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'If You Choose to Abort, You Have Acted As an Instrument of Satan': Zimbabwean Health Service Providers' Negative Constructions of Women Presenting for Post Abortion Care

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Abstract
Purpose Health service providers play a crucial role in providing post abortion care in countries where abortion legislation is restrictive and abortion is stigmatised. Research in countries where these factors apply has shown that health service providers can be barriers to women accessing post abortion services. Much of this research draws from attitude theory. In this paper, we utilise positioning theory to show how the ways in which Zimbabwean health service providers' position women and themselves are rooted in cultural and social power relations. In light of recent efforts by the Zimbabwean Ministry of Health and foreign organisations to improve post abortion care, we explore the implications that these positionings have for post abortion care.
Method As part of a larger study on abortion decision-making, the data featured in this article were collected using in-depth semi-structured interviews with six health service providers working in different facilities in Harare, Zimbabwe. Discursive and positioning thematic analysis was used to analyse the data.
Results Our analysis points to women who have abortions being positioned in negative terms, as transgressors of acceptable norms; irresponsible and manipulative; and ignorant. The health service providers drew from cultural, religious, gender and trauma discourses that portray abortion as evil and socially unacceptable. Reflexive positions taken up by the health service providers include positions as being experts, helpers and protectors of culture/religion, sympathisers and professional positions as health care providers.
Conclusion The continued strengthening of post abortion services should be conducted in conjunction with dialogical interventions that challenge health service providers to reflect on the power relations within which women who terminate pregnancies are located, that contest their negative positionings of these women and that present alternative narratives and subject positionings for both the women who have abortions and the health service providers.

Keywords Abortion · Health service providers · Post abortion care · Positioning

Introduction

Health service providers play a key role in a range of abortion processes [1, 2]. Through interaction with women before, during or after the abortion procedure, health service providers have an influence on how women experience their abortion [2, 3].

In countries with liberal abortion laws, the influence of health service providers starts when women present at health facilities requesting an abortion. Even in liberal legislative environments, health service providers sometimes do not provide all the information necessary, turn women away for no apparent reason and act as a deterrent for women seeking abortions [1, 4–6]. In contrast, where abortion laws are restrictive, formal health service providers generally only interact with women who have had abortions (usually performed illegally under unsafe conditions) during post abortion care [7, 8]. In settings where abortion laws are restrictive, research has shown that some health service providers have negative attitudes due to personal, cultural and religious beliefs [8–10].

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Due to these attitudes, some health service providers tend to be judgmental and to reprimand women who are seeking post abortion care [8–10].

The negative attitudes shown by some healthcare providers appear to be affected by the reasons for the abortion, with some reasons being seen as more acceptable than others. Health service providers are more likely to be supportive of abortion due to rape or incest, severe foetal genetic disorders, threat to the life of the woman or in the case of HIV/AIDS than in the case of socio-economic or personal reasons [11, 12]. An earlier Zimbabwean study which explored health workers' attitudes in relation to medically supervised abortion found that a majority of nurses were against any type of abortion and would not consider treating women who had undergone an unsafe abortion [13].

In this study, we seek to extend the understanding of health service providers' responses to post abortion care through the use of positioning theory. While attitude theory tends to individualise responses to a particular issue [14], positioning theory, which draws from discursive psychology, allows for a multi-level analysis that interweaves how people position each other and themselves within conversation with social and discursive power relations [15]. Positioning has been defined as:

> the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which what one person says positions another. And there can be reflexive positioning in which one positions oneself [15].

Our interest was in exploring how health service providers interactively position women who have unsafe abortions and the reflexive positions which they (the health service providers) took up. These positionings are not seen as static, but rather as dynamic and fluctuating depending on the narratives, metaphors and images through which they are constructed. Positioning (both reflexive and interactive) is a discursive practice that may be taken up in conversation in both compliant and resistive ways (i.e. an individual may accept the way in which they are positioned by another or resist it).

Methods

Participants and Setting

The study was conducted in Harare, Zimbabwe, as part of a PhD project that explored women's and health service providers' narratives on abortion between March and June 2014. In addition to the data reported on in this paper, the PhD project elicited the narratives of women who had undergone an abortion about how they came to make the decision and proceeded to terminate the pregnancy.

