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POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

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A Thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Doctor of Philosophy (Public Health).

11 May, 2021

Declaration

I, Alexander Kagaha, declare that this thesis is my own, unaided work. It is being submitted for the Degree of Doctor of Philosophy (Public Health) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



(Signature of candidate)

11th day of_May 2021

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.

Dedication

I dedicate this work to my Dad, Paul Isiko and Mum, Edith Isiko.

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This thesis begun from a messy point of abstraction and grew into realistic and researchable ideas, through the invaluable platforms offered by CARTA and my supervisor. Professor Lenore Manderson received this concept with interest and positively criticised and nurtured my ability to critique. I benefited enormously from Lenore's expertise in reproductive health and anthropological lenses. Her critical eye and love for details allowed me to master how to track the microphysics of power in practices, and to locate the pathways through which macro forces shape local responses. Professor Manderson supported me to secure additional funding for both research and academic writing retreat. To her, my thanks are beyond measure and I will forever be indebted to her. I also in a special way express my gratitude to the assessors, Professor Deevia Bhana and Professor Susan Goldstein, for their invaluable time and input into this study during my interim seminar. Your effort is highly appreciated and this thesis would have been less without your comments.

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List of Acronyms/Abbreviations

AC	Abortion Care
ANC	Antenatal Care
CBC	Complete Blood Count
CDA	Critical Discourse Analysis
CEHURD	Centre for Health, Huamn Rights and Development
CID	Criminal Investigation Department
CME	Continuous Medical Education
D&C	Dilation and Curettage
DFID	United Kingdom's Department for International Development
FBO	Faith-Based Organisation
FP	Family Planning
GFF	Global Financing Facility
GoU	Government of Uganda
HB	Haemoglobin
HRAPF	Human Rights Awareness and Promotion Forum
IDI	In-Depth Interview
IUD	Intrauterine Device
MA	Medical Abortion

MAKSS REC	Makerere University School of Social Sciences Research Ethics Committee
MCH	Maternal and Child Health
MoH	Ministry of Health
MPDSR	Maternal Perinatal Death Surveillance and Response
MPoA	Maputo Plan of Action
MVA	Manual Vacuum Aspirator
NGO	Non-Government Organisation
NORAD	Norwegian Agency for Development Cooperation
PAC	Post Abortion Care
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Maternal to Child Transmission of HIV/AIDS
QoC	Quality of Care
RBF	Results-Based Financing
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescents Health
SIDA	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
UBOS	Uganda Bureau of Statistics
UHC	Universal Healthcare Coverage
UNCST	Uganda National Council of Science and Technology

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
V-CAT	Value Clarification and Training
WHO	World Health Organization

Operational Definition of Key Concepts

Abortion Care	This is used to refer to services of pre-abortion counselling, safe abortion, post-abortion care, and post abortion family planning information and counselling.
Biopolitics	This term is used, in this thesis, to refer to a set of procedures, strategies and instruments that are used to control, regulate and model subjects' biological features (obstetric system functioning) into a population that is desired by the state. The term embodies logics or ways of knowing/thinking and acting that set the limits of imaginable or possible conducts.
Biopower	This refers to the conjunction of strategies adopted by the state and non-state institutions, for the efficient government of the life processes of women's population, and the use of their biological features of sex, birth and reproduction, as tools to discipline an individual woman's reproductive conducts.Counter governance This refers to the mechanisms through which health workers and participants in policy making practice oppose, contest and suppress the effect of the logics and practices which are designed to govern and direct their conducts.
Epistemic governance	This refers to the art of using knowledge production and communication to shape the construction and problematisation of policy issues, and to control and direct the discursive relationships in which priority setting occurs towards the desired interests of institutions and states.
Governmentality	The term is used to refer to the productive and creative ways, logics and techniques that are used to organise, and direct the

	conduct of individual and population behaviours, towards the desired interests of the governing institutions and states.
Normalisation	This refers to the process in which power and knowledge are fused together and used to establish the truth, organise everyday life based on normative expectations, and ensure individual's submission to the collective norms
Neoliberalism	Refers in this thesis to a distinct form of reason or rationality that organises everyday life, and shapes or governs the conduct of ones' self towards others in the image of economics.
Obstetric Violence	The appropriation of women's body and reproductive processes by health personnel, which is expressed by dehumanising treatment, an abuse of medicalisation, and the pathologisation of natural processes. This results in the loss of autonomy and ability of women to decide freely about their bodies and sexuality, negatively impacting their quality of life. Reproductive materialism This refers to the ways by which neoliberal institutions and institutional practices construct and relate to women's reproductive bodies, health issues, and conditions of vulnerability as a means for pursuing entrepreneurial motives.
Silencing	This term is used to refer to technologies of resistance by which health workers suppress the surveillance power of the state, enabling them to stay unnoticed in the healthcare system as they work in the context of restrictive law, morality and health care policy.

