

## ORIGINAL RESEARCH ARTICLE

# The Challenges Procuring of Safe Abortion Care in Botswana

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## Abstract

Botswana's national healthcare system has experienced substantial investment as a result of a growing economy and stable government, and improvements in quality and access are notable. Despite these advances, women's reproductive health continues to suffer as a result of unsafe abortion. The personal, financial, and health costs of women seeking dangerous illegal terminations, or crossing national borders to procure a legal abortion, are evident. Twenty-one in-depth, qualitative interviews with Botswana were conducted to gain some insight into the factors which make terminating an unwanted pregnancy difficult in Botswana. This small study demonstrates that there are important socio-cultural constraints, in addition to the legal barriers, that make abortion problematic. These constraints are entrenched in the wider issue of women's rights and status in society. (*Afr J Reprod Health* 2013; 17[4]: 43-55).

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**Keywords:** Abortion, Botswana, maternal mortality, Africa, women.

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## Résumé

Le système national de soins de santé du Botswana a connu des investissements importants en raison de la croissance économique et de la stabilité du gouvernement, et des améliorations dans la qualité et l'accès sont remarquables. Malgré ce progrès, la santé de la reproduction chez les femmes continue à souffrir à cause de l'avortement non médicalisé. Les coûts personnels du point de vue financiers et de la santé des femmes qui cherchent l'interruption illégale dangereuse ou qui franchissent les frontières nationales pour se procurer un avortement légal, sont évidents. Vingt-et-un entretiens en profondeur qualitatifs auprès des Botswanais ont été menés pour obtenir un aperçu des facteurs qui rendent difficile l'interruption d'une grossesse non désirée au Botswana. Cette petite étude démontre qu'il existe des contraintes socio-culturelles importantes, en plus des obstacles juridiques, qui rendent l'avortement problématique. Ces contraintes sont enchâssées dans la question plus large des droits et la situation des femmes dans la société. (*Afr J Reprod Health* 2013; 17[4]: 43-55).

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**Mots clés:** avortement, Botswana, mortalité maternelle, Afrique, les femmes

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## Introduction

Deemed one of the world's 13 'economic miracles'<sup>1</sup>, Botswana has prospered since the discovery of mineral deposits. Botswana's national healthcare system has experienced substantial investment as a result of a growing economy and stable government, and improvements in quality and access are notable. Despite these advances, a period of residence in the country indicated that women's reproductive health continues to suffer. Of particular concern is the high rate of maternal mortality, to which illegal abortions contribute significantly. In 2010, deaths from abortion complications were the leading cause of maternal mortality at 13.4%<sup>2</sup>.

In addition to maternal mortality there are significant personal and financial costs of unsafe abortion. The total annual cost of post-abortion care in sub-Saharan Africa is between \$80m and \$145m, and this would be at least doubled if all the women who needed such care actually received it<sup>3</sup>. The psychological and personal costs for women are great. Confusion, guilt and depression often follow abortion<sup>4</sup>. Suicide associated with the turmoil of unwanted pregnancy and abortion is yet another cost<sup>5</sup>. Inter-generational productivity is affected by maternal deaths or morbidity in the family and this has repercussions for the economy<sup>3</sup>.

Little has been written about the issues surrounding abortion in Botswana. The present

research aims to contribute to creating a dialogue around reproductive health concerns that have been previously under-reported. This small study demonstrates that there are important socio-cultural constraints, in addition to the legal barriers, that make abortion problematic. These constraints are entrenched in the wider issue of women's rights and status in society.