Zimbabwe has restrictive abortion legislation, with abortion being permitted under stringent administrative conditions and only in cases of unlawful sexual intercourse (rape and incest), foetal impairment, threat to a woman's life or a serious threat to her physical health. In this study, we use post abortion care to mean all levels of care, treatment or referral performed by health service providers, including community health workers. In Zimbabwe, the most common post abortion care interventions are manual vacuum aspiration and the administration of misoprostol (medication used to start labour, cause an abortion and treat postpartum or post abortion bleeding) [3].

The Ministry of Health in Zimbabwe (MOHZ) together with Venture Strategies Innovations (VSI), a global health non-profit organisation, recently tried stepping up efforts to improve post abortion care through introducing misoprostol in some health facilities. However, this was short lived and VSI has withdrawn [16]. This initiative followed the 2012 MOHZ implementation of a new post abortion policy which allowed women to access post abortion care without being reported to the police [16]. While the work of the ministry is commendable in improving post abortion care, not much is being done to address staff attitudes on abortion.

Six service providers were recruited through purposive sampling, viz. having experience in post abortion care. For diversity, they were recruited from three different healthcare settings: two nurses from a local clinic, two nurses from a major hospital and two community health workers from a local township. The first author, who previously provided counselling for women who had an abortion in Harare, recruited the service providers through visiting each of the facilities and ascertaining who was eligible and available for recruitment.

The number of participants was limited to six due to practicalities (availability of health service providers willing to participate, time for the PhD and funding) within the larger project. All participants were female except for one community health worker from the township. The average age of the health service providers was 39, with a range from 28 to 52; the average year of experience in providing post abortion care was 13; the years of experience ranged from 2 to 28 years. The participants were selected due to their interactions, post abortion, with women who have had unsafe abortions which constitutes the vast majority of abortion in Zimbabwe [16]; the nurses treat women at a local clinic and referral hospital, assessing the patients, providing medication and referring to doctors or inpatient treatment where necessary; the community health workers identify women in need of assistance, and help in obtaining initial medical treatment. As revealed by the health service providers and women who had aborted a pregnancy who were interviewed as part of the larger project, most

of the women seen by the health service providers would have self-induced using sticks, chemicals, natural abortifacients and various concoctions.

Data Collection

Qualitative in-depth semi-structured and open-ended interviews were conducted probing the providers' experiences of providing post abortion care and their personal and societal views on abortion. Questions were purposefully posed in a neutral fashion. The interviews were digitally recorded and transcribed verbatim. The interviews were conducted by author 1 in Shona. The interviews were translated by author 1 and then given to a professional translator for checking. Author 1 is a clinical psychologist undertaking, at the time, a PhD in psychology; he thus has experience in interviewing people on sensitive topics, and previously counselled women who had undergone abortions. While gendered dynamics may be expected in a male researcher interviewing mostly female study participants, none expressed concern when asked if they were comfortable with how the interview had progressed.

The interviews with the nurses were conducted in a private room at the hospital and local clinic, respectively. The interviews with the community health workers were conducted in private rooms at their homes. The interviews lasted between 45 min and an hour. All participants provided written informed consent, and confidentiality and anonymity were ensured. Each participant was given a pseudonym. Ethical approval was obtained from the Medical Research Council of Zimbabwe (MRCZ) and the Rhodes University Psychology Department Research Projects and Ethics Review Committee (RPERC).

Data Analysis

Data were analysed using discursive and positioning thematic analysis, using Braun and Clarke as a guide [17]. We went through five stages which included a familiarisation with the data by reading and re-reading the data, noting down initial ideas, generating initial codes, collating codes into potential themes, generating a thematic map and defining and naming positioning themes. Discursive and positioning analysis interweaves how people position both each other and themselves in conversation with and understanding of social and discursive power [15].