CHAPTER ONE

INTRODUCTION

Maternal deaths resulting from unsafe abortion care practice have become a global crisis, not only because of the magnitude of deaths but also because of the convergence of global business interests and reproductive health governance in healthcare delivery. Responding to reproductive healthcare concerns have proven ineffective in the face of unsafe abortion (Say et al., 2014; USAID, 2018). Universal healthcare coverage as a global norm informing technically sound, standardised policy responses withers in the face of the evidence of obstetric violence associated with unsafe abortion care practice within the healthcare system. This thesis is an attempt to deepen knowledge about this crisis and the social reproduction of obstetric violence among women with abortion care needs in Uganda's restrictive setting.

Using a critical ethnographic approach, I interrogate and analyse normalised metanarratives and national maternal healthcare priority setting conferences to uncover the hidden interests and illuminate the mechanisms of domination and the technologies of governance. I also explore normalised abortion care practice to uncover how health workers navigate the restrictive policy and law on abortion to deliver healthcare outcomes. Nested within critical social theory and with guidance from post-structuralism, my central concern for this analysis is the role of power in organising practices and its performative effect. I draw on Foucauldian concepts of governmentality to understand how neoliberalism and the Ugandan state, through policy, control and regulate women's sexual and reproductive health. In so doing, I employ the concept of counter-governance to illuminate how participants in policy making and abortion care practice counter and/or appropriate the restrictions on abortion and the neoliberal infrastructure of incentives.

In this thesis, I illustrate that global institutions, through their epistemic rationalities, control the organisation and direct the identification of national maternal healthcare priorities towards high-impact interventions. This is achieved through: (i) The production of compliant participants through an infrastructure of incentives for self-interest as entrepreneurial actors, and (ii) Epistemic rationalities that silence interventions with no quantifiable evidence-base. The political technologies are used to secure and deepen the role of the private sector in delivering maternal healthcare, while

they also mystify pressing local institutional reforms needed to respond to women's unmet abortion care needs. Universal and normalising metanarratives of maternity, maternal healthcare, and motherhood collude with state controls to suppress opportunities for articulating structural and institutional conditions that precondition risky abortion care practice and offset obstetric violence against women. Therefore, national biopolitics and neoliberal governmentality render participation in policy-making a means to legitimise global interests in local policy-making processes. I illuminate the highly subtle mechanisms through which this is achieved.

Secondly, I argue that the rationalities of health workers involved in abortion care transform care practice into a means for pecuniary pursuit. Care practice is interpreted in terms of the monetary goals that heath workers seek to achieve. Privatised healthcare delivery in restrictive contexts is difficult to monitor and regulate, enabling health workers to turn into entrepreneurial actors who make care practice instruments for financial gain. Standards and guidelines normalise discrimination against women with induced care concerns, and mask and conceal risks associated with surreptitious abortion care in restrictive contexts where there are no effective mechanisms to monitor adherence.

Finally, I argue that neoliberal ideology creates a dialectic in rationalities for care delivery. Health workers' reason is used to justify choice and applied outlawed technologies, and juridical and surreptitious practices in care become meaningful instruments to enable health workers to escape state surveillance, discipline, and punishment. Such practices are only condemned if there are undesired ends in relation to policy, legal and moral restrictions. Through silencing practices, health workers try to counter state governmentality in order to appropriate opportunities created by the deepening of business norms in care delivery. Therefore, rather than being an empathetic practice of care, abortion care delivery is increasingly an instrument. At the policy level, the system of valuing maternal healthcare responses renders marginal healthcare conditions unattractive for national responses. Participants are made to focus on what yields measurable impact, ignoring systemic interventions. The performative and productive effects of power will likely continue producing obstetric violence to women with unmet abortion care needs.