### *Methodological framework*

This is the report of a preliminary study. As considered above, the legal restrictions on abortion, and the health and social impacts of unsafe and illegal abortion constitute an important reproductive health issue. The purpose of the research discussed here was to investigate the factors that make terminating an unwanted pregnancy difficult in Botswana. I conducted in-depth interviews rather than employing quantitative methods. Qualitative research is vital for 'understanding the cultural and social context of abortion and its social epidemiology'<sup>6</sup>, and is the most appropriate technique for investigating illegal activity<sup>6</sup>. 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. I used qualitative interviews to explore how individual people think about abortion and the meanings they create in doing so<sup>7</sup>. The research was conducted within a feminist framework<sup>8-10</sup>. For the purposes of this article, the methodology used most relevantly reflects the theoretical considerations of the study.

Women's 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 this research I aimed to access the views of a group of individuals whose voices would otherwise remain unarticulated<sup>9</sup>.

The research took place in Gaborone, the capital of Botswana. Urban society in Botswana is in a constant state of flux as a result of rapid economic development since independence in 1966. Attitudes are transforming from a conservative, community-based religious worldview, 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. Since the primary aim of this research was to investigate socio-cultural attitudes surrounding abortion, the socio-cultural transformations being experienced in the city at the time of the research (2011) offered a complex and dynamic research site.

Two-thirds of my sample was recruited by the snowball technique, which is a useful method in situations where access is difficult, such as when researching a sensitive topic<sup>11-12</sup>. Since abortion in Botswana is both a cultural taboo and an illegal activity, a certain level of trust was required for participants to discuss this topic and I would have struggled to enrol total strangers. The other third consisted of my initial sample, which, due to my small social and work network, was limited to an opportunistic group of friends and acquaintances. For this reason, my sample is exploratory rather than representative. In addition to the 19 main participants, I conducted modified interviews with a human rights lawyer who has published research on abortion in Botswana, and a former obstetrician who now specialises in women's health research.

All but one participant were under 50 years of age, and none had more than three children. Most professed Christian affiliation, all were black citizens of Botswana, the most atypical feature being their urban residence, though some were born in rural areas. Four participants were men: this was strongly requested by some of the female interviewees on the basis that men should have to answer questions about a problem for which they were perceived to be responsible (unwanted pregnancy).

I approached potential participants in person. It proved practically difficult to arrange interviews due to the informal attitude towards time and place that characterises social interaction in Botswana, however, all but two of those approached were successfully interviewed.

Having only basic knowledge of the Setswana language and no access to an interpreter, it was not possible to conduct interviews in the national language. However, all the interviewees had been educated in English to at least GCSE (or equivalent) level, and seemed comfortable

speaking with me in English. Nonetheless, this might have contributed to the extent to which they appeared to present 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 Botswana as 'they', rather than 'us'.

I was perceived as both an 'insider' – living and working in Botswana, albeit as a short-term volunteer, and as an 'outsider', being an unpaid, white foreigner. The latter had some advantages since as a foreigner I was not considered to be subject to the same code of taboo as Botswana. 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<sup>9</sup>. 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.

### ***Data and their analyses***

The data in this study are the interview transcripts, supplemented by the small amount of relevant literature available. The interviews varied between 19 and 52 minutes in length, and were preceded by a full explanation of the purpose of the interview. Informed consent was gained from each participant, with the understanding that withdrawal was possible at any stage. To ensure anonymity, each respondent was given a pseudonym for use in any reporting of results. Interviews were digitally recorded and later transcribed for analysis. The focus was on attitudes and views, not experiences, and while this led to some loss of potentially interesting information, it seemed appropriate in a culture where discussion of all matters relating to sex and taboo are abortion is highly controversial.

Feminists assert that structured interviews reinforce a traditionally hierarchical relationship between researcher and the 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<sup>13</sup>. 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 whatever they feel is important<sup>9</sup>. 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 narrative<sup>7</sup>.

I transcribed all of the interviews. I noted themes as they arose from the reading of the transcript, and amalgamated sub-themes into larger categories where appropriate. Data from each interview were placed into thematic categories where statements concerning a common topic could be compared across the interviewees. Constraints on the research project meant that the sample for this preliminary study was small and relatively homogenous. This prevented any meaningful statistical analysis of the data. There was no indication that variables such as age, residence or education in the sample had any impact on the views expressed by the participants.

