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Policy and practice of abortion care in eastern Uganda

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Abstract

Although unsafe abortion is recognised as a global health concern, the quality of abortion care services remains low, services are inaccessible, and comprehensive abortion care responses remain deprioritised among national priorities for maternal and reproductive health improvement. Investigation into abortion care policy and practice is often clothed in normative binary categorisations of medical practices and abortion care technologies: into safe and unsafe, permitted and prohibited care practices, immoral and moral conducts. These are defined by health care institutional policies, the state law on abortion, and normative claims of reproductive justice. In all these narratives, the mechanisms through which obstetric violence and reproductive injustice emerge and are reproduced elude investigation. This doctoral project takes the debate away from normative analysis to the embodied, constitutive and performative effects of power in the articulation of abortion care policy and in the practice of the delivery of care. The investigation of practices is nested within and contingent upon the neoliberal ideology of reproductive consumerism, biomedical constructions of risky women's reproductive bodies, and the normative claims that seek to produce birthing women's bodies. Using critical ethnographic methodology, I explored the narratives of different stakeholders surrounding the formation and orientation of abortion policy in Uganda, examined the ways in which medical technologies influence abortion care practice, explored the influence of power operations on quality of abortion care delivery, and analysed the effects of the enforcement of the law on abortion on reproductive justice. I observed three national conferences on RMNCAH matters, and in two regional quality of care improvement meetings in Eastern Uganda, between August 2018 and March 2019. I also conducted 47 in-depth interviews with an array of stakeholders. Drawing on the concepts of biopower, biopolitics, governmentality and counter-governance, all data were analysed to uncover the mechanisms by which power shaped the practices and outcomes of policy-making and abortion care delivery practices.

My study findings show that policy and abortion practices are sites in which power is enacted, reproduced, resisted and transformed. Forces of governmentality are imposed, contested, and appropriated by participants while at the same time, participants mobilise counter conducts through surreptitious practices which weaken the ability of the state to regulate care practice. Counter

conducts also increase obstetric risks. Although restrictive power induces conducts of self-regulation because of fear of apprehension, restrictions in practice are negotiated and appropriated in ways that allow evasion of state surveillance, in pursuit of pecuniary motives. The risks that occur within care practices are not inherent in medical technologies but emerge from an assemblage of things, including the processes of panic. The contexts of fear and panic also induce maladaptive post abortion emergency care, which further exacerbate the risks and contribute to obstetric violence and death. In such instances, health workers deploy tactics of silencing what happened during and post abortion care.

During policy priority setting, the organising effect of neoliberalism control take place through an epistemic language that emphasises investment in high-impact interventions and rewarding results-based financing; the ordering of keynote addresses, and determination of participants in the conference, all combined to efface abortion care discourses from the national agenda. Articulation of reproductive health priorities was further framed in the normative expectations of women as birthing bodies, and reproductive health needs were identified along the continuum of birth. This in effect effaced the reproductive health discourses of induced abortion care, since it fell outside the normative and dominant interests in policy making. During discursive practice, the fear of being detected, ostracised and stigmatised all made advocates for reproductive health rights turn to silence. Silence as a strategy undermined the possibility of bringing abortion care issues on the national agenda. In implementing the law on abortion in Uganda, my findings indicate that this results in victimless crime, since both the health worker and the woman who aborts act against and are implicated. However, the law enforcement practice stigmatises health workers and women in communities. To secure their freedom from the retributive justice, health workers had to compensate the families. In reproductive interventions, emphasis on women's bodies as centres of risks conceal the violent relationships and unsupportive family ties that underpin unwanted pregnancy, which result in the need for induced abortion. These interventions normalise the idea of abortion as a woman's problem, and ignore the intimate partner relationships, family and communities from which her identity is indivisible.

I contribute to the theorisation of risk and safety in healthcare practice by showing that risk emerges from processes of panic triggered by fear of apprehension; I show how this produces maladaptive emergency handling. I argue that risk and safety are reconstructed in the process of

selecting and using particular medical technologies, with time-saving technologies used to reduce the risk of apprehension and ensure effectiveness in procuring a termination regardless of age of gestation. Risk and safety are emergent outcomes, rather than objective conditions inherent in particular medical technologies or institutionalised care. I also generate the concept of reproductive materialism as an analytical tool to examine how the interface of bioeconomic rationality and reproductive technology in unregulated care practice introduces reproductive risks, turns women into material objects and care practices as instruments for the pursuit of pecuniary motives. I argue that these strip care practice of its ethic and women of their dignity, and relate institutional practices to gains. I conclude that binary theorisation, which privileges structure over agency and hegemony over dialectics, fails to recognise the transient mechanisms of reproducing obstetric violence and reproductive health injustice. Based on the findings from this research, reproductive health matters are complex assemblages, with embodied productive and performative meanings and power, which cannot be reduced to either structure or agency, dialectics or hegemony. I argue that coming to terms with this complexity requires theories and methods to investigate the performative, embodied and productive effects of normalised reproductive health interventions, structures, practices and epistemes. In this quest for new knowledge, non-traditional realities such as language, silences, communicative materials, and routine practices will have to be recognised and brought into display.