To address obstetric violence, a critical consciousness is needed to enable the construction of new ways of participation that disrupt performative effects of neoliberalism and state governance in policy

making, and that intervene to prevent practices in healthcare that enact and reproduce obstetric violence against women needing abortion care.

Background to the Study

Why do young women in developing countries continue to die of preventable conditions related to unsafe abortion? About 50 percent of abortions globally are unsafe, accounting for 13 percent of global maternal deaths (Dastgiri et al., 2017; Prada et al., 2016). About 62 percent of women who die from unsafe abortion are from Africa; at 18 percent East Africa has the highest level of unsafe abortion mortality (Ngwena, 2014). In Uganda, according to one health systems survey, cases of induced abortion increased by seven percent from 2003 to 2013 (Prada et al., 2016), and some 400,000 unsafe abortions are estimated to occur each year (CEHURD, 2015). Addressing the unmet abortion care needs of young women is critical to achieve universal healthcare coverage and reduce healthcare inequality.

While access to safe and quality care post-abortion can prevent maternal deaths, the delivery of the service is often poor. In Uganda, only 50 percent of women receive post abortion care and these services are not readily available (Mulumba et al., 2017; Renzaho et al., 2017). Half of the women with abortion care needs use unsafe methods, in unsafe places, with assistance from others with inadequate skills. Low quality and ineffective delivery of abortion and post abortion care are attributed to the negative attitudes of some health workers particularly towards young women assumed or known to have sought an abortion (Guttmacher, 2013; Jonas etal, 2017; Rukundo et al., 2015). Women suspected of having sought an illegal abortion are routinely humiliated and harassed by health workers (Rogers & Dantas, 2017; Suh, 2018).

To address unmet abortion care needs, global and local interventions focus on the promotion of institutionalised or health facility-based abortion care delivery and the use of standardised tools and guidelines for abortion care delivery (Tunçalp et al., 2016). Medical technologies for abortion care delivery have been classified into ‘safe’ and ‘unsafe’ categories. Midwives and nurses have been integrated to deliver care (Ganatra et al., 2017; WHO, 2015a), using ‘safe’ medical technologies to scale up quality abortion care delivery. However, there is an increasing trend towards the use of medical technologies considered ‘unsafe’, while ‘safe’ medical technologies have failed to guarantee

quality outcomes (Bechem et al., 2016; Benson et al., 2017). There is therefore clear evidence that standardised interventions, the categorisation of technologies, and the integration of midwives and nurses, do not always work effectively and appear to be insufficient to redress mortality associated with abortion.

Another debate centres on the dialectics between pro-life and pro-choice discourses as explanatory accounts of reproductive health justice. Pro-life discourses are often conceptualised as barriers to the effective delivery of abortion care, while the liberalisation of the law on abortion is seen as a means to promote abortion care as a health right (Berger et al., 2016; Freeman, 2017; Mishtal, 2018) and enhance access to abortion care services. However, even in liberalised legal regimes like South Africa and Columbia, backstreet abortion practices remain high and the quality of abortion care is often very poor (Blackie, 2014; Klugman, 2008; Roa & Klugman, 2014). There is no convincing evidence that the liberalisation of the law increases the delivery of and access to better quality abortion care services.

The most critical and influential debate that draws the attention of all concerned stakeholders in abortion care delivery centres on the role of policy-making in prioritising neglected maternal conditions and making healthcare systems responsive to unmet abortion care needs. This idea centres on the premise that participatory engagements empower participants to articulate fundamental concerns such as unmet abortion care needs (Smith & Shiffman, 2016). Yet experience in many developing countries does not lend credence to this premise, as many women continue to suffer from preventable conditions of abortion care which find no place on the national agenda for maternal healthcare responses. What explains the continued effacing of abortion care delivery from the national agenda for maternal healthcare responses in Uganda, where multiple stakeholders participate, including advocates of abortion care delivery as a health right? Participation is assumed to be a neutral process and maternal healthcare outcomes are assumed to be universally all-inclusive. However, policy-making occurs within and is contingent upon specific socio-cultural, political and neoliberal ideological values.