Analysis

We found that the health service providers' interactive positioning of women who had abortions was almost entirely negative (with some, but little, nuancing of this negativity), while their reflexive positionings enabled them to cast themselves in a positive light. These interactive, and accompanying reflexive, subject positions were enabled by various discourses. We found that, despite the differences in years of training, roles (nurse versus community health worker), workplace (clinic, hospital, community setting) and gender, these positionings were consistent among our participants. The extracts presented in the analysis below exemplify patterns that emerged in the data. We note in our subheadings the interactive positionings of the women and the reflexive positionings of the health service providers enabled by a particular discourse.

Cultural/Religious Discourse: Transgressor Versus Protector Positions

Drawing on a cultural/religious discourse, health service providers positioned those who have had unsafe abortions as wrongdoers who have transgressed both cultural (or social) and religious norms. Cultural norms and religious beliefs have been seen to operate as regulatory discourses which provide scripts on how people should behave [18–20]. This is seen in the following extracts:

Extract 1

Tasha [local clinic nurse]: There is no religion in this country that permits such evil. … This is a lowly act in the eyes of God. Deuteronomy says, 'thou shalt not kill' and whoever kills has committed a grave sin. So those who terminate will get their punishment in full from God. That is why you see people in the community looking down upon this act because most are Christians. So if you choose to abort you have acted as an instrument of Satan.

Extract 2

Tasha [local clinic nurse]: Culture says no, never, it is not allowed. A child is a gift from God and there is no child who dies of hunger when living in our community. People help each other in raising the child so abortion is never the answer. The child does not belong to one person alone; it belongs to all of us.

Extract 3

Terry [community health worker, male]: A child is sacred and they should not be killed. That is why people do it in hiding. They are running away from our culture and do not want to be seen.

The constellation of culture and religion seen in the abovementioned extracts is consistent with research

conducted in Ethiopia and Ghana where abortion was seen as culturally and religiously unacceptable [21, 22]. This understanding allows for the women who have had abortions to be positioned as wrongdoers who disregard community values. Tasha uses strong religious language (evil, instrument of Satan) and quotes from the Bible to position the women as sinners who will receive punishment for their actions. Terry and Tasha evoke the value of children culturally and religiously. The women who have abortions are positioned by Terry as knowing that what they are doing is wrong, and of having other options; as such, they have to hide their transgressions. These extracts also speak to children being seen as social capital and the emphasis on childbearing and motherhood in pro natal societies such as Zimbabwe.

The culture/religion discourse allows for social and religious moral judgements to be brought against the woman:

Extract 4

Sife [hospital nurse]: One thing when speaking about proper morals terminating is immoral.

Extract 5

Mimi [community health worker]: They are people with no morals already so terminating is not a problem for them.

Extract 6

Vovo [local clinic nurse]: The community does not want us to lose our morals. That is why it punishes them [by stigmatizing them] when they do this.

Extract 7

Tasha [local clinic nurse]: You have done something that is immoral so we are not related to you anymore; you have lacked morals. You have failed to do a service to your community, so they will spit you out. People become disgusted by you and you also start being disgusted at yourself.

In the abovementioned extracts, moral judgement allows for women who had an abortion to be positioned as lacking a commonly understood moral compass. The community is seen as safeguarding these morals; the health service providers view themselves as being part of the community (e.g. 'we are not related to you') and as such they position women who have abortions as lacking respect for community values and deserving of the stigma they receive.

The health service providers reflexively take a position of protectors of cultural, religious and moral norms for the good of community:

Extract 8

Mimi [community health worker]: You have done something that is frowned upon so we stigmatise you.

Extract 9

Terry [community health worker male]: We look down upon them obviously and we say they have committed a crime….

Extract 10

Joan [hospital nurse]: Stigma is there in the community especially if people know that you terminated. The community is the protector of culture and culturally you cannot abort. A person ends up being stigmatised with us pointing at them saying that these are the murderers. When there are reasons like rape there is no stigma. It just comes up when the community considers your reasons to be invalid and selfish.

In the abovementioned extracts, Mimi, Terry and Joan position themselves as belonging to an 'us' group that has the right to stigmatise and look down upon those who have abortions, who are placed in the 'them' group. The women who have abortions are seen as going against 'our' religion, 'our' culture and 'our' laws. Here, culture and religion are homogenised and every rational person is seen as having the same beliefs. The health service providers position themselves as protectors of these beliefs. In extract 10, Joan moderates this position by implying that stigma only applies in unreasonable circumstances (when your reasons are invalid or selfish) while also acknowledging that she breaks the confidentiality of the client.

