Nursing the Stigma: Conflicting Realities of Abortion

by
René Raad

Thesis presented in fulfilment of the requirements for the degree of Master of Social Anthropology in the Faculty of Arts and Social Sciences at Stellenbosch University

UNIVERSITEIT
iYUNIVESITHI
STELLENBOSCH
UNIVERSITY
100
1918 · 2018

Supervisor: Thomas Cousins, PhD,

Faculty of Arts and Social Sciences

Department of Sociology and Social Anthropology

December 2018

Stellenbosch University https://scholar.sun.ac.za

DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

December 2018

Copyright © 2018 Stellenbosch University All rights reserved

All rights reserved

Stellenbosch University https://scholar.sun.ac.za

Abstract

In 1996, South African women gained the right to exercise “control over their bodies” through the Choice on Termination of Pregnancy Act (CTOPA). This was a crucial advance for women, as it represented the recognition of reproductive rights by South Africa’s first democratically elected government. In 2018, despite having this public service available, many South African women still seek out informal abortion services or pay to have their pregnancy terminated at private healthcare facilities. With the legal framework of the CTOPA supporting a woman’s right to terminate her pregnancy, there should be little need for additional services outside of the public healthcare sector, yet the large number of advertisements for unaccredited abortion services plastered on the walls of public transport and lamp posts suggest otherwise. Various explanations are offered for why women do not make use of state-sanctioned, formal abortion services, including social stigmatization, religious dissuasion, and lack of knowledge of available services. Another possible reason that deters South African women seeking to safely terminate their pregnancies is that public healthcare providers leave women feeling degraded and ashamed.

In this thesis, however, I examine the experiences and perspectives of those who are involved in providing safe and legal abortion services and explore how these providers navigate the moral ambiguities of a woman’s right to choose. By spending time in three non-governmental organization healthcare facilities, I reflect on the experiences of Termination of Pregnancy providers in their everyday life – experiences that are constituted and mediated by the various collectives with whom they identify and in which they form their individual moral codes. I do this to understand better how ethical and moral dilemmas are negotiated and how this shapes the understanding of what it means to access the right to safe and legal termination of pregnancy.

Stellenbosch University https://scholar.sun.ac.za

Opsomming

In 1996 het Suid-Afrikaanse vroue die reg gekry om 'beheer oor hul liggame' uit te oefen deur die Wet op Keuse oor die Beëindiging van Swangerskap. Dit was baie belangrike vooruitgang vir vroue, aangesien dit die erkenning van voortplantingsregte deur Suid-Afrika se eerste demokraties verkose regering verteenwoordig het. Ondanks die beskikbaarheid van hierdie openbare diens, versoek talle Suid-Afrikaanse vroue in 2018 steeds informele aborsiedienste of betaal om hul swangerskap by privaat gesondheidsorgfasiliteite te laat beëindig. Aangesien die regsraamwerk van bogenoemde wet vroue se reg om hul swangerskap te beëindig, ondersteun, behoort daar min behoefte te wees aan bykomende dienste buite die openbare gesondheidsorgsektor, tog dui die groot hoeveelheid advertensies vir ongeakkrediteerde aborsiedienste wat wyd en syd op die mure van openbare vervoer en lamppale geplak word op die teendeel. Verskeie verduidelikings word voorgehou waarom vroue nie gebruik maak van staatsgoedgekeurde, formele aborsiedienste nie, insluitende sosiale stigmatisering, godsdienstige ontmoediging en gebrek aan kennis van beskikbare dienste. Nog 'n moontlike rede wat Suid-Afrikaanse vroue daarvan weerhou om hul swangerskap veilig te beëindig, is dat openbare gesondheidsorgverskaffers vroue verneder en skaam laat voel.

Hierdie studie het 'n ondersoek behels na die ervarings en perspektiewe van partye betrokke by die verskaffing van veilige en wettige aborsiedienste en die manier waarop hierdie verskaffers die morele dubbelsinnighede van 'n vrou se reg om te kies, hanteer. Op grond van tyd deurgebring by die gesondheidsorgfasiliteite van drie nieregeringsorganisasies besin ek oor die ervarings van verskaffers van swangerskapbeëindiging in hul daaglikse lewe – ervarings wat deur die onderskeie gemeenskappe met wie hulle hul vereenselwig en waarin hulle hul individuele morele

Stellenbosch University https://scholar.sun.ac.za

kodes vorm, saamgestel en bemiddel word. Dit is gedoen in ŉ poging om beter te verstaan hoe etiese en morele dilemmas hanteer word en hoe dit begrip vorm van wat dit beteken om toegang te hê tot veilige en wettige swangerskapbeëindiging.

Stellenbosch University https://scholar.sun.ac.za

Acknowledgements

Writing a master's thesis has been a significant challenge and would not have been possible without the love, encouragement and support from the various people that I make mention here:

Firstly, I would like to thank my supervisor, Prof. Thomas Cousins for your passion, patience and commitment to my project, despite being on a different continent. Your time, efforts and kind supervision were an invaluable resource for this project coming into existence. It was a great honour to work under your supervision.

A special thank you to Kristen Harmse, who was a willing ear whenever this project felt to be an impossible feat. I am extremely grateful and indebted to you for your creative input from the beginning to end of this research. You are an incredible friend and I am genuinely appreciative of everything you have done to make this thesis more manageable.

I would additionally like to express my deepest appreciation for Graeme Hoddinott, Dillon Wademan, and Hanlie Myburgh, whom I worked with at the Desmond Tutu TB Centre (DTTC) for a portion of this thesis. Thank you for reading through my work and for allowing me to use you all as sound boards as I tried to make sense of my ideas. In addition, I thank Jorge Gonzalez, who supported me similarly from abroad, as well as for being a careful editor of this thesis.

I am thankful to my family for their unceasing encouragement and support. With special mention of my mother, Janine Raad, who told me almost daily how proud she was. Your words of encouragement were fuel while writing into the early hours of the morning.

Stellenbosch University https://scholar.sun.ac.za

Finally, to my partner, Donovan Martin, who loved me through the highs and lows of putting this thesis together and for keeping our home and lives in order, so I could invest my time and focus into producing this project. I want to thank you for showing me the power of remaining positive, believing in myself and working with a plan and intent. Thank you for believing that I could. I cannot describe my gratitude and appreciation. I love you.

Stellenbosch University https://scholar.sun.ac.za

Table of Contents

Chapter One: Introduction 10
Situating the study **13**
Conceptual Orientation **15**
Methodology **19**
Reflections, limitations and challenges **24**
Anonymity **29**
Chapter Summary **31**

Chapter Two: Situating the Study 36
Abortion in South Africa (1970 - Present) **42**
Abortion Access in Contemporary South Africa **48**
Gagged: The undue burden on TOP provision **50**
Field Sites **57**
Avoidance and Objection **66**
Conclusion **68**

Chapter Three: Vulnerability as Resistance 69
The Workshop **73**
A Field of Relations: Vulnerability and Agency **76**
TOP Provider Concerns **81**
Conclusion **89**

Chapter Four: Negotiating Stigma 92
"You're brave to work there" **94**
"Gilead is within you" **98**
Conclusion **103**

Chapter five: (Counter) Public Discourse 105
Abortion Politics in Tension **106**
Publics and Counterpublics **107**
The Art of Resistance **108**
The Event **115**
Rethinking the (Counter)Public **118**
Conclusion **121**

Chapter Six: Voices of Women Seeking Abortion 123
Media and the Representation of Women's Voices **126**
Conclusion **139**

Stellenbosch University https://scholar.sun.ac.za

Chapter Seven: Conclusion 140
Reference List 146

Stellenbosch University https://scholar.sun.ac.za

Chapter One: Introduction

"There are few doctors who are willing to do this. It is not a nice thing, to pull a foetus apart." Katrijn and I were speaking candidly one morning in mid-2017 about second trimester Termination of Pregnancy (TOP) provision. We sat in a café in one of Cape Town's up and coming neighbourhoods, where she had moved to be closer to her daughter. As she stirred the cream in her coffee, Katrijn explained South Africa's desperate need for TOP providers and how this had been a continuous theme in her 20 years of experience working in the South African healthcare system. Katrijn had arrived in South Africa from the Netherlands in 1997, as the *Choice on Termination of Pregnancy Act* (CTOPA) was beginning to be implemented. "I came specifically for it," she explained. "I thought it was so wonderful that there was a message being sent to the rest of Africa." What Katrijn described as a "wonderful law" had provided South Africa with the green light to begin termination of pregnancy (TOP) services, but what Katrijn came to realize once beginning her work is that, despite its implementation, South Africa did not have an abundance of healthcare workers who were willing to provide TOPs to help bring the law to its full fruition.

CTOPA gave South African women the right to exercise control over their bodies and since the act was passed, South Africa's public health system has offered free TOP procedures to women of any age within their first twenty weeks of pregnancy, while TOPs up until twenty-four weeks can occur under particular medical circumstances. The CTOPA replaced a 1975 law that required women to seek permission from physicians, and in some cases magistrates, in order to terminate their pregnancies. This was a crucial advance for women, as it represented the recognition of reproductive

Stellenbosch University https://scholar.sun.ac.za

rights by South Africa's first democratically elected government (Guttmacher *et al.*, 1998:191).

There are few words that have stuck with me quite as well as Katrijn's did on the morning I asked her about South Africa's lack of TOP providers – "It is not a nice thing, to pull a foetus apart." These are words that are not only striking, but ones that highlight the moral dilemmas that healthcare workers find themselves contemplating when presented with the option of providing a service which unreservedly saves the lives of thousands of women, whilst simultaneously ending the potentiality of a child. Katrijn was a woman who had spent her career aborting foetuses in order to restore the life for the women asking for her aid, but her words showed me that she was also a woman who understood the discomfort of her profession and was not thoughtless in its practice. In our time speaking with one another, she did not give me the impression that she experienced guilt. Katrijn believed that a life was only a life once the foetus was viable, but she did have an understanding for her colleagues's reluctance. Her decision to provide TOPs did not make Katrijn any less caring, nurturing, and supportive, despite what the many critics of TOP providers would often claim. Katrijn was well respected and cared for in the community she served and was responsible for the training of many of the providers based in the Western Cape I later came to find.

In this thesis, I explore how the experiences of TOP providers have been shaped, continues to be shaped and further shapes the social field of abortion stigma and thus access to safe and effective TOP care. To do this, I develop an ethnographic account, drawing on the experiences of service providers like Katrijn, that explores how those involved in providing safe and legal TOP services navigate the moral ambiguities of a

Stellenbosch University https://scholar.sun.ac.za

woman's right to choose. I do this to better understand the contestation that takes place within and through the political and the social and how these struggles manifest as an obstacle to access much needed TOP services.

Among the suggestions that social stigmatization, religious dissuasion, and lack of knowledge of available services are prominent deterrents for South African women seeking to safely terminate, is the suggestion that public healthcare providers leave women feeling degraded and ashamed (Harries *et al.*, 2014). I seek to explore not only this question, but also the question of whether these suggested deterrents impact the everyday lives of healthcare workers who provide termination of pregnancies and thus affecting access to care.

In trying to understand the experiences of TOP providers, it is necessary to understand the broader narratives around such experience. Experience as a concept is unreliable, as it is not simply experience for experience's sake. In order to understand experience, one must engage with the various contextual elements that construct experience. Thus, in this thesis, I lay out each of these contextual elements as I work through each chapter. The chapters lay out a broader set of contextual issues in order to better frame and substantiate my claim that the experience of stigma around TOP services is part and parcel of a bigger political question about how access to TOP services is contested. The contestation takes place within and across political and social terrains and manifests within access to services. The chapters that follow highlight these contestations and how they structure the social field of abortion stigma, which sets the scene to better explore the everyday experience of TOP providers and the integral role stigma plays in shaping how they navigate these experiences.

Stellenbosch University https://scholar.sun.ac.za

Situating the study

South Africa's history of apartheid still leaves a prominent scar on the public health service's ability to cater effectively to its population (Coovadia and Mantell, 2010) and, as Amnesty International explains through their 2017 *Barriers to Safe and Legal Abortion in South Africa* issue, "Despite efforts to invest in the public health care system since 1994, inequalities remain deeply entrenched" (Amnesty International, 2017). The comparison of infrastructure and resource disparity exists and persists between the public and private healthcare systems creating challenges for poor South African women to access safe and effective TOP services. While private healthcare services attract a majority of medical professionals, 83% of the population relies on the weakened and overburdened public health sector to meet their healthcare needs and, as a result, this strain greatly worsens inaccessibility to safe and effective TOP care at a primary healthcare level (Amnesty International, 2017).

The public and private healthcare sector offer various sorts of TOP procedures. Firstly, the first trimester TOPs, which are also referred to as "medical abortions," by the providers I interviewed. Medical abortions are largely provided by trained midwives and are done so through medication and self-care at home. Secondly, Second-trimester TOP, which is also known as a surgical TOP, is carried out by medical doctors with the support of trained nursing staff. The surgical TOP, which may account for as much as a third of all TOP services, is done so via a manual vacuum aspiration (MVA) procedure and is carried out under local anaesthetic (Department of Health South Africa, 2005; Morroni and Moodley, 2006:96-574). Both procedures are considered to be safe and effective and in South Africa's public healthcare sector, are offered freely to the unemployed or subsidized for those who are considered low-income earners (Republic

Stellenbosch University https://scholar.sun.ac.za

of South Africa National Department of Health, 2014; Western Cape Government, 2014).

Katrijn was a second-trimester provider and worked for various clinics and hospitals in South Africa. She provided not only in the Western Cape, but also in other provinces in South Africa. At the time of our conversation, Katrijn was flying to neighbouring provinces fortnightly in order to assist hospitals that could not find providers to meet their demand. "I'm too old now," she laughed when I asked if she flew every week. "I did that, when I was younger."

Katrijn's experiences are one of the many confirmations that will appear in this thesis of the barriers to safe and legal termination of pregnancy, on which Amnesty International (2017) reported. Despite having this public service available, many South African women still seek out clandestine abortions[1] and put their lives and reproductive health at risk when making use of these dangerous "services." Amnesty International (2017) suggest that there are three key barriers attributing to this phenomenon. Firstly, the failure to regulate conscientious objection, which allows healthcare providers to refuse to terminate a pregnancy based on their moral or personal beliefs. Secondly, inequalities in access to services for women and girls from poor and marginalised communities, and, thirdly, lack of access to information on sexual and reproductive rights including how and where to access legal TOP services.

[1] Termination of a pregnancy administered by people lacking the necessary skills, or in an environment lacking minimal medical standards, or both

Stellenbosch University https://scholar.sun.ac.za

Conceptual Orientation

Termination of pregnancy is a generally contested and stigmatised service, as it contradicts a long history around women's body politics and supposed purpose, which has been predominantly understood to be a vessel of fertility. The role of bearing the future generation that has been placed on women has additionally placed much of the woman's value on her ability to reproduce.

Weidner and Griffitt (1984) argue that abortion stigma is an attribute that greatly discredits the subject it falls upon and reduces the subject to a status of being "tainted" - a definition that has built Goffman's (1963) original concept of stigma. Since Goffman's original work, researchers have begun to explore more thoroughly how abortion stigma is produced, perpetuated, and normalized, as well as the role it plays in shaping policy, laws, and the shared experience of communities and the individuals that comprise them (Kumar, Hessini and Mitchell, 2009; Norris *et al.*, 2011; Kumar, 2013). In doing so, understandings of stigma have shifted, and researchers and activists alike have made great strides in mobilising efforts to combat its production.

Classically the way we think about stigma has been of established categorisations that consist of various attributes and behaviours, which enable others to develop preconceived ideas or anticipations of one's social identity. These established categorisations are socially discrediting in nature and result in the stigmatised person being classified as undesirable. Classically, these established categorisations have ranged from physical deformity, character blemishes and prejudice (Goffman, 1963:2).

Stellenbosch University https://scholar.sun.ac.za

More recently, an extensive literature on stigma, stigmatisation, stigmatising has been produced by sociologists and psychologists, which has taken forward Goffman's theory. Jacoby (1994) and Scambler (2004) in particular have addressed the concepts of "enacted" and "felt" stigma, which are both etymologically similar but produce different effects on the individual subjected to it. Felt stigma, also known as "internal stigma" or "self-stigmatisation", is an internalisation of feeling "lesser than" or devalued by others. This is usually accompanied by shame and a sense of inferiority (Scambler, 2004; Stuenkel and Wong, 2013). Enacted stigma, also known as "external stigma" or "discrimination", is perceptions by others that are directed toward the individual who is considered to have a discrediting feature.

Individuals who experience stigma, however, can experience both kinds. Those who are subjected to enacted stigma can experience it through modes of avoidance, gossip and outright confrontation. While felt stigma in turn causes the individual experiencing stigma to produce behaviours such as silence and avoidance to minimise the effects of enacted stigma.

The purpose of differentiating these various types of stigma is to make sense of the ways they are produced and perpetuate one another; this is useful in order to refine the concept and further understanding of how it affects the lives of the stigmatised through prejudice, discrimination and social rejection, to name a few (Hogan, 2003; Stuart, 2011). But stigma as a concept is slippery. It does not fully explain how and why a category of person is devalued or the processes that lead to discriminatory or violent action. The more it attempts to reveal about the scene it inhabits, the more it equally

Stellenbosch University https://scholar.sun.ac.za

obscures. In this thesis, I found that the concept of stigma is alive for my interlocutors, but that its analytical value for the anthropologist was limited.

The definition of stigma itself is varied as it has been applied to a large array of contexts which transform its meaning as it is reapplied. Although it is important that analyses of stigma are inclusive of the diverse contexts in which stigma arises, it is still unclear what is meant when the term is used (Link and Phelan, 2001). In my own fieldwork, my participants use the word "stigma" in a range of ways. However, they are not referring specifically to the domains outlined by Goffman or those who have built upon his work. They are instead talking about their experiences of a socially contested field and they use the word stigma to capture it. What their words point to are the conflicting understandings of what it means to terminate a pregnancy, to foster or terminate a potential life, and their own positionality in it. This conflict, which I discuss in the various chapters of the thesis, contains unresolved feelings that interfere with my interlocutors own ability to take a stand. It reveals vulnerabilities and resistance and in some cases defensiveness. What my participants refer to as "stigma" is not best captured by Goffman's concept of stigma, but rather is a shape-shifting word that articulates experiences, perceptions, and relationships.

With each use of the word "stigma" from my participants, it became clear that what was actually being discussed was a proxy for the various social relations that are embedded in what my participants called "stigma." When I realised that stigma obscures as much as it reveals, it became clear that I needed to de-emphasise the analytical framing of stigma and instead allow the data to drive alternative concepts, such as silence, vulnerability and resistance. I thus embrace my participants'

Stellenbosch University https://scholar.sun.ac.za

terminology throughout this writing and use the word as they have throughout. Thus, talk of "stigma" becomes a way of talking about discomfort, anxiety, fragility and fear. Each chapter below shows a different aspect of what this kind of talk addresses in a more fully enfleshed and contextualised analysis.

In this thesis, the "stigma" I explore is experienced by TOP providers, of whom the majority perform the most basic of pregnancy terminations – medical abortion. Although I do speak to TOP providers who are doctors and perform second trimester terminations, most of my interlocutors are referred to as "nurses". In South Africa, nursing is a profession that has historically been considered "woman's work" (De Beauvoir, 1983) and a profession that is "commonly associated with the ideological feminine qualities of being loving and kind and the vocational drive to care for people" (Bolton, 2016:172). When considering how my key informants occupy both the role of nurses and TOP providers in a space where abortion is a highly contested practice, a conflicting reality of their role in the healthcare system emerges and the multi-layered nature of what they refer to as "abortion stigma" becomes more clear.

In their exploration of nurses's roles in the CTOPA, Xaba *et al.*, (2016:69) note that nurses are the largest category of healthcare providers and that, despite their centrality to improved health and health systems performance, there is little documentation of the voices and experiences of nurses in broader health policy advocacy or the morally ambiguous service they are asked to provide. Thus, understanding the impact of abortion stigma on TOP providers and nurses specifically may be a key component to understanding the lack of TOP providers in the Western Cape of South Africa, whilst further informing the success of the informal abortion sector.

Stellenbosch University https://scholar.sun.ac.za

Methodology

In order to tend to my research questions, I spent 145 hours, over a period of six months, in the field and conducted a total of thirty interviews while doing so. I visited the three clinics a total of twenty-three times and alternated my time between "hanging out" (Geertz, 1989) inside the clinic with staff or outside with the protesters that gathered routinely every Saturday. Spending time informally with staff and protesters allowed me to "immerse" myself within the clinic and its surroundings in order to better understand and experience the abortion scene in Cape Town (Malinowski, 1922). In addition, I attended five events that were hosted at the clinics, either by the clinic staff themselves or by activist groups that were in one way or another informally affiliated with them. The events ranged from celebratory to raising awareness about TOP services. One event that I make mention of specifically in chapter five was a celebration of TOPs being legalised in South Africa for twenty years at the time of its happening.

The methods chosen to conduct this research were predominantly participant observation (De Walt and De Walt, 2011), open-ended, semi-structured, and ethnographic interviews (Russell Bernard, 2006:210-250) and deep hanging out (Geertz, 1988). These methods were chosen to enable me to listen sensitively to the ways in which my participants speak and understand the contexts in which they work, which went beyond the strictly verbal aspects of the interviews conducted. The interviews provided insight into the ways in which healthcare providers navigate the ethical and professional challenges of performing TOP, in the context of their life-worlds and provided thick and useful descriptions to think through the larger questions

Stellenbosch University https://scholar.sun.ac.za

of the right to choose, citizenship, identity, and agency. The interviews took place in the clinics themselves during work hours, whenever the providers and staff had a moment to spare.

In addition to the healthcare professionals, I spent time with a number of pro-life protesters who identified with various Christian groups from around the Western Cape. My time spent with the protesters was done so observing and interacting with them. The protesters could be found outside the clinics, gathered on weekends and sporadically during the week. During my time in the streets outside the clinics, I witnessed six protests that usually occurred on Saturday mornings. I interviewed eight protesters across those six events and continued informal talks following, as they had shown interest in participating in my research. Some of the interviews took place during the protest, while others met me privately for coffee for more lengthy discussions. The protesters that gathered outside did so within their church congregational groups, pro-life movement groups that were independent of a church, and sometimes independent individuals who had come across the protest, either through word of mouth or by witnessing the gathering and joined.

Within the clinics, I interviewed not only providers, but assisting staff, such as administrative staff and cleaning staff. Each provider that participated in my research was interviewed at least twice. The interviews were sometimes formal, but more often took place casually between the everyday activities of the clinic. With certain providers, enough rapport had been developed to conduct informal interviews over the phone after hours, when access to their time at the clinic was sometimes more challenging. Independent providers who were not employees of the clinics were additionally

Stellenbosch University https://scholar.sun.ac.za

interviewed, in spaces of their choosing and the frequency of these interviews alternated between one and three interviews.

Of the three clinics I visited, each was based in prominent and accessible areas of Cape Town and was connected by various modes of transportation, which allowed for easy mobility for clients and staff. I interviewed fifteen participants, observed seven protests and hung out on the premises, which in its entirety made up the 145 hours spent in and around the clinics. Consent was obtained in order to voice-record the interviews and once interviews were completed, I transcribed each over a period of two months. Interviews were coded manually, which involved the process of identifying emerging themes and grouping the data into these themes based on a grounded approach, as well as established theoretical frameworks which I apply and discuss in the chapters to follow (Russell Bernard, 2006: 387-412).

The anthropological methods and techniques used in this thesis were deep hanging out (Geertz, 1988), participant observation (Geertz, 1973; De Walt and De Walt, 2010), and open-ended, semi-structured interviews. The ethnographic techniques employed in this thesis were employed to develop a thick description of the ethical and moral worlds that healthcare providers navigate when negotiating the issue of abortion in contemporary South Africa. "Hanging out," as Geertz (1988) describes, allowed me to observe and interact with TOP providers and protesters while remaining attentive to all the various elements of any social situation presented to me during my time in and around the clinics.

In using participant observation, ethnographic interviews, and a Geertzian approach to

Stellenbosch University https://scholar.sun.ac.za

"hanging out," I was able to spend more time with the providers and their fellow colleagues that worked within the clinics. During this time, while waiting for providers to see their clients, I was able to talk informally to administrative and other support staff, who equally shared insight into the nature of being affiliated with organisations that are more colloquially known as "abortion clinics," and who shared their experiences of navigating these realities in everyday life. It was through spending this time immersed within the clinics that I was able to develop insight into experiences of providers, the space of the clinic, and the lives of providers beyond its walls (Malinowski, 1922).

The semi-structured and open-ended interviews provided insight into the ways in which healthcare providers navigate the ethical and professional challenges of performing TOP in the context of their life-worlds, but our discussions were further complimented and bolstered by participant observation (Russell Bernard, 2006:342-387). Participant observation has marked differences to what is more commonly understood as observation in related fields. Observation in anthropology is described by Geertz (1973) and De Walt and De Walt (2010) as aiming to gain a close and intimate familiarity with a given group of individuals and their practices through an intensive involvement with people, over an extended period of time in their cultural environment. My own research used observation in the sense described by Geertz, which is expansive in its ambition to describe and understand all aspects of a "social situation," similarly to how Gluckman (1940) defined it, as well as the dynamics of the processes involved in the everyday lives of staff members. Because I sought out to understand the subtle expressions and experiences of those involved in offering TOP, I aimed to keep the scope of observation as wide as possible, in line with the methodological rigour described by DeWalt et al (1998), Geertz (1973) and Gluckman (1940). This included

Stellenbosch University https://scholar.sun.ac.za

paying close attention to the kinds of speech being used, how people interact within the workspace, in what style, and with what feeling.

I conducted thirty interviews with people involved in TOP provision and the protesting thereof. The majority these interviews were conducted at the three clinics in Cape Town and included speaking to nurses, management, cleaning staff, and administration staff in order to get a more comprehensive understanding of the environment in which healthcare providers find themselves working. Interviews that were not conducted inside or around the clinics, took place in coffee shops and café's by participants choice. All participants that allowed me to interview or observe them have been anonymised in this paper.

Both Amelia and Joan, TOP providers from the Cedar Row Clinic and the Cinci Freedom Clinic, helped me to understand how providers navigate the moral ambiguities of TOP provision, not only within the clinic as they faced the protesters who stood outside, but beyond the clinic as well – in their homes, families, churches, and within themselves. In chapter four, I pay close attention to the statements made by Joan and Amelia and make use of thematic analysis to organize the various themes that emerged. Ethnographic interviews and participant observation were used specifically as field research techniques, as they were the most appropriate techniques for yielding the kind of data sought by my research questions.

Drawing on Peter Redfield's (2013) *Life in Crisis* and Joao Biehl's (2013) *Vita* in order to research the clinics was particularly helpful. While Redfield (2013) makes use of organisational ethnography, Biehl (2013) employs singular cases, which allowed me to draw on and expand upon both methods. I have found that organisational ethnography

Stellenbosch University https://scholar.sun.ac.za

is valuable for exploring organizations as cultural communities and singular cases are helpful for exploring the individual insights of unconnected cases; however, this research project incorporated the strengths of each, by going beyond the institution to engage with individuals therein and connecting unrelated experiences to accomplish this. In doing this, I was able to observe a space in which ethics and politics come together, in order to pay attention to those trying to navigate the abortion debate in very charged institutional and political contexts.

Reflections, limitations and challenges

Conducting an ethnographic analysis of termination of pregnancy in Cape Town provided many challenges and opportunities for reflection around the various ethical and political nuances thereof. In addition, navigating a stigmatised field such as this one presented methodological challenges to providing a thick description. To give an example of these challenges, I return to the brief description of the pro-life protesters outside of the Mino Valley Clinic, who stood in an orderly manner with wooden crosses resting on their legs as they prayed into their megaphones.