The above argument is further extended by another related premise on the role of network partnerships in identifying global maternal healthcare priorities and mobilising resources in response (Klugman, 2008; Smith & Shiffman, 2016). Partnerships such as the Reproductive, Maternal,

Neonatal, Child and Adolescents Health (RMNCAH) are assumed to be critical vehicles to promote equitable maternal healthcare services delivery. RMNCAH operates within the neoliberal global financing facility (GFF) whose norms and interests guide maternal healthcare investment in developing countries. National governments are often advised to focus on different interventions that yield 'high-impact' returns to investment, and global expertise, anchored on 'evidence-based knowledge', is used to identify interventions for 'results-based financing' (RBF) (Béhague & Storeng, 2013; Storeng & Béhague, 2016, 2017). This premise enjoys the privileged status of organising maternal healthcare responses, framing the construction of maternity, and identifying priorities. However, the continued occurrence of obstetric violence among women with abortion care needs puts into question the logics and intentions of this premise.

These debates are, however, often abstracted from the real circumstances of abortion care delivery and policy making practice. It is necessary to place these debates in local contexts in which abortion care delivery occurs and national maternal healthcare priorities are set. Unsafe abortions typically occur in the context of extreme poverty; Eastern Uganda, where this thesis is set, has the highest poverty density in the country, accounting for 35.7 percent of the poverty headcount in Uganda (UBOS, 2016). Income levels are low in the region: 45 percent of the population engages in subsistence farming, while others engage in fishing and small-scale retail trade. Many young girls engage locally in transactional sex, and some are brought to towns by older women who are no longer able to attract clients. Sexual abuse is high, and 13.2 percent of females in reproductive ages (15-49) experience sexual violence (UBOS, 2016). Under these conditions, how can the integration of health workers and categorisation of medical technology increase delivery and access to abortion care services?

Religion strongly influences sexual and reproductive health practices, including abortion and abortion care delivery (Larsson et al., 2015). About 45.1 percent of the population is Anglican, 39.3 percent Catholic, and 13.7 percent Muslim. These religions places high value on children and abortion is classified as an immoral and evil practice that terminates the life of innocent persons. Personhood is conceptualised as beginning from the moment of conception among Christians and ensoulment among Muslims (Al-Matary & Ali, 2014; Hessini, 2008). Among Catholics, the use of artificial methods of family planning is negatively sanctioned; others narrowly conceive of modern

contraception within family planning. At the same time, many young people are sexually active outside marital relationships, resulting in early child bearing age and teenage pregnancy.

Uganda has a very high unmet need for contraceptives, with only 39 percent contraception prevalence rate and a very high fertility rate of 5.4 births per woman (Uganda National Population Council, 2019). The sexual and reproductive health standards and guidelines only provide for the delivery of post abortion care, not comprehensive abortion care delivery. Attempts to develop a policy on abortion care are often contentious, resulting in its withdrawal due to disagreements from stakeholders, as occurred in 2016 (Cleeve et al., 2016). The 1995 Constitution prohibits any person from terminating the life of an unborn child, except in limited circumstances in which the practice is aimed at saving the life of a mother (Ngwena, 2014). Yet there is no law enacted to effect the operationalisation of the constitutional provision (CEHURD, 2015). Law enforcement therefore relies on the Penal Code, which criminalises any health worker who aids a woman to abort, except under medical conditions as may be provided under the law. In this thesis, I shed light on the possibility that the expanding categories of health workers involved in abortion care delivery increases the scope, scale and quality of abortion care delivery under such restrictions.

In the face of obstetric violence resulting from unsafe abortion, the debate needs to be reframed to capture the broader neoliberal ideological influences and the local biopolitics in which abortion care delivery and policy are embedded. My focus in this doctoral thesis is on the performative effect of neoliberal ideology, the moral and legal restrictions on policy-making, and abortion care delivery in Uganda. I am concerned with the neoliberal focus on high impact interventions, evidence-based knowledge, and normalised metanarratives on maternity that dominate maternal healthcare responses at national level. I am particularly concerned with how these relate to effacing the discourses of abortion care delivery from national maternal healthcare priorities, and reproducing risky and unsafe abortion care outcomes.