Gendered Behaviour Discourse: Irresponsible Versus Responsible Helper Position

Women who have had a TOP are positioned by health service providers as irresponsible, reckless and making poor choices in terms of not abstaining, and furthermore, not using protection or family planning when they do engage in sex:

Extract 11

Terry [community health worker, male]: Condoms are free; birth control pills are there; but people do not

use them and they want us to feel sorry when they get pregnant. It is their fault.

Extract 12

Sife [hospital nurse]: Why hasn't she used a condom? … There are so many methods of family planning. I think they should utilise all these methods rather than to kill.

Extract 13

Vovo [local clinic nurse]: As for me they disgust me. If you have sex and fail to protect yourself, you should live with your decision. We give condoms for free. Use them.

Extract 14

Vovo [local clinic nurse]: Everyone knows that if you sleep with a man without protection or if you are not on any family planning pill, you will become pregnant. So if a person says they cannot take care of the child or the person responsible has run away, we ask, 'Why did you do it in the first place? Aren't you the one who enjoyed unprotected sex? So, live with the consequences that come with it'

Extract 15

Tasha [local clinic nurse]: So we treat for free people who have been irresponsible on their own. That money would be better used somewhere else. … you are the one who had the sex. It is your problem so why make it a problem for the whole country?

In these extracts, the health service providers position the women as reckless and irresponsible and thus deserving of being stigmatised for breaking gendered norms. Recklessness and irresponsibility are portrayed three ways: (1) failing to take up their gendered responsibility to prevent pregnancy by using freely available contraception; (2) deciding to abort rather than take up their gendered role of mothering; (3) needing care after abortion, thereby utilising limited state resources. The recklessness and irresponsibility are linked to selfishness and seeking enjoyment from unprotected sex, the result of which places an undue burden of care on health service providers and on the community and country.

The positioning of women as irresponsible is strengthened in the health service providers' eyes as those having abortions are positioned as prostitutes:

Extract 16

Mimi [community health worker]: Some of them do not want to work as they are used to this bar-hopping. … The reason they have many pregnancies is that it is a risk of their business.

Extract 17

Terry [community health worker, male]: And the problem is most of the people who terminate are prostitutes. They would have seen that, 'How can I have a baby when I want to work? I want to see my customers and the baby is a hindrance' so they abort.

In the abovementioned extracts, the women who have had abortions are positioned as 'prostitutes' who use abortion as a contraceptive. Sex workers are socio-culturally and religiously looked down upon and this fits well with the irresponsible and reckless positions. The reasoning is that abortion (given that it is immoral and evil) would not be contemplated by *normal* women but only by irresponsible prostitutes who engage in risky behaviours and end up conceiving. Mimi positions 'prostitutes' as opting to not to work like other normal people, while Terry argues that their work gets in the way of being responsible about wanting and caring for children.

Women's irresponsibility was seen as going unpunished because of their manipulative behaviour in escaping censure from the law:

Extract 18

Sife [hospital nurse]: You never quite know now living in this time of corruption that those who terminate are actually tried [in court] or they just pay off the police and judges. It is very possible. … People just buy and their crime disappears.

Extract 19

Vovo [local clinic nurse]: The law is in name only. There is corruption so people just pay off the judges or the police and the case disappears. This is what makes people continue terminating because they know they will get away with it. If a person would go to jail, this practice would end.

The manipulative woman constructed in the abovementioned narrative is seen as part of a corrupt system that needs to be tightened. All the other complicated and multifaceted factors that play a part in abortion are rendered non-existent by this positioning. Thus, if the law is made a little tighter, the *manipulative woman* would be forced to carry the pregnancy to full term or, she would be prosecuted for having had an abortion.

