest incomes (Government of Botswana, 1995) and yet maternal responsibility for supporting a family appears to be accepted as unproblematic; abortion is thus not considered to be a justifiable solution to the emotional and economic strains of single parenthood for women.

In my analysis of the interviews I discovered that the demographic characteristics of my participants had little or no discernible effect on the attitudes and knowledge they expressed. My interviewees reflected variations in age, occupation, sex, religious affiliation, marital status, number of children and siblings, and place of birth. However, the internal differences of the group were offset by similarities; all were English-speaking, held above-average education and lived in the capital Gaborone at the time of my research. All were over 18 and under 60, and most were employed as professionals. In these respects the internal variation of my sample was restricted, and did not represent the demographic structure of the population at large. In addition, the group was small at just 21 people. This could explain why these factors appeared to have little impact on my participants' responses, as the sample was not large enough to reveal variations in response patterns. My interviews enabled me to build a partial understanding of some of the issues surrounding abortion, as articulated by my participants. In order to gain a comprehensive understanding of this national problem a considerably larger study is required,

[46] While such an interpretation could also have suggested an assumption that if the father was present there would be no financial difficulty, this is unlikely given the high levels of unemployment and poverty in the population at large.

encompassing rural dwellers, non-English speakers, the under-privileged, the under-educated, young teenagers and the elderly.

A further limitation of my research was that my over-cautious approach to ethical considerations led me to avoid asking any questions about interviewees' personal experience of abortion and unwanted pregnancy. As such, I was only able to draw general opinions and responses to hypothetical situations. Whilst this information is valuable in its own right, the meanings of from a study on abortion would be vastly enriched by including women who had experienced abortions or unwanted pregnancies. It is possible that the 'abstract principles' demonstrated by the interviewees might be inconsistent with their behaviour in 'concrete situations' (Harris and Mills, 1985: 139). This is supported by research that found women in South Africa who had had an abortion had been theoretically anti-abortion prior to suffering an unwanted pregnancy themselves (Braam and Hessini, 2004). Researching women suffering from unwanted pregnancies would increase understanding of the issue by illuminating not just theoretical attitudes, but tangible experience. Exploring the 'duality between actual behaviour and expressed attitudes may present an opportunity to shift thinking around the issue of abortion and needs to be explored creatively' (ibid: 48).

'The logical consequence of a male-defined and male-dominated world view is that experiences that are not directly informed by men's experiences, notably pregnancy, childbirth, abortion and violence against women, are not seen as priority areas' (Braam and Hessini, 2004: 46). Women's reproductive health and rights must be taken seriously as part of Botswana's developmental programme, in which gender equality is a crucial element. Gender inequality can only be intensified by proscribing legal abortion, because of 'the biological fact that women carry the exclusive health burden of contraceptive failure' (Cook, 1993: 78). Continuing to criminalise abortion represents an unacceptable failure to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning' (CEDAW, article 12.1, cited in UN, 2002).

That the consequences of a restrictive abortion law fall only on women is exacerbated by the fact that approximately half of the population live in female-headed households. It is therefore important that these women are able to support themselves and their families financially. Female-headed households are some of the poorest in the country, suggesting that women do not have adequate recourse to the paid employment needed to maintain a decent standard of living. Meekers and Ahmed (1999) argue that the

welfare of such families depends on the education level of the female head, because educated women have better chances of finding paid work. They point out that if these women are prevented from continuing their education by an unwanted pregnancy, it becomes increasingly difficult for them to escape poverty. Furthermore, if a woman died or became disabled as a result of unsafe abortion, her family would lose a vital resource and this would contribute poverty in the community (Braam and Hessini, 2004), particularly as 'income earned by women is much more likely to improve the social status, health and standard of living of families than income earned by men' (ibid: 46). Unsafe abortion also places huge strains on healthcare systems, limiting the medical resources available to the community at large. Access to legal abortion can contribute to women having higher levels of education, formal wage employment, and improved economic and social autonomy (Cohen, 2012). Effective family planning and abortion services tend to lower poverty rates and increase the financial and emotional welfare of children born (ibid.).

Researchers recognise that abortion has always been a widespread practice, and will continue to occur regardless of cultural, social or legal restrictions (Henshaw et al, 1999; Cook and Dickens, 2003; Brookman-Amissah, 2004; Hord and Wold, 2004; Sai, 2004). Research on abortion in Africa in particular illustrates how criminal sanctions are dysfunctional. They do not limit the number of abortions that take place, but rather force women to approach unsafe and illegal providers. This is pertinent in Botswana, where the complications of unsafe abortion are consistently the greatest causes of maternal mortality. 'Under current laws [...] women are effectively criminalised for the reproductive choices they make, contributing to the trauma they already experience in seeking an unsafe abortion' (Braam and Hessini, 2004: 45). If women are to be protected from these dangerous illegal procedures, the only appropriate response is to remove abortion from the criminal agenda and place it on the public health agenda (Cook and Dickens, 2003; Hord and Wold, 2004). For this to be viable, the society in question must first experience broad liberalisation of social and cultural norms. Doctors need to be clearly informed of women's legal rights, and prepared to pass this information on to women presenting with unwanted pregnancy. Should the current law be liberalised, women must have greater levels of economic independence and bodily autonomy to allow them to take advantage of reproductive health services (Benson, 2005). Furthermore, health-care facilities must be able to handle the change (ibid.). Should abortion become decriminalised, inexpensive and accessible services are required to ensure that poverty is not a barrier to women seeking to terminate a pregnancy (Teklehaimanot, 2002).