The Research Problem

As already noted above, Abortion Care (AC) delivery is of low quality and limited in scope and scale in Uganda and unsafe abortion is recognised as a major contributor to maternal deaths (Cleeve et al., 2017; Guttmacher, 2013a; Olson & Kamurari, 2017). However, there is inadequate knowledge about

both the policy and practice of AC, and little is known about why abortion care delivery is excluded from national maternal healthcare priorities. Participatory policy-making processes are assumed to be neutral, serving all-inclusive maternal health conditions. Restrictive law, morality, and neoliberal ideologies based on expertise knowledge, metanarratives of 'high impact' interventions, and 'evidence-based' measures are ignored for their role in silencing opportunities for abortion care prioritisation. Although participation is assumed to be empowering, stakeholders may represent differing interests, power and status. Equally, moral and legal restrictions may prevent actors from articulating abortion care discourses. However, the mechanisms through which stakeholders assert, enact and reproduce power, negotiate interests, or resist domination have not been examined.

Both the organisation of care practice and the context of AC should be explored to uncover the foundations and drivers of low-quality abortion care. While care practice is hinged on policy implementation through local institutions and health facilities, little is known about how institutions shape AC practice, and enact and reproduce systems of control and discipline over health workers in a restrictive legal context. Health workers are assumed to be always compliant with the system guidelines that govern their conduct. Consequently, mechanisms and tactics of resistance applied in abortion care remain hidden. Yet attempts to regulate the quality of AC may be curtailed through surreptitious practices, and this may have consequences of risky healthcare outcomes. Studies conceive abortion care to be a product of individual health workers, isolated from the institutional context in which AC is located (Cleeve et al., 2017; Glenton et al., 2017). However, AC is inextricably linked to the processes, relationships, rules, and values regulating both the conduct of health workers and quality of healthcare. There is limited critical focus on the influence of neoliberal ideology, and of the biopolitical forces within which care practice is situated.

Drawing on a critical ethnographic approach, I illustrate how policy-making and abortion care delivery practices are performative effects of power, which operate in subtle ways to enact and reproduce forms of obstetric violence against women with abortion care needs. This investigation was informed by critical social theory and post-structural conceptions of care and policy-making practices. I have used concepts of power to illuminate how neoliberalism and biopolitics govern participants in policy-making practice and how, through a spectre of counter governance practices, health workers appropriate neoliberal opportunities and subvert the law to stay unnoticed.

Research Question

How does power operate in policy priority setting and abortion care practices in a restrictive context?

The overall purpose of this study was to investigate what happens in the practices of policy-making and abortion care delivery in Eastern Uganda, since power underpins policy making and care practice. The broader intention was to uncover operations of domination and tactics of resistance, and reveal hidden performances that underpin poor abortion care outcomes.

Study Objectives of the Study

1. To explore the narratives of different stakeholders surrounding the formation and orientation of abortion policy in Uganda
2. To examine the ways in which medical technologies influence abortion care practice
3. To explore the influence of power operations on quality of abortion care delivery, and
4. To analyse the efficacy of implementing the abortion law and adhering to quality of care standards for abortion care delivery.

Scope of the Study

This is a critical ethnographic inquiry into policy making and abortion care delivery practices in Eastern Uganda. Data were collected through multiple methods in multiple settings. I conducted ethnographic observations of national maternal healthcare priority setting conferences under the RMNCAH, and of regional quality of care improvement meetings at time of study organised by independent non-government organisations. In these observations I attended to the organisation of these practices, the discursive performances embedded therein, and how these linked to policy outcomes. Using this critical approach, I focused on how the neoliberal construction of maternity, business norms, and technical expertise contributed to effacing abortion care discourses from national priorities. I also focused on how neoliberal ideologies and national biopolitics governed participants to produce the desired policy outcomes. For AC practice, I focused on what care delivery meant in

the restrictive context, and how health workers navigated the restrictive regime of law and policy that governed their conduct. In following this through, I examined the outcomes of abortion care practice. I focused on what was hidden and suppressed by normative morality and law, the categorisation of medical technologies for abortion care delivery, and the conditions that produced them.

Field work was conducted between August 2018 and May 2019 in Eastern Uganda. Power dynamics were explored within the context of the current law on abortion in Uganda and the policy that provides only for post abortion care delivery. I consider how neoliberal ideology deepens private sector interests in maternal healthcare delivery. The data generated through in-depth interviews were analysed not as individual capabilities but as embodied worldviews inscribed by different governments (the state, religious institutions, and global institutions).