I watched the protesters demonstrate their disapproval of the Mino Valley Clinic's provision of TOP services, they similarly stared back at me. It was clear that the pro-life protesters were unsure of my intentions as I stood across from them. The protesters comprised nine men and five women, each holding a sign with a quotation and evocative image printed upon it. The signs read: "Take my hand, not my life," "Abortion is the ultimate child abuse," "One heart stops, another heart breaks," and "Soul at conception." With their signs and props well displayed, they began to pray

Stellenbosch University https://scholar.sun.ac.za

loudly while pointing their megaphones toward the clinic door. After each set of prayers, they would repeat that their presence in front of the clinic was intended to reach women considering abortion.

Beside me, in a parking space closest to the clinic door there was a large 4X4 motor vehicle that the protesters had arrived in. Pasted on the sides of the car were posters and signage that would later be the centre feature of photos that I would be asked to take on behalf of a protester. “Don’t forget to get the signs on the car in,” Ursula, the organizer of this particular protest, reminded me. The vehicle with its size and signage demanded attention and sat about four meters from the door sending a clear message to anyone who entered. Its position felt deliberately invasive.

I had approached the protesters after their prayers and began to explain my research. A quieter woman who was a little shorter than me had been looking over and smiling while I spoke to the group. When our discussion ended and my research plan had been well received, our group dispersed with kind smiles and waves of our hands. “I knew you were kind,” I heard from behind as I began to walk away. It was the quieter woman, Denise, who shuffled closer as she grabbed my arm. “I saw you from across the street and I knew you had a good heart,” she added, as she looked up at me intently. I thanked her for her kind words, confused by where they had come from. I had only reassured each protester of my intentions to write about them kindly and fairly, a formality that I realised in that moment I had taken for granted, as it became clear to me that the pro-life protesters had had experiences with unfavourable coverage and research before my own. Before walking away, Denise gave me a hug and concluding “I could see it in your eyes.”

Stellenbosch University https://scholar.sun.ac.za

It is *her* eyes I have since remembered when writing about the protesters. In that moment, Denise had showed me a vulnerability that I would come to find was an integral part of being involved in what they called the "pro-life" movement. She and her fellow protesters had entrusted me with her experience and the anxieties that accompanied standing in a pro-life protest. It had become apparent that pro-lifers and pro-choicers alike experienced the emotional labour of engaging in often vitriolic exchanges around the question of abortion rights. Their participation became a trade-off: opening oneself to public scrutiny and criticism, whilst simultaneously allowing one to fight for a cause in which one strongly believed. As I watched the protesters, week by week, I witnessed the contentious interactions that took place between protesters and passers-by. The interactions ranged from civil discussions to yelling and name-calling, and each protesting group handled the ridicule differently and my feelings toward the interactions depended on the group that received it.

Meeting Denise and other protesters like her presented conflicting emotions for me, as I had often dreaded my interactions with the pro-life protesters. As someone who identifies as pro-choice, I found it challenging to interact with the protesters who vehemently disagreed with a service I strongly supported. The nature of the pro-life rhetoric often felt oppressive of women and their reproductive rights. Also, it had often been insensitive to the social and economic circumstances that many women found themselves in and did not shy away from painting women who fell pregnant "out of wedlock" as "indecent." In these instances, the encounters I experienced felt aggressive, violent, and disrespectful, and I found it extremely difficult to work through those feelings before, after, and during interviews.

Stellenbosch University https://scholar.sun.ac.za

Ilana Van Wyk (2014) writes about her difficulty with sympathizing with her informants. In a chapter of the book *Ethical Quandaries in Social Research* titled "*The Ethics of Dislike*," Van Wyk argues that despite the common idea that "dislike" for those we study may threaten the basis on which we make our claims, if acknowledged and thought through rigorously, it should not hamper one's ability to create an accurate and informed argument. In the case of my own research, I found myself faced with similar frustrations to those which Van Wyk (2014) describes. I found my participants, especially the protesters who stood outside the clinic, often infuriating and at times cruel.

However, it was protesters like Denise and Millie, whom I discuss in more detail in chapter five, who provided me with perspective on how pro-life supporters think and feel that were kind, compassionate, and ultimately encouraging of my interactions with protesters as my fieldwork commenced. These mixed experiences with protesters speak to the complexity of human relationships and to the nuances of the abortion debate itself. Experiences such as these emphasize the need for the kind of ethnographic techniques I made use of in order to understand the perspectives of key figures in this debate, as a comprehensive examination of a position or a phenomenon often involves frustration, sympathy, hatred, and understanding.

During my time in the field, I experienced protesters as defensive toward anyone who approached them to discuss their movement. The resistance to open discussion was undeniable and the tension between protesters and those who identify as pro-choice could generally be described as hostile. Standing beside Millie, Ursula, and others as

Stellenbosch University https://scholar.sun.ac.za

they held their signs outside the clinic was the part of my research I dreaded most. Standing alongside them, I experienced the wrath of passers-by that found their pro-life position appalling and endured the gruelling stares that left me feeling judged, embarrassed, and ashamed. "Why don't you work on promoting contraception instead?" one woman had shouted as she pushed her way into the middle of the group. Her dogs stepped on the signs leaving prints as they moved over them. She pointed a finger at Ursula's face before describing her disgust for their beliefs and walking away.

After continuous confrontational encounters from passers-by, protesters have developed an emotional wall to protect them from ridicule and it took some time before they trusted me. After spending time with me, protesters like Ursula and Denise began to speak more openly about themselves and their motivations for joining the pro-life movement. I began to think of these interactions with protesters as trying to bring down their defensive walls that inhibited them from being vulnerable with me. I began to realise that if I could sit through enough pro-life rhetoric about why abortion was "evil," they would eventually realize I was not there to verbally attack them or humiliate them as so many had done before me. In Chapter three, I discuss in more detail the vulnerabilities involved in being engaged in abortion provision and activism and reflect on how these vulnerabilities constitute the field of relations in and around abortion clinics and their surroundings.

While I have sought to reflect carefully and critically on my own pro-choice commitments as I have developed the arguments in this thesis, I have also sought throughout this text to represent pro-life protesters like Millie, Denise, and Ursula respectfully, as they allowed themselves to be vulnerable to someone asking them

Stellenbosch University https://scholar.sun.ac.za

questions about a topic that their movement had often been slandered for. I am aware that in the process of writing and the positions that I take up in this thesis, it is easy for members of the pro-life movement who frequent these spaces in protest to be read as antagonists or even as "bad" people. This is not my intention. Rather, I seek to describe the broader context in which the pro-life movement has become a part of the abortion debate in contemporary South Africa and I do so with respect not only to the clinics, but pro-lifers as well.

Anonymity

When beginning this research, I had not anticipated the struggles with anonymizing my participants. I had not known how few TOP providers there were in the private sector and as I later found out, there was a lack of TOP providers in the public sector as well. It was due to this lack of providers that made writing about TOP provision in Cape Town challenging. It has been difficult to perfectly hide each provider's identity without losing certain nuances that come with describing each individual's life. Discussing employment histories, which are important to understand the complexities involved in each person's sense-making, could be an identifier of who my informants are. In an attempt to avoid making my informants easily identifiable, I have been intentionally ambiguous and vague about their life histories, race, and areas of work.

I have renamed all the participants as well as the clinics, as anonymizing usually requires, but I have additionally been ambiguous about the location of the clinics, as well as the description of the areas in which the clinics are based, as they could serve as identifiers in a province as specifically marked by race and class as the Western Cape. Although obscuring these details might impose a limitation on the research, the paucity of providers and the resulting difficulty of anonymizing them is indicative of a

Stellenbosch University https://scholar.sun.ac.za

larger a problem of access to TOP services, which, although challenging, informed my research and allowed me to spend more time with the few providers that were willing and available.

The providers that I spent the most of my time with are Katrijn, whom I mentioned above, as well as Joan and Amelia, whom I discuss in later chapters. All three providers are in some way connected to one of the three women's reproductive health clinics that made up my field sites. The clinics all offer TOP services among their other reproductive health services, but at a cost which is often subsidised according to the area in which the clinic is based. I have given the three clinics the names Cedar Rowe Clinic, Mino Valley Clinic, and Cinci Freedom Clinic, which are sprawled across the Cape Town area in fairly accessible areas that are closely located to public transport.

In this thesis, I do not interview women who have terminated a pregnancy or who have sought out to terminate a pregnancy. My interactions with women who have had a TOP remains within secondary literature and through observation in workshops or within the clinic. I made the decision not to interview women who had TOPs because of the intense research ethics permission process that I needed to navigate in order to obtain permission to conduct this research. The process to obtain ethical permission to conduct this research comprised multiple applications that were returned to me over a period of six months for refinement and clarification. In order to stay within the scope and time frame of a master's degree I chose to focus on those who provide TOP services, as they are not seen as a "vulnerable" study population, as women who have terminated a pregnancy are, but still have insight into the larger abortion scene. Choosing to focus

Stellenbosch University https://scholar.sun.ac.za

on TOP providers effectively moved my project through the ethics regime in a timely manner.

Chapter Summary

The title of this thesis, "Nursing the Stigma," is intentionally ambiguous in meaning. "Nursing," a term associated with caring and nurturing a subject back to health, paired with "stigma," a term that has a negative association of marking someone to become judged and isolated were chosen not only because "nurses" and "stigma" are integral components of this thesis, but additionally because both of these words project a variation of meaning within different contexts (Cavell, 1979). The title does not imply that stigma must be nursed, but instead raises the question of whether stigma is nursed, continuously, by the constant reinforcement of various factors, such as ideologies that are informed by larger institutions like churches and states, or by the nurses, or TOP providers as I more often refer to them, who nurse their own wounds which are inflicted by stigma.

Much like the words above, the concepts "abortion" or "terminating a pregnancy" are embedded with their own meanings, which are projected from context to context. The use of the term "abortion" or "termination of pregnancy (TOP)" has been used in specific ways in this thesis. While the two terms are very similar in meaning, they evoke different emotions and associations in different contexts. Typically, "abortion" carries with it negative connotations and is associated with murder and a callous action; conversely, termination of pregnancy has a more clinical association and is referred to a procedure more than the results or consequences of said procedure. In terms of the terms used by my informants, I noticed that the health care providers referred to

Stellenbosch University https://scholar.sun.ac.za

"termination of pregnancy" or "TOP" and "abortion" interchangeably, but more often used TOP when referring to the procedure. The term "abortion" was used more often when discussing the more informal aspects of provision, such as their experiences of others stigmatising their work, or the negative perceptions associated with a clinic that "does abortions." The protesters, who preferred to refer to TOP's as "murder," also opted to use the term "abortion" and never called the procedure a TOP. Thus, in this thesis I use the terms according to the logic used by the TOP providers with whom I spoke. When referring to the procedure, I use the term "termination of pregnancy" or "TOP." When referring to the procedure in a more informal context, meaning the perceptions or emotions attached to it, I refer to the procedure as an abortion. Additionally, I use the term "abortion" when referring to larger debates or discussions around the concept of abortion or abortion stigma.

In the following chapter (chapter two), I provide a brief history of the social struggle for access to abortion, as well as the history of the provision of termination of pregnancy services by the state – locally and globally. I do this in order to describe more broadly the context in which the contemporary abortion scene has manifested. I draw heavily on Susan Klausen's (2015) history of the debate in South Africa, *Abortion During Apartheid*, as her description of this pertinent moment in South African history provides a moving and thorough account of the challenges and barriers experienced by women and healthcare workers in seeking out and providing TOP services during apartheid. Additionally, I provide a brief history of reproductive health and abortion in a global context and how this history has bearing on contemporary South Africa, up to and including the 2017 reinstatement of the Global Gag rule under the Trump administration. The global North's influence on South African attitudes toward

Stellenbosch University https://scholar.sun.ac.za

reproductive health policy and practice and the African Christian Democratic Party's (ACDP) attempts to mimic the regulations and "undue burdens" that have been proposed and enforced in the US and parts of the UK are examples of this, on which I elaborate in chapter two. There, I also discuss the current social context of South Africa's abortion debate and examine both the lack of nurses and lack of demand for nurses to provide TOPs in public-sector clinics.

In chapter three, I describe the field of relations that is constituted through vulnerability and violence within the abortion scene. I use the clinics where the TOP providers, protesters, and women who seek TOP services come together and interact as a microcosm to better explain how these vulnerabilities and resistance constitute the space where abortion stigma is perpetuated. To do this, I describe a workshop that was hosted by a local activist group that I have renamed the "Jersey Girls." The workshop was formed with the intention of creating an event that would celebrate twenty years of legal TOP services in South Africa, and from the discussions, provide a glimpse into the concerns around conscientious objection and barriers to access that emerged. The workshop, which brought TOP providers, women who have had TOPs, reproductive health activists, and artists together, provides a point of departure to demonstrate how vulnerability and resistance is experienced, thought through, and acted upon within this highly controversial and stigmatised field.

.

In chapter four, I unpack abortion stigma experienced by TOP providers more explicitly as I explore how TOP providers negotiate abortion stigma within this often controversial and morally ambiguous field. I describe how providers like Joan and Amelia make sense of and understand their service in relation to the larger collectives

Stellenbosch University https://scholar.sun.ac.za

and institutions with which they identify and make sense of their worlds therein. Amelia and Joan share stories of their experiences as TOP providers and how they understand the treatment they receive from family, friends, and strangers as a result. The collectives that shaped Amelia and Joan's subjectivities provide insight into how these TOP providers negotiate their own values and moral codes alongside larger questions of ethics that are informed by larger debates about women's reproductive health rights, the point at which life begins, and the sanctity of life to name a few. Joan and Amelia's navigation of this morally ambiguous service provides insight into how stigma emerges and affects not only women who seek out the service, but those who provide TOP services as well – offering more insight into the possibilities of why there is a lack of providers in the South African healthcare system.

In chapter five, I step outside the experience of TOP providers in order to explore the "right to choose" through the opposing discourses of the pro-choice and pro-life movements of which the TOP providers engage in. There, I focus on a group of people whom I refer to as "pro-life protesters". I explore the ways in which these opposing discourses struggle to occupy a normative position in the public sphere in order to reflect on the question of how rights and laws relate to each other in the context of the debate over access to TOP services, despite the legal framework put in place to secure it. I do this by making use of Michael Warner's (2002) *Publics and Counterpublics* to unpack how these publics struggle for hegemonic power and as a result have more influence on the realisation of CTOPA in 2018. Chapter 5, although not directly dealing with TOP experiences, is important to understand the context in which TOP providers experiences are formed and informed. Understanding the normative discourse around their highly controversial field provides insight into the larger public discussion around

Stellenbosch University https://scholar.sun.ac.za

abortion and how it affects access to TOP care.

In chapter six, I continue to look outside the TOP providers direct experience to better understand the context in which their experiences are formed. I discuss the question of silence and voice as it arises around women who seek out abortions in the informal sector. The difficulty of representing these women's voices is constitutive of a broader problematic in reproductive health research, journalism, and general public discourse. Drawing on Gayatri Chakravorty Spivak's (1988) original essay *Can the Subaltern Speak?* I ask, "Can the woman who seeks an abortion speak?" In doing so, I seek to think through the question of how the experiences and perspectives of women who seek abortions might be presented and represented in the public sphere. I do this in order to unpack the ways in which women who have had abortions are represented across various media. I do not introduce new ethnographic material in this chapter, as conducting research directly with women who have had abortions was not within the scope of my research. However, in finalising this thesis on abortion stigma and its impact on effective TOP service provision, I felt it necessary to address the problematic silence of those who are affected most.

Stellenbosch University https://scholar.sun.ac.za

Chapter Two: Situating the Study

In contemporary South Africa, there is a crisis of women seeking out unsafe abortions from the informal abortion sector. In 2012 it was estimated that, globally, 19 million women seek out unsafe abortions each year, with 82 000 of those unsafe abortions resulting in death of the mother (Hayes G, 2013).). The majority of these unsafe abortions take place in developing countries, such as South Africa. Whether the legal framework of developing countries like South Africa supports access to TOP services or not, terminating a pregnancy is typically accompanied by stigma that is informed by leaders from larger institutions, such as political and religious leaders (Grimes *et al*., 2006).

In this chapter, I discuss the history and context of TOP services and reproductive health legislation in the context of South Africa, and I situate this in a broader, more global context of debates about women's reproductive rights and termination of pregnancy. It is important to locate the project in a larger history of struggle around access to TOP services, as this history has had influential effects on South Africa. Because these debates have played out differently in various regions of the world, for the purpose of this chapter I discuss the histories of the United States and the United Kingdom as they have had a significant influence on South African struggles for access to TOP. In addition, I discuss what TOP legislation looked like in 2017, both globally and in South Africa. I do this in order to situate the experiences and narratives of my interlocutors within the medical, social, and political contexts of the abortion debate as it is unfolding in contemporary South Africa.

Stellenbosch University https://scholar.sun.ac.za

The early twentieth century marks the era in which the movement toward reproductive freedoms and better reproductive healthcare for women emerged (Nichols, 2000). Prior to this, the Victorian era too ushered in a shift in morality, but despite popular thought, the Victorian era did not bring with it a silence on sex and sexuality, instead, it became discussed in new manners and forms across various domains, in what Foucault refers to as "incitement to discourse" (Foucault, 1978:17-35). Foucault argued that discourses about sex and sexuality could not be silenced or repressed at all, and instead details examples of it emerging in outlets, such as scientific discourse, psychiatry, and religious confession, to name a few. In the case of termination of pregnancy, I argue that a similar emergence to talk and act upon this sexual reproductive health procedure manifested within in the informal abortion sector, where stigmatizing language does not tend to occur. As a result of the booming success of the informal abortion sector, a deep concern to keep women and the unborn children safe emerged.

The concern for the unborn set the stage for the global movement to liberalize reproductive health policy and the early 1900s ushered in successful campaigns to make contraceptives available and accessible for women, in both the United States and the United Kingdom. Leaders in the movement, such as Margaret Sanger and Marie Stopes each opened what were termed "birth control clinics" in their respective countries and began to publish books addressing the importance of birth control. Sanger and Stopes made contraceptives available in order to empower women and argued that granting women the choice of when to reproduce would put them on an equal footing with men. Sanger's (1917) work *Family Limitation* had her prosecuted due to its controversial nature and Stopes's (1919) *Married Love or Love in Marriage* was similarly banned.

Stellenbosch University https://scholar.sun.ac.za

Stopes however continued to edit a newsletter titled *Birth Control News*, which provided practical guidance to sex and reproductive health. Despite Stopes and Sanger's books being banned, both activists were still influential within the movement to liberalise reproductive health policy and continued to initiate discussion within the public discourse. Sanger and Stopes argued that family planning would reduce the demand for illegal abortion services, and by the 1930s their voices had been heard. Birth control clinics were established in the UK, and later in the US. The clinics they established are better known today as Marie Stopes International (MSI) and Planned Parenthood Federation of America, respectively. Both clinics continue to play an important role in contemporary post-apartheid South Africa.

Marie Stopes International has approximately fourteen clinics based in South Africa, gaining and losing some year by year with the country's precarious nature of TOP services. Because demand for TOP services fluctuates, the clinics and their employees find themselves in an unpredictable situation, forcing some clinics to close their doors and allowing others to open or reopen again. This precarity can be attributed to many factors, such as abortion stigma, lack of staff, etc. In the United States's context, Planned Parenthood in 2017 had become a leading opponent of President Trump and his office's attempts to steadily restrict and defund the organisation. This resonates with the South African context where, in 2018, conservative attempts to regulate TOP services are being led by the African Christian Democratic Party (ACDP), which has proposed changes to TOP provision law. The ACDP's proposed changes to the TOP provision law mimic changes made to the laws in the US under the Trump administration. This is one instance where debates in the global North have had a powerful influence on South Africa's abortion landscape. For this reason, I give a

Stellenbosch University https://scholar.sun.ac.za

detailed history of Euro-American struggles for women's reproductive rights and show how they shaped South African debates in the remainder of this chapter.

The 1950s marked a period when women in the global North began to fight more actively for their rights to terminate their pregnancies. The mobilisation of the feminist movement resulted in a growing demand for liberalised legislation that would grant women reproductive control. In 1967, the first US states began to decriminalize abortion making it legal to terminate in very particular circumstances. Colorado, California, and Oregon were among the few that made termination permissible in cases of rape, incest, or mental and physical disability of the mother or child. This also meant that women were allowed to terminate if their pregnancy would result in bodily harm. Technological advances and safer, simpler medical techniques strengthened the pro-choice cause. Abortion began to be legalized in various states up to the 24th week. With TOP provision laws being subject to each state, a back and forth of appeals and repeals of TOP legislation took place in each state, leaving the finer details of when and where a woman can terminate ambiguous and often confusing.

In 1973, The trial of Roe v Wade between Norma McCorvey, who went by the name Jane Roe for anonymity, and the State of Texas, would bring this ambiguity to a close by creating national guidelines that all states would adhere to. McCorvey had sued on account of being denied safe and effective TOP treatment and pursued her case under the pseudonym Jane Roe. The U.S. Supreme Court found the denial of access unconstitutional and, to honour the 14th amendment[2], found that all women should be

[2] The 14th amendment addresses citizenship rights and equal protection of laws

Stellenbosch University https://scholar.sun.ac.za

able to decide whether to continue with or terminate their pregnancies. The new law, however, did allow for regulations to be placed in order to protect the woman's health as well as the viable foetus's.

Foetal rights became solidified in civil law once Norma McCorvey won her case and TOP provision became legalised. The formation of foetal rights, which considers a foetus a legal subject by granting it various protections, followed many decades of debate around the so-called "sanctity of life," which argued that human life was sacred and should be protected from acts such as termination of pregnancy. The debates around the sanctity of life continued to fuel right wing religious concern and abortion stigma, as the pro-life movement appealed to women's guilt and sense of shame to curb abortions. Abortion stigma continues to have an impact on access to TOP services in both Euro-American and South African contexts, as women seek out alternative methods to terminate their pregnancies ("informal" or back-street" abortions) and healthcare systems lack healthcare workers who are willing to provide TOP services.

Since Roe v Wade came into effect in the United States in 1973, pressures on political leaders to overturn the legislation had continued until 1989, when then presidential candidate and pro-life politician George H. W. Bush significantly limited access to affective termination treatment once he took office. President Bush allowed state hospitals to stop providing TOP services, transferring a large burden of TOPs onto private clinics, such as Planned Parenthood. In more contemporary times, Roe v Wade has continued to be challenged by the religious right, but until now, in 2018, the U.S. Supreme Court has held firmly that a state cannot ban TOPs before viability[3]. This is

[3] Able to live on its own or outside the uterus.

Stellenbosch University https://scholar.sun.ac.za

beginning to change in 2018 as Republican politicians are building plans to overturn Roe v Wade as a new Supreme Court justice nomination process gets under way (Foran, 2018).

As Michel Foucault (1978) suggests in volume one of *History of Sexuality*, the historical emergence of the state's attempt to regulate reproduction and the appropriate use of sex was accompanied by the development of new norms of sexuality and desire, policed by means of shame and secrecy, medical authority, and public institutions dedicated to regulating the correct conduct of the self and the policing of the family.

The production of abortion stigma has since had implications for TOP providers in the U.S., who not only have to contemplate whether they will provide, but, since 1993, have additionally become victims of anti-abortion attacks carried out by rightist extremists. The attacks have ranged from harassment and vandalism of clinics and providers's personal property to kidnapping and murder. In 2000, Marc Levin and Daphne Pinkerson directed a documentary following a Christian terrorist organisation called the "Army of God," as the members who refer to themselves as "soldiers" recall the organisation's previous violent attacks on clinics and providers.

Since 1977, the United States and Canada have collectively undergone 153 incidents of assault on providers, clinics, or assistants of TOP services. Of the assaults, there have Violent attacks take up much of the media coverage when they are enacted, but what is rarely covered in media reports is the everyday harassment and abortion stigma that are endured by TOP providers. Cohen and Connon (2015) detail the everyday effects harassment and surveillance of TOP providers, who similarly in this thesis encompass

Stellenbosch University https://scholar.sun.ac.za

not only doctors and nurses, but also the administrative and support staff who participate in and facilitate providing safe and effective TOP care to their clients Cohen and Connon's book, *Living in the Crosshairs: The Untold Stories of Anti-Abortion Terrorism*, recounts the experiences of 87 providers who were each intimidated by the pro-life movement, and as a result of which, they live in fear.

In 2016, the National Clinic Violence Survey conducted by the Feminist Majority Foundation found that the incidence of violent attacks on clinics and staff members thereof was steadily increasing with each year since 2010 (Spillar *et al.*, 2017). The violence reportedly included threats of arson, bombing, and gunfire, as well as having personal information of the providers themselves and their family posted on the internet in order to incite violence and harassment (Spillar et al., 2017). Cohen and Connon (2015) report that providers take extreme, but necessary, measures of caution to protect themselves from these encounters. Some providers described wearing bulletproof vests to work and wearing disguises to pass through protesters who would try and stop them from reaching the clinic each day. This raises the question of whether the fear of providing TOPs due to the stigma surrounding the whole field and the potential for life-threatening attacks discourages healthcare professionals from becoming TOP providers.

Abortion in South Africa (1970 - Present)

Since the 1970s, the Global North began granting women the rights to take control of their own reproductive health, while in South Africa, Hodes (2013:527) argues that the move toward more liberalised laws lay stagnant under Apartheid rule. Indeed, abortion under apartheid was legal, but only so if done to save a woman's life or to complete a

Stellenbosch University https://scholar.sun.ac.za

miscarriage. In contrast to the Global North, South African women were regulated reproductively in order to maintain a very particular ideological structure of white supremacist rule. Klausen (2015) illustrates in her book *Abortion Under Apartheid* how the regime, which ruled from 1948 to 1990, focused on maintaining the wellbeing of the white minority by policing the sexuality of not only white women, but black women as well. This was done in an attempt to curb "swamping," which Hodes (2013:531) describes as an "anxiety about political and demographic dominance by black South Africans."

By the early 1960s, the fear of swamping was not limited to the South African black population but extended to the fear of the growing South African "poor white" population, who were considered to be failing and losing their sense of whiteness due to living like or with black South Africans. Pockets of the white population grew poorer, as a result of the country entering into an economic depression (Norling, 2015). In 1974, the state rolled out a massive, free birth-control programme for black South Africans, whilst simultaneously limiting access to legal TOP s for white South Africans in an attempt to ensure that the white population continue to increase alongside a growing black population (Kaufman, 1996). The birth control programme was highly motivated by eugenics, which grew in popularity with the belief that the "racial degeneration" of the poorer white population was not being caused by the environment, but rather by the integration of white and black communities. As white poverty continued to rise, birth control was utilized in an attempt to limit what was believed to be weaker genes from reproducing and to allow for what was perceived to be stronger and more racially resilient genes of the white population to continue to reproduce (Dubow, 1995; Bank, 2015).

Stellenbosch University https://scholar.sun.ac.za

A conservative vision of sex and sexuality was enforced by the National Party (NP) who worked hand in hand with the Dutch Reformed Church to reinforce the religious ideologies that underpinned Apartheid and white supremacist rule (Hodes, 2013:531). Alongside the discouragement of participating in sex before marriage and extramarital affairs, South Africans were additionally forbidden to participate in interracial dating, which assisted the state in policing racial and sexual boundaries and ensure the continuation of their envisaged pure race. This ensured that no white citizens "betrayed a white racial identity," which became pivotal in performing this superiority (Klausen, 2015:9) This was evident in parliamentary meetings, which, through their course, continuously justified the subjugation of Black people, who in the eyes of the Christian state were considered to be barbaric and uncivilized. The rhetoric of white South Africans as God's chosen people was made common rhetoric to justify their governance over the country and those who live in it (Klausen, 2015).