My research has shown that there are multiple obstacles to full reproductive health rights for women in Botswana. Not only is abortion legally proscribed, but it appears that socio-cultural conditions prevent women from achieving bodily autonomy. Botswana is currently experiencing a certain level of social and cultural transformation, resulting in increased economic and legal opportunities for women. However, advances in sexual and reproductive health rights have been negligible, particularly outside of the city (Emang Basadi, 1996). This can be partially explained by a widespread fear that liberalising abortion laws will cause a decline in 'moral' values, inevitably leading to a drastic increase in demand for abortion (Gage-Brandon and Meekers, 1993; Sai, 2004). Developing countries that have made it safe to terminate a pregnancy have not witnessed any such response, but rather a notable decline in maternal mortality (Sai, 2004), and yet the fear of sexual anarchy persists. For these anxieties to be weakened enough for reform to be considered, the root of such beliefs must be addressed.

The social construction of unwanted pregnancy as a result of women's 'promiscuous' sexuality must be tackled, for 'sexual intercourse cannot simply be presumed coequally determined' (McKinnon, cited in Harding, 1992-1993: 18). In the context of male dominance, 'meaningful consent is not possible' (ibid.). To claim that women ought to bear an unwanted foetus to term as punishment for their 'carelessness' neglects to take into account the patriarchal conditions under which they and their sexual partners have been socialised, conditions which prohibit women's control over sex and contraceptive use. As McKinnon aptly asserts: 'Choice means little when women are powerless' (cited in Harding, 1992-1993: 19). While such punitive conceptualisations exist, legal reform will be ineffectual in increasing women's reproductive autonomy. For reform to be genuinely effective, it must be pro-actively linked with the cultural setting of the women it is supposed to benefit. Campaigns must be generated from a socio-cultural context which take localised perceptions of sexual health issues into account; progress will otherwise be merely superficial (Mogwe, 1992).

Appendix I: The demographic attributes of the participants

Table 1. Number of participants by age group.

Age group	Number of participants
0-20	3
21-30	6
31-40	8
41-50	3
50+	1
Total	21

Table 2. Number of participants by religious affiliation.[47]

Religious affiliation	Number of participants
Christian	13
Roman Catholic	1
Muslim	2
Agnostic	1
Atheist	4
Total	21

Table 3. Number of participants by marital status.

Marital status	Number of participants
Married	8
Single	13
Total	21

Table 4.Number of participants by number of children.

Number of children	Number of participants
3	4
2	4
1	1
0	12
Total	21

[47] Categories were not preselected; religious affiliations were defined by participants.

Table 5. Number of participants by highest level of formal education.

Highest level of formal education	**Number of participants**
GSCE (or equivalent)	3
A-level (or equivalent)	4
Undergraduate degree	9
Postgraduate degree	5
Total	21

Table 6. Number of participants by sex.

Sex	**Number of participants**
Women	17
Men	4
Total	21

Table 7. Number of participants by number of siblings.

Number of siblings	**Number of Participants**
0-2	8
3-4	8
5-6	0
7-9	2
10-2	1
N/A	2
Total	21

Table 9. Number of participants by urban or rural origin.[48]

Origin	**Number of participants**
Rural	14
Urban	5
N/A	2
Total	21

[48] All participants were living in the Gaborone area at the time of my research (2011).

Table 8. Number of participants by occupation.

Occupation	**Number of participants**
Alumni co-ordinator	1
Assistant bursar	1
Caterer	1
IT technician	1
Lawyer	1
Lead physician for women's health programme	1
Librarian	1
NGO employee	1
Student	3
Student exchange officer	1
Teacher	4
Technical education officer	1
Unemployed	1
Visual Artist	1
Web designer	1
Writer	1
Total	21

Appendix II: Interview information sheet given to the participants

Interview Information

My name is Stephanie Smith. I am conducting research on the subject of pregnancy-termination in Botswana, and will be writing a paper on the subject at university later this year. I will be taking part in a research-based MA course in Women's Studies at York University, England.

If you agree to participate, we will have a discussion about the issues surrounding pregnancy-termination here in Botswana. There will be open-ended interview questions to guide our talk.

All information will be kept **strictly confidential**. Information given by you will be made anonymous through the use of a false name. No information that could be used to identify you personally will be made public.

I will be taking an audio recording of the interview to enable me to write an accurate transcript of our discussion. The transcript may be published, but the audio recording will not be made public.