Contributions Arising from the Thesis

My inquiry into abortion care in Uganda produced strong accounts of the technologies of domination and tactics of resistance. In this thesis, I illuminate how epistemic rationalities of neoliberalism organise policy-making practice, privileging the biomedical construction of maternity and understandings of quality of care while suppressing anthropological and sociological conceptions of the same. I also illuminate how, through both discursive and organising effects, neoliberalism creates an infrastructure to achieve the compliant conduct of participants in the maternal healthcare priority setting conference. In addition, I show how the system of values used to rank and prioritise maternal healthcare issues employs silent mechanisms, ignoring interventions that do not yield quantifiably measurable outcomes.

I offer a critical analysis of maladaptive practices in healthcare and evasive practices used to weaken state surveillance and regulation of care practice. I reveal highly subtle practices – such as juridical practices, surreptitious conduct, and the silencing of the dead following abortion or post abortion care – as tactics of resistance which health workers have adopted to avoid surveillance and the disciplinary effects of the state. This knowledge is necessary for the task of addressing obstetric violence by attending to practical aspects of healthcare practice. In addition, I illustrate how participants in policy-making are reconstituted into compliant individuals and are complicit in effacing marginal maternal healthcare issues like abortion care discourses from the national agenda. This consciousness lays a

foundation for emancipatory reforms in policy-making practices that can eventually address the obstetric injustice inherent in the healthcare system.

Through this study, I aim to contribute to the theorisation of risk and safety in healthcare practice. I show how risk emerges from processes of panic triggered by fear of apprehension, and how this produces maladaptive emergency handling. I also illuminate how 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 terms of ability to work on any pregnancy regardless of age of gestation. I therefore provide an understanding of risk and safety as emergent outcomes, rather than as objective conditions inherent in particular medical technologies or institutionalised care.

In addition, I contribute to methodological practice. Through reflexive practice, I contribute to understanding positionality in research as a discursive practice, in which power terrain shifts depending on the research participant. Drawing on my experience of interviewing high-level participants, I illustrate how research participants may seek to redirect a study towards known directions of interest and may challenge a researcher to shift the line of inquiry. I suggest the value of awareness of such challenges to transform research practice and increase the credibility of findings. In triangulating critical discourse analysis, ethnographic observations and in-depth interviews, I illuminate how deeper and richer knowledge can be generated by linking multiple contexts (neoliberalism, biopolitics and health facility situations) and practices.

While I am confident of the conclusions of this study, some areas may require further inquiry. In particular, the complex organisation of policy making practice and the performative agency of communicative materials in policy-making. Finally, in this study I focused on participants in policy-priority setting, law enforcement and abortion care delivery practices, whose perspectives are insufficiently investigated, but not on the women who sought abortion or post-abortion care. Integrating the voices of women who seek abortion care will allow for a holistic understanding of abortion care delivery practice.

Organisation of the Thesis

This thesis has eight chapters. In this first chapter, I offer background information about abortion care delivery, illuminating the magnitude of the problem and the core debates that shape interventions. In chapter two, I explore the theoretical and conceptual issues related to the policy and practice of abortion care and highlight the critical perspectives which this study illuminated. Chapter three, the literature review, summarises existing knowledge and gaps in the field of abortion care delivery and policy-making in Uganda, including the knowledge gaps which this study addressed. These three chapters provide the conceptual and theoretical foundation of the study, highlighting the neglected and under-researched dimensions, concepts and insufficiently convincing knowledge claims in the face of obstetric violence.

Chapter four, on methodology, offers the ontological foundations and epistemological implications of investigating performative practices of care and policy making. Based on these conceptions, I offer the rationale for research design, choice of methods and data collection techniques. I describe the study sites, how data were analysed, and how credibility of findings was guaranteed in the study. Finally, I reflect on the research practice and discuss the methodological challenges I experienced.

Following this, I present four chapters on results, prepared as manuscripts for publication. Chapter five is on policy-making practice, and in this I present the major discourses on abortion care and power contestation in policy making practice. I focus on the concept of governmentality and counter governance, and illuminate how neoliberal rationality and state technologies, specifically legal, moral and policy restrictions, govern the conduct of policy-making participants to appropriate and regulate women's sexual and reproductive bodies. In chapter six, I present findings on how abortion care practice varies across categories of healthcare facilities, revealing the different practices through which health workers navigate state restrictions and stay unnoticed in the healthcare system. I also discuss how the categorisation of medical technologies, criminalisation of abortion care delivery, discipline and control, and pecuniary interests, as is, enacts obstetric violence against women with abortion care needs. I conclude by challenging the objective construction of risk, and argue that this is an emergent outcome contingent upon the processes and application of medical technologies.