Similarly to the U.S., South Africa had its own public court trials that shook the judiciary's stance on TOP provision law and impacted the country's perceptions of abortion and reproductive health. Klausen (2015) documents the November 1972 trial that prosecuted Derk Crichton and James Watts for "conspiring to perform abortions on white teenagers and unmarried young women." The case went to the Supreme Court of South Africa and, because of the status of Crichton, a well-known doctor and professor in gynaecology who was famously outspoken on abortion advocacy, attracted the attention of the South African public. The case, Klausen (2015) argues, demonstrated the lengths Crichton would go in order to provide safe and effective TOP services, as he teamed up with a non-medical abortionist, Watts. Watts was a "blue

Stellenbosch University https://scholar.sun.ac.za

collar" Shell employee, for whom tertiary education was never an option. Watts became a self-taught informal abortionist after reading ample literature on biology and physiology at his local library and book outlets (Klausen, 2015:114).

King Edward Hospital, which at the time was considered formally to be a hospital reserved for the black population, was where Crichton was employed as the head of the maternity ward. Crichton had begun attracting women of all races due to his outspokenness, but Apartheid's strict TOP regulations obligated Chrichton to turn them away, leaving those desperate to terminate to turn to informal abortion services. Much like today, South African women sought out clandestine or more colloquially known "backstreet" abortion services that often resulted in death or irreversible damage to their bodies, with Groote Schuur Hospital in Cape Town, for example, reporting between 2,800 and 4,200 women admitted for miscarrying annually (Klausen, 2015:19).

By law, Crichton was unable to begin an abortion, but could complete one if a woman arrived at the hospital while miscarrying. Furthermore, Crichton was required by law to ensure that the termination ended safely and obliged when necessary. It was clear to Crichton and his nursing staff that women were initiating terminations with informal abortionists and turning to the hospital in order to complete the miscarriage safely. In 1972, Crichton's nurses brought his attention to an informal abortionist named Watts, whose name circulated in the wards and whose clients seemed to evade infection, due to clean working spaces, sterilized equipment, and safe termination practices. Crichton established a relationship with Watts to work together in creating a safe environment for women seeking abortions. It was agreed that when patients approached Crichton to terminate their pregnancies, he would send women to Watts to begin the abortion on

Stellenbosch University https://scholar.sun.ac.za

the promise that Watts would tell the women to return to Crichton to complete it safely in the hospital. Additionally, women who approached Watts first would be sent to Crichton to complete the termination, creating what Klausen would refer to as the Crichton-Watts system (2015:121).

Crichton's outspokenness about South Africa's antiquated abortions laws made him a target for the South African government, which, as Klausen (2015) describes, put plans into motion to bring his career to an end. Sergeant Dan Matthee, describes how he was hired by the Minister of Health to investigate Crichton and the "alleged country-wide abortion network" in 1969 (Klausen, 2015:124). Shortly thereafter, "the trial the world was watching" began and Watts and Crichton were charged for illegally performing abortions. The focus remained on the young white women seeking abortions, which further highlights the Apartheid state's concern for the white body and maintaining the preservation of the white race (Klausen, 2015: 107-138).

Klausen (2015: 105-143) describes the case as one of humiliation for the women involved, with full media coverage seeking to make an example of them to prevent other young women seeking to procure abortions. In addition to humiliating the women who had sought out abortions, the court case also served as an attempt to discipline and punish the white doctor who was willing to provide abortions. The trial became a spectacle to enforce fear within not only the public who may seek to terminate their pregnancies, but also in the doctors, nurses, and other medical professionals who may have considered providing TOPs.

In the trial's conclusion, Watts was imprisoned for six months at Durban Central Prison,

Stellenbosch University https://scholar.sun.ac.za

but continued his practice once being released. Crichton was let off with a hefty fine and allowed to continue practicing medicine. The judge acknowledged that, although Crichton had broken the law, Crichton, like other men in the medical profession, found himself in a position where he was managing an illegal abortion crisis and the judge understood Crichton's concern with ensuring women's safety. The fine and public spectacle did not, however, deter Crichton, who was again prosecuted in 1973 when he created a similar abortion network with Dr. Angini Maharaj (Klausen, 2015:140-144). Both doctors were once again met with sympathy by the judge, who acknowledged the work being done as an attempt to deter women from inducing their own abortions in an unsafe manner. Crichton and Maharaj were fined, and returned to work shortly after (Klausen, 2015:144-145). In 1974, a meeting of the South African Medical and Dental Council (SADMC) was held to reassess Crichton and Maharaj's crimes. The committee that was commissioned to discuss the case ultimately decided to enforce the harshest punishment on both medical professionals: Crichton and Maharaj were struck off the medical roll in July, 1974 (Klausen, 2015:146).

Klausen's (2015) *The Trial the World is Watching* explicated in great detail how the South African government "disciplined and punished" women and medical professionals who violated the Christian sexual norms of Apartheid South Africa. This is useful to think about with regards to this thesis, as I posit that women who seek out TOP services and the healthcare workers willing to provide them in contemporary South Africa are met with similar tensions when contemplating whether terminating pregnancies are in line with this society's moral and sexual norms. The material that I provide in the chapters that follow resonates with the sense of social and ethical crisis experienced by these practitioners in the 1970s in the way that shame, stigma, and moral

Stellenbosch University https://scholar.sun.ac.za

crisis surround the concern with abortion in contemporary South Africa. Although Crichton is only one case, his story is emblematic within the larger scope of this discussion, as it reveals how the Apartheid State and the media were crucial actors in the production of shame around women seeking to terminate their pregnancies and the healthcare workers willing to provide them.

Abortion Access in Contemporary South Africa

After its enactment in 1996, the Choice of Termination of Pregnancy Act (CTOPA) was credited for reducing maternal mortality by 91% by 2005 (Jewkes *et al.*, 2005). The CTOPA allowed abortion up until 12 weeks gestation and up until 20 weeks gestation under extenuating circumstances including: a pregnant woman who does not feel their social and economic circumstances are suitable to raise a potential child, a woman having a compromised mental health state, foetal abnormalities, pregnancy due to incest, or pregnancy due to rape. Despite reduction in maternal mortality and the continued support of liberal abortion laws, in contemporary South Africa, high self-induction abortion rates continue to occur (Constant *et al*., 2014) In order for an abortion to be considered "self-induced," the abortion must make use of tools or medications that are outside of the scope of evidence-based abortion regimens. Alternatively, the procedure must be conducted by a person without the necessary skills or facilities that meet medical standards (World Health Organisation, 2008)

In their study on "Self-induction of abortion among women accessing second-trimester abortion services in the public sector" in Cape Town, Constant *et al.* (2014:304) found that methods most commonly used by women who had self-induced their own abortions were "remedies and herbal products, rather than medications procured from backstreet

Stellenbosch University https://scholar.sun.ac.za

providers". Methods used to induce terminations are often ones that are harmful to women's bodies and can leave those who ingest them physically mutilated or result in death. South Africa has a thriving industry of informal abortion providers who operate outside of the legal framework and facilities outlined in the CTOPA (Constance et al, 2014). According to global reproductive health group Marie Stopes International, up to 58% of the estimated 260 000 abortions that take place in South Africa annually are informal (Hayes, 2013).

Jewkes *et al.* (2005) found that abortions conducted outside of evidence-based abortion regimens and facilities were done so for various reasons, such as time-limit constraints when finding out one's pregnancy had exceeded the twenty-week gestation mark, negative perceptions around such services, a lack of referrals from healthcare workers that chose to conscientiously object, misinformation about the side effects of having an abortion, and the fear of encountering healthcare workers or pre-abortion counsellors that may intimidate them (Harries, Stinson, and Orner, 2009; Orner *et al.*, 2011).

Harries *et al.* (2007) while researching delays in "seeking an abortion until the second trimester," found that abortion providers had become increasingly scarcer and that the TOP providers who did provide such services found it challenging to manage the burdened number of women seeking to terminate. In addition, Constant *et al.* (2014:304) found that "less than 75% of the 40 designated facilities [in South Africa] are functional, and at some, services are offered only every second week or on a monthly basis." The lack of trained and willing providers resulted in delays that can take weeks to attend to and further created barriers for women seeking safe and effective abortion care (Harries, Stinson, and Orner, 2009).

Stellenbosch University https://scholar.sun.ac.za

According to the CEO of Marie Stopes, Simon Cooke, despite progressive abortion legislation, “many women in South Africa don't even know that abortion is legal” (Capazorio, 2014). This ultimately drives women into the clandestine industry that has many “providers” that are well advertised and easily accessible. Posters to find these clandestine abortion providers are plastered all over city walls, trains, and lampposts with “safe abortions” printed in large font. At times overwhelming public surfaces, these posters have become a part of everyday city life. Amnesty International (2017) published a report on *Barriers to Safe and Legal Abortion in South Africa* assessing how far South Africa had come in terms of TOP provision. The cover of the issue featured a collage of photos of “safe abortion” posters that had been taken within the surrounding blocks of a legal women’s reproductive health clinic in Cape Town. The abortion services advertised on these “safe abortion” posters are carried out by non-medical professionals who masquerade as medical practitioners and the use of their services has repercussions not only for the wellbeing and fertility of the woman seeking TOP services, but in extreme cases, the remedies used can be life threatening.

Gagged: The undue burden on TOP provision

In 2017, President Donald Trump’s inauguration was met with protest not only in the United States but in Cape Town and around the globe. The women’s march on Washington, D.C. took place on 21 January, 2017, one day after Trump’s inauguration and was imitated globally with a worldwide participation that was estimated at five million people (Hartocollis and Alcindor, 2017). The march protested the statements Trump had made during his campaign involving immigration reform, LGBTQ rights, and the environment, but also sought to object to his apparent beliefs about women’s

Stellenbosch University https://scholar.sun.ac.za

reproductive health and healthcare reform (Bakhtian, 2017; King, Castillo and Agrawal, 2018).

Trump's promises to reform healthcare meant not only reform of the Patient Protection and Affordable Care Act, (more commonly known as "Obamacare"), but also reproductive health services, as the U.S. knew it. Abortion clinics struggling to stay open, the filing of multiple bills that would, among other things, criminalize abortions for severe foetal abnormalities and make cremation or burial for foetal remains mandatory were among the concerns. The lack of access to termination of pregnancy services was growing, and with the threat of the Global Gag rule becoming reinstated, countries outside of the U.S. who rely on U.S. funding to support such services began to feel the pressures as well.

Donald Trump and his vice president Mike Pence, who is known to be an unapologetic anti-abortion legislator, had come under scrutiny for being "anti-women," particularly in regard to reproductive healthcare. Pence had gutted funding for Planned Parenthood in his governing state of Indiana, which resulted in the closing of multiple clinics during his tenure (Littlefield, 2017). During President Trump's 2016 campaign, Pence publicly stated that his views on abortion were heavily guided by his faith and, since 2007, Pence had become infamous in the pro-choice community for seeking out ways to defund Planned Parenthood and supporting legislation that acted as a barrier to women accessing safe and affective TOP services (Pradhan, 2016).

Pence's 2016 interventions in Indiana required women to attend abortion counselling prior to terminating and forced women to endure waiting periods that often placed them

Stellenbosch University https://scholar.sun.ac.za

outside of the legal termination time frame (Mcardle, 2018; Nash *et al.*, 2018). These requirements were not unique to Indiana, with many states, such as a Ohio, simultaneously passing legislation that restricted access to TOP services and as well as their provision (Mcardle, 2018; The Editorial Board, 2018). In 2018, however, the Federal Appeals Court ruled that Mike Pence's attempted legislation to ban pregnant women from terminating their pregnancies based on the foetus's gender, race, or in the case of disability, was unconstitutional (Mcardle, 2018; Stempel, 2018).

The restrictions target what Gold and Nash (2017:1) have identified as three broad areas: firstly, restriction targeting TOP providers, which require "providers to have unnecessary admitting privileges at local hospitals, banning the use of telemedicine for medication abortion and limiting the provision of abortion to physicians." Secondly, counselling and waiting-period requirements that force providers to inundate women with information about the consequences of terminations, which Gold and Nash (2017:1) argue are not based on scientific evidence. In 35 states, women are required to receive counselling prior to termination, and providers are required to relay information that varies according to each respective state. In 13 states, providers are required to inform the woman of the foetus's ability to feel pain, while in six states, providers are required to counsel that life begins at conception. Providers are also forced to list the various possible consequences of termination, which include risks around mental health, future fertility, and increased rates of breast cancer. The counselling, alongside lengthy waiting periods that are required on "the faulty premise that women need additional time to consider their decision" can discourage a client seeking termination (Gold and Nash, 2017:1). Finally, the Rose and Nash (2017) argue that there are restrictions using foetal pain as a pretext, claiming that a foetus can feel

Stellenbosch University https://scholar.sun.ac.za

pain at 20 weeks and therefore need protection – a premise they again argue is false.

In South Africa, these kinds of restrictive measures are beginning to be discussed as political parties, such as the African Christian Democratic Party's (ACDP) proposed 2017 amendment bill that, similar to the legislation being passed in the United States, would create barriers to access to TOP services. Among the suggestions the ACDP made to amend the CTOPA was to make ultrasounds compulsory for women seeking to terminate their pregnancies, as well as a mandatory counselling session that would require the woman to see images from the ultrasound. Given the limited provision of TOP services in South Africa, the ACDP's proposed amendments would create additional barriers for women seeking to terminate.

In the United States, these "weaponized" restrictive methods have begun to add up. Carmon (2015:1) reports that between 2010 and 2016, states enacted 338 new TOP restrictions, which account for nearly 30% of the 1,142 TOP restrictions enacted by states since the 1973 Supreme Court decision in *Roe v. Wade.* Many reproductive health activists consider these restrictions to be an "undue burden," which is described as the intention of creating substantial obstacles for women to make use of their fundamental rights and access legal TOP provision.

The legal concept of undue burden was established in 1992 as a result of the case Planned Parenthood v. Casey. This case became monumental for women's reproductive rights, as it redefined several provisions that had been established by Roe v Wade. Planned Parenthood v Casey emerged from statutes that were enacted by Governor Robert Casey of Pennsylvania in 1988 and 1989. The statutes required minors to obtain

Stellenbosch University https://scholar.sun.ac.za

permission from their parents before termination, as well as requiring a woman to notify her husband. Information that clinics provided to patients also became regulated and, ultimately, providers were policed into providing information to clients that could impact their decision. Additionally, waiting periods of 24 hours had to be met before a woman could terminate her pregnancy (The Supreme Court of the United States, 1992).

Planned Parenthood challenged the state and Casey, arguing that the statutes were unconstitutional. The US Supreme Court agreed that women have the right to access safe and effective TOP provision prior to foetal viability, and from this case, the "undue burden" standard was created. The new standard ultimately invalidated the requirement of women to notify their husbands of their intentions to terminate. The standard was later clarified in the 2016 case Whole Woman's Health v Hellerstedt (Carmon, 2015).

As promised, on 23 January, 2017, Trump re-enacted the Global Gag rule as one of his first acts of his presidency. Anxiety around how this would affect TOP provision, research, and activism erupted globally. The executive order, also known as the "Mexico City Policy" bans international NGOs or organisations receiving US funding from providing TOP services, offering information, and counselling – even if TOPs are legal in the country in question. If organisations receiving U.S. funding were to do so, they would lose funding immediately. Redden (2017) reports that the United States is the largest donor to global health efforts with the United States Agency for International Development (USAid) providing $3 billion alone. With the executive order in place, organisations and groups based outside of the U.S. that benefit from U.S. funding stand to lose large amounts of their financial support if they do not abide by the Global Gag rule. Organisations that run the risk of losing funding subsequently also risk losing

Stellenbosch University https://scholar.sun.ac.za

financial support for services they may offer that are not TOP related. Marie Stopes International, which provides support for a variety of health-related issues such as essential supplies of contraceptives globally, was reported to have lost 17% of its donor income as a result of the Global Gag rule (Edwards, 2018).

In South Africa, the Global gag rule caused concern for the U.S.-funded private facilities that offered TOP provision or sub-services relating to TOPs, in addition to their main centre objectives. Sub-services that include counselling and referrals offered by many of the non-profit health organisations were now in a precarious position. South Africa's stigma-related barriers make private facilities a necessity in providing safe and effective TOP care in 2018, and U.S.-funded organisations have come under pressure to stop providing any TOP related services.

In early 2017, while the effects of the gag rule were still being realised, the new policy had already silenced organisations who rely on U.S. funding. My fieldwork became more restricted as organisations who offered reproductive health services and counselling stopped returning emails. Of those who did respond, some expressed concern that they could not participate during this precarious time when the gag rule's implications were not fully understood. It became clear that non-profit organisations were reluctant to speak out of fear that they would lose financial support (Pilane, 2017).

The 2017 gag rule is not the first gag rule to have been enacted. Since its initial establishment in 1984 by Ronald Reagan, the gag rule has been rescinded and reinstated across various presidencies, starting with the Clinton administration who lifted the gag rule in 1993 and alongside it, brought an end to the federal bans that inhibited the use

Stellenbosch University https://scholar.sun.ac.za

of foetal tissue from aborted foetuses for research purposes (Gezinski, 2012). In 2001, as one of his first acts as president, George W. Bush reinstated the Global Gag rule. Barack Obama later rescinded it in January 2009 during his presidency and made considerable efforts to protect funding for TOP care in the United States by signing pro-choice abortion law that contained funding for TOPs and weakened conscience protections for medical workers creating access barriers for women in predominantly pro-life states (Gezinski, 2012:840; Starrs, 2017:485).

The implementation of the Global Gag rule illustrated to South Africa how influential the United States's decisions around reproductive health and termination of pregnancy are around the rest of the world. My argument here is that in order to understand the South African context, it is necessary to track the history of the politics of TOP service provision in the U.S., not only because the various funding constraints have an impact so directly on South Africa, but also because it plays an important role in constructing an influential public discourse around the political, medical, and social contexts of abortion.

Although the nature of South Africa's access to abortion challenges differs to those of the U.S., as access is not caught up in a back and forth of legislation, the prominent use of clandestine abortion service suggests that South Africa's barriers lie elsewhere. By tracking the history of abortion struggles in the U.S. alongside the current context in which South African TOP services function today, I further examine the difficulties that women face while trying to access safe and effective TOPs in South Africa in the pages below.

Stellenbosch University https://scholar.sun.ac.za

In order to situate the relationship between American and South African national contexts and the ordinary worlds of the clinics in which I worked, I now turn to a brief introduction of the three clinics that constituted my field sites. I turn also from a more distanced review of literature to a thicker mode of ethnographic description, including institutions, spaces, and people that I came to know well over six months in late 2016 and early 2017.

Field Sites

The three clinics that I spent time in from December 2016 to June 2017 are based in the Western Cape and make up three of the four clinics that offer legal, private termination of pregnancy services in the province. The clinics, for which I have assigned pseudonyms here, are the Mino Valley Clinic, Cinci Freedom Clinic, and Cedar Rowe Clinic. I describe each space in detail and introduce the main figures who frequent them in order to contextualise how these figures make sense of their positions within this space. The figures that I introduce in this chapter appear in later chapters and occupy various positions in the social field of the struggle for access to safe, legal TOP services in South Africa. Some figures are TOP providers, which includes supportive staff for the clinics. Others are pro-life protesters who frequent the clinics to protest the TOP services that are offered amongst the range of reproductive health services performed by the clinic.

Mino Valley Clinic

I arrived outside the Mino Valley Clinic on the morning of 24 September, 2016, also known to South Africans as Heritage Day. Heritage Day celebrates South Africa's diversity after the end of its Apartheid past. In 1995, Heritage Day was marked by

Stellenbosch University https://scholar.sun.ac.za

former South African President Nelson Mandela as a day to move forward from South Africa's history of state-sanctioned racism and segregation and to instead embrace diversity that was not limited to race, but encompassed faith, sexuality, and gender amongst other historically contentious categories. It was thus ironic that outside the Mino Valley Clinic on that day, a demonstration was underway consisting of "pro-life" protesters objecting to the clinic's provision of TOP services. Despite the gathering outside, the Mino Valley Clinic continued to operate as usual and clients passed in and out of its doors doing their best to ignore the crowd of pro-lifers confronting them. The protest illuminated the discrepancies among the protesters, providers, clients, and observers, each of whom held different ideas and beliefs that had come to shape what each individual would call a "moral code" that would guide their stance on a woman's right to choose.

Heritage Day 2016 marked the end of a year-long ban on anti-abortion protests within fifty metres of the clinic. Cape Town Mayor Patricia De Lille had put the ban in place and the pro-life protesters who often frequented the clinic space had been vocal about their view that the ban was unconstitutional. It was 9:30am and a group of fifteen protesters had gathered on the cement island that partitioned the road in front of the Mino Valley Clinic. Beside each protester was a large wooden cross that balanced comfortably on their legs and as the sun rose, the shadows of the crosses elongated and stretched into the road. With rosaries in hands, megaphone for amplification, and placards, the protest and prayers began. It continued for two hours as they stood in unison carrying out their demonstration.

Stellenbosch University https://scholar.sun.ac.za

In 2017, pro-life protesters could be found outside the Mino Valley Clinic almost daily. Some days they would gather in groups to protest, while on other days you could find one or two protesters happily standing alone. Large or small, the gatherings comprised of various groups that identify with different Christian denominations and independent pro-life support groups within Cape Town. The groups rotate week by week, with Saturdays serving as their main day of protest. On Saturdays, protesters usually arrived around 11am and spent an hour or two in protest before moving on with their day. "They're not early risers," I had heard the nurses at Mino Valley Clinic say, as they giggled to themselves.

Mino Valley Clinic was the largest of the three clinics and additionally the busiest. It was also the clinic with the most security. The clinic was equipped with multiple locked gates and biometric security features, adding new meaning to "gatekeepers." To reach the providers, I would need to gain access to the reception area, which was gated at the front door and another to enter the clinic where the nurses tended to clients. There was a door to ensure privacy when speaking to administration staff, while management staff could be found three floors above through two more gates and large wooden doors. As a researcher, moving through this place proved to be a challenge. Blending in and immersing oneself felt almost impossible as I waited behind each gate to enter. The security added an additional pressure to move purposively through this space. It became challenging to "hang out" around providers without feeling out of place or disturbing their busy work schedule. As a result, I spent the least time in Mino Valley Clinic, meeting providers outside in coffee shops instead, to avoid becoming a nuisance.

Stellenbosch University https://scholar.sun.ac.za

Surgical procedures were held at Mino Valley Clinic, while Cinci Freedom Clinic and Cedar Rowe Clinic referred their surgical TOPs elsewhere, often to Mino Valley Clinic. "Doctors Day" is what Mino Valley Clinic called these days, which were scheduled twice a week. At Mino Valley Clinic, it was the surgical doctors and managers that I spent more time with due to the busy schedules of the nurses. Doctors, although just as busy as nurses, were often in attendance at workshops and advocacy gatherings, while the nurses were not. Thus I was able to speak to the doctors more casually and it was there that I was introduced to Katrijn and whom I later met for coffee.

Cedar Rowe Clinic

Cedar Rowe Clinic is based in the heart of one of Cape Town's main transport hubs. During the afternoon, the street vibrates with the bustle of people that walk through it in droves. In early February of 2018, I made my way through a busy taxi rank, just off the Main Road to get to Cedar Rowe Clinic. I passed through a side street and into a large parking area that was bordered by stalls selling fresh vegetables, shoes, and other items that were seemingly mismatched and odd. The parking area, much like the Main Street before it, was full of people and the combined noise of excitable voices was impenetrable.

Amelia was a TOP provider at Cedar Rowe Clinic. I called her in the hope she would be on the premises. Cedar Rowe Clinic was only open for two days a week, for reasons that were unclear, according to those who worked there. There were guesses from the receptionist, Hazel and Amelia herself, that the lack of providers in Cape Town made it impossible to keep clinic doors open, but whether this is why the clinic remained closed for the majority of the week was never confirmed.

Stellenbosch University https://scholar.sun.ac.za

The gate at the entrance of Cedar Rowe Clinic had a bulky lock and chain wrapped around it. Hazel came to the gate, but was unable to open it, as Amelia had the key. “Do you have an appointment?” Hazel asked. “I’ll let her in,” Amelia said popping her head out from behind a door, smiling brightly as always. She unlocked the chain and explained it was an unusual addition to their normally fully functioning electric gate. “Why keep it locked?” I asked. Having seen the locked gates at Mino Valley Clinic and now at Cedar Rowe Clinic, they were beginning to feel like a common feature. “To be safe,” she answered. The clinics were soft targets for robberies. This had been explained to me by one of the managers at Mino Valley Clinic who was visiting from Gauteng. In addition to the option to pay online via EFT, the clinic also dealt directly with cash, which made it not only attractive for women who did not want their termination to be on any record, but also left it vulnerable to robbery.

Cedar Rowe Clinic was the smallest clinic of the three, with one consultation office, a reception office, a small lounge, and kitchen area, but the layout of the clinic turned out to be as complicated as finding the clinic itself. As I waited for Amelia, whose client waiting list grew with each passing hour, Hazel offered to give me a tour of Cedar Rowe Clinic. As we walked through the kitchen and around a corner, the clinic began to unfold into what had once been a fully functioning women’s reproductive health facility. There were examination rooms, a private lounge, a laundry room, and a medical waste room – all no longer in use. What was left was the front area I had originally entered into, with one consultation room, where among other reproductive health services, Amelia performed medical abortions only. The empty space raises a question about the viability and precarity of clinics, such as these.

The clinic began to fill up. A young couple, two girls, and one more woman sat beside

Stellenbosch University https://scholar.sun.ac.za

me in the waiting area. "I'll be with you in a moment," Amelia told me, as she called the first client in. Hazel approached me. "Do you want to sit with me in the kitchen?" she asked. I joined her, and she spent the next two hours informally chatting to me about the inconsistent nature of the clinic staying open and the uncertainty around how many days upon which it would operate in a week. Hazel's anxieties around her financial and job security were manifest as she sat at her desk rubbing her hands together uncomfortably. I could sense throughout our conversation, that Hazel was concerned that she would be interpreted as ungrateful for the position she held, and she often boasted about her satisfaction with working at the clinic in between her concerns. Hazel had been an employee at Cedar Rowe Clinic for over a decade and had seen it grow, transform, and more recently shrink once more.

Of the three clinics that I spent time in, Cedar Rowe Clinic was not the only clinic that had an air of precarity to it. Mino Valley Clinic too had a certain inconsistency with providers being shifted and moved from the clinic to other facilities in the Western Cape. During my six months of fieldwork, providers had at times been moved permanently to different facilities, and I would either have to call them or travel to their new work spaces to follow up on interviews. An administrator at Mino Valley Clinic had once confused me as a provider waiting to interview to be hired, and once clarifying why I was in the clinic, had mentioned in passing that new providers were hired frequently and that she "couldn't keep up." Her intimation of a constantly rotating set of healthcare providers stuck with me and had become apparent across all the clinics, as those who worked for them would later confirm for me.

Cinci Freedom Clinic

The street on which Cinci Freedom Clinic was located had a similar energy to what I

Stellenbosch University https://scholar.sun.ac.za

experienced in the streets below Cedar Rowe Clinic. The road was busy, filled with cars, people, and the minibus taxis that, in South Africa, famously, do not abide by standard road rules. Cinci Freedom Clinic, however, was easily spotted from the road and quite accessible not only by car but also by bus and by train, whose tracks ran parallel to it. Cinci Freedom Clinic was functioning five days a week with more staff than Cedar Rowe Clinic, despite it being a converted home and not a space intentionally built to be a clinic.

The converted home allowed what was originally bedrooms to become functioning consultation offices. One of these offices was occupied by Joan, a healthcare provider who additionally managed the clinic. Joan's office led out onto a reception area, which I imagined having been the living area before the home was converted. The garage outside was now a laundry room, where all sheets and clinical linens were laundered. Joan and the other healthcare providers who worked alongside her had an outside kitchen area where they could take a break, smoke a cigarette and chat in between clients, but with time, I was told it was very rarely used. I had originally thought it would be a wonderful space to sit with providers to talk, but found it was rarely utilized and my interactions with providers would need to be fit into their busy schedules. At all three clinics, providers for the most part were consistently busy and moments that were calmer were spent in their respective offices completing paperwork. Finding time to interview staff was a waiting game with hope that there would be a momentary gap that I could join them while they completed administrative tasks, to try to capture some of their already limited time. As a result, I very rarely spoke to providers together at the Cinci Freedom Clinic.