In positioning the women as irresponsible, the health service providers are positioning themselves as able to discern

what responsible behaviour is. This enabled them to take up a helper/adviser position in which they try to advise women wanting to have an abortion, particularly those at high risk of terminating pregnancies, such as 'prostitutes':

Extract 20

Mimi [community health worker]: These are bad people [prostitutes]. I usually talk to them and ask them how much they get from the bars. And they say there is not much money but they have no choice. What can we do? If only we could find something to do. I asked one if she got implements to farm tobacco if she would do that and she said, yes, she could work. They know that what they do is not sustainable and they want to work but they have no choice. I told them that as you grow older the man will no longer be finding you attractive.

In extract 20, Mimi positions herself as a caring person who wants to help prostitutes to stop doing their work and provides a hypothetical suggestion for alternative employment, such as tobacco farming. The help she offers is in the hope that women would conform to her worldview on abortion and of gendered relations (men are only attracted to younger women). Help does not extend to support during and after an abortion.

Trauma Discourse: Ignorant Versus Sympathetic Position

Closely linked to the irresponsible position was the use of an ignorant position. While women who have abortions were positioned as irresponsible in getting pregnant, they were also positioned as being ignorant of the consequences of having an abortion:

Extract 21

Vovo [local clinic nurse]: It touched my heart as she died and left three children. Why did she do it? Ah, if she had only kept the pregnancy and left the husband. Ah, to die for that, leaving your children to suffer because of bad choices. She failed to think and she died for that.

Extract 22

Tasha [local nurse]: It [abortion] has severe emotional problems and those who terminate do not know this. They become scarred for life. I have worked with people who terminate for 20 years and I have not seen anyone who has been happy about their decision. All of them have guilty conscience that eats them all the time and the wounds will be with them all their life.

The health service providers position women who have had abortions as being ignorant of the physical and emotional consequences of having an abortion. Vovo, in extract 21, draws from a personal story of loss to justify her positioning of the women as ignorant. Vovo draws from her encounter with abortion-related morbidity and mortality which she finds distressing. Tasha draws on a position of expertise ('I have worked for 20 years') to convince the listener of the veracity of the ignorance positioning. Trauma is credited in her talk to the abortion itself and not the circumstances surrounding an unwanted pregnancy, having secretly procured an abortion or facing stigma and shame.

The positioning of women as ignorant allows the health service providers to take up a reflexive position of sympathiser. As seen in the abovementioned extracts, sympathy is not directed to the woman who has had an abortion per se but for the 'sorry' situation she has created for herself. The sympathy is for the pain in which the woman who has had an abortion puts herself and those around her through making poor choices. The taking up of this position ignores all the other circumstances surrounding a woman's pregnancy and puts the focus squarely on the woman.

Professionalism Discourse: Reflexive Position

Despite the negative positions contained in the health service providers' talk of women who have abortions, they positioned themselves as professionals who are not affected by their feelings or attitudes:

Extract 23

Terry [community health nurse, male]: As a person who is used to it, I just work. I actually encourage people to try and use safe methods if they want to terminate.

Extract 24

Tasha [local clinic nurse]: But I gave an oath to give help as a nurse despite what I believe. So now it does not affect me. … Our job is necessary because if we do not help, these people will die in their home which is a much bigger shame. So we just help despite our beliefs.

Extract 25

Vovo [local nurse]: When we are at work we work. Whatever I believe in does not influence how I work. I help everyone no matter what they have done. So hating what they do does not stop me from doing my job.

The health service providers in the abovementioned extracts position themselves as being professionals who are there

to help women who have had abortions despite their personal opinions towards abortion. The health service providers do not see their personal opinions as having any influence on the women, which, as research has shown, is not necessarily true [8–10]. The professional helper positioning portrays a good-hearted professional who does their job without bias. Terry, who is a male community health worker, goes further to state that he supports safe abortion. This positioning is, however, inconsistent with their vociferous condemnation of women who have had abortions. The health service providers are aware of these contradictions, and reconcile the inconsistency by taking up the professional tag where help is the *end goal*, despite one's personal beliefs.

Discussion

Our study sample is small and thus the conclusions we draw cannot be generalised. Nevertheless, the fact that similar discourses and subject positionings were evidenced across the three divergent sites of healthcare provision provides some evidence of the pervasiveness of these discourses and subject positionings in health service circles. In addition, the women whom we interviewed (who had abortions) as part of the larger study confirmed that negative attitudes and stigmatisation were part of their everyday life; many were scared to report to clinics/hospitals for post abortion care due to the health providers' attitudes, despite experiencing severe complications [23].