## **Results**

### **i) Obtaining an abortion: fact and belief**

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<sup>14</sup>. 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<sup>15</sup>.

According to Mogwe, the effectiveness of the amendments in terms of practical application and access is negligible<sup>14</sup>. 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 fetal impairment, where no definition of this 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<sup>16</sup>. 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 in Botswana, 14 respondents answered that it was illegal with no exceptions: 'it's not allowed. It's illegal. Period.'<sup>17</sup>

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. When asked, 'can you tell me anything about backstreet abortion?', 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 fetus. 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<sup>18-21</sup>; coffee granules<sup>18</sup>; furniture polish and oil<sup>22</sup>; vinegar<sup>23</sup>; methylated spirits and laxatives<sup>24</sup>; tubes from pens<sup>22</sup>; and wire coat hangers<sup>21,25</sup>. Two respondents mentioned pharmaceutical drugs<sup>19,26</sup>. They may have been referring to Cytex (or Misoprostol), an arthritis treatment drug which was reported to have been sold 'underground' as an abortifacient<sup>27</sup>. Other 'home methods' reported in the media include

potassium, reported to have been used by secondary school children<sup>28</sup>, and sticks from the *mother plant*<sup>29</sup>.

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. However, 15 of my respondents portrayed backstreet providers as just 'some random person' who is untrained<sup>24</sup>: 'I think it's just a woman, you know someone, just anybody'<sup>30</sup>. 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'<sup>31</sup>, 'charlatans'<sup>20</sup>, and their service as a 'scam'<sup>19</sup>. 12 interviewees spoke directly of the danger surrounding backstreet abortion: 'They die, people have died'<sup>32</sup>. 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'<sup>22</sup>. There was one exception to the interviewees' negative perceptions of backstreet providers: Mabedi described them as 'quite trained and experienced' in traditional medicine<sup>17</sup>. 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]'<sup>17</sup>.

Interviewees reported that the system of backstreet abortion relies almost exclusively on women. Most of the providers are women, and 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'<sup>31</sup>. 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)*<sup>26</sup>.

Laone's laughter suggests that the idea of men being party to finding and using a backstreet abortionist is nonsensical. 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'<sup>22</sup>; that women 'don't talk about abortion with men'<sup>33</sup>. 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:

*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<sup>25</sup>.*

This story demonstrates that 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 how to procure a backstreet termination. My other interviews support this. All of the female respondents demonstrated knowledge of backstreet abortion.

A minority of my interviewees mentioned GPs, gynaecologists and nurses, who provide illegal abortions in Botswana for a high fee, but 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<sup>34</sup>.*

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'<sup>30</sup>. 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'<sup>35</sup>. An examination of the relevant newspaper articles demonstrated that an abortion usually becomes public only when a maternal fatality or a found fetus draws media attention<sup>36-40</sup>. It is likely that terminations provided by trained medical professionals would result in fewer fatalities and more thorough concealment of the fetal 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 [...] 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<sup>25</sup>.*

Notwithstanding Oratile's concerns, the data generally portrayed doctors who commit illegal abortion in a more positive light than backstreet providers.

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. With only seven respondents mentioning this alternative, it was the least cited of all the means to terminate a pregnancy. Crossing the border to procure an abortion was portrayed by those who did mention it as simple and common:

*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<sup>30</sup>.*

Mabedi explained that this is what 'our Batswana women do, they simply cross the border now'<sup>17</sup>. 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.

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'<sup>31</sup>. The majority of respondents said 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.