Joan is a single mother who described herself as someone who "likes working with

Stellenbosch University https://scholar.sun.ac.za

people one to one. Not in groups." Joan was funny. She had a wit about her and almost always had a playful smirk on her face. Conversations with Joan often felt like a game where I had to guess whether it was sarcasm or blunt honesty. She had also previously worked in research and I had a feeling that she had fun teasing researchers, like myself, who wanted her to participate in their studies. In addition to her playfulness, she was also kind and supportive, and when describing her attitude to her work and providing TOPs she said, "I love the people, never mind what they come here for."

When asked if Cinci Freedom Clinic was well known in her community, Joan answered "not really. If you tell them you're working for Cinci Freedom Clinic, the odd one out will say, '*Ohhh.*'" Her voice strained here to emphasise how uncomfortable people become when hearing about her employment at a clinic that provides TOPs. I asked if they were judgmental, to which she responded, "Yes, because it's an abortion clinic. They don't know it as anything other than an abortion clinic." Cinci Freedom Clinic, much like Mino Valley Clinic and Cedar Rowe Clinic, provided various women's reproductive healthcare services, which Joan unpacked for me more clearly as our talk continued. The clinic's services included pap smears, STI screenings, breast exams, urine analysis, family planning, and what Joan referred to as "overall wellbeing." When I asked what services Cinci Freedom Clinic is best known for, Joan quietly laughed and said, "abortions… That's the majority."

All three of the clinics I spent time in are well known for their TOP services and, at times, despite the other reproductive healthcare services they provide, are more commonly known as "abortion clinics" by South Africans who are aware of them. Throughout this thesis, I speak mostly of their TOP services as it is the service in which I chose to explore. The clinics themselves, however, market their additional services

Stellenbosch University https://scholar.sun.ac.za

quite well in their advertising and after spending enough time with Joan and Amelia, I realised it was important to them that the clinics in which they were employed were represented completely and accurately for the services they provided.

I asked Joan what had led her to work for Cinci Freedom Clinic, to which she responded: "I was already in an 8[am]-5[pm] job, working in research." Joan had worked at one of the local universities and their affiliated hospitals in clinical research. When she left, she wanted to continue her regulated work schedule of 8am-5pm. In South Africa, healthcare providers can work shifts up to twelve-hours and longer, often during the night. Sometimes I heard providers express their frustrations with the public healthcare system and shifts that began and ended at inconvenient times. The long shifts made it difficult for parents in particular to create structure and routine for their families and to participate in everyday activities, such as picking up one's children from school. It seemed that the more I spoke to providers, the clearer it became that the structured and regular hours of private clinics were attractive to those who had children.

I asked Joan if it was merely the work schedule that had brought her to Cinci Freedom Clinic or whether there was a larger ideological premise for opting to provide TOPs. "I had never been against abortions, so for me, that wasn't an issue," she told me. Joan continued to describe her previous employment, which included delivering babies and doing research on children with Foetal Alcohol Syndrome (FAS). It was from this exposure to foetuses with FAS at various stages of pregnancy that familiarised Joan with TOPs and the circumstances that would drive women to seek one.

In the section to follow, I discuss what I refer to as "avoidance" and "objection" within the healthcare system. As healthcare providers are given the choice to avoid and object to providing TOP provision to any woman seeking to terminate her pregnancy, only

Stellenbosch University https://scholar.sun.ac.za

unless there is no alternative provider to perform the procedure. The section to follow describes the broader context in which objecting and avoiding TOP provision and training creates as stigma is further perpetuated by various actors within the healthcare system.

Avoidance and Objection

Katrijn, the medical doctor I had met with for coffee to discuss second trimester had made it clear, during my time spent with her that South Africa's medical training lacked severely in terms of training for terminations. "It's not part of the curriculum for medical students," she had said. "You have to go for special training – especially second trimester." In chapter three, lack of training re-emerges as a point of discussion that I explore further, but I mention it here to add context to the challenges in South Africa in acquiring TOP providers and bringing the CTOPA into force.

Katrijn's feelings about lack of training is one expert practitioner's perspective. Harries et al. (2014)) also found that conscientious objection and its unregulated use by healthcare professionals was a major contributor to the shortage of facilities providing TOPs in South Africa. Conscientious objection is the right to object in principle to a legally required or permitted practice. Conscientious objection originated as a refusal to "perform mandatory military service because of personal or religious moral objections to killing" (Fiala and Arthur, 2014:13). Fiala and Arthur (2014:20) argue that allowing conscientious objection into the sphere of reproductive health is problematic as it creates a contradiction in terms of the patient's "rights to life and bodily security" by giving the healthcare worker "the authority to abandon patients whom they are duty bound to serve." Fiala and Arthur (2014:20) note that by bestowing this authority on healthcare workers to deny patients, who are mainly women,

Stellenbosch University https://scholar.sun.ac.za

reproductive healthcare, they essentially deny services to a "vulnerable population," making this an issue of gender discrimination.

In South Africa, the CTOPA does not directly address Conscientious Objection, but can and has been applied within the South African healthcare system under the right to freedom of conscience in the Constitution, with the warning that those who prevent or "obstruct access to legal abortion services are guilty of an offence, punishable by a fine or imprisonment" (Amnesty International, 2017:8). Although healthcare professionals have the right to refuse provision in cases where a woman's life is not at risk, conscientious objection is only applicable in relation to the direct provision of TOP procedures, not to pre- and post-TOP care, as some may feel. This means healthcare workers are required to provide information and referrals for women who are seeking to terminate. Despite the clarity of the CTOPA and its regulations of conscientious objection, Amnesty International (2017:8) reports that there is confusion among healthcare providers about their obligation within TOP provision. This allows for conscientious objection to be applied in an "ad hoc, unregulated, and at times incorrect" manner (Amnesty International, 2017).

Providers who choose to utilize their right to conscientious objection ultimately provide barriers for the providers who are willing to assist. A common theme that arose during my fieldwork was the struggle to find all the necessary medical professionals involved in a TOP procedure who are willing to provide the various necessary services, especially in the case of second trimester TOPs, which require not only an "abortionist," but an anaesthesiologist and assistant nurses. In addition, a provider had shared with me in passing, it can be challenging even to find a room to perform a procedure in if

Stellenbosch University https://scholar.sun.ac.za

the manager of the facility one was working in was against TOPs.

Conclusion

The context of contemporary South African abortion becomes clearer when read vis-à-vis the history of abortion in the Global North. It is useful to examine the history of the debate in the U.S. as their highly Christianised public discourse about “shame,” “life,” and the rights of the foetus deeply informs South Africa’s views about the “sanctity of life” and what it means to be a good woman. I suggest that the American public debate powerfully shapes the social conditions in which practitioners’s struggle to navigate the ethical quandaries and ambivalences around TOP in South Africa.

Highly Christianised discourse that informs policy around reproductive healthcare and women’s access thereto causes restrictions and barriers, not only through legislation but additionally through the shame and guilt experienced by women seeking to terminate pregnancies and the medical professionals contemplating whether to provide TOP services. The avoidance and objection to TOP services by healthcare providers creates an additional undue burden on TOP service provision. Abortion stigma becomes internalised by women and providers and materialises in avoidance and objection, limiting access to those who need the service and forcing them into the informal sector where they receive unsafe abortion services.

Stellenbosch University https://scholar.sun.ac.za

Chapter Three: Vulnerability as Resistance

In the beginning of 2017, I attended a workshop held at the Mino Valley Clinic that was created to celebrate the twenty years since the CTOPA had been enacted in South Africa. The workshop was an effort to bring local artists together to discuss and create work that would speak to the occasion, and from this gathering, various themes of vulnerability, violence, and resistance emerged. In this chapter, I consider the ways in which vulnerability and resistance are entangled, mediated, and mitigated, in the relationships amongst women who offer TOP services, those who seek TOP, and the people who are involved in supporting or opposing these women. I begin with a scene from a work of Zimbabwean fiction because it brings into focus a concern I have with the ways in which vulnerability is constituted as a relation *between* people, rather than as a condition or quality of an individual. I seek to show how social relationships are necessarily dependent on making oneself vulnerable to (an)other, through risking oneself in the face of risk and violence that in the end might be overwhelming or annihilating.

Yvonne Vera's *Butterfly Burning* (1998) is a story about Phephelaphi, a young and independent Black African woman, caught in the web of colonial patriarchy in 1940s Rhodesia, now known as Zimbabwe, where women's autonomy was limited. The nature of township life meant that aspects that would otherwise be relegated to the private sphere were on constant display and scrutiny by the shared community. Phephelaphi is described as well-educated and dedicatedly so, as she knows it will be a contributing factor to her liberation from colonial patriarchal structures. Phephelaphi wants to be the first native trainee nurse and is granted the opportunity that will change

Stellenbosch University https://scholar.sun.ac.za

her life course. During this time, she has fallen in love with Fumbatha and begins cohabiting outside of marriage. However, Fumbatha, the antagonist, is discouraging of her ambitions. Before starting her training to become a nurse, Phephelaphi finds out that she has fallen pregnant – a condition that leaves her no longer eligible to continue her schooling. In desperation, Phephelaphi induces her own abortion, which angers Fumbatha. Fumbatha in rage admits to affairs. Overwhelmed by the conflicting emotions of sadness, shame, and fear for wanting to follow her passions, Phephelaphi sets herself on fire in an ultimate act of freeing herself.

From Phephelaphi's tale it is clear that she embodies a sense of vulnerability, as she becomes subject to unfortunate circumstances that leave her in a position that is seemingly helpless. Vulnerability, a word from the Latin *vulnero,* meaning "I wound" or "injure" is typically positioned as an opposing stance to resistance. To be vulnerable implies a more passive role than that of the more active resistance that is associated with agency. In the case of Phephelaphi, her vulnerability seems to lack agency as she ultimately ends her life to escape the uncertain future that will follow the highly stigmatised event of her terminating her own pregnancy.

In this chapter, I will consider the non-fictional stories of South African women whose experiences of vulnerability and violence similarly relate to that of Phephelaphi's. I will consider, while drawing on the work of Judith Butler how vulnerability is, despite its association with weakness and helplessness, is in fact a form of agency and necessary in the act of resistance. To elaborate, "vulnerability" in this thesis was a challenging concept to pin down, as much like stigma, its meaning changed with the context in which it was placed. For the sake of this chapter I think of vulnerability as a willingness

Stellenbosch University https://scholar.sun.ac.za

to make oneself open to and receptive to ideas, acts or others in ways that could potentially result in a form of violence – whether it be a violence of the body or mind.

Additionally, I want to reemphasize that the use of vulnerability in this chapter acknowledges that despite the risk one takes in opening oneself up to this potential violence, there is an agency in doing so. And instead of the women discussed here being perceived as vulnerable and helpless, I instead wish to flip this idea of their vulnerability on its head and address the agency they took in their willingness to be open to potential violence within a context that had backed them into a corner. It is here where Butler suggests, strength lies. One is open to woundedness and injury, but in the same vein open to being cared for, being loved, and shifting power in one's favour. Once it is accepted that we are interdependent, vulnerability can be reconciled and used – making it hardly passive, but an act of agency in and of itself.

Additionally, I make the distinction between being helpless and being agentive, as I argue that being vulnerable is a necessary feature of the human condition, which without, the abortion scene which I describe in this thesis would not exist. Post-Structuralist philosophers and anthropologists, such as Marcel Marcel Mauss (1954), Jacques Derrida (1994) and Butler, Gambetti and Sabsay (2016) argue in different ways, that in order for social life to exist at all, we have to be open and receptive to others. What is to follow is a description of a workshop which is made up of various actors that participate within the South African abortion scene – including women who share similar stories to that of Vera's fictional character, Phephelaphi. The workshop serves as a point of departure to demonstrate how one's willingness to be vulnerable is

Stellenbosch University https://scholar.sun.ac.za

a necessary act of agency and resistance, but how this act is in fact dependant on one's relation to others.

In other words, thinkers such as Cavavero and McCuaig (2009) and Butler, Gambetti and Sabsay (2016)) are critical of the idea that human beings are entirely autonomous and instead expose our relation to and dependence on others. One must give and receive not only material and symbolic goods, but also be in a position to give and receive beyond that of the tangible and include abstract values like "fertility." To continue the thought of vulnerability as one's willingness to be open to and receptive to ideas, acts and others, we could conceptualise vulnerability as an abstract value in exchange. In conceptualising vulnerability as an exchange, I think alongside Mauss's (1954) notion of "the gift," which describes gift-giving for the peoples of the Pacific Northwest as a complex system of exchange, comprising of power, shame and violence. Much like the gift, I suggest that this power, shame and violence is also present in the exchange of vulnerability in the abortion scene. However, in addition to vulnerability acting as a necessary function of agency, it also powerfully shapes the field of relations that exists within the abortion scene has a ripple effect across bodies and lives – ultimately affecting access to resources and care.

In making an argument about attending to vulnerability, I find it useful to use a description of the workshop mentioned above, that was hosted by an initiative, whom, for the purpose of this paper, I will call the Jersey Girls. The Jersey Girls is an activist group that assists women across the country to access safe and legal TOP services, while additionally participating in and creating opportunities for women to discuss and challenge the stigmatization of TOP services. The workshop was attended by TOP

Stellenbosch University https://scholar.sun.ac.za

providers, activists, artists, and women who had terminated both within and beyond the formal healthcare sector and thus, for ethics reasons, will be discussed more broadly than other areas of this thesis. Many participants of the workshop did not fall within the category of those who provide TOP's and thus, the workshop description becomes a slightly shallower account of experience. However, the experiences described by the women in attendance creates a useful point of departure to discuss the various areas of the healthcare system and their individual lives affected by the intense moral equivocation provoked by debates around abortion. In order to preserve the key points of the workshop discussion, I include the TOP provider concerns of the structural inefficiencies of the South African Healthcare System, as well as their experiences of resisting the stigmatization of their services. I do this to draw out the particular forms of power, risk, and threat that I suggest are at stake in the provision of TOP services in contemporary Cape Town. Whilst the accounts of activists and women who had had TOP's experiences, are discussed more broadly, paying closer attention to themes that arose from their experiences such as ideals of womenhood, abortion stigma, vulnerability and agency.

The Workshop

Alice, the founder of the Jersey Girls, initiated the discussion and, throughout the workshop, elaborated on "stigma" and its many meanings: "abortion stigma," she had explained, is a "shared understanding that abortion is morally wrong and/or unacceptable," but added that this was context-specific and that "stigma" is locally constructed and could take shape in various ways. She continued to discuss abortion stigma's link to "ideals of womanhood" emphasizing that it specifically related to the idea of women as mothers.

Stellenbosch University https://scholar.sun.ac.za

Alice’s notions of womanhood and motherhood were drawn from Kumar, Hessini and Mitchell (2009), whose names sat firmly on the projection screen. Kumar, Hessini and Mitchell (2009:2) developed an operational definition in order to propose how stigma around abortion can be produced, perpetuated, and normalized. Goffman's (1963) conceptualisation of stigma as well as Das's (2001:10), Kumar, Hessini and Mitchell (2009:4) show how “stigma” is contagious, describing abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideal of womanhood.

The question of “womanhood” or “what a woman is” is discussed in detail by feminist scholars such as Russo (1976), De Beauvoir (1983), and Mistral (2008), who critically examine the societal expectations that a “good woman” should desire to be a mother. These societal pressures emerged in the discourse at the workshop and were reinforced by the participants’s shared experiences of how abortion had featured in their lives. Some provided TOPs, some had had TOPs provided for them, and others knew of someone for whom abortion had played a significant role in their lives. Most women commented on the fear of disappointing one’s family and community by being affiliated with this service in some way, and all agreed that the social repercussions were problematic. The discussion illuminated the expectation of women to meet what Goffman refers to as “virtual social identity.” There is an expectation of women to grow up and bear a healthy child (Bolton, 2005). However, as mentioned by Lipp (2011), the “actual social identity” does not always match the virtual one. In South Africa, the expectation to be a “good woman” discussed by the aforementioned authors is evermore present, which was expressed explicitly by the attendees of the workshop.

Stellenbosch University https://scholar.sun.ac.za

So, what does this mean for nurses and healthcare workers performing TOP procedures, who for the most part in South Africa are made up of women? Kumar, Hessini and Mitchell (2009:628) argue that: "A woman who terminates a pregnancy often defies long-held ideals of subordination to community needs. She uses her agency to deem a potential life unwanted and then acts to end that potential life." Norris *et al.* (2011) add that this is not unique to the woman who seeks TOP services, but extends to the providers who perform them. Norris et al. (2011) argue that the effects of the stigma attached to TOP provision can weigh heavier on providers who "have to cope with an ongoing relationship to abortion," as they are considered to be making "life or death judgments" and thus putting their moral capacity into question, which is deeply disturbing to the more commonly accepted "moral order" (Keusch, Wilentz and Kleinman, 2006). As a result, say Norris *et al.* (2011:7), anti-abortionists often reduce providers to "cruel and callous manipulators," while the women who receive the procedure become "damaged goods."

Thus, both pregnant women and nurses are vulnerable to abortion stigma in various, and, at times, double-downed ways. This raises the question of how vulnerability works to draw people together in some places, while dividing them in others. Gambetti (2016), argues that vulnerability is inseparable from agency and therefore should be repositioned as an integral component. This is useful for my argument here, by which I show that the field of relations within the broader abortion debate is complex. It is complex particularly in the microcosm of the clinic and the struggles that play out around it, including those who frequent it and the protesters outside. In order to affect change, it is necessary to understand the social relations between each member of the

Stellenbosch University https://scholar.sun.ac.za

scene and the ways in which vulnerability is constituted between providers, demonstrators, the law, the public, and even the foetus. What is revealed is the way in which one is obligated to become vulnerable to another, and to others in general, if the social is to be not merely possible, but cultivated and nurtured. In the following section, I will explore the vulnerability that emerges in different degrees and in different ways amongst the actors that participate and interact within this field of relations.

A Field of Relations: Vulnerability and Agency

Beginning with the primary scene of vulnerability, the key figure in the context of TOP, arguably, is the woman seeking to terminate her pregnancy. Consider Tamara, a workshop attendee, who shared a personal story about her decision to terminate her pregnancy. Tamara, in a moment of vulnerability, mapped a scene of pain and difficulty surrounding her decision. She shared her concerns about what impact the race of her unborn child would have on the relationship with her family, which was further complicated by her financial situation and her uncertain status with the child's father. In cases such as Tamara's, the pregnant woman assesses her vulnerability to the new and potential lifeform within her, thereafter seeking out the TOP service. In doing so, the woman makes herself vulnerable to the physiological procedures of terminating a pregnancy and is made vulnerable by this medical intervention that will need to enter into her body. Women like Tamara must become vulnerable to the TOP provider, the organization, or institution that is willing to perform the biomedical operation on her, as well as become vulnerable to the perceptions and beliefs of her friends, family, and the public once the procedure is completed.

Stellenbosch University https://scholar.sun.ac.za

The pregnant woman seeking to terminate is thus vulnerable not only to the physiological procedures, but additionally to abortion stigma. The foetus, however, is imagined as being vulnerable for different reasons. In particular, the foetus's potential to transform into a legal subject – a baby – is crucial in imagining and defining the "unborn child" as vulnerable. Berlant, (1994:147) writing about the U.S. context, argues that the "pregnant woman becomes the child to the foetus, becoming minor and less politically represented than the foetus, which is in turn more privileged by law, paternity, and other less institutional family strategies." More so, Berlant (1994:149) argues that the foetus is conceived as being "vulnerable to law and to abortion." Furthermore, Berlant (1994:149) notes the pregnant woman and the foetus are forced to *compete* over contestations as to what constitutes not only the "good life" and the "exceptional citizen." Put more simply, the very vulnerabilities of the woman and foetus are forced to compete with one another. To illustrate this, returning to the case of Tamara, a competition emerged between herself and the foetus as to what constituted legitimate personhood. The foetus is vulnerable, to borrow Berlant's (1994:150-151) formulation, due to having "no autonomous body" and therefore having no voice to engage in the negotiation of the interventions of the medical procedure that would ultimately, in the mind of the pro-life protester, "destroy," "kill," or "murder" the unborn child and all of its potential.

As Agamben (1998) discusses in *Homo Sacer*, the question of sacrifice begins to emerge as the foetus increasingly enters into social and political life. The protesters, in the foetus's defence, position themselves as concerned with the foetus's vulnerability and imagine themselves as what I call "defenders of the unborn." This position stands in direct opposition to the woman, the TOP provider, and the law, each of which allows

Stellenbosch University https://scholar.sun.ac.za

and facilitates termination. Berlant (1994:150) describes the pro-life rhetoric as one that exposes the "magical and horrifying spectacle of amazing vulnerability" of the foetus, an "unprotected person" who is a "citizen without a future." The protesters who stand outside Cedar Rowe Clinic who self-identified as Christian and are by the nature of their faith invested in the structure of the traditional nuclear family. The pregnant woman seeking to terminate her pregnancy is in direct opposition to the conventional values and representation of the Christian-idealised nuclear family.

Berlant (1994), albeit in a different context, offers us a reading of what is at stake when pro-lifers construct the foetus as possessing a particular political subjectivity and personhood. She argues that unlike African-American citizens, the foetus has no access to the political public sphere of the United States. She writes that the foetus has "no voice" and therefore does not have the "kinds of agency" that are required to participate in the political public sphere. What the pro-lifer's rhetoric achieves is establishing what Berlant (1994:151) would call "fetal personhood" that is reliant on a particular mode of representation that gives voice to what the protesters perceive as the voiceless. Giving a voice to what is perceived as voiceless is a strategy that seeks not only to establish the autonomy of the foetus but also demonstrates that the foetus is a citizen that seeks to be heard and cries "for the dignity of the body" – the unborn body (Berlant, 1994:151).

The impact, however, on the pregnant woman is recast by pro-life rhetoric as the intimate opposite of the foetus's body. The pregnant woman faces various barriers in order to access reproductive healthcare services, such as healthcare providers who make use of conscientious objection and inequality of access to services. In addition, the

Stellenbosch University https://scholar.sun.ac.za

woman is viewed as merely a vessel for the unborn, as her own life and health comes to be seen as secondary. What is threatening for protestors is a vision of social death that follows from the death of the family as a normative ideal. Makaziwe, another workshop attendee, opened up about her experience of being deterred from accessing TOP services at South African hospitals because of the treatment of pregnant women within the healthcare system, referring specifically to the experience of her friend who allegedly had been physically assaulted by a healthcare provider. Makaziwe instead sought to terminate her pregnancy in the informal abortion sector. An advert posted in a local newspaper guided her to a man who gave her four tablets that were to be inserted vaginally (by him). Makaziwe returned home and aborted the foetus. The trauma of having to induce the termination motivated her to ask a friend to remove the foetus from her home. The foetus was removed and placed upon the bin outside. Makaziwe explained that the garbage collectors would not pick up the garbage on their rotation. With each morning that passed where the foetus had not been removed, Makaziwe relived the trauma of her experience.

Despite the trauma that Makaziwe experienced, her termination avoided all the risks so often involved with terminating informally. For the most part, Makaziwe successfully terminated her pregnancy. However, she was not so lucky the second time she turned to the informal abortion sector. In what follows, Makaziwe's narrative about her second abortion is indicative of how vulnerability and violence are intertwined and embedded when women seek to terminate their pregnancies informally. Makaziwe was left in pain, leaving her physically crippled and having to be admitted to a hospital's emergency room (ER). Makaziwe's failed attempt to access these informal services avenues to

Stellenbosch University https://scholar.sun.ac.za

terminate her pregnancy is a rich illustration of the kind of vulnerabilities that pregnant women face in trying to reclaim their body.

Makaziwe concluded her narrative by saying that she "still has moments of not being able to speak," reemphasizing the trauma endured in her near-death experience. Makziwe's experience of "not being able to speak" stands in tension with pro-life rhetoric that casts the foetus as having no voice. If we take Makaziwe's claim of not being able to speak seriously, what can be said about her agency? Makaziwe is an example of the concern that Gayatri Chakravorty Spivak (1988) engages in her now-classic essay *Can the Subaltern Speak.* Spivak questions whether it is possible to perceive what the subaltern's experiences are, as their circumstances and historical contexts make their voice only heard through the representation of others. In chapter six, I explore more thoroughly the voice of women like Makaziwe who have had abortions, yet whose voices are rarely represented by themselves. In the case of my own thesis, I am aware of the difficulty and irony involved in my attempt to give voice to someone like Makaziwe here: I must anonymise her voice and speak on her behalf; my argument necessarily mediates, and stands on behalf of, her experience.

To consider Makaziwe's actions and the silence she describes that followed, how are we to understand her sense of agency? In thinking with Butler, Gambetti and Sabsay, (2016) it is not clear whether Makaziwe's actions reaffirm our sense of someone acting on their own behalf, in their own interests, or if she is merely subject to entirely over-determining conditions that have left her in a state of silence. Silence, as a coping mechanism, is significant for those who are exposed to or who have the potential to be exposed to abortion stigma, as concealing one's relationship to abortion can prevent

Stellenbosch University https://scholar.sun.ac.za

stigmatisation. However as Quinn and Chaudoir (2009) a note, concealed stigma leads to an experience of internalisation, where the subject begins to stigmatise themselves. This tension around speaking and not speaking is how we might think about the subject's ability to act on her own behalf. Veena Das's (2007) *Life and Words* shows how trauma can continue in the everyday lives of urban Punjabi families who were subjected to trauma which surpasses the event in the form of memory and an overall silence, which those subjected to violence have adopted. Examining the repercussions of the 1947 partition of India and the women who were subject to devastating ethnic violence have been silenced, yet still have agency to continue with day to day activities. Das (2007) examines that it is not in what they say, but what they do not say that is telling of their agency. Choosing not to speak of the violence, on the surface, seems to resemble a state of fragility. However, Das (2007) demonstrates in her descriptions of the everyday life of Punjabi families that it is the act of continuing to participate in everyday life, albeit in silence that shows strength and agency. Violence is inflicted on the body and dealing with it becomes an individual act, altering one's sense of self and how they relate to the world, but it is in this everyday act of picking up the pieces, moving out of the lifeless position of the event, and continuing with the mundane that one exhibits agency. Makaziwe similarly after facing trauma had too continued to participate in everyday life, despite in silence and had finally found her voice at this workshop.

TOP Provider Concerns

While I have used Makaziwe's story as a lens to explore the vulnerabilities that I have argued are intertwined with women seeking to access TOP services, her story is not isolated. Marie Stopes International (2012:6) estimate in their *Global Impact Report*

Stellenbosch University https://scholar.sun.ac.za

that "9 million women resort to unsafe abortions to end unintended pregnancies. This causes around 82 000 women to die every year" globally. As each year passes, more and more stories of women's experiences begin to emerge in scholarly literature, activist projects, newspaper and magazine articles, online, and on social media. Makaziwe's story about her friend who was physically assaulted by the healthcare workers while visiting a South African hospital illustrates the abuses some women experience at the hands of healthcare providers, while helping us better understand the fear situated in public discourse, around seeking out healthcare from providers who may not agree with your healthcare decisions.

Indeed, there are TOP service providers who take on the responsibility of ensuring that women's bodies are not secondary to the foetus. Here I focus on the experiences of two TOP providers, Lavinia and Rose, who also attended the workshop discussed above. These TOP providers, I suggest, do the work of making themselves open – and thus vulnerable – to having a woman approach them to terminate their pregnancies and in doing so, make themselves vulnerable to the scrutiny of their families, friends, and the general public.