In chapter seven, I examine abortion care practice through a focus on quality of care. Here, I draw on the biopolitical concepts of governmentality and counter-governance as analytic tools to illustrate how health workers' choices, decisions and care practices are conditioned and contingent upon local morality, health policy guidelines, national law, and a financialised healthcare context. I argue that health workers' counter governance practice of silencing dead bodies post abortion constitutes, enacts and reproduces obstetric violence. I conclude by calling for reimagining quality of care in a framework of power, to rethink the law, policy and practice as constitutive elements.

Chapter eight turns to questions of abortion care, law and reproductive health justice. I present findings on the efficacy of implementing the abortion law in Uganda, revealing the limitations of using the law to advance reproductive health justice for women with abortion care needs. I also discuss how the law on abortion, founded on morality, embodies conditions and reproduces sexual and reproductive health injustices for women.

Chapter nine is an integrated narrative, which synthesises the findings from chapters 2-8. I discuss my theoretical contributions and the implication of the findings within the critical social ethnographic inquiry. I end with a summary of the findings and conclusions (chapter 10). Drawing on the findings from my research, I offer insights into what needs to be done to address obstetric violence among women with abortion care needs, and I offer directions to areas for future research.

CHAPTER TWO

LITERATURE REVIEW

In this chapter I review the existing literature on policy and practice of abortion care in Uganda and elsewhere. I consider the existing literature on the conception of care practice, medical technologies for abortion care delivery, quality of care, and policy making in the context of restrictive moral and legal contexts and neoliberal ideology. Across these themes, I focus on illuminating existing knowledge and identify gaps in research on the organisation, mechanisms and productive effects of power that operate through care and policy making practices. Summarising these gaps, I illustrate the conceptual framework of care and policy making practices and the methodological implications considered for this study. I begin with the context and drivers of unsafe abortion.

Context

Significant numbers of women are pregnant in Uganda while they are young. In 2016, 25 percent of women aged 15-19 years were reported as ever pregnant, one percent more than were pregnant in 2011 (UBOS, 2016). Most of these pregnancies occurred among young women from the lowest wealth quintile of the population. Pregnancy among young women is very risky for medical and physiological reasons, but the social costs of early pregnancy appear to be a particularly compelling reason for young women to seek abortion. As illustrated in an anthropological study in South Africa, many young women are saddened and fearful on learning that they are pregnant because they had not planned it (Mkhwanazi, 2014), and many keep their pregnancies secret for fear of anger from their parents. Other studies in the region have also reported on experiences of fear and regret (Atekyereza & Mubiru, 2014; Duff et al., 2017; Kaye, 2008; Krugu et al**.,** 2016). At the same time, a complex interaction of morality, legal restrictions and social and economic deprivations among many young women are underlying factors of unsafe abortion practice.

Most unplanned and unwanted pregnancies end in unsafe abortion, defined as “a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both" (Shah & Ahman, 2010: 1). Unsafe termination increases health risks (Watson et al., 2014), with the effects of unsafe practice felt directly on the female bodies. Many women experience incomplete abortion, heavy bleeding, uterine perforation,

and damage to the cervix, all of which compromise their health and reproductive futures (Melese et al., 2018; Mellerup et al., 2015). Most cases of abortion are undertaken clandestinely, either assisted or self-induced (Mandira et al., 2016; Aparna et al., 2009; Cleeve et al., 2017; Kabiru et al., 2016). Those who assist in procuring abortion (elderly women, sisters and friends, chemists, traditional birth attendants, teachers and boyfriends) lack the technical skills and operate in unsafe conditions. Reports of abortion are limited and therefore unreliable in restrictive contexts. Spontaneous and induced abortions, and safe induced and unsafe abortions, are fused in records to avoid the legal implications of procurement of abortion (Suh, 2018; Melese et al., 2018). Mortality rates may be underestimated because of this, making national aggregation of data difficult.