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. It is important to note that the participants in my study were of the middle classes; by describing these women as being from 'ghettos' and 'the poor neighbourhoods of town'<sup>31,19</sup>, 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.'<sup>17</sup>

## ii) What makes abortion problematic in Botswana?

Abortion is perceived as 'a shameful deed' in Tswana culture<sup>31</sup>. 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'<sup>42</sup>. 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'<sup>30</sup>. 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'<sup>30</sup>.*

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' and there is 'a level of comfort in having restrictions'<sup>43,21</sup>. Barati 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'<sup>33</sup>. 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'<sup>33</sup>. 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:

*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'<sup>33</sup>.*

Research has supported Barati's suggestion that women do not tend to benefit from the law. Changes to the law mean that women can vote, instigate court cases and claim land from the district land board<sup>44</sup>. However, women's inferior social and economic position results in them being 'excluded from exercising their rights fully'<sup>44</sup>. 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<sup>16</sup>. 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<sup>44-45</sup>. 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<sup>34</sup>.*

This suggests that women are expected to possess particular personality traits 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 fetus 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!!'<sup>21</sup>. The concept of child-bearing as a compulsory act of womanhood 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'<sup>30</sup>. My interviews strengthened Mogobe's claim that in Botswana, 'motherhood is rather a mandate and not an option'<sup>46</sup>. 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'.

The interviews indicated that the significance of children in Tswana culture is an important factor in attitudes to abortion, and reflects the common pronatalist culture found across Africa. Braam and Hessini attribute the historical problematic of abortion in Africa to this pronatalist perspective<sup>47</sup>, 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 'Botswana believe that children are a blessing'<sup>23</sup>. Many participants pointed to the sense of pride and respect to be achieved through child-bearing, because: 'having a number of children is also a kind, some sort of, *richness* in the family'<sup>48</sup>.

To be infertile or to choose not to have children was to 'deny who you are'<sup>19</sup>. Jessica spoke of the Setswana proverbs which paint images of children as one's pillars, explaining how 'your children are what you are, and who you are'<sup>18</sup>. This implies that the only way for women to overcome their inferior position in society is to bear as many children as possible. 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?'<sup>33</sup>. Several of my interviewees asserted that to be 'virile and fertile' is fundamental to one's identity<sup>43</sup>. They thought it was unacceptable to terminate a pregnancy when you could give the child away to somebody 'unlucky' enough to be infertile.

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 a home for a child in Botswana'<sup>32</sup>. The transfer of children between family members, or from one family to another, appeared to be a common and acceptable occurrence. The interviewees described the various types of kinship support available for child-rearing: the extended family might aid the mother practically or financially: 'If you happen to be the

successful one, then you have to [take care of the child]'; 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'<sup>34</sup>; the infant might be (unofficially) adopted by a family member in the village to be raised as their own child: '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'<sup>21</sup>; 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 (one's child) and they think you're their cousin, or you're their older sister or brother'<sup>19</sup>.

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 that this is instead a result of anti-abortion sentiment in the community. One aspect of this could be the function of children as a financial resource where government welfare provision 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.

My interviewees' discussions of kinship support lacked 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 well-being of the child, rather than with mother's mental and physical health.

Abortion and infanticide have historically been connected with witchcraft and other such superstitious beliefs in Botswana<sup>49</sup>. 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'<sup>18</sup>. 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'<sup>43</sup>. 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 the phrase used for abortion is '*go senya mpa*', which translates as 'to spoil/destroy the stomach'. Discussion of abortion is thus only accommodated by the cultural language of Botswana as a destructive act. The taboo surrounding abortion 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 act'<sup>43</sup>. 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'<sup>21</sup>. 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'<sup>22</sup>. Another reason given for the taboo on termination was that: 'it's about killing isn't it [...] no one wants to talk about it'<sup>24</sup>.

Of my participants, 17 aligned themselves with an organised religious group. The correlation between religiosity and lack of support for abortion is well established<sup>50-52</sup>, 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<sup>31</sup>.*

Thirteen participants claimed that religiosity influenced how they thought about abortion, particularly the Catholic doctrine which states that the soul enters the body at conception, thus becoming a person worthy of God's protection<sup>50</sup>: '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'<sup>30</sup>. 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, an ambivalence shown by other participants too.