TOP providers, like Lavinia and Rose, I argue make themselves vulnerable to ideas, acts and others in at least four ways. First, they are vulnerable to the pregnant woman whom they must either accept or deny care to. Second, they are vulnerable to the organisation that they work for, taking on all of the organisation's rules and regulations. Third, they are vulnerable to the law in similar ways to how the pro-lifers imagine the foetus to be vulnerable to the law; that is, providers are compelled to operate within the legal terms and frameworks and need to be prepared to suffer if they violate these legal

Stellenbosch University https://scholar.sun.ac.za

parameters. Finally, the healthcare workers are vulnerable to the protesters outside, their families and friends who hold their own individually formed value system, and the general public with whom they interact.

In order to attend better to this descriptively, I return back to the workshop and focus on three themes that emerged to highlight the vulnerabilities of the service providers as they navigate the obstacles within the healthcare sector and beyond it. The three themes are, respectively, the limits of conscientious objection, the perceived inefficiencies of training of up-and-coming healthcare providers in South Africa, and finally, the concerns of those involved in TOP provision being rehired outside of the healthcare sector if potential employers are aware that they have played a role in supporting TOP services.

Conscientious Objection

The workshop raised the urgent and complex issue of conscientious objection and the more general concern with healthcare workers allowing their personal beliefs to influence their provision of care. Conscientious objection, as mentioned in chapter two, is an action that allows healthcare workers who are trained in TOP provision to deny providing the service if it is in conflict with their personal beliefs. However, in accordance with the CTOPA, healthcare workers are legally obligated to provide TOPs in cases of emergency where there is no alternative. Maya is an employee of the Mino Valley Clinic, Lavinia is a comprehensive trainer and surgical TOP provider, and Rose is a reproductive health trainer. These three women discussed the limitations created by conscientious objection, as well as where they believed the gatekeeping to the provision and training of this service lie.

Stellenbosch University https://scholar.sun.ac.za

Maya explained that 30% of pregnancies in South Africa are unwanted, a statistic comprised of annual healthcare reports collected by thirteen private sector clinics across South Africa, of which the Mino Valley Clinic was included. The statistics also included figures from government reports collected from the public health sector records that Maya had reconciled. However, I could not find the figures mentioned in the public sphere. On the contrary, Haffejee *et al.* (2017), found from their study exploring the factors associated with unintended pregnancies in KwaZulu-Natal, that two thirds (64,33%) of pregnancies in South Africa are unintended pregnancies.

“We have the law to support it,” Maya had continued, “yet there are many challenges despite this.” Maya tackled this from the perspective of the providers’s contributions to this statistic, by not referring women to TOP providers if they do not wish to provide the service themselves. Maya elaborated further and explained that the healthcare workers who refuse to provide TOP services do so under the claim of conscientious objection. The CTOPA has been contested by those who believe it is being abused, e.g., not referring the client to a provider who is prepared to provide the service.

Maya’s concerns are reinforced by Harries *et al.* (2014:8) who explored the impact conscientious objection has had on service provision and found that in some cases, it was being used on broad grounds by a “range of hospital and clinic staff, even those not directly involved in TOP provision.” This refusal provided unnecessary barriers to the providers who wanted to provide TOP services, with some of my participants making mention of the challenges they sometimes face to find anaesthesiologists,

Stellenbosch University https://scholar.sun.ac.za

nursing assistants, or even a hospital room if the person in charge of coordinating operating rooms did not agree with the surgery.

The discussion around conscientious objection prompted Lavinia, a TOP provider from the public sector, to continue the discussion. “Conscientious objection is a right, not a law,” she said, adding, “The struggle is to create an understanding among those who exercise this right that it is also a right of women to be referred.” Alice, who had been sitting quietly at the workshop, elaborated on Lavinia’s point; she described how the Jersey Girls regularly encounter women who are not aware that it is their right to be referred. Rose, who sat beside Lavinia, followed these thoughts and expressed her concern about abortion “stigma” around healthcare workers and how, in order to avoid the stigmatization, healthcare workers inevitably block access for clients. Rose provided the example of Lavinia’s previous employer, saying, “There is only one manager who supports termination where Lavinia worked. People are interested in providing the service, but people in power are counteracting this progress.” Rose argued that the problem is not with the attitude of healthcare workers, but rather others higher up in the managerial chain, about whom she was not specific. “Nothing has changed,” she concluded, meaning nothing had changed since the CTOPA had been legalised.

“We fight every day,” Lavinia continued, with regard to conscientious objection and the blocking of TOP services. “This service needs to be provided… Management is causing barriers and it’s pushing our women to illegal providers.” Lavinia works within the public sector and despite the availability of free TOP services, many still choose to make use of NGOs and non-accredited providers where they are required to pay. Drawing on the small body of research that currently exists, Harries *et al.* (2015:2)

Stellenbosch University https://scholar.sun.ac.za

found that women avoided the public health sector TOP services for reasons such as "stigma, privacy concerns, and conscientious objection by providers." This matches Lavinia's observations. The aforementioned deterrents "often discourage women from seeking TOP services within the public sector and sometimes force women outside of the legal system entirely" (Harries *et al.*, 2015:2). Lavinia concluded her thought with a testimony of her commitment to TOP provision, "Most parts of my work [are about] fighting barriers and making sure people are trained in provision and that people have access." Her passion was palpable and her frustrations with the current state of her field were substantial.

Training Concerns

The concerns expressed by Lavinia and Rose were not unique within the public healthcare sector. Over coffee, Katrijn voiced similar anxieties about the lack of training. She felt that nothing had been done to implement the "fantastic new law" and that there was nothing being "pushed" by anyone to bring it to fruition. "There is a lack of training in the healthcare system and a lack of conversation," she argued, providing the example of a local university who had asked her to train their medical students in manual vacuum aspiration (MVA). MVA is a tool that uses aspiration, or "suction," to remove uterine contents from the cervix after a miscarriage or during an induced abortion. "MVA" she said, "…not abortion." Katrijn explained that she was explicitly asked not to say "abortion" or speak of abortion during her lecture. "How the fucks' sake can I train them in MVA and not say abortion?" she asked in frustration, throwing her hands up.

Stellenbosch University https://scholar.sun.ac.za

Katrijn also recalled moments where she had felt the students themselves were uncomfortable with abortion, but it was unclear whether she believed that the discomfort was a product of being educated by teachers who reinforced this discomfort by policing the language in which the content was taught. She described a sonar course where medical students were asked to practice their skills in determining how far along a pregnancy was on an actual pregnant client. The clients who came in were women who needed to be scanned to determine whether they were eligible to terminate. “When they found out, they didn’t want to do it,” Katrijn explained. This was a problem for Katrijn, but a problem she was not surprised by. “Abortion is not a part of their training; it’s not part of the curriculum for medical students.”

Katrijn’s frustrations are echoed by Roland E. Mhlanga (2017) who discusses how the CTOPA is a significant step forward in women’s reproductive rights, but “the momentum for realising the full extent of this very progressive law may be entirely lost if there aren’t enough trained health professionals to enact it.” Mhlanga's (2017) article was published shortly after the ACDP announced intentions to regulate TOP services in a new amendment bill. Mhlanga (2017) wrote about his concerns of conscientious objection to termination of pregnancy procedures that creep into medical and nursing education and training and warned about the serious implications it was beginning to have on women’s reproductive health.

Much like Maya, Rose, Lavinia, and Katrijn’s accounts in the public and private health sectors, Mhlanga (2017) emphasized a growing concern that conscientious objection and the associated stigma was resulting in “the shortage of healthcare providers who have the requisite training and knowledge to provide these services as well as pre- and

Stellenbosch University https://scholar.sun.ac.za

post-procedure care" (Mhlanga, 2017:1). In addition, he expresses a concern that healthcare workers who utilize conscientious objection will not have adequate training to provide TOPs in emergencies when they are legally obligated to.

The lack of trained professionals, or rather the lack of demand from medical professionals to be trained, leaves South African women seeking to terminate their pregnancies in a more vulnerable position. As shown above, all actors involved within TOP provision, whether it be receiving, providing, or protesting, constitute this concept called vulnerability. Vulnerability as it is understood in this thesis is not "helplessness," although I acknowledge it is fragile, ambivalent, and filled with risk and dangers. I argue that despite its fragility, ambivalence, and risk, it is necessary to develop a more positive concept of vulnerability, as Butler, Gambetti and Sabsay (2016) understand it. Vulnerability is more open to others and, in the context of receiving, providing, and protesting abortion, it is necessary, as it is conscious of the risks, fragility, and dangers, but allows the subject to act agentively.

Reputational Concerns

Maya spoke about the concerns every employee of the clinic has once starting there. "I get the 'Mino Valley' face," she explained, referring to a face of judgment and discomfort from those she shares her profession with. "It's something that follows me everywhere," she says before describing incidents where she had previously felt judged. Maya had been followed to her car by a pastor and called evil. Maya's experiences were not unique. Gita, also an employee of Mino Valley Clinic, had struggled to find a company who would install a biometric security system for the clinic, simply because they were considered an abortion clinic. When asked, Gita had similar stories to Maya

Stellenbosch University https://scholar.sun.ac.za

about being followed to her car by protesters or had had people stand in front of her car to obstruct her access to the road.

Those working in the clinic felt severely afflicted by the stigma of being involved in the delivery of TOP services and although I have not developed a theory of social capital within this thesis, it is clear that being associated with the clinic severely impacts people's abilities to secure employment elsewhere. The social capital of those working in the clinic dramatically decreased because of the stigma that surrounds it. The access to resources that would usually be embedded in these social relationships disappeared with Maya adding a concern about being rehired if she ever left the clinic: "We are aware that it adds a layer of complexity to people's CV. We see it a lot." Gita had once shared similar concerns with me over a talk in her office. Although not done so in this thesis, stigma and social capital deserve closer conceptual attention in these contexts.

Conclusion

In working through the various statements of Lavinia, Rose, Gita, Maya, and Makaziwe, I have sought to show how the social and the institutional are constituted by means of speech acts, gestures, and institutional and legal arrangements that depend on a form of constitutive exchange of vulnerability. I have taken the workshop as a space in which this exchange of vulnerability is staged in the fight over the right to safe and effective TOP services. As argued by Mauss (1954); Derrida (1994); Butler, Gambetti and Sabsay, (2016) vulnerability itself offers the grounds for a more relational form of agency. While TOP practitioners might be understood to be agents in the medical system and in South African society at-large, the testimonials provided by my participants suggest that their capacity to act freely is conditioned less by their

Stellenbosch University https://scholar.sun.ac.za

experience of helplessness and more by a form of agency fostered through their willingness to be vulnerable.

The workshop illustrated through the unpacking of vulnerability and its field of relations that not all vulnerabilities are equal and that some are considered worthier of ethical or moral consideration than others. It additionally showed how entangled with one another these vulnerabilities are and how they begin to impact each other, such as the various structural factors that concern TOP practitioners who feel inhibited and constrained within in their field.

Whereas proponents of either side of the TOP debate come down on supporting either the mother's right to choose or the real and imagined vulnerabilities of the foetus, very few consider the palpable vulnerabilities of the TOP practitioners simply doing their job. While legal statutes protect the rights and vulnerabilities of the women seeking TOP services, some social projects seek to protect and elevate the vulnerabilities of the foetus. The women I interviewed often felt a sense of vulnerability in the face of little structural support. In a system that explicitly protects and legitimates a woman's right to choose, TOP practitioners are positioned in an uneven and dangerous territory, in which their agency to act according to law and right is questioned and confronted on a daily basis.

What this chapter offers is a more comprehensive perspective on the complexity of TOP services in contemporary South Africa. Whereas a wealth of material is available concerning the contested citizenship and vulnerability of women seeking TOP services and the protesters who stand against them, very little literature provides a perspective

Stellenbosch University https://scholar.sun.ac.za

on the difficulties and complexities faced by TOP practitioners. In a time and place where existing legislation is being questioned and amended and citizenship is being debated and contested, I suggest that the complex and multiple vulnerabilities associated with seeking and offering TOP services should be examined within both a comparative global context and in relation to the specificities of the South African situation.

Stellenbosch University https://scholar.sun.ac.za

Chapter Four: Negotiating Stigma

In her critically acclaimed novel, *The Handmaid's Tale*, Margaret Atwood (1986) provides a fictional depiction of Foucault's "biopolitics" as her imagined Republic of Gilead focuses on population control and simultaneously demonstrates what biopolitical governing practices might look like in a contemporary, if not dystopian, context. The book explores themes of misogyny and the suppression of reproductive rights, as Offred, the *Tale*'s main protagonist, and other handmaidens navigate their way within in a fundamentalist, theocratic dictatorship that has transformed them into "invisible" women who bear children for the elite. Offred is forced into this role, which has been created in an attempt to save the declining population, after the majority of upper-class women became infertile. The Republic of Gilead returns to "traditional values" in a militarized fashion and women like Offred are stripped of their rights and become subjects to a multitude of extreme regulations. Fertility grants handmaids higher status in the Republic of Gilead and handmaids are led to believe that, by bearing children, they are serving God and their country. With this honour, handmaids willingly police one another in a self-regulatory fashion to ensure the sanctity of the handmaid's role remains as such. As the tale unfolds, Offred rediscovers independence and individualism as she negotiates her role in The Republic of Gilead and becomes autonomous in her thoughts and actions before she is taken away to an unknown fate.

Although a heretofore unrealistic and severe depiction of power and reproductive control, Atwood's (1986) *The Handmaid's Tale* is a useful medium to think through alongside our own modes of reproductive control in 2018. In this chapter, I explore how TOP providers navigate the moral ambiguities of their controversial vocation. Through

Stellenbosch University https://scholar.sun.ac.za

their accounts of stigma and its self-regulatory qualities, I discuss how employees in women's health clinics, much like Offred, negotiate and understand their positions within this reproductive healthcare system, providing TOP services. Here I draw on Foucault's (1988) thinking in his *Care of the Self*. I argue, more specifically, that the "stigma" these providers describe is the means by which the process of "subjectivation" occurs, where, as subjects, they become autonomous in their thoughts and actions as clinicians and citizens. With this in mind, I explore how TOP service providers like Amelia and Joan are navigating, challenging, and reshaping the field that is simultaneously shaping them. This dialectical relationship is theorised by Pierre Bourdieu (1990) in *The Logic of Practice*, but I am more concerned here with understanding the way in which stigma is understood in discourse, feelings, and actions.

Amelia is the manager of Cedar Rowe Clinic and Joan is the manager of Cinci Freedom Clinic. Both clinics are small and very rarely have more than two nurses on shift at the same time. Both Joan and Amelia identify as Christians and both describe moments of having felt ostracized by their community, family, or friends on account of their profession. In order to think through subjectivation as Foucault (1988) understood it, I explore how these experiences impact their lives as they perform the procedures that often leave them vulnerable to criticism from those outside the healthcare system, as well as within it.

Before I begin, it is important to address the notion of stigma around abortion, as it addresses many concerns, some of which are religious while others relate more to gender, sex, fertility, or class, and yet others may have to do with concerns with propriety. Because of this, I place "stigma" in inverted commas so as not to take for granted what we mean by stigma, even though my interlocutors may sometimes talk

Stellenbosch University https://scholar.sun.ac.za

about "stigma" in more ordinary ways (Lambeck, 2010). "Stigma" is a widely explored concept within medical anthropology and related fields and is researched extensively in regard to patients and concerns such as TB and HIV/AIDS, leprosy, obesity, and abortion. The concept of "stigma" is, however, rarely considered in relation to the healthcare providers themselves. Stigma is briefly addressed in Paul Farmer's (2014) *Diary: Ebola*, which discusses brutal attacks on public health officials after a fear developed among the public in Liberia that the healthcare providers carry the virus. However, having reviewed the relevant literature, it is clear that careful attempts to explore and understand the effects of "stigma" on healthcare providers are relatively few. This project seeks to contribute to the understanding of TOP providers and the effects of stigma on their experiences providing TOPs in order to understand how TOP providers negotiate ethical and moral dilemmas and how this shapes the understanding of what it means to access the right to safe and legal termination of pregnancy.

"You're brave to work there"

"You're brave to work there; that's what they always say," Amelia explained. Amelia, the manager at Cedar Rowe Clinic, is a young, self-identified coloured[4] TOP provider and Christian woman. Amelia was originally trained as a midwife and had once told me how she had "fallen in love with midwifery" and the delivery process. Amelia had changed professions and moved to a position in TOP services for its promise of more regular hours and better pay, which was better suited to the lifestyle expenses of a single mother. "Single mom" was how Amelia first chose to describe herself; "Registered Midwife Professional Nurse" came second.

---

[4] "Coloured" is a racial classification in Southern Africa and is composed primarily of people who are "mixed race."

Stellenbosch University https://scholar.sun.ac.za

Amelia had explained this to me on our first meeting in her office, which doubled as one of the clinic's consultation rooms and as I sat listening to her unpack the details of her life, it was clear that she was a kind, caring, and nurturing woman. Amelia was 35 at the time and her daughter Grace had just started school. Amelia and Grace had moved to Cape Town together from an old town in the Cape Winelands, where Amelia had been practicing midwifery.

Amelia described being a single mother as challenging and admitted that she had underestimated the difficulty of raising a child on her own. "Me and her dad [sic], we weren't together when I found out [I was pregnant]." She explained, "The first thing I said to him when I told him I'm pregnant now, I said, 'abortion is not an option.' It wasn't for me. It wasn't at all." Amelia identified as a Christian and believed wholeheartedly that life began at conception. "I wanted her; I loved her from the moment I found out I was six weeks pregnant." When Grace turned three, Amelia admitted that the responsibility of single parenthood began to take its toll. "I could feel the pressure of being alone. Things just got hectic for me. The responsibility of [Grace], work, and finances — I actually felt for the first time: Why didn't I abort?" Amelia's love for her daughter was undeniable and I did not get the sense that Amelia regretted her decision to have Grace. Amelia's description of their life together felt genuinely fulfilled, but the struggle Amelia had endured to reach the point of re-evaluating her own moral code was evidently a large one and not uncommon. "I've been saying to myself ever since, God forbid I […] fall pregnant again unmarried and unplanned, but if I had to, abortion would definitely be an option for me because I know now, as much as I love my child and I thank God for her, if something like that had to happen again, it would be an option."

Stellenbosch University https://scholar.sun.ac.za

Amelia understood the complexities of motherhood and, despite her Christian beliefs about abortion and her understanding of "life" and when it begins, Amelia had through her own experience begun to grapple with and challenge the structures that had shaped her views of abortion and life itself. "It was a battle," she explained, as she described the long and hard year of deep reflection and self-scrutiny she had undergone. Amelia explained that her relationship with God had not been as strong at the time she had begun working at Cedar Rowe Clinic and that her relationship with God and Christianity had grown significantly stronger in the months that followed. Amelia repeated the monologues she would have with herself where she questioned her own judgement and whether it was right to be at the clinic, telling herself "you know this isn't right." Amelia later found that she had "been missing the bigger picture" and through what she described as strengthening her relationship with God and communicating her concerns to Him, she came to the conclusion that God had placed her at the clinic for a reason.

"You're here for a reason. You've reached your purpose that God has placed you here and you are not gonna get another job, you're not gonna get another opportunity or be able to leave this place until you have fulfilled what you need to fulfil," she had told me. Amelia believed that her purpose at the clinic is to facilitate and support women through their decision-making about terminating their pregnancies and explained that most women are unsure of whether they want to terminate when they arrive. She realised her purpose was to provide a safe and supportive space for her clients where she could "be honest and just be someone that [clients] feel that they can trust." It was through this realisation that Amelia became content with her decision to stay employed

Stellenbosch University https://scholar.sun.ac.za

at the clinic, despite the fact that the service she provided clashed at times with her Christian moral values and beliefs.

Foucault's (1984) concept of "subjectivation" rests on the idea that when the subject turns their gaze inward, they begin to take up a relation of the self to the self, what he called the "cultivation of the self." Through subjectivation, Foucault (1994:264) argues that renegotiating the moral codes we are handed by what we consider to be moral authorities is where self-transformation occurs and "the care of self" begins. I have found it useful to draw on this concept in thinking about the women providing TOP services in Cape Town. In addition to these processes, Amelia made personal decisions to better accommodate her conscience. She explained that although she was trained differently, Amelia would now, if asked, disclose to her clients that there was a heartbeat. Amelia believed this to be honest and supportive in assisting a client in making an informed decision. Amelia recalls two clients changing their minds about terminating their pregnancies since she had begun working at Cedar Rowe Clinic, but says that she cannot be sure if it was because she answered their questions about the foetus's heartbeat.

Explaining her profession was not uncommon for Amelia, though she did not make it seem as though it was something that would hold her back from continuing her work. Amelia described two instances where she had to explain her job and her choice to terminate pregnancies. First, to a woman Amelia had worked for as a midwife, who had been visibly disappointed in her decision to take the job at the Cedar Rowe Clinic. "I could never do that," the other woman had said; "I am a Christian." Amelia explained how this interaction had upset her: "I am a Christian too!" Amelia told me passionately

Stellenbosch University https://scholar.sun.ac.za

and, although she did not recall this instance as one that prompted the inner "battle" of conscience she had previously described, I was curious as to whether this and other interactions that spoke to her faith may have played a role.

The second experience was with a teacher at Grace's school. The female teacher asked Amelia where she worked and, although Amelia did not experience her reaction as judgemental, Amelia did feel compelled to explain the range of other services that the clinic provided. This is something Amelia often experienced when people asked her what she did. "I will say, 'You know I don't like saying this,' but then I tell them. I tell them exactly what I do. You know people always ask, 'Where do you work?' Then I say at a women's health centre. Then they say, 'Oh where?' and I say, 'You know Cedar Rowe,' and they say, 'You're so brave to work there.'" Amelia concluded with a laugh, "They always say that." Amelia never had clarified what exactly was meant when people said this, but by her own admittance, "most people don't agree with it." By "it," Amelia was referring to abortion itself and, by association, the provision of the service. To Amelia, this answer was more meaningful than I had originally imagined, and she explained that, for her, it was a "confirmation that I am there for a purpose and it's not so bad to be there… when God's done with me being there, then I'll be done."

"Gilead is within you"

A pertinent moment in *The Handmaid's Tale* is a discussion between Offred and Aunt Lydia, who by virtue of her role in the Republic of Gilead, is assigned to help assimilate the remaining fertile women into their new roles as "Handmaids." At the "women's centre" where Aunt Lydia works to reprogram the handmaids whom she calls the "lucky ones," she reminds Offred that "[…] the Republic of Gilead … knows no

Stellenbosch University https://scholar.sun.ac.za

bounds. Gilead is within you." Aunt Lydia claims this in an effort to emphasize that reproductive control and regulation is not only reinforced by the state, but additionally from within ourselves. Aunt Lydia's words explain that handmaids, much like people in 2018, police themselves as well as one another to avoid discipline and punishment. In the case of Gilead, this punishment took place in the form of mutilation that would be carried out by the state. In the case of contemporary South Africa, punishment is more insidiously inflicted through what my informants refer to as "abortion stigma," leaving the recipient feeling ashamed and isolated. This is much like Amelia's experience with her colleague and child's kindergarten teacher where opted to volunteer further information and clarification to pre-empt any anticipated stigma. Atwood's (1986) *Handmaids Tale* creatively depicts the various shifts that Foucault (1975) discusses in *Discipline and Punish,* where spectacles are designed to not only discipline the body, but also the soul.

In the case of Amelia, her conversations had with God as she built her relationship and reconfirmed her moral understandings showed just that. Amelia described her battle of conscience as a private matter between her and God and said she never spoke to family and friends about her deliberations. One could argue that the doubt she experienced before finding contentment was remnant of the regulative technologies described by Foucault (1975) and Aunt Lydia. But Amelia was not the only provider that found herself battling with her conscience.

Joan, a provider and manager of the Cinci Freedom Clinic, had explained that she felt judged many times during her time working for the clinic. "I've learned from Amelia," she explained, whom she knew through a network of providers. "I now say 'Oh we are doing reproductive health.'" It became clear that figuring out how to cope with feeling

Stellenbosch University https://scholar.sun.ac.za

judged by others when disclosing the details of their profession and how to best respond, was something that nurses and providers collectively spoke about often.

Joan was someone that I often struggled to make sense of. She was kind and warm, yet simultaneously guarded and withdrawn. She would move seamlessly between these two personas as she spoke about her feelings and understanding of TOP provision and at times contradicted herself if not explicitly then implicitly in her descriptions of how she felt about certain aspects of it. She identified as Christian and spoke about her church and how she felt the Afrikaans Christian community, that she was a member of, was more conservative than their English counterparts. Ultimately, it became clear that the values she had developed from being part of these collectives were in conflict with the way others perceived the values of her profession. Through the stories Joan shared, it was clear that she wanted to provide safe and affective TOP care. Although she never explicitly said this, her tenderness and affection for helping the women she saw on a daily basis came through in her anecdotes. She wanted to do provide TOPs not only for the sake of her clients, but because she saw the rewards of this service. She helped women empower themselves and offered an alternative to those who were in desperate need.

When asked how she felt about providing TOPs on a daily basis, Joan answered simply, “I have no problem… I won’t say, per se, ‘happy’ [about] doing what I’m doing, because it’s still a conflict, but I don’t have a problem doing it. It’s my conscience that’s got a conflict, but I don’t have a problem with it.” Joan’s separation of ego and conscience echoes the split in the self, described by Foucault (2013) in his discussion of subjectivation. Although seemingly contradictory, Joan’s answer provided an insight into the larger ethical dilemmas she was presented with by being a Christian woman.

Stellenbosch University https://scholar.sun.ac.za

Joan felt that clients sometimes wanted her to tell them "It's fine," but felt strongly that it was not her place to do so. "I still have my conscience to sort out," she explained. She recalled a client who had arrived at the clinic during her sixth pregnancy for her fifth termination. "It was hectic," she said, "but what can you do? You just provide the service and then you follow up with the family planning; you can't be judgmental." Joan was judging the client according to the institutional structures and values that she had grown accustomed to. Despite this though, Joan felt strongly that it was not her place to ever let the client know and that the client's agency to make decisions for herself was more important than her own feelings about the client's circumstances. Despite never telling the client how she felt, Joan did admit to her frustrations. "I wanted to slap her face," she said. This is an expression that illustrates the challenging nature of TOP services for a provider whose own ethical convictions are clashing. "Once bitten, twice shy," she added. "If you're not going to learn from the first mistake, you're not going to learn from the fifth one." Although such women are in a minority, Joan was concerned with and frustrated by the possibility of women using abortion "as a contraceptive." This was a phrase that had come up among providers and protesters and referred to women who had sex without using conventional methods of contraception, instead relying on TOP services to end their pregnancies if they occurred.

Joan was made uncomfortable by the idea of abortion "as a contraceptive" and believed it crossed a line in what she felt comfortable doing. Her tone when telling stories of assisting women out of desperate situations was different to the tone to the stories she shared of women who she felt abused the system. In terms of a moral code, the provision of these two types of terminations were not weighted the same for Joan. "It's a moral issue; why do you want to come in every time and drink tablets that put

Stellenbosch University https://scholar.sun.ac.za

you[rself] in pain or do a surgical? You know? It's stupid."

When asked where she stands on the question of where life begins, Joan answered, "I've never thought of it that way. I don't think about it. I don't go that deep. For me, if I go that way, I'm going to be doomed. So, its early pregnancy and it's an embryo. Finished." The words flew out of Joan's mouth faster than anything else she had said prior to my inquiry. She spoke firmly, and I felt uncomfortable pressing for more. I imagined that the speed with which she spoke was a literal manifestation of how fast she wanted to rid her mind of the thought.