The topic of pregnancy-termination is naturally a sensitive topic, and some participants may find it distressing. I will NOT ask you about personal experiences and would ask that you do not offer any such information. We will only talk generally about the subject. You may decline answering any questions that you are uncomfortable with.

If you chose to participate, you are free to withdraw at any time before, during, or after the interview process, and you are not required to give a reason. We can stop the interview at any time, and if you are uncomfortable with my questioning or note-taking activities, please let me know immediately so that I can change what I'm doing.

If you have any questions about me, my research, or our interview before we begin, please do not hesitate to ask. If you want to ask a question after the interview at any stage, you can contact me at: smith.s.stephanie@gmail.com

Before September 2011, you can also contact me at: Maru-a-Pula School, Private Bag 0045, Gaborone. (I will be leaving Botswana in September). From September 2011, you can contact me at: 16 Dendrum Close, Oakworth, Keighley, West Yorkshire, BD22 7JQ, UK.

Appendix III: Interview consent form

Interview Consent Form

Please ensure that you have read the attached sheet, 'Interview Information Form', before completing this consent form.

- I have been informed of and understand the purpose and procedures of this study and the purpose and procedures of this interview.
- I understand that I am free to withdraw my consent and discontinue my participation in this interview or study at anytime.
- I understand that the interview will be digitally recorded and then transcribed.
- I understand that my words may be quoted directly. I agree that the researcher may publish documents that contain quotations by me (under a false name, in order to protect my anonymity.)

Circling YES below means that you grant copyright permission to the researcher for the purpose of publication:

I agree to be quoted directly under a false name - YES NO

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study.

Participant's name: _____

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

Please provide the following background information about yourself:

Sex: M / F

Age: Under 20 21-30 31-40 41-50 50+

Highest level of formal education: _____

Occupation:_____

Religious affiliation: _____

Relationship status: _____

Number of children: _____

Number of siblings: _____

Where in Botswana are you from? _____

Appendix IV: Interview guide

Interview Guide: Thank you/confirm read and signed consent form.

- We're going to be talking about abortion in Botswana today. Generally, would you say it's a conversation that people are willing to have?
- How far would you say that abortion is a taboo topic here?
- Why do you think that is?
- What does the word abortion bring to mind? How does that make you feel?
- Do you think your religion affects your feelings about abortion?
- Does Setswana culture affect your feelings about abortion? How so? *(childbearing as vital to a woman's ID, women's rights as imposition of Western culture)*
- Have you travelled at all? How has that experience affected your opinions?
- Do you feel that people's feelings and beliefs about abortion have changed at all in recent years? *(modernisation, women's rights movement)*

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- Under what circumstances do *you* feel that abortion might be acceptable?
- Are the following acceptable reasons to have an abortion, both in your eyes and in the eyes of society? Describe:
    - ~ Financial problems
    - ~ Pregnancy caused by rape or incest
    - ~ Mother infected with HIV or AIDS
    - ~ Mother's health generally poor
    - ~ Control of family size
    - ~ Problems with relationship – e.g. unstable, too new
    - ~ Child conceived through extra-marital intercourse
    - ~ Age of mother – too old or too young
    - ~ Badly timed – career/school etc
- If a woman became pregnant and the circumstances for having a baby weren't ideal, who would usually be involved in the decision about whether or not she would have an abortion? *(kept secret? extended family, husband, boyfriend, woman herself, the State)*
- If the pregnant woman was insistent that she wished for an abortion, would she have the final say in the matter, even it went against what her family or boyfriend wanted?

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- Can you tell me anything about the morning after pill in Botswana? (*attitudes to it, usage, availability)*
- Do you see the morning after pill as being more aligned with contraception, or with abortion?
- If a woman wanted to terminate her pregnancy, but couldn't go to a standard clinic or hospital because the abortion would be illegal, what might she do?
- Can you tell me anything about backstreet abortion in Botswana? *(does it happen, how often, who does it – traditional healer, the woman herself? methods used, how much does it cost, is it dangerous)*
- If a woman has decided to have an abortion, how would she go about finding somebody who could provide such a service? (*help from family, friends, networks)*
- The newspapers are filled with incidents of what they term 'foetus dumping' or 'baby dumping'. Can you tell me anything about that? *(What does it mean? Why does it happen?)*

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- Are you aware of the legal status of abortion in Botswana?
- Abortion is restricted by law in Botswana. Why do you think this might be? *(childbearing/fertility, culture, religion, status of women, other).*
- Do you think that foetus dumping/backstreet abortion would happen less if abortion was legal?
- Would legalising abortion encourage sex without condoms? (*HIV/AIDS)*
- Do you think that people actually *want* abortion to be legalised here? (*liberalisation of laws from doctors)*
- Do you think abortion should be legalised in Botswana? If so, should it be available on request, or should it be restricted in some way? *(individual basis, proof of circumstances...)*

Anything to add, questions I should have asked?
~~~~~~

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