The religious pro-life argument has been mobilized in many anti-abortion campaigns, and appeared to be a common principle among my participants: 'I believe that everybody has a right to life [...] and nobody really has a right to take someone else's life'<sup>48</sup>. 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' or 'taking away a life'<sup>31,53</sup>. 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'<sup>34</sup>. 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'. 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?*

*Mabedi: We are a Christian country. I think that explains it all<sup>17</sup>.*

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 the woman's part: 'if you've

committed abortion you're dirty, you're careless, you are all sorts of things'<sup>32</sup>. When asked if they thought abortion should be legalised, many interviewees expressed concern that permissiveness would be equivalent to declaring a 'free-for-all'<sup>24</sup>, in which 'many people will just go around sleeping around knowing that they'll terminate the thing'<sup>54</sup>. 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. Jason and Kagiso demonstrated the 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<sup>24</sup>.*

*In the country we are trying to fight HIV and AIDS [...] you know people have to change their ways [...] sexual patterns and so on<sup>53</sup>.*

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'<sup>18</sup>, referring to becoming pregnant accidentally. Faith, of the 41-50 age group, echoed this view: 'If you get sexually active at any age then you must live with the consequences<sup>54</sup>.' Despite this alignment of views, the majority of respondents thought that views about termination of pregnancy were changing with each new generation. Respondents claimed that successive generations were beginning to be open to the need for abortion, but 'you can forget about the older generation' shifting their beliefs<sup>17</sup>. 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'<sup>54</sup>. Others commented less emotively: 'amongst youth, they seem to believe in it. That people do make mistakes'<sup>34</sup>.

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. Interviewees agreed that men would be displeased with this change:

*You're my wife, you need to do what I tell you, you know, you can't have an abortion [...] so when you stand up for yourself it's like oh, it's because you're watching Oprah*<sup>23</sup>.

Older women tended to view western values as a negative influence, while younger women suggested that non-traditional ideas could be a source of freedom. Michelle implied 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. 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*<sup>30</sup>.

While most interviewees accepted that views on termination (and women's autonomy in general) are starting to shift, they asserted that the process was restricted to urban areas and limited in scope:

*You're starting to get career women [...] but women are, I mean children are still quite important to the idea of family. So women are still expected to marry, have kids [...] it would be seen as relatively weird and unbecoming if a couple remains childless.*<sup>20</sup>

## Conclusions

Alongside the legally circumscribed status of abortion in Botswana, there are social and cultural factors that 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 by making reproductive decisions that represent 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, it was 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<sup>16</sup>.

The interviewees repeatedly emphasised the value of children, asserting that children are a blessing and that no pregnancy should be terminated. 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.

The value placed on children 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. 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. The participants showed intolerance towards women prioritising 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.

The beliefs of many Botswana centre on a conservative Christian viewpoint, which does not permit abortion and associates it with killing. 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.

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. 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'<sup>55</sup>.

That the consequences of a restrictive abortion law fall only on women are 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 argue that the welfare of such families depends on the educational level of the female head, because educated women have better chances of finding paid work<sup>56</sup>. 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. 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<sup>38</sup>. Effective family planning and abortion services tend to lower poverty rates and increase the financial and emotional welfare of children born<sup>57</sup>.

Researchers recognise that abortion will continue to occur regardless of cultural, social or legal restrictions<sup>58-62</sup>. Criminal sanctions are ineffective. They do not limit the number of abortions that take place, but rather force women to approach unsafe and illegal providers. This is

pertinent to Botswana, where the complications of unsafe abortion are consistently the greatest cause of maternal mortality. 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<sup>59-60</sup>. 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 to be prepared to pass this information on to women presenting with unwanted pregnancies. 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, and health-care facilities must be able to handle the change<sup>63</sup>. 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<sup>64</sup>.

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