A silence followed as she leant forward and put her forehead to her palms, balancing her weight on her elbow firmly propped on the desk. "If you meet people and they want to know 'So what job are you doing?' and I say, 'I'm working at Cinci Freedom Clinic,' [there is] no click [no register of what the clinic does]," she began to explain. When asked what the clinic does, Joan would always choose what she felt to be the honest route and up until a few months prior to our conversation, she simply said, "we do abortions." This is a response that Joan felt elicited judgement from others. I asked if she said it as bluntly as she had to me that day. "Yes, because that is what we're doing and then you can see the faces drop." When asked if she had ever felt judged for the service she provides, she answered, "Yes." She paused for a moment and laughed. It was not a laugh of humour, but rather a laugh of tired sadness, a sigh that implied that feeling judged was something she had encountered far too often and had learned to cope with. "It's very difficult," she said. Joan began to share how she had told her family what she does and how they all had reacted differently. "With my parents, it was fine because they knew from the start." She continued. "I *thought* my other sister knew also and when she found out, she was very upset. She said she couldn't believe I was doing

Stellenbosch University https://scholar.sun.ac.za

it." When asked about how her sister feels about Joan providing TOPs now, she replied, "She's fine now, because it is my job," adding, "but we don't speak about it."

Feeling judged for providing TOPs was not limited to her experience outside the clinic. Joan's stories of being ridiculed showed how she experienced just as much judgement within the four walls designed to support the provision of TOPs. Joan recalled a time where a partner of her client had come with her to the termination and had caused a scene in the clinic to try stop her. "How can you do this?" he had asked her. This was a question Joan was not unfamiliar with. "This is between you and her," she had told him. "I can't tell her what to do. At the end of the day, it is her decision and I'm not going to stand in her way." The man was furious, and Joan had been confronted in a space she had usually perceived to be safe from this sort of ridicule.

Conclusion

Through Amelia and Joan's accounts, I have explored the various individuals who constitute collectives that have shaped what they understand to be values and ethical codes. In this chapter, I have discussed how these individuals are regulated by forms of discipline that are expressed by moral modes informed by larger institutions and how this permeates into communities, families, and the workplace in which they find themselves (Chiweshe and Macleod, 2017). I argued, by making use of Foucault's (1984; 1974; 1988; 2013) concepts of subjectivation, surveillance and *Care of Self*, that healthcare workers like Amelia and Joan are reflecting on the various ways in which clinicians are socialised through a "medical gaze" (Foucault, 2003) and negotiating their understandings of "ethics" and their obligations to them.

Stellenbosch University https://scholar.sun.ac.za

As Foucault (1978) suggests, since the beginnings of liberal political thought and republicanism transformed the American and French revolutions, power is no longer asserted through direct threats to life. In a more self-regulatory fashion, power is now more focused on how one ought to be preserving and extending one's life in order to obtain the best quality of life. In doing so, Foucault (1975) argues that, as a public, we begin to regulate and police ourselves. This self-regulation emerged throughout my fieldwork, but especially in the cases of Amelia and Joan, whose shared experiences beyond the clinic and within their private lives illustrate the difficulties of navigating, resisting, and reforming one's own moral code. Amelia and Joan's experiences show how, much like Foucault (1975) describes, they police themselves according to their own moral codes, which are informed by larger collectives with which they identify. Additionally, their experiences show the complexities of how one resists one's own moral socialisation and develops agency within the back and forth engagement in the battle of conscience.

TOP providers like Amelia and Joan fit well the description Holmes, Jenks, and Stonington (2011:109) offer of clinical trainees within contemporary biomedical training programmes. Clinicians are "not simply socialized and malleable, but are also active subjects who make choices, resist subjugation, accommodate power differentials, and use techniques to actively craft themselves." However, it was witnessing how Amelia and Joan made sense of their positions – as they went back and forth on what was "right," "wrong," "good," and "evil" –about delivering this service, that revealed how they came into a sense of "self" as subjects by interacting with and challenging the structures and institutions that had shaped their feelings and actions in the ordinary practice of offering TOPs.

Stellenbosch University https://scholar.sun.ac.za

Chapter five: (Counter) Public Discourse

I had met Paul outside of Mino Valley Clinic on a Saturday, the most popular day for protesters to gather outside the clinic, but for Paul, it was just another day. Paul was well known to the TOP providers for his pro-life persistence. He stood outside the clinic more often than any other protester I had seen before and I had seen a picture of him circulating on social media in a form of online protest. Paul was reserved when I approached him and sceptical of my intentions. "We've had people take advantage of us before," he explained to me, as he sheltered himself under a large black umbrella that had the words "abortion is evil" printed on it. The words stood out more than the other signage I had seen before, as it was in a red font that looked like dripping blood. Paul explained that many journalists and writers had previously approached him and other protesters and that they had "foolishly trusted them." "We cooperated," he continued, "We wanted our side of the story to be heard." To their disappointment, the protesters who worked with the writers mostly found that they were later written about in a way that they described as "poorly" and felt they were made out to be "fanatics" for their beliefs.

In this chapter, I explore the other side of the coin by describing the experiences of the protesters that stand outside the doors of the Mino Valley Clinic, in order to further expand on the contestation structuring the social field of abortion stigma, in which the experiences of TOP providers are informed. The South African public sphere finds itself in a discussion around whether a woman should have the "right to choose" and the attempt to become the dominant and normative discourse and practice has resulted in a back and forth debate. To better describe this, I unpack Michael Warner's (2002) analysis of the relationship between the "public sphere" and the opposing

Stellenbosch University https://scholar.sun.ac.za

"counterpublic," and do so within the context of the opposing pro-life and pro-choice movements in South Africa. Later, I raise a larger question of who might constitute various counterpublics in this abortion debate by drawing on James C. Scott's (1985) *Weapons of the Weak: Everyday Forms of Resistance*, as I assess the techniques and strategies utilised by the pro-life protesters who position themselves as the oppressed.

Abortion Politics in Tension

Pro-life rhetoric is situated within a larger religious discourse where the foetus is humanized and referred to as a child, the unborn child, or preborn child. It produces an image of a life that is in a process of growth – life inside the womb and life outside the womb. The rhetoric additionally positions pregnant women as mothers, further humanizing the foetus as more than an object or a mass of cells, but rather something – someone – in need of nurture and care. For the pro-life protesters outside Mino Valley Clinic, life within the womb is verified by the faith in which they subscribe and follows the "consistent life ethic" logic, formed in the 1980s by Christian pro-life leaders such as Cardinal Joseph Bardin (Trahan, 2017:29). The consistent life ethic opposes human interference with ending life, such as abortion, euthanasia, and assisted suicide and is based on the foundation of "natural rights." Natural rights are based on the premise that our human rights stem from our humanity and not from government legislation that imposes limitations on what it means to be "alive." Thus, consistent life ethic becomes a commitment to what the pro-life protesters construct as human dignity and sanctity of life and translated into an obligation to fight for and defend "life" in the name of God.

In South Africa, the abortion tension lies mainly within the public discourse, as currently the right to abortion sits firmly within the *Bill of Rights*, which states that

Stellenbosch University https://scholar.sun.ac.za

"Everyone has the right to bodily and psychological integrity, which includes the right [...] to make decisions concerning reproduction," found in chapter two of the South African Constitution (Republic of South Africa, 2008). The law does not remain unchallenged, as political parties such as the ACDP propose amendment bills to counter the *Bill of Rights*.

Publics and Counterpublics

Michael Warner (2002), in conversation with Habermas (1991), describes the notion of "the public" as a central component of the social landscape that is often overlooked as a tool for understanding our contemporary world. Warner's (2002) public and counterpublic are constructed out of active discourse – speech acts, with forms and functions, that reify, reinforce, and oppose the norms of the public sphere. The public and counterpublic consider the social concerns occurring in the public sphere and acknowledge how their discursive acts exist and interact with the normative discourse in relation to the existing public sphere (Warner, 2002:113-114). The conditions under which the counterpublic forms, Squires (2002:446) argues, is "in reaction to the exclusionary politics of dominant public spheres and the state" and stem from publics of historically oppressed identity groups, who have formed a coexisting public within a shared marginal identity.

In the pro-life versus pro-choice debate, we see Warner's (2002) public and counterpublic actualise as each position's discourse is used as a counter-ideology to resist the normative discourse of the existing public sphere. Each position has much at stake as they engage in rhetoric about reproductive health, sanctity of life, and ethics, seeking to affect some kind of change. For the pro-life supporter, it is a question of life

Stellenbosch University https://scholar.sun.ac.za

and death, as they fight to save the life of an unborn child, who is voiceless and ultimately defenceless at the hands of modern medicine. For the pro-choice supporter, it is to fight for the woman's right to choose and whether she continues a pregnancy. The pro-choice movement fights to empower women with reproductive freedoms, after a history of women resorting to desperate measures to end their pregnancies, and to allow women to gain access to opportunities that would not normally be available to pregnant women or mothers.

The Art of Resistance

I found that the pro-life tension manifested most intensely in an interaction I had with Paul and Millie on Heritage Day. Paul's demeanour as he spoke with me was short and impatient, similarly to many other protesters with whom I had spoken. Paul was defensive and somewhat dismissive, and I assumed this was an act of resistance that he and other protesters had cultivated throughout the continuous clashes with those who opposed them. As mentioned previously, Paul and other protesters had a mistrust for the media and others who approached them to write about their cause. "They take one line," he explained, "and make us sound crazy." I had been told of examples of newspapers and student research papers where protesters felt they had become vulnerable to share their story, only to be met with a final written work that falsely represented their side.

Paul raised his hand to his face and covered his mouth. He had been struggling with toothache for a while, an ailment that he explained left him less active in protest. Paul was well known as a protester and I had often heard stories of him and his colourful vehicle that parked outside of the clinic. He was described as someone who harassed women as they entered the clinic, but this is not how he appeared on the day we had

Stellenbosch University https://scholar.sun.ac.za

met.

Paul stood amongst four women and took a backseat to the debates that ensued with passers-by. I had asked him why he chose to not engage with those who did not agree with his protest and rather watch the women argue. He laughed, waved his hand out to gesture that the women had it under control and then spoke again about his tooth as a hindrance. This was not the "infamous" Paul I had heard of. The Paul that was described within the general pro-life "public" was a more vocal character who imposed and infringed on women's freedoms and was perceived as intrusive and rude.

Despite his characterization, Paul believed himself to be a space of refuge for women who wanted to change their minds about terminating their pregnancy. He believed strongly that no woman wanted to abort, but were pressured by outside voices, naming the "fathers" and "boyfriends" specifically. Paul saw himself as a male figure that could provide a different narrative to these women's lives and spent multiple days a week sitting outside the clinic in case they needed it. He described the numerous accounts he had had with the male figures that he felt pressured women to terminate and mentioned instances where he had shouted at them to "leave her alone" or pleaded with the women not to be influenced by them. Paul was visibly passionate about his cause, despite his aching tooth that pacified him.

Paul then signalled to Millie who stood beside him. She had been one of the more energetic members I had seen at the protests and had seemed for the most part unbothered by any pedestrians who passed by and heckled, as she walked around the island in the road excitedly. Millie was young and told me how it was her first time protesting, before coming to a halt as Paul asked her to share her story.

Stellenbosch University https://scholar.sun.ac.za

Millie's smile tensed. The story Paul had asked her to share was the story of her abortion and how she came to be a participant in the pro-life movement. She placed her hands on my shoulders and told me that it was important for me to hear her experience. Millie had been living a fast-paced life in Los Angeles, one she described as rather debauched, with liquor and illegal substances as her guiding light. Millie eventually found herself to be pregnant and similarly to what Paul described, felt that the man who had helped her conceive was beginning to pressure her to terminate. Millie reluctantly terminated her pregnancy in Los Angeles and explained that to this day she was still haunted by her action and felt resentful for being influenced to do it. She described how every year since terminating her pregnancy, she would fall into a deep depression around the date of the procedure, which would usually result in wild, alcohol-fuelled nights. There was a deep sadness to Millie's description of her past and it was obvious that it was a facet of her emotional being she wished would not resurface.

Millie's experience of her termination resulting in long term psychological distress is a trope believed and often used by protesters to dissuade women from terminating their pregnancies – a notion that is widely critiqued (Robinson GE, Stotland NL, Russo NF, Lang JA, 2009; Marecek, Macleod and Hoggart, 2017). However, for Millie, finding a safe haven in the protesters that she now stood beside had become a source of comfort that she believed was tending to her wound. Millie had seen the protesters praying outside of the clinic once she had returned to Cape Town and she explained how she had approached them one day, as the guilt she was carrying had become too heavy to carry alone. Millie had feared that by talking to the protesters, she would experience judgement and abortion stigma, as they held signs saying how evil abortion was. To

Stellenbosch University https://scholar.sun.ac.za

Millie's surprise, her willingness to be vulnerable paid off, as the protesters had welcomed her with open arms and given her the space of healing she had sought out.

The day I first met Millie was her first protest and her infectious smile was one that beamed with pride for participating in a demonstration that may possibly stop another woman from experiencing what she had. It was women like Millie that Paul felt his duty to protect. His concern extended the pro-life concern to more than the unborn and included what the pro-life movement referred to as "the mothers," too. In addition to Paul standing outside of the clinics, the pro-life concern for the potential emotional trauma women may experience from terminating a pregnancy could be found in quotations on their protest signage, such as "One heart stops, another breaks."

Millie's story made Paul's persistence outside the clinics become even clearer. His concerns were also not imagined. An article published in the *Mail and Guardian* (*M&G*) about "forced abortions" covered a number of stories that began to emerge of women in South Africa whose pregnancies had been forcibly aborted (Pilane, 2018). The experiences of the women who had been forced to terminate were found during a hashtag trend on the popular social media site Twitter. The trend was titled "Heartbreak Hotel" and had been started by Sindisiwe Van Zyl, whom Pilane (2018) describes as a "HIV clinician and patient rights activist." Van Zyl started the hashtag with the intention of hearing the stories of those who were currently dealing with heartache, and among the responses, Pilane (2018) reports, were stories of women whose partners and family members allegedly drugged them to forcibly terminate their pregnancies. Pilane (2018) additionally reports that the Health Practitioners Counsel of South Africa

Stellenbosch University https://scholar.sun.ac.za

(HPCSA) have received complaints of healthcare workers who allegedly administered abortions against pregnant clients's will.

My understanding of what was at stake for pro-life protesters when they stood outside Mino Valley Clinic was bridged by conversations with Paul, Millie, and Hazel who I discussed in chapter two, and their willingness to provide testimonies of their everyday lives. From our conversations, it became clear how the inspiration for their protest was intricately weaved into their life experiences, the more they became relatable. In fact, this is what I found with almost all of the protesters the more we spoke. Their smiles were kind, warm, and often given if they saw me passing by their demonstration. At times, I was called over to assist in documenting the protest through photos and videos. They would hand me phone after phone as if I were documenting a family vacation.

I found my entanglement with the protesters extremely challenging, as I often disagreed with them to the point of frustration and at times contempt but having seen some of their kindness, my ability to be fair and reflexive in my approach to represent their views fairly became easier. The protesters had made very clear to me that they were concerned about being misrepresented in my work and, as mentioned previously, they felt particularly attacked by previous writers who had approached them. It was clear that the protesters feared being cast as extreme and fascist for their commitment to consistent life ethic and that they perceived their commitment to be one founded on love for God and the voiceless foetus. However, the tactic of using evocative language and imagery in their protest served to disrupt complacency in those who encountered them and inspire reflection on the abortion debate.

Stellenbosch University https://scholar.sun.ac.za

A protester who was particularly convincing of this was Adam. Adam was the first protester I had met, and we had spoken outside of Mino Valley Clinic for about an hour as the protest commenced. He had asked me to hold his stack of cardboard signs for a moment as he dug in his bag. Adam handed me the stack facing down and as I turned it over, a sign labelled "Close the baby butchery" stared back at me. I gasped in shock at the evocative nature of the words he had chosen. This had been the first and only time I had lost composure during my time spent with protesters. Adam laughed as he took the sign back, impressed with his work.

Adam worked with a student pro-life movement at a local South African university. During our conversations, he had mentioned his involvement in student relations on campus and explained that he often conducted seminars at nearby institutions. He had invited me to events based in another South African province and had been quite adamant that I needed to hear the truth about abortion. Adam made it abundantly clear that he wanted me to be exposed to new materials and so-called truths in this debate, not only for what he perceived to be my own benefit, but also to allow me to write a piece that he felt would accurately represent the pro-life perspective. A few days after meeting him, I received a folder of pro-life literature in my email inbox to assist with this.

Much like his commitment to exposing me to pro-life "truth," Adam explained that his intentions with the protests was to do the same and by doing so, educate women seeking to terminate their pregnancies and ultimately deter them. Adam believed that if enough women were deterred, the Mino Valley Clinic would run out of business. He proudly provided the example of two clinics elsewhere in South Africa where he believed this

Stellenbosch University https://scholar.sun.ac.za

tactic had proven successful. Adam made it clear that he had high hopes for the closure of the Mino Valley Clinic, too. He felt that the pro-life movement was far larger than one could comprehend and that the media strategically did not report on the protests that took place outside the clinics to oppress the protesters who were currently active. Adam unpacked his belief of a hidden agenda when it came to protesting by providing the examples of Fees Must Fall protests happening concurrently.

Adam's proposed notion of a larger pro-life following was correct, as Mosley's *et al.* (2017:926) analysis of the 2013 South African Social Attitudes Survey (SASAS) found that "negative attitudes toward abortion are common in South Africa – over half of respondents felt abortion was always wrong in both cases (foetal anomaly and poverty) combined." In addition, negative attitudes towards abortion have been recorded in the South African context through various qualitative papers and have found that there was high variability in attitudes when considering moral acceptability, legal acceptability, circumstances in which the pregnancy began, religion, and perceptions of gender and gender roles (Harries *et al.*, 2007; Harries, Stinson, and Orner, 2009; Patel and Johns, 2009; Patel and Kooverjee, 2009; Macleod, Sigcau, and Luwaca, 2011; Wheeler *et al.*, 2012; Gresh and Maharaj, 2014). However, Mosley's *et al.* (2017) survey found that despite the variances among the intersections of stigma, 50% of respondents still reported that they believed abortion to be "always wrong" no matter the circumstances, with a dramatic increase to 75% of respondents believing it was wrong if a woman's motivation to terminate was based on financial restraints.

Stellenbosch University https://scholar.sun.ac.za

The Event

As mentioned above, protesters believed clinics providing TOP services are an attack on "life." The protesters positioned themselves as advocates for the unborn, and at times became very emotional when their pleas went unheard. A good example of this comes from the night of the exhibition that the artists from the workshop organised by the Jersey Girls I discussed in chapter three. The artists had brought their completed works to the Mino Valley Clinic, which for the night had been transformed into an art studio. The exhibition fell on First Thursdays, a Cape Town event that takes place on the first Thursday of every month, when the streets come alive as art galleries and museums open their doors to the public for free evening perusal. The clinic was unrecognisable. Maya, Gita, Katrijn, and even some of the administration staff from Cinci Freedom Clinic were in attendance.

I volunteered and assisted the Jersey Girls with interviewing the artists. I spent the majority of the evening outside speaking to visitors and welcoming them inside. I was surprised that no protesters were present, but, as volunteers, we had been briefed about the potential for protesters. The rights of the protesters were laid out clearly and we were told that they could only be removed if they threatened harm. We were also assured that South African protesters were mild in comparison to their U.S. counterparts and that there was not much to worry about.

About an hour into the evening, I began to notice individuals standing idly outside the doors and pulling people aside after they had been inside the clinic to view the artwork. There were four men and two women. The other volunteers began to murmur amongst themselves, curious about who these individuals were. It was unclear if they were

Stellenbosch University https://scholar.sun.ac.za

organised protesters who had come to the clinic or people who had passed by and felt it important to spread their message. What was clear was that they were not in agreement with the clinic's celebration of twenty years of safe and legal TOP services in South Africa.

"I want to speak to an artist!" one of the women shouted angrily. An artist was standing beside me and she approached the distressed woman. "Why are you doing this? They are innocent," she said, referring to aborted foetuses. The artist, visibly uncomfortable, began to stumble over her words trying to explain her position. Maya had overheard and approached to support the artist in answering the distressed woman's questions. The conversation continued with each question the woman asking being more combative than the last. Maya calmly continued to explain her position to the woman, who became more visibly distressed. The other protesters had come to stand behind her in support and their conversation raised topics from sanctity of life to adoption to children living on the street.

After some time of going back and forth with Maya, the distressed woman left and walked over to me. "Are you an artist?" she asked. I told her I was not an artist, but instead was volunteering to support the event. Following my response, the woman sprang into a line of questioning I had so often heard from the protesters outside of the clinic on Saturdays. "Why do you not value life?" "Why are you not a Christian?" "Why won't you return to Christ?" all followed swiftly in a fast paced and zealous interrogation. The woman's language became more evocative as she spoke about the "blood of the king" and how He was calling out to me to return to the kingdom of God. "He loves you," she shouted as her eyes welled with tears and stared at me intently.

Stellenbosch University https://scholar.sun.ac.za

"He wants you to come back to Him. He will protect you." I felt my emotions stir, as I watched her perform in front of me and her eyes pleaded that I leave the clinic and go with her.

I thanked her and explained my position before calmly but firmly denying her request. Other protesters sensed my discomfort and after a brief talk they escorted her away. I went inside to recuperate from the overwhelming experience that nearly brought me to tears – not from guilt or shame, as I had previously understood protesters to be intending, but rather a discomfort from the evocative nature of her words, her distressed calls, and teary eyes. Having spent time with Millie, Paul, and Hazel I now better understood what was at stake for the distressed woman as she cried in front of me.

I came to understand through experiences such as the ones I describe here that the protesters believed themselves to be a minority group under attack and conveyed themselves as such. The protesters perceive themselves to be both an oppressed minority and rightful members of the public at large, the moral majority, to borrow from American discourse. In the context of Warner's (2002) work, the protesters positioned themselves as a counterpublic and, for all intents and purposes, given South Africa's legal framework and the infrastructure designed to implement, support, and provide TOPs, I could understand why. However, when considering the larger normative discourse of the South African public about abortion and a woman's right to choose, the question of who or what constitutes a particular counterpublic arises.

I would like to consider the protesters sympathetically for a moment as I reflect on the position in which they perceive themselves to occupy. James C. Scott (1985) discusses in *Weapons of the Weak: Everyday Forms of Peasant Resistance* the organisation of

Stellenbosch University https://scholar.sun.ac.za

resistance that has come about as a result of historically oppressed groups not being able to enjoy the opportunity of having open political discussion. Scott (1985) argues that the resistance we so often see as a mobilization of a mass collective rarely occurs, and instead is more often found in subtle arts of resistance or "transcripts" that can be observed playing out in everyday life. Scott (1985:16) provides examples of the ordinary weapons of the relatively powerless groups: "foot dragging, dissimulation, desertion, false compliance, pilfering, feigned ignorance, slander, arson, sabotage, and so on." Scott considers these subtler forms of resistance as ones that err on the side of defiance.

Scott's (1985) study of everyday forms of resistance has, since the 1980s, become popular among anthropologists as more light is shed on the dynamics of power, dominance, and the oppressed. Not without its critiques, Scott's (1985) considerations of the techniques used by the "weak" has been impactful in understanding resistance in various contexts. How then might one think with Scott's (1985) notion to resistance to better understand the forms of protest around access to abortion in South Africa? Clearly, this is a provocative and risky suggestion, but I do not intend to suggest that pro-life protestors are somehow an oppressed minority. Rather, in using these ideas to think about a group of predominantly middle-class and Christian protesters who stand outside of the Mino Valley Clinic, I seek to inhabit, sympathetically and very briefly, the position that they are performatively trying to occupy: that of an oppressed minority.

Rethinking the (Counter)Public

To elaborate further on my initial allusion to Warner's (2002) notion of publics and counterpublics, Warner explores how performance, such as the protesters demonstrations outside on Mino Valley Clinic, has the means to change politics.

Stellenbosch University https://scholar.sun.ac.za

Warner (2002) challenges the common understanding of "a public" and describes it as a space that exists by virtue of being called into being, instead of merely the "public sphere." There are a number of criteria by which Warner (2002:422) suggests a public comes to exist, including that a public is self-organized, creates a space of relation among strangers, has a reflexive circulation of discourse that is ongoing overtime, and is "world making."

In following Warner's (2002:414) understanding of "a public," it is, at least on the surface, conceivable that the pro-choice discourse within South Africa would occupy a normative status within homogenous and passive "publics." The pro-choice position is supported by a legal framework and has been so in South Africa for over twenty years. The larger legal discourse of safe, effective, and free TOP services being available has brought together a collection of individuals through the circulation of public law and official discourse.

Within a public, such as those who describe themselves as pro-choice, counterpublics emerge to oppose the discourse of the existing pro-choice norm. Counterpublics interact and play with the current discourse, and by doing so, create a new discursive arena in which the counter discourse will receive an audience and ultimately dismantle the system in which it opposes through a newly formed subculture (Warner, 2002). This is what pro-life protesters perceive themselves to be doing as they participate in pro-life activities, such as demonstrating outside the Mino Valley Clinic and facilitating other pro-life campaigns.

Those who imagine themselves to be taking up a position as a "counterpublic" of some kind in relation to abortion, however, are clearly not an oppressed minority by any objective measure. Indeed, in order for a public to become a counterpublic, the public

Stellenbosch University https://scholar.sun.ac.za

must exist in "a conflictual relation to the dominant public" and must be structured by alternative assumptions that challenge the conventions and beliefs that make up the public to which they stand in opposition (Warner, 2002:423). But additionally, counterpublics are considered a subordinate subculture within the larger discourse that they challenge. Warner (2002:422-423) describes a counterpublic as "socially marked" by participating in its opposing discourse. In following this thinking, it is easy to see how protesters who are subject to public verbal abuse, and who believe the larger structures of law and liberal media are against them, perceive themselves to occupy this position.

When considering the above criteria of what constitutes the prefix "counter" in relation to the abortion debate, the answer to who occupies this opposition is unclear. Given South Africa's legislation on TOP provision and the relatively small number of protesters that stand outside the clinics, one would assume the counterpublic are those who identify as "pro-life;" however, in reality, "the right to choose" and legal TOP services in South Africa occupy only a brief historical window where it has been supported by the infrastructure of law and policy. This support has indeed provided more access to safe and effective TOP care, in addition to a growing normative value within the public sphere that has sought to make access to safe TOP services socially acceptable.

It is true that the right to terminate a pregnancy has been a marginal position that only recently has enjoyed legal protection, but it is hugely contested in everyday life by the broader South African public (Mosley *et al.*, 2017). The pro-life, Christian conservative perspective that enjoyed a normative position in South Africa since the foundation of the Republic are now able to take up the performative position of an embattled minority.

Stellenbosch University https://scholar.sun.ac.za

The dilemma I face when writing about the pro-life and pro-choice arenas is to make sense of who might be said to more accurately occupy the position of counterpublic. Pro-life South Africans who cast themselves as an oppressed minority might not see the normative social power that their Christian, middle-class values enjoy.

The relationship between the public and counterpublic and the slippery slope of identifying who occupies these positions suggests an unstable relationship between discourses and collectives. The protections instated in South Africa's legal framework in 1996 continue to face severe criticisms from significant constituencies in contemporary South Africa. This is seen not only in the streets where protesters gather, but in the experiences of the providers such as Amelia and Joan who tell us that being pro-choice can often be met with hostility, forcing them to resort to omitting details of their work and performing TOPs in secrecy and shame.

Conclusion

It is not clear who between the pro-life and pro-choice movements occupy the dominant space of the public and counterpublic. As demonstrated in this chapter, both occupy an ambivalent and unstable relationship to the "right to choose." I bring this contestation to the fore as it is important to acknowledge in the current moment of TOP provision where unsafe abortions continue to be performed, despite a legal framework that allow women to access safe and effective TOPs. When women have the right to choose whether to terminate a pregnancy, why are over half of all terminated pregnancies in South Africa estimated to be unsafe (Sedgh *et al.*, 2012)?