As shown in the data extracts presented here, the health service providers used cultural/religious, gendered and trauma discourses to position women who have had an abortion in negative terms, as transgressors, irresponsible, manipulators and ignorant. Their views of abortion, which was seen as culturally unacceptable and evil, framed how they positioned women as gendered beings. For example, a *proper woman* would not consider such an evil practice, but rather accept her reproductive status no matter the circumstances, including, for the most part, rape and incest. Only women without morals, like 'prostitutes' would fail to use contraception and consider abortion. Women who had an abortion were blamed for making reckless and irresponsible choices that led to the abortion. More nuanced positions, such as Joan's caveat about abortion after rape being acceptable, were evidenced in very little of the health service providers' talk.

The positions taken by the health service providers included disciplining the women through stigmatisation and protecting cultural, religious and gendered norms. The health service providers here operate as societal regulators and *punish* women who have abortions in a number of ways: through humiliation, discouraging them from abortion and telling them how wrong they are. As regulators, the health service providers took up positions of being the *good* people trying to counter cultural and moral degradation.

When women were positioned as irresponsible and ignorant, the health service providers could take up the position of helper and sympathiser, respectively. The helper position means setting the women on the correct responsible course, which means always using contraception when not intending to conceive, never having an abortion and finding employment beyond [presumed] sex work. In the sympathiser position, the tone is one of pity for women who find themselves in difficult circumstances because of their poor choices.

The complete absence of talk around the men's role in the relationship, or all the other circumstances surrounding a pregnancy points to the vilification of women as the guilty parties in any abortion. These silences around relationship or contextual issues are concerning as research has shown that abortions involve many factors [6]. The woman is seen as having the responsibility to make sure that pregnancies do not occur by using protection. When pregnancies do occur, the women are tasked with the responsibility of pursuing options other than abortion.

Despite the negative positioning of women who have abortions, the health service providers insisted that they are professional in their interactions with women. They saw no contradiction between the sanctions and stigmatisation that they impose on women and their role as a health professional.

Implications for Post Abortion Care

Research shows that 'moral-, social- and gender-based reservations about induced abortions appear to influence health service providers' perceptions of and attitudes towards induced abortions and, consequently, their relationship with the patient who wants an abortion' [22]. Our data show how health service providers are enmeshed within their sociocultural environment, and that there are restricted scripts available to describe abortion and women who undergo them.

The current efforts by the Ministry of Health in improving post abortion care must include dialogical spaces where the kinds of discourses used and the subject positions invoked by health service providers are unpacked. The positions taken up by the health service providers point to a 'culture' of not questioning their own positions nor their own views. They regarded their statements as being the 'truth' and understood themselves as implementing taken-for-granted cultural, religious and gendered beliefs or practices. These positions need to be questioned and challenged in trainings of post abortion care, through reflecting on the power relations within which women who have had abortions are located, contesting the negative positionings of these women and presenting alternative narratives and subject positionings for both the women and the health service providers. If women fear going for post abortion care due to concerns around what health service providers might say or do, then the rates of maternal mortality will continue to be high [24].

The health service providers' silence on the broader social and environmental circumstances that make a pregnancy unsupportable also needs to be challenged. For example, while family planning was mentioned, there was no acknowledgement on the providers' part concerning women's challenges accessing and using contraception. One way of addressing health service providers' beliefs and attitudes is through values clarification workshops (such as the ones run by Ipas), which are meant to help them deal with their personal beliefs surrounding abortion [25]. The blame that is put on the women who have abortions needs to shift to understandings of the complex interaction of micro- and macro-level dynamics. With these kinds of understandings, health service providers would be better positioned to provide post abortion care and to assist in changing community narratives and views of abortion particularly, as we note in this paper, in light of their positioning themselves as stakeholders with the community.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee (Medical Research Council of Zimbabwe and the Rhodes University Psychology Department Research Projects and Ethics Review Committee) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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