As the two main positions struggle to become the dominant and normative discourse in the public sphere, it becomes clear that who occupies the position of counterpublic is

Stellenbosch University https://scholar.sun.ac.za

not as straightforward as protesters would imagine. In their attempts to portray themselves as marginalised and vulnerable, the protesters obscure the fact that these ideas hold enormous appeal as a normative idea for many South Africans. As such, it is no wonder that women resort to informal abortion providers to avoid abortion stigma. It is clear that rights, such as the right to terminate a pregnancy, derive their force not only from law but from the broader social agreements forged in the public sphere. Such a right is unstable if it does not enjoy common agreement with public attitudes and perception. In order for such a right to be actualised and enjoyed, it needs to be embodied in the everyday and ordinary practices that bring publics and counterpublics into relationship with each other. As can be seen in South Africa, without this broader social support, the "right" to safe and effective TOP services becomes inaccessible.

Stellenbosch University https://scholar.sun.ac.za

Chapter Six: Voices of Women Seeking Abortion

In 1972, Foucault spoke in defence of Jean Carpentier in *Apprenons à faire l'amour* [Learn to make love]. Jean Carpentier had circulated work on contraceptives and abortions in the effort of spreading awareness about sexual reproductive rights and sex education. Carpentier was charged for this act, as it was believed to bespeak a wider concern of sexuality and push against the normative moral strictures of the West. Carpentier was unable to practice medicine for a year. Michel Foucault (1972) argued that Carpentier's punishment demonstrated that medicine had become a "guardian of morality" and, in doing so, was determining what it meant to be good or evil, criminal and non-criminal. In the case of abortion provision that was being debated at the time, doctors who had to make crucial decisions about provision became subject to similar criticisms.

As suggested elsewhere throughout this paper, the healthcare system in contemporary South Africa finds itself in a similar moment of debate about the moral contours of abortion. In its failure to bring the CTOPA into full legal force, these contours of moral and normative debate still dictate abortion provision; just as Foucault (1972) noted in *Médecine et luttes des classes,* these regulations form a real obstacle for women, and in particular poor women, to access TOP services. Although this thesis focuses on the experiences of TOP providers, I use this chapter to better explore the women who fear accessing the services the TOP providers provide, as these women make up the abortion scene in which TOP providers exist within. TOP providers, such as Lavinia, Rose, Joan, Amelia and Katrijn are acutely aware of the women who fear them and their services and as explored in the Jersey Girls workshop in chapter 3, place themselves in

Stellenbosch University https://scholar.sun.ac.za

vulnerable positions within their family, communities and colleagues in order to provide for the women who seek abortions outside of the formal public health sector.

It is the voices of these women that I wish to pay closer attention to in this final chapter. Until this point in my argument, the voices of women seeking TOP services have constituted a silence, with the exception of Makaziwe in chapter three. There is a simple reason for this: in order to conduct this research for a master's dissertation, I had to navigate a research ethics permission process through the university, like all others conducting human subjects research. Obtaining permission to conduct the present research comprised multiple applications that were returned to me over a period of six months for refinement and clarification, as I worked through the nitty-gritty aspects of researching and writing about abortion. To stay within the scope and timeframe of a master's degree, I made the decision to talk to those who are involved in providing abortion services – a term I used with the intention of encompassing everyone within the abortion scene. I had thought this would be a more effective strategy to move my project through the ethics regime faster than if I had sought out to speak to women who had terminated their pregnancies, primarily because these women constitute what university ethics boards designate as a "vulnerable" group.

The ethics regimes through which all human subjects research move are of course necessary and admirable, as they ensure the protection and safety of research participants, who in the case of my own research were a particularly vulnerable group. However, the decision not to include the voices of women who have terminated their pregnancies did not feel like a choice, but rather felt forced by a field of anxiety that is structured around the highly sensitive and controversial subject of abortion (Williams,

Stellenbosch University https://scholar.sun.ac.za

1977). Speaking to women who had had an abortion in a manner that would produce a finely grained ethnographic study would, I felt, have presented major obstacles for the Stellenbosch University ethical clearance body. I felt anxious about enduring a long and complicated delay in starting my fieldwork.

Executing an ethnographic study such as this that included the voices of women who had terminated their pregnancies is not impossible, even with the ethical clearance that must be obtained. As I read more widely around access to abortion in South Africa, I began to notice that much of the literature also has a silence at its heart; I began to consider how the voices of women themselves are not only largely absent, but also how deeply vexed the question is how to represent the voices of a subaltern group such as women seeking abortion services. Thus, in this chapter, I ask how one accounts for the experiences of women who have had abortions or have chosen informal abortion services. While the question of how clients experience and encounter service providers is a crucial one, there remains a constitutive silence at the heart of the literature on abortion in South Africa, which I now see is equally present in my own work. What do women in South Africa who seek out abortions actually think and feel? How do they express themselves? What is at stake in the difficulty of these women speaking for themselves and of having their voices mediated by others?

In this chapter I question: “Can the woman who has an abortion speak?” I do not introduce new ethnographic material here as it was not within the original scope of the study nor covered by institutional ethics permission. Rather, I reflect on secondary literature from South Africa in order to consider the question of how women’s voices are represented. I do this in order to show how the contestation around a woman’s right

Stellenbosch University https://scholar.sun.ac.za

to choose taking place within the political and social, manifests as barriers to accessing TOP care and ultimately silences those most in need. I suggest that if one looks across texts and utterances in the public sphere and various scholarly literatures, it becomes clear that it remains difficult to capture the experiences of women who have abortions. My aim is to consider how the silence at the heart of abortion research and public discourse shapes the way in which women develop agency and the potential to become actors of political society. It is through a relation of vulnerability, or openness to the possibility of being wounded that women become autonomous within a context where they have little access to the resources and services they need (Chatterjee, 2004).

To do this, I explore how and in what ways can she, the subaltern woman seeking the abortion, speak? What, when given the opportunity, does she and the voices of the women like her say of their experience of getting an abortion? How are they represented by the authors that write of them and how are these voices aggregated to become a political space? Here I examine four examples of women's experience of seeking out abortions in South Africa. Some are represented in academic papers, others through NGO storytelling pages, and finally, a blog of one woman's personal experience of having an abortion.

Media and the Representation of Women's Voices

The first example I examine is Drinking steel wool and brandy to induce an abortion: "Why I did it," an article on News24 by journalist Laura Bratton (2017), who attempts to explain why some women are seeking TOPs but are reluctant to make use of the formal public healthcare system. In seeking to make legible the rationale of such women, much descriptive effort is given to outlining the circumstances and conditions

Stellenbosch University https://scholar.sun.ac.za

of women's lives, pregnancies, and terminations. The paradoxical effect of adding more context is to erase more completely women's voices. For example, in describing the experience of a women that Bratton (2017) calls "Nohle," the author must anonymise her and thus erase her name in order to protect her identity. Nohle is described as a middle-aged sex worker from the Eastern Cape who had had five abortions both in and outside of the South African healthcare system. The article details Nohle's reasoning and experiences within these various spaces and notes that she chose to initially make use of the informal abortion sector because of stigma.

> "Nohle is originally from Ngcobo in the Eastern Cape. She says that at age 14 she was raped by a man in his early 20s and became pregnant. She moved to Langa where her mother was living. Nohle was three months pregnant when she tried to induce an abortion. She drank a mixture with crushed steel wool and brandy which her neighbour had told her about. She says after she drank it she felt dizzy and exhausted. She collapsed and was taken to Karl Bremer Hospital.
>
> Nohle's second attempt to induce an abortion was when she was 16. She was then working as a sex worker and living with friends in Langa. Some clients paid extra not to use condoms. She became pregnant. She did not know whether the father was her boyfriend or one of her clients. When she was two months pregnant she was advised by a friend to buy pills from a store in Langa. She took one of the pills with vodka and brandy. She says she had cramps and bleeding and went to the hospital.

Stellenbosch University https://scholar.sun.ac.za

> Nohle had three more abortions, when she was 20, 26, and 30. All were performed in hospitals. She says the nurses in the hospitals treated her well."
>
> Bratton (2017)

From the description, it is clear that Nohle was financially dependent on sex work and that risky sex behaviours brought in more money. As an anonymised figure, Nohle is used in this article as a representation of women who take desperate measures to survive unfortunate circumstances and, in the context of unwanted pregnancies, how these women navigate the abortion scene in order to terminate. Nohle's experience is written from the perspective of the article's author and although her experience is described in detail, the story is captured in the authors voice instead of Nohle's herself. Aligned with the article's aim, Nohle's experience helps capture why women turn to the informal abortion sector, but Nohle's actual reasoning for turning to the informal sector goes no further than the quotation: "Why did she not choose the public health system for her first two abortions? "Because of stigma, first," she says" Bratton (2017). The author further unpacks and elaborates on this notion of stigma without the use of Nohle's direct, first person voice: "… sex workers living in townships fear abortion procedures in hospitals because of stigma. The stigma has less to do with the hospital itself than with the way abortion is perceived by the women's families, friends, and partners, says Nohle." Bratton (2017).

Grammatically speaking, the person speaking is one step removed through the use of indirect reported speech, which is paraphrased into English that is suitable for a reasoning, reasonable, reading public. The rest of the article reinforces the claim that

Stellenbosch University https://scholar.sun.ac.za

stigma plays an integral role in women's health-seeking behaviours but does so by interviewing the spokesperson for Marie Stopes Clinics, who, unlike Nohle, is quoted throughout the article. The spokesperson provides reasons as to why women would turn to the informal sector, such as the anticipation of stigmatisation, which Nohle attributes to her reasons for avoiding the formal healthcare sector.

The second example I examine is: "It didn't take long for [the foetus] to come out. There was a human-like form," published in the *Mail and Guardian*'s Bhekisisa section, by Ina Skosana (2017). Skosana (2017) tells the story of a woman who, for the sake of anonymity, is named Buhle Bhengu. Bhengu reports having two abortions. The first is with an informal abortion provider whose advert Bhengu had found on the street, and the second with a woman who seemed more professional, but whose results almost killed her. Skosana (2017) argues that women turn to illegal practices as they feel they have few choices, and Bhengu's experiences are used to demonstrate that. Bhengu's story, much like Nohle's before, is also written in the words of the author that is representing the woman in question, and again the name has been anonymised. However, the Bhekisisa article uses more direct quotations to capture Bhengu's story in comparison, as they unpack the events that unfolded:

> "The man put on a pair of white surgical gloves, then got down on his knees at the foot of the makeshift bed. He slowly pushed the tablets into her vagina. The 23-year-old woman was lying in a flat in downtown Johannesburg. She stared motionlessly at the ceiling. "It wasn't painful, just uncomfortable," she recalls. "But I had no choice." An overpowering smell of incense filled the room. The woman remembers: "It looked like a place

Stellenbosch University https://scholar.sun.ac.za

> where they worked with muti."The man explained the procedure. He was going to give her medication. "Some of the pills I would have to drink at home, the others he would insert inside my vagina." The woman pauses. "I got his number from an advert in the newspaper. It said: 'Safe, pain-free, same-day abortion'."
>
> (Skosana, 2017)

As the article continues, Bhengu is quoted sharing how she was traumatized from her experience of terminating. She describes the foetus that was expelled as "human like," and further elaborated on her regret for terminating outside of the formal health sector. Bhengu's reasons for terminating are however not clear in the description of her first termination, nor are her reasons for going the informal route in the first place. Her second termination however is explained in more detail as the author further elaborates on Bhengu herself, describing her as hardworking and as a sole provider for her family after her partner lost his job.

> "My partner said he would support any decision I took because, financially, I was a single parent." Bhengu knew she wouldn't be able to support another child, so once again she decided to have an abortion. Only this time she was going to make sure she went to a real doctor
>
> (Skosana, 2017).

As the article continues, Bhengu is described to have sought out what she believed to be a certified abortion provider, who gained her trust, as she offered counselling in addition to the termination. The practitioner gave Bhengu medication that left her on

Stellenbosch University https://scholar.sun.ac.za

the brink of death and was rushed to a private medical doctor for an emergency surgical abortion, bringing the article to a close with a powerful quotation from Bhengu: "[The doctor] said I could have died" (Skosana, 2017).

Both of Bhengu's encounters with the informal sector are harrowing accounts that left Bhengu feeling degraded and afraid. It is not uncommon for women who seek out informal abortions to have these experiences, which often times result in not only emotional trauma, but physical mutilation and sometimes death. Stories such as Nohle's and Bhengu's emerge in various media to shed light on the dangers of this practice, but they additionally show how difficult it is to directly represent the voices of women who make use of them.

The systemic erasure of women's voices while representing them in articles such as the ones above is what Gayatri Chakravorty Spivak (1988) posits in her classic essay: *Can the Subaltern Speak?* There, Spivak (1988) questions the ability of the liberal, western academic that attempts to speak on behalf of the subaltern, but her query can be extended to that of journalists, activists, officials, and others seeking to speak on behalf of women seeking TOP services in South Africa. Spivak (1988) concludes that the subaltern cannot speak, as their voice is altered and represented through the tailored perspective of those who write on their behalf – a notion I explore further as I work through the other examples of women's voices.

The third example is a narrative entitled: 16-Year-Old Me & The Reasons For My Abortion. The narrative is of an experience of a woman who had an abortion in South Africa, which was published on the Marie Stopes International website (Marie Stopes

Stellenbosch University https://scholar.sun.ac.za

South Africa, 2016). The post is among two others on the topic of "Abortion Stories" and is not uncommon for women's reproductive health organizations to make use of on their websites. The purpose of these testimonies is unclear, as the website posts them without introduction or detail, but similarly to the Bhekisisa and News24 articles, the story is not written out in the form of a blog, but rather quotations which are then used amongst contextual description from a second author. The first of three stories is Lebo's, who was sixteen at the time of falling pregnant with her partner five years her senior:

> "When I told Thulani about the pregnancy, I immediately knew I had to terminate unless I wanted to raise the baby alone. I thought about what it would be like to tell my single, hardworking mother about my pregnancy, and the idea terrified me. So when I told Thulani I would have an abortion, he said he'd find a doctor to help me."
>
> (Marie Stopes South Africa, 2016).

The first-person narrative describes Lebo's fear of having to tell her mother about her pregnancy, as well as realizing that if she continued her pregnancy, she would do so alone. It is uncertain from the post where Lebo is from and what was available to her, but it is made clear to the reader from the time and manner in which she gathered the money for the abortion that she was very poor.

> We had to save up for nearly a month to have enough money to pay the man. I lied to my mom and said I needed money for a school trip, and Thulani managed to get hold of the rest. Then, one Wednesday, I bunked

Stellenbosch University https://scholar.sun.ac.za

> school and the "doctor" came to meet us at my house in the morning. He gave me two pills to take right away and another two to 'clean out' my uterus, which I had to take that night."
>
> (Marie Stopes South Africa, 2016).

Although the post gives us insight into Lebo's experience and makes use of many quotations to do so, similarly to the articles cited above, we are once again confronted by Spivak's (1988) concern about whether and in what ways the voice of the subaltern can be represented.

The fourth example is an academic source by Harries et al. (2015), who conducted an *exploratory study of what happens to women who are denied abortions in Cape Town, South Africa*. The study is one of the few papers I was able to find that captured direct quotations of South African women speaking about their experiences seeking to terminate pregnancies. The study showcased how women seek abortion services outside of legal facilities if services from accredited facilities are not available to them. In the case of Harries et al.'s (2015) research, it was women who had been denied termination due to financial constraints or complications around gestational age (too early or too far along) that tended to seek informal TOPs. From my experiences during fieldwork and my reading of the available literature, I suggest that more subtle barriers, such as the fear of being mistreated by nurses, fear of poor service, and in some cases, a distrust for biomedicine, would also result in women seeking TOP services from unaccredited facilities.

Stellenbosch University https://scholar.sun.ac.za

Of the small sample interviewed, Harries et al (2015) found that women responded to being denied access to abortion services in a variety of ways: continuing with their pregnancy, returning to terminate at a later stage, and others sought out informal avenues to terminate their pregnancy. However, by their own report, none that sought out to terminate in the informal sector carried through with it.

Below is a direct quotation from one of the participants that took part in the study. I cite it at length in order to give the reader a more comprehensive sense of the person quoted and the grammatical structure of the expression. The quotation is provided in the first person and in doing so is used to give a sense of immediacy to the woman's experience. Yet, I as an author cannot ignore the fact that this is a quotation that is attempting to capture through first person singular the experience of a woman who sought out an abortion, but it is done so through the representation of Harries et al. (2015) and then again, here, by me. The study however provides additional detail before the quotation below and explains that the participant sought out an illegal provider as a result of cost and bad experiences in the public sector previously in order to best provide context for the reader.

> I was extremely desperate. I googled everything from abortion clinics on the internet, everything from that abortion drug until I found someone because they were offering to drop it off. ... If you google abortion clinic sites, .. You will find hundreds of them, and to be honest, what also scared me was going to one of our public hospitals... I decided to try one of these numbers and he called back immediately, and I said –I want to make an appointment – I explained to him that I was thinking of maybe coming to

Stellenbosch University https://scholar.sun.ac.za

> have a look… He said – there's an ATM on the corner, I'll meet you there. And every little bit of common sense that I had was saying – no you won't… I'm not going to do anything, OK let me just see, … I met him and there's like a cell phone shop .. you could walk through and then there was a trailer. There was a lopsided bed… I asked him – but you advertised a clinic, there is no clinic… I asked how this works. He said –the pills are R1 200 … he didn't even speak about any kind of examination. He didn't even ask how far pregnant I was … I realized it was not a real clinic, because I know that at Marie Stopes until a certain point you could go it's regulated and there is a clear time table,. I asked where's the after-care clinic. And then he says it's very, very safe. … he could help insert the four tablets into your woman's parts … I had to either stop fooling myself into thinking that something's going to happen and I knew that this is as far as it goes and I would have to actually go and seek help at a government facility or something and I resigned myself to that and I left…"
>
> (Harries *et al*. 2015:4)

Harries et al (2015) include quotations that are relevant to their study's aim and multiple women's experiences are recorded as a result. The women whose experiences are used are described generally by the socio-demographic information provided, such as the mean age of all participants, education history, and employment history, as well as contraceptive use. However, each participant's contextual background is not unpacked in detail, as it is not within the scope of the research. Pertaining to my question of voice, the lack of detail creates further distance between the reader and the women whose stories are being quoted. The quotation above is one of several that demonstrates,

Stellenbosch University https://scholar.sun.ac.za

women's concerns with accessing the public healthcare system (Harries *et al*., 2015) similarly to the News24 (Bratton, 2017) and Bhekisisa (Skosana, 2017) articles discussed above. The quotation effectively outlines the ways in which women may seek alternative healthcare practices if denied TOP services from safe and effective providers, but the woman's story, although brought to the fore, becomes multi-vocal as it travels through various iterations and restatements, from the first occasion of its telling, to its editing in the process of writing, to its final publication and then consumption by a professional readership. This is precisely the concern that Spivak (1988) has with the difficulty of definitively locating the voice of the subaltern. What access does the reader or listener have to the unmediated voice or experience of the woman seeking an abortion?

All of the women described in the various fora above were represented through a particular lens, which in one way or another camouflaged them to protect their identity. The anonymising of each woman is a necessary function not only in research, but additionally for women who fear stigmatisation and have to hide their identities in order to have a voice and operate within the logic of shame. It is useful to consider whether within these broader social and political categories of women, there is a subset of the women who seek out informal abortions whose voices and interests are difficult to represent, such as the women discussed in the examples above. I raise this question in order to discuss whether this subset of women is in the process of becoming "political society."

Political society, in Chatterjee's (2004: 40) formulation, are those who are excluded from what is more commonly understood as civil society and as a result are forced to

Stellenbosch University https://scholar.sun.ac.za

access services in often informal or illegal ways in order to live and work. An example concerns the political strategies deployed by the state to better manage the urban slum dwellers that illegally occupy land. Chatterjee (2004:82-85) argues that these strategies reveal how those who occupy political society are constructed as "in need" and manageable – a political subject – rather than agents of their own existence, with the autonomy to engage in the everyday comings and goings of citizenship.

Chatterjee (2004:30) describes the idea of citizenship and "civil society" as "a closed association of modern elite groups, sequestered from the wider popular life of the communities, walled up within enclaves of civic freedom and rational law". In developing countries, like India, where Chatterjee's (2004) work is based and South Africa where this research takes place, the elites to which Chatterjee refers make up a well-educated, predominantly middle- to upper-class section of the overall population. Due to economic circumstances, this collective is relatively small and therefore does not describe the majority of the developing world. Chatterjee (2004:39) argues that, due to this, what we commonly understand to be "civil society" is "demographically limited," as it only tends to the bourgeois within post-colonial settings .

The slum dwellers that Chatterjee (2004) describes are therefore not treated as members of civil society by the state, and as a result of not fitting the unique criteria of citizenship, represent something resembling more of a "population." Populations, Chatterjee (2004) argues, are objects of the welfare state and have a client-patron relationship as they gain access to governmental programmes, NGO aid, social movements, and criminal overlords. These are the mediators in which political society gain access to resources, such as welfare and housing.

Stellenbosch University https://scholar.sun.ac.za

Due to the resource constraints of most developing countries, it is impossible to meet the needs that do not fit into the generalized needs of the entire country's population without placing strain on the state's capacity to deliver benefits to the entire population and inviting "further violation of public property and civic laws" (Chatterjee, 2004:37-40). As a result, what emerges is a population that resorts to a myriad of self-governing techniques that allow members of political society to gain access to the means of survival that include state grants and illegal activity – in other words, allocation to citizenship is derived from deviance and access to resources is found by unconventional and at times unorthodox means, such as criminal activity or participation in informal sectors.

Although Chatterjee's (2004) work has a specific focus on India, the contexts which he describes can be applied to South Africa and its healthcare system. In a South African context, it can be argued that we too have our own "political society," who have formed as a result of struggling to gain access to governmental services, despite the wide net of welfare the government attempts to offer. These "populations" and collectives that arise in the form of religious affiliations, "tribes," etc., create new forms of government to which members thus become subject.

In specifically considering the matters relating to women's reproductive health and access to TOP services, I argue that it would be naïve to assume that because TOP is legal in South Africa, that all members of South Africa could gain access to these services. While considering the various collectives that members of our own "political society" formed, it could be argued that despite the free access to TOP services, use of

Stellenbosch University https://scholar.sun.ac.za

these services could be rebuffed if they were discouraged by collectives that were considered a greater authority than the law itself.

Conclusion

Using the examples of a women who have had abortions voices in various forums and thinking alongside Spivak's (1988) *Can the Subaltern Speak?* it is shown that the women who seek out the abortion in the informal abortion sector constitute, in social terms, a "silence" in society and are therefore vulnerable in the South African context. The woman who seeks an abortion in the informal sector has yet to find a voice in the larger discourse around access to safe and effective TOP service provision, and, as a result, we are unable to represent her experiences and what she actually feels in order to speak to the greater question of lack of access to effective and safe abortion care.

As Chatterjee (2004) demonstrates, the woman who seeks to terminate her pregnancy outside of the formal healthcare system, similarly to that of her political society, finds agency within what is perceived as the safer hands of anonymity in the informal sector, a space where they are heard and recognised. The fear to enter into the public health sector and interact with TOP providers, it is shown, is shaped by the fear of experiencing abortion stigma. Understanding how abortion stigma affects access to care from the perspective of the women seeking TOP services, provides more insight into the field of relations within the abortion scene in which the experiences of TOP providers sit firmly within.

Stellenbosch University https://scholar.sun.ac.za

Chapter Seven: Conclusion

This thesis explored how those involved in providing safe and legal abortion services navigate the moral ambiguities of a woman's right to choose. I did this, in order to better understand the impact that the decision to provide safe and effect TOP care in South Africa has on their everyday lives. In exploring this question, I found that TOP providers experience abortion stigma that is perpetuated not only within their day to day experiences with family and friends, but within their navigation of their work life and work relationships and within the medical field itself. It is in this attempt to understand these experiences that I found that, not only does abortion stigma inhibit women from seeking a safe and affective service, but it demotivates action from medical professionals to train to become TOP providers. Additionally, abortion stigma presents a challenge to those who are trained to provide the service as the impact TOP provision has on their home and working lives remains an additional concern. Lastly, and in alignment with an overarching concern of this research, namely access to TOP services, abortion stigma additionally causes women to fear the public healthcare system and ultimately pushes women into the informal sector, where their bodies are at risk of mutilation and death.

By exploring the various collectives with whom the TOP providers I interviewed identified, I was able to better understand how providers like Joan and Amelia, for example, negotiated the ethical and moral dilemmas that arose from providing TOPs. These dilemmas were shaped by the various collectives with which they identified, such as the Christian church, the nursing profession, families, etc., and the dilemmas had a considerable influence on how TOP providers understanding of what it means to access the right to safe and legal termination of pregnancy was shaped. Joan and Amelia are

Stellenbosch University https://scholar.sun.ac.za

not unique in their experience, and I have shown that this is a negotiation that the healthcare workers who are presented with the choice to provide TOPs have to confront when considering whether the service is in alignment with their own uniquely formed set of values.

However, experience as a concept is unreliable, as a wealth of anthropologists have demonstrated (Turner *et al.*, 1986). Thus, in order to understand the descriptions that TOP providers offered of their experiences, I have explored the broader narratives surrounding these experiences and engaged with the various contextual elements that construct how TOP providers understand their worlds. Through various lenses that made up the chapters of this thesis, I have offered a more comprehensive understanding of the abortion scene in which TOP providers's experiences are constructed. By reflecting on the history and contemporary context of TOP provision and describing the field of relations that abortion stigma shapes and is shaped by, I was able to better understand the personal experiences and vulnerabilities of TOP providers and how they navigate this morally ambiguous field. In seeking to understand their experiences, I was able to further explore the other side of the coin by exploring the various publics and counterpublics that constitute the field of relations around TOP. By examining who dominates the normative discourse around TOP provision, I sought to understand why and how the right to TOP in South Africa is fragile and only partially taken up. Finally, I have sought to show how TOP providers's experiences can be better understood in relation to the impact that effective TOP provision could have on the South African abortion scene. This concern is articulated by the providers who attended the workshop I describe in chapter 3 and is illustrated by the women who remain the most vulnerable, on whom I reflect in chapter 6. These chapters have unpacked the diverse contextual

Stellenbosch University https://scholar.sun.ac.za

issues that frame and situate how abortion stigma manifests within the South African abortion scene and how it ultimately affects the bigger political question of access to safe and effective abortion care.

In chapter 2, I discussed the history and social context of reproductive health in the global North with termination of pregnancy as the specific focus. This chapter elaborated on the influence that these histories have had on the South African abortion scene in contemporary Cape Town. The South African abortion scene becomes clearer when understood beside the histories and current social context of the global North, as the highly influential and public discourse around reproductive health and the right to choose informs South Africa's public discourse in various ways. Therefore, in order to flesh out what the interlocuters in this thesis describe when speaking about "shame," "life," and what it means to be a good woman and healthcare worker, these combined histories and contemporary contexts are important to situate these narratives within, as they comment on the medical, social, and political contexts of the abortion debate. These discourses, as shown, powerfully shape the social conditions in which TOP providers navigate the ethical quandaries of providing TOPs in South Africa.

Contributors to this context are the pro-life protesters who stand outside one of the clinics in which I conducted my fieldwork. The protesters, healthcare workers, and women seeking TOP services make up the field of relations in which the abortion scene materialises. In chapter 3, I show how, by means of speech acts, gestures, and arrangements of actors, the "social" and "institutional" are constituted by means of vulnerability, and how entangled with one another these vulnerabilities are. These entanglements impact one another in various ways and this is demonstrated through the

Stellenbosch University https://scholar.sun.ac.za

workshop I attended with Cape Town artists, TOP providers, reproductive health activists, and women who had had an abortion.

The workshop showcased the kinds of vulnerabilities that must be put into circulation in order for the right to choose to be negotiated in public discourse and further showed that with vulnerability comes a semblance of agency. However, as described by the women at the workshop, despite their vulnerability and resilience, there are still feelings of hopelessness as they resist the institutional stigma embedded in the structures in which they exist as medical professionals. The testimonials of Katrijn, Rose, and Lavinia show that TOP practitioners are inhibited by the structural elements that suppress their agency to provide. Chapter 3 showed that the vulnerabilities of many diverse actors are at stake, such as the foetus and the women seeking TOPs; equally, a certain neglect of the vulnerabilities of those in TOP provision is evident as the healthcare system struggles to employ providers to support the provision of this service.

Chapter 4 dove deeper into the TOP service providers's experiences of abortion stigma and its ability to influence those exposed to it in a self-regulatory nature. Through their testimonies, Amelia and Joan showed how they navigate, resist, and reform their own moral code whilst negotiating the moral ambiguities of being a TOP provider. Understanding each individual moral code and where it stems from, aids us in understanding how it shaped Amelia and Joan's understanding of their own position in the field of TOPs. In addition, Joan and Amelia provided insight into the collectives they identify with and which contribute to their understanding of ethical conduct and moral codes. Through their telling of their stories and how their values and ethical codes align with them, I showed how institutions such as church and state shape and are

Stellenbosch University https://scholar.sun.ac.za

shaped by communities, families, and workplaces, such as the clinic.

Joan and Amelia's experiences illustrate how abortion stigma has the effect of making its subjects police themselves. Joan and Amelia were subject to moral codes that were informed by various institutions, such as the Christian church. The chapter additionally showed how both Joan and Amelia had moments of resistance as they thought through their own socialisation, as they became more exposed to the complex realities that brought women to seek TOPs in the first place. Joan and Amelia's testimonies illustrate how TOP providers develop their agency as they battle their conscience. It was through their negotiations of what it means to be "right," "wrong," "good," or "evil" when considering TOP service provision that revealed how Joan and Amelia came into their sense of "self" by interacting with and challenging the institutions that shape their subjectivities, while simultaneously reshaping their understanding of the field in which they work.

I have further sought to show that, despite a legal framework supporting TOP services, the law providing women the right to choose is fragile on account of public discourse and opinion in which abortion stigma manifests. Chapter 5 discusses the tension in which this law is situated as the debates in the public sphere shift on whether a woman should have the right to choose. As discussed in this chapter, the question of whether pro-life discourse or pro-choice discourse occupies the normative public discourse is ambivalent as it is clear that a legal framework is not enough for the right to come into its full fruition after 21 years of existence. In order for a right to be enjoyed, the law needs to be in alignment with public attitudes and perception, as well as supported by law, policing, and a range of other institutions, if it is not to remain inaccessible.

Stellenbosch University https://scholar.sun.ac.za

Finally, chapter 6 shows how abortion stigma silences the women who are most vulnerable – those who turn to the informal sector for abortions. In an attempt to explore whether this particular subaltern can speak, I examined various texts that reflect on the experiences of women who have had abortions or sought out abortions. After reviewing these texts, it became clear that, despite the CTOPA being in effect for 21 years, it remains difficult to capture the voices and experiences of women who seek out TOP services and that in social terms, and this silence in society makes it difficult to understand what women truly experience. It is through this silence that we see the challenges that the public health system faces to address the question of access to safe and effective TOP services.

Together, the chapters in the thesis show the contestation that takes place within and through the political and the social and how these struggles manifest as an obstacle to access much needed TOP services. In this thesis I have reflected on these contestations and how they structure the social field of abortion stigma and offered an approach to how we might better understand the everyday experience of abortion providers and the role that stigma plays in shaping their working lives and the services they offer.

Stellenbosch University https://scholar.sun.ac.za

Reference List

Agamben, G. (1998) *Homo Sacer: Sovereign Power and Bare Life*. 1st edn. California: Stanford University Press. doi: 10.1017/CBO9781107415324.004.

Amnesty International (2017) *Briefing: Barriers to Safe and Legal Abortion in South Africa*. United Kingdom.

Atwood, M. (1986) *The Handmaid ' s Tale*. New York: Random House Publishing.

Bakhtian, N. (2017) 'Women's marches, occurring across seven continents, include a focus on environment', *Grist*, 19 January.

Bank, A. (2015) 'Fathering volkekunde: race and culture in the ethnological writings of Werner Eiselen, Stellenbosch University, 1926–1936', *Anthropology Southern Africa*, 38(3–4), pp. 163–179. doi: 10.1080/23323256.2015.1075854.

De Beauvoir, S. (1983) *The Second Sex*. London: Penguin Books.

Berlant, L. (1994) 'America , " Fat ," the Fetus', *boundary 2*, 21(3), pp. 145–195. Available at: https://www.jstor.org/stable/303603.

Biehl, J. (2013) *Vita: Life in a Zone of Social Abandonment*. Berkeley and Los Angeles, California: University of California Press.

Bolton, S. C. (2005) 'Women ' s Work , Dirty Work : The Gynaecology Nurse as " Other "', *Gender, Work and Organization*, 12(2). doi: 10.1111/j.1468-0432.2005.00268.x.

Bolton, S. C. (2016) 'Women ' s Work , Dirty Work : The Gynaecology Nurse as " Other "', *Gender, Work and Organization*, 12(2). doi: 10.1111/j.1468-0432.2005.00268.x.

Bourdieu, P. (1990) *The logic of practice*. 1st edn. California: Stanford University Press. doi: 10.1007/BF00680104.

Bratton, L. (2017) 'Drinking steel wool and brandy to induce an abortion: "Why I did it"', *News24*, 26 October.

Stellenbosch University https://scholar.sun.ac.za

Butler, J., Gambetti, Z. and Sabsay, L. (2016) *Bouncing Back: Vulnerability in Resistance*. Durnham, North Carolina: Duke University Press.

Capazorio, B. (2014) ‘Abortion hacks still kill in SA’, *Times Live*, 14 July. Available at: http://www.timeslive.co.za/thetimes/2014/07/14/Abortion-hacks-still-kill-in-SA.

Carmon, I. (2015) *The next wave of abortion restrictions is here*, *MSNBC*. Available at: http://www.msnbc.com/msnbc/the-next-wave-abortion-restrictions-here.

Cavavero, A. and McCuaig, W. (2009) *Horrorism: Naming Contemporary Violence*. New York: Columbia University Press. Available at: http://www.jstor.org/stable/10.7312/cava14456.

Cavell, S. (1979) *The Claim of Reason*. New York: Oxford University Press.

Chatterjee, P. (2004) *The Politics of the Governed*, *The Politics of the Governed Reflection on Popular Politics in Most of the World*. New York: Columbia University Press. doi: 10.3917/mult.045.0174.

Chiweshe, M. and Macleod, C. (2017) ‘“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’, *International Journal of Behavioral Medicine*. International Journal of Behavioral Medicine, 24(6), pp. 856–863. doi: 10.1007/s12529-017-9694-8.

Cohen, D. S. and Connon, K. (2015) *Living in the Crosshairs: The Untold Stories of Anti-abortion Terrorism*. New York: Oxford University Press.

Constant, D. *et al.* (2014) ‘Self-induction of abortion among women accessing secondtrimester abortion services in the public sector, Western Cape Province, South Africa: An exploratory study’, *South African Medical Journal*, 104(4), pp. 302–304. doi: 10.7196/SAMJ.7408.

Coovadia, H. and Mantell, J. E. (2010) ‘Adolescents and HIV in sub-Saharan Africa: a timely issue and missed opportunity.’, *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*, 51(7), pp. 852–854. doi: 10.1086/656362.

Stellenbosch University https://scholar.sun.ac.za

Das, V. (2001) 'Stigma, Contagion, Defect: Issues in the Anthropology of Public Health', *NIH Conference on Stigma and Global Health: Developing a Research Agenda.*, 128(4), pp. 1–276.

Das, V. (2007) *Life and Words: Violence and the Descent into the Ordinary*. Los Angeles: Univerisity of California Press.

Department of Health South Africa (2005) *Termination of Pregnancy Update. Cumulative Statistics Through 2004.* Pretoria.

Derrida, J. (1994) *Given Time: I. Counterfeit Money*. Chicago: University of Chicago Press. doi: loc? SLU Pius PQ2191.S63 D4713 1992.

Dubow, S. (1995) *Scientific Racism in Modern South Africa*. Cambridge: Cambridge University Press.

Edwards, S. (2018) *One year on, full impact of 'global gag rule' begins to emerge*, *Devex*. Available at: https://www.devex.com/news/one-year-on-full-impact-of-global-gag-rule-begins-to-emerge-91902.

Farmer, P. (2014) 'Diary: Ebola', *London Review of Books*, 36(20), pp. 38–39.

Fiala, C. and Arthur, J. H. (2014) '"Dishonourable disobedience" - Why refusal to treat in reproductive healthcare is not conscientious objection', *Woman - Psychosomatic Gynaecology and Obstetrics*. Elsevier GmbH, 1(C), pp. 12–23. doi: 10.1016/j.woman.2014.03.001.

Foran, C. (2018) 'The plan to overturn Roe v. Wade at the Supreme Court is already in motion', *CNN*, 29 June. Available at: https://edition.cnn.com/2018/06/29/politics/abortion-roe-v-wade-supreme-court/index.html.

Foucault, M. (1988) *The History of Sexuality: The care of the self*. New York: Knopf Doubleday Publishing Group.

Foucault, M. (1994) 'Ethics: Subjectivity and Truth', in Rabinow, P. (ed.). The New Press. doi: 10.1017/CBO9781107415324.004.

Stellenbosch University https://scholar.sun.ac.za

Foucault, M. (2003) *Michel Foucault: Birth Of The Clinic*. London: Routledge Classics.

Foucault, M. (2013) *Ethics: Subjectivity and Truth*, *Journal of Chemical Information and Modeling*. doi: 10.1017/CBO9781107415324.004.

Foucault, M., Calhoun, C. and Hurley, R. (1978) *The History of Sexuality*. New York: Pantheon Books.

Gambetti, Z. (2016) 'Risking Oneself and One's Identity: Agonism Revisited', in *Bouncing Back: Vulnerability and Resistance*. Durnham, North Carolina: Duke University Press, pp. 28–52.

Geertz, C. (1973) *The interpretation of cultures: Selected essays*, *The Interpretation of Cultures: Selected Essays*. New York: Basic Books Inc. doi: 10.4324/9781912128310.

Geertz, C. (1988) 'Interpretation of Cultures: Selected Essays by Clifford Geertz', *Journal of Comparative Physiology B*, 158(3), pp. 301–305. doi: 10.1007/BF00695328.

Geertz, C. (1989) *Works and Lives: The Anthropologist As Author*. California: Stanford University Press.

Gezinski, L. B. (2012) 'The Global Gag Rule: Impacts of conservative ideology on women's health', *International Social Work*, 55(6), pp. 837–849. doi: 10.1177/0020872811421619.

Gluckman, M. (1940) *Analysis of a Social Situation in Modern Zululand*, *Bantu Studies*. Abingdon, United Kingdom: Routledge.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. London: Penguin Books.

Gold, R. B. and Nash, E. (2017) 'Flouting the Facts: State Abortion Restrictions Flying in the Face of Science', *Guttmacher Institute*, 9 May.

Gresh, A. and Maharaj, P. (2014) 'Termination of pregnancy : Perspectives of female

Stellenbosch University https://scholar.sun.ac.za

students in Durban , South Africa', *Suppl on Population Issues in South Africa*, 28(1), pp. 681–690.

Grimes, D. A. *et al.* (2006) 'Unsafe Abortion: The preventable pandemic', *The lancet: World Health Organization: Sexual and Reproductive Health Series*, 1(4), pp. 1–13.

Guttmacher, S. *et al.* (1998) 'Abortion reform in South Africa: A case study of the 1996 choice on termination of pregnancy act', *International Family Planning Perspectives*, 24(4), pp. 191–194. doi: 10.2307/2991980.

Habermas, J. (1991) *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society.*, *Contemporary Sociology*. doi: 10.2307/2072652.

Haffejee, F. *et al.* (2017) 'Factors associated with unintended pregnancy among women attending a public health facility in KwaZulu-Natal, South Africa', *South African Family Practice*. Taylor & Francis, 60(3), pp. 79–83. doi: 10.1080/20786190.2017.1396790.

Harries, J. *et al.* (2007) 'Delays in seeking an abortion until the second trimester: A qualitative study in South Africa', *Reproductive Health*, 4(7). doi: 10.1186/1742-4755-4-7.

Harries, J. *et al.* (2014) 'Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study', *Reproductive Health*, 11(1). doi: 10.1186/1742-4755-11-16.

Harries, J. *et al.* (2015) 'An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa', *Reproductive Health*, 12(1), pp. 1–6. doi: 10.1186/s12978-015-0014-y.

Harries, J., Stinson, K. and Orner, P. (2009) 'Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa', *BMC Public Health*, 9(296). doi: 10.1186/1471-2458-9-296.

Hartocollis, A. and Alcindor, Y. (2017) 'Women's March Highlights as Huge Crowds Protest Trump: "We"re Not Going Away'', *The New York Times*, 21 January.

Stellenbosch University https://scholar.sun.ac.za

Available at: https://www.nytimes.com/2017/01/21/us/womens-march.html.

Hayes G, F. K. and W. M. (2013) *Global Impact Report 2012: Reaching the under-served*, *Marie Stopes International*. London. Available at: https://www.mariestopes.org/media/2164/global-impact-report-2012-reaching-the-under-served.pdf.

Hodes, R. (2013) 'The Medical History of Abortion in South Africa, c. 1970–2000', *Journal of Southern African Studies*, 39(3), pp. 527–542. doi: 10.1080/03057070.2013.824770.

Hogan, M. F. (2003) 'The President ' s New Freedom Commission : Recommendations to Transform Mental Health Care in America', *Psychiatric Services*, 54(11), pp. 1467–1474.

Holmes, S. M., Jenks, A. C. and Stonington, S. (2011) 'Clinical Subjectivation: Anthropologies of Contemporary Biomedical Training', *Culture, Medicine and Psychiatry*, 35(2), pp. 105–112. doi: 10.1007/s11013-011-9207-1.

Jacoby, A. (1994) 'Felt versus Enacted Stigma: A Concept Revisited.', *Social Science & Medicine*, 38(2), pp. 269–274.

Jewkes, R. *et al.* (2005) 'The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change', *BJOG: An International Journal of Obstetrics and Gynaecology*, 112(3), pp. 355–359. doi: 10.1111/j.1471-0528.2004.00422.x.

Kaufman, C. (1996) *The Politics and Practice of Reproductive Control in South Africa: A Multilevel Analysis of Fertility and Contraceptive Use*. University of Michigan.

Keusch, G. T., Wilentz, J. and Kleinman, A. (2006) 'Stigma and global health: developing a research agenda', *Lancet*, 367(9509), pp. 525–527. doi: S0140-6736(06)68183-X [pii]\r10.1016/S0140-6736(06)68183-X.

King, L., Castillo, A. and Agrawal, N. (2018) 'At Women's Marches nationwide, setting sights on the ballot box and hailing #MeToo', *LA Times*, 20 January.

Stellenbosch University https://scholar.sun.ac.za

Klausen, S. M. (2015) *Abortion Under Apartheid: Nationalism, Sexuality and Women's Reproductive Rights in South Africa*. London: Oxford University Press.

Kumar, A. (2013) 'Everything is not abortion stigma', *Women's Health Issues*, 23(6), pp. 4–7. doi: 10.1016/j.whi.2013.09.001.

Kumar, A., Hessini, L. and Mitchell, E. M. H. (2009) 'Conceptualising abortion stigma', *Culture, Health and Sexuality*, 11(6), pp. 625–639. doi: 10.1080/13691050902842741.

Lambeck, M. (2010) *Ordinary Ethics: Anthropology, Language, and Action*. 1st edn. New York: Fordham University Press.

Levine, M. and Pinkerson, D. (2000) *Soldiers in the Army of God*. United States.

Link, B. G. and Phelan, J. C. (2001) 'Conceptualizing Stigma', *Annual Review of Sociology*, 27(2001), pp. 363–385.

Lipp, A. (2011) 'Stigma in abortion care: Application to a grounded theory study', *Contemporary Nurse*, 37(2). doi: 10.5172/conu.2011.37.2.115.

Littlefield, A. (2017) 'Thanks to Pence, Indiana Now Has One Less Abortion Clinic (Updated)', *Rewire News*, 26 July. Available at: https://rewire.news/article/2017/07/26/thanks-pence-indiana-now-one-less-abortion-clinic/.

Macleod, C., Sigcau, N. and Luwaca, P. (2011) 'Culture as a discursive resource opposing legal abortion', *Critical Public Health*, 21(2), pp. 237–245. doi: 10.1080/09581596.2010.492211.

Malinowski, B. (1922) *Argonauts of the Western Pacific*. London: Routledge & Sons.

Marecek, J., Macleod, C. and Hoggart, L. (2017) 'Abortion embedded and embodied in social relations: Challenges for feminist psychology', *Feminism and Psychology*, 27(2), pp. 133–143. doi: 10.1177/0959353517704877.

Marie Stopes South Africa (2016) 'My Abortion Stories: 16-Year-Old Me & The Reasons For My Abortion'. Available at: https://www.mariestopes.org.za/abortion-

Stellenbosch University https://scholar.sun.ac.za

stories-16-year-old-reasons-abortion/.

Mauss, M. (1954) *The gift: The form and reason for exchange in archaic societies*. 1st edn, *The Gift: The Form and Reason for Exchange in Archaic Societies*. 1st edn. London: Cohen & West. doi: 10.4324/9781912281008.

Mcardle, M. (2018) 'Court Says Indiana Ban on Selective Abortions Is Unconstitutional', *National Review*, 20 April.

Mhlanga, R. E. (2017) *Health workers are undermining women's right to abortion.*, *Daily Maverick*. Available at: available: https://www.dailymaverick.co.za/article/2017-08-13-health-e-health-workers-are-undermining-womens-right-to-abortion/?utm_content=bufferf0ad4&utm_medium=social&utm_source=twitter.com&utm_campaign=buffe. (Accessed: 20 August 2017).

Michel Foucault et le membres du G.I.S. (1972) '"Médecine et luttes des classes", Vers une antimédecine? Le médecine, la malade et la société', *La Nef*, (No 49), pp. 67–73.

Mistral, G. (2008) *Madwomen*. Chicago: The University of Chicago Press.

Morroni, C. and Moodley, J. (2006) 'Characteristics of clients seeking first- and second-trimester terminations of pregnancy in public health facilities in Cape Town', *South African Medical Journal*, 96(574).

Mosley, E. A. *et al.* (2017) 'Abortion attitudes among South Africans: findings from the 2013 social attitudes survey', *Culture, Health and Sexuality*. Taylor & Francis, 19(8), pp. 918–933. doi: 10.1080/13691058.2016.1272715.

Nash, E. *et al.* (2018) 'Policy Trends in the States, 2017', *Guttmacher Institute*, 2 January. Available at: https://www.guttmacher.org/article/2018/01/policy-trends-states-2017.

Nichols, F. H. (2000) 'The Women's Health Movement', *History of the Women's Health Movement in the 20th Century*, 29(1), pp. 56–64. doi: 10.2190/5XUN-VX3H-KMWM-F17M.

Stellenbosch University https://scholar.sun.ac.za

Norling, J. (2015) *Family Planning and Fertility in South Africa Under Apartheid*. University of Michigan.

Norris, A. *et al.* (2011) 'Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences', *Women's Health Issues*, 21(3), pp. S49–S54. doi: 10.1016/j.whi.2011.02.010.

Orner, P. J. *et al.* (2011) 'Access to safe abortion: Building choices for women living with HIV and AIDS', *Journal of the International AIDS Society*. BioMed Central Ltd, 14(1), p. 54. doi: 10.1186/1758-2652-14-54.

Patel, C. J. and Johns, L. (2009) 'Gender role attitudes and attitudes to abortion: Are there gender differences?', *Social Science Journal*, 46(3), pp. 493–505. doi: 10.1016/j.soscij.2009.02.006.

Patel, C. J. and Kooverjee, T. (2009) 'Abortion and contraception: Attitudes of South African university students', *Health Care for Women International*, 30(6), pp. 550–568. doi: 10.1080/07399330902886105.

Pilane, P. (2017) 'Loophole could protect South African organisations from US gag rule on abortions', *Bhekisisa*, 16 November. Available at: https://bhekisisa.org/article/2017-11-16-00-loophole-could-protect-south-african-organisations-from-us-gag-rule-on-abortions.

Pilane, P. (2018) *Forced abortions: A new frontier in the war on women's bodies?*, *Bhekisisa*. Available at: http://bhekisisa.org/article/2018-01-18-00-forced-abortions-a-new-frontier-in-the-war-on-womens-bodies (Accessed: 20 January 2018).

Pradhan, R. (2016) 'How Mike Pence embraced Obamacare', *Politico*, 15 July. Available at: https://www.politico.com/story/2016/07/mike-pence-obamacare-225590.

Quinn, D. M. and Chaudoir, S. R. (2009) 'Living With a Concealable Stigmatized Identity: The Impact of Anticipated Stigma, Centrality, Salience, and Cultural Stigma on Psychological Distress and Health', *Journal of Personality and Social Psychology*, 97(4), pp. 634–651. doi: 10.1037/a0015815.

Stellenbosch University https://scholar.sun.ac.za

Redden, M. (2017) '"Global gag rule" reinstated by Trump, curbing NGO abortion services abroad', *The Guardian*, 23 January. Available at: https://www.theguardian.com/world/2017/jan/23/trump-abortion-gag-rule-international-ngo-funding.

Redfield, P. (2013) *Life in Crisis: The Ethical Journey of Doctors Without Borders*. Berkeley and Los Angeles, California: Univerisity of California Press.

Republic of South Africa (2008) 'Constitution of the Republic of South Africa, 1996 15th Amendment Act of 2008', 243(December 1996), pp. 1–216.

Republic of South Africa National Department of Health (2014) *Uniform Patient Fee Schedule 2014*. Cape Town.

Robinson GE, Stotland NL, Russo NF, Lang JA, O. M. (2009) 'Is there an "abortion trauma syndrome"? Critiquing the evidence.', *Harvard Review of Psychiatry*, 4(17), p. 268–90.

Russell Bernard, H. (2006) *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. fourth. London: AltaMira Press.

Russo, N. F. (1976) 'The motherhood mandate', *Journal of Social Issues,* 3(32), p. 143–153. Available at: http://dx.doi.org/10.1111/j.1540-4560.1976.tb02603.x.

Sanger, M. (1917) *Family Limitation*. New York: The Project Gutenberg ebook.

Scambler, G. (2004) 'Re-framing Stigma: Felt and Enacted Stigma and Challenges to the Sociology of Chronic and Disabling Conditions', *Social Theory & Health*, 1(2), pp. 29–46.

Scott, J. C. (1985) *Weapons of the Weak: Everyday Forms of Peasant Resistance*. 1st edn. New Haven, Connecticut: Yale University Press.

Sedgh, G. *et al.* (2012) 'Induced abortion: incidence and trends worldwide from 1995 to 2008', *Lancet*, 379(9816), pp. 625–632.

Skosana, I. (2017) '"It didn't take long for [the fetus] to come out. There was a human-like form."', *Bhekisisa*, 17 February.

Stellenbosch University https://scholar.sun.ac.za

Spillar, K. *et al.* (2017) *2016 National Clinic Violence Survey*. California. Available at: http://feminist.org/anti-abortion-violence/images/2016-national-clinic-violence-survey.pdf.

Spivak, G. C. (1988) ‘Can the Subaltern Speak?’, in Williams, P. and Chrisman, L. (eds) *Colonial Discourse and Post Colonial Theory*. New York: Columbia University Press.

Squires, C. R. (2002) ‘Rethinking the Black Public Sphere: An Alternative Vocabulary for Multiple Public Spheres’, *International Communication Association*. Washington, 4(12), pp. 446–468.

Starrs, A. M. (2017) ‘The Trump global gag rule: an attack on US family planning and global health aid’, *The Lancet*. Elsevier Ltd, 389(10068), pp. 485–486. doi: 10.1016/S0140-6736(17)30270-2.

Stempel, J. (2018) ‘U.S. appeals court blocks Indiana “selective” abortion law’, *Reuters*, 20 April. Available at: https://www.reuters.com/article/us-usa-abortion-indiana/u-s-appeals-court-blocks-indiana-selective-abortion-law-idUSKBN1HR01R.

Stopes, M. C. (1919) *Married Love: A New Contribution to the Solution of Sex Difficulties*. 6th edn. London: Pelican Press.

Stuart, H. (2011) ‘Editorial The Need for Stigma Research and Action’, 1(1), pp. 1–2. doi: 10.1017/CBO978.

Stuenkel, D. L. and Wong, V. K. (2013) ‘Stigma’, in Lubkin, I. M. and Larsen, P. D. (eds) *Chronic Illness: Impact and Intervention*. Jones and Bartlett Publishers, pp. 43–65.

The Editorial Board (2018) ‘An Ohio Bill Would Ban All Abortions. It’s Part of a Bigger Plan.’, *NY TImes*, 25 March. Available at: https://www.nytimes.com/2018/03/25/opinion/ohio-abortion-ban-bill.html.

The Supreme Court of the United States (1992) *Planned Parenthood of SE Pennsylvania v. Casey 505 U.S. 833*. Available at: http://www.apa.org/about/offices/ogc/amicus/planned-parenthood.pdf.

Stellenbosch University https://scholar.sun.ac.za

Trahan, A. (2017) 'Public Attitudes Toward Legal Abortion , Euthanasia , Suicide , and Capital Punishment : Partial Evidence of a Consistent Life Ethic', 42(1), pp. 26–41. doi: 10.1177/0734016816682567.

Turner, V. *et al.* (1986) *Experience and its Expressions*. 1st edn, *The Anthropology of Experience*. 1st edn. Edited by E. M. Bruner and V. W. Turner. University of Illinois Press. doi: 10.1017/CBO9781107415324.004.

Vera, Y. (1998) *Butterfly Burning*. New York City: Farrar, Straus and Giroux.

De Walt, K. M. and De Walt, B. R. (2010) *Participant Observation: A Guide for Fieldworkers*. 2nd edn. Maryland: AltaMira Press.

De Walt, K. M. and De Walt, B. R. (2011) *Participant Observation: A Guide for Fieldworkers*. 2nd edn. Maryland: AltaMira Press.

Warner, M. (2002) 'Publics and Counterpublics', *Quarterly Journal of Speech*, 88(4), pp. 413–425.

Weidner, G. and Griffitt, W. (1984) 'Abortion as a stigma: In the eyes of the beholder', *Journal of Research in Personality*, 18(3), pp. 359–371.

Western Cape Government (2014) *Western Cape Government Hospital Tariffs: An Overview 2014*.

Wheeler, S. B. *et al.* (2012) 'Attitudes and intentions regarding abortion provision among medical school students in South Africa', *International Perspectives on Sexual and Reproductive Health*, 38(3), pp. 154–163. doi: 10.1363/3815412.

Williams, R. (1977) '15_Williams-Structures_0.Pdf', in *Marxism and Literature*. New York: Oxford University Press, pp. 129–217.

World Health Organisation (2008) 'Information sheet Safe and unsafe induced abortion Global and regional levels in 2008 , and trends during 1995 – 2008 Information sheet', *Information Sheet*, pp. 1–8. doi: WHO/RHR/12.02.

van Wyk, I. (2014) 'The Ethics of Dislike in the Field', in Posel, D. and Ross, F. (eds) *Ethical Quandaries in Social Research*. HSRC Press, pp. 198–213.

Stellenbosch University https://scholar.sun.ac.za

Xaba, M. and Rispel, L. (2013) ‘Ensuring women’s right to choose: Exploring nurses’ role in the Choice on Termination of Pregnancy Act’, *Agenda*, 27(4), pp. 69–78. doi: 10.1080/10130950.2013.867626.