The Abortion Care Problem

Abortion care in this study includes pre-abortion counselling, safe abortion, post abortion care and family planning services. The delivery of abortion care is limited in scale and scope. In Uganda, only 50 percent of women who develop complications from unsafe abortion receive post abortion care (PAC) services (Mulumba et al., 2017). Another study in Uganda indicates that only 14 percent of health facilities that offered post abortion care delivered counselling services (Prada et al., 2016). A third study, focusing on the reproductive health needs of young people, revealed that Post Exposure Prophylaxis (PEP), abortion services, and counselling services were not readily accessed (Renzaho et al., 2017). Similar findings are reported for other countries. A systematic review of studies on abortion in low income countries indicated that everywhere, the provision of Sexual and Reproductive Health (SRH) information as part of PAC was overlooked, and was inconsistently conveyed by PAC providers, if at all (Rogers & Dantas, 2017). To save life, timely healthcare delivery and/or referral to appropriate care is critical (WHO, 2015b). Abortion care services are marred by moral judgements and stigmatisation. As noted above, in Uganda, health workers acted negatively towards young women assumed or known to have sought an abortion, resulting in the provision of poor quality PAC (Guttmacher, 2013; Jonas et.al, 2017; Rukundo et al., 2015). Similarly, in Senegal, women are routinely humiliated when they are assumed to have aided in procuring illegal abortion (Suh, 2018). Several studies have reported moral judgements and the impact of this in other African contexts (Amroussia et al., 2017; Beynon-Jones et al., 2017; Chiweshe & Macleod, 2017; Suh, 2018). Health workers who disapprove of adolescents' sexual activities may be reluctant to

provide PAC or other sexual and reproductive health services (Jonas et al., 2017). Overall, health workers have negative attitudes towards providing abortion care services, particularly where abortion is illegal (Izugbara et.al, 2017; Rogers & Dantas, 2017), and this compromises quality of care.

Stigmatisation in abortion care delivery has been inadequately theorised. Stigmatisation serves to discipline, control and punish health workers and women who defy moral and legal codes against the practice (Andaya & Mishtal, 2016; Eklund, 2017; HRAPF, 2016). Healthcare workers who delivery abortion care services may be stigmatised by their colleagues as well as the community but little attention is given to how this affects care delivery. It is often assumed that health workers merely comply with the forms of discipline, control and regulation brought against them by stigmatisation. Health workers, as conscious actors, retain the capacity to think, reason and act. In the neoliberal context where entrepreneurialism is integrated into healthcare delivery, a new structure of incentives shapes the motives for healthcare delivery (Larner, 2000). Presumptions that health workers are always compliant impede understanding how and why they deliver abortion care in a restrictive context. Understanding how they counter state control, disciplinary and punitive effects in restricted contexts of care may explain the occurrence of obstetric violence in healthcare practice, but may also explain great acts of kindness and support to women operating outside the boundaries of the law.

The organisational context is important in understanding abortion care practice. Studies often take a narrow focus on the moral judgements of health workers (Chiweshe & Macleod, 2017), ignoring normative, cultural and ideological inclinations. Such a focus obviates understanding the institutional linkages to care practice. Healthcare practice is also shaped by institutional arrangements, classified according to ownership: public or government owned health facilities, private but non-profit making facilities, and privately owned facilities oriented towards profit-making. Such categorisation may influence how health workers respond to patients with abortion care needs, and whether or not care services are delivered. Studies of other maternal healthcare services indicate that private and non-profit making health facilities are likely to offer better care than government owned facilities (Rogers & Dantas, 2017), and these services may be more likely to ignore the organisational processes, rules and conditions upon which quality of abortion care may be anchored.

Medical Technologies

Quality of care improvement largely focuses on the use of medical technologies, training and expanding categories of healthcare workers involved in abortion care delivery (Abdella et. al, 2013; WHO, 2015a). Recent studies indicate that health workers still lack adequate and comprehensive skills training on abortion care services (Cleeve et al, 2016; Izugbara et al., 2017). Some studies have focused on the role of medical technologies, with those classified as 'safe' reducing risks and producing better maternal health outcomes (Ansari & Abbas, 2017; Ara, et.al, 2018; Benson et.al, 2017;WHO, 2015a; Ganatra et al., 2017). Although gaps in resources and supply stock-outs undermine service delivery, not all health workers use modern medical technologies even when available, and they may ignore medical technologies which are categorised to be safe. For instance, in one study in Eastern Uganda, abortion care was not provided to the community even after the necessary resources, such as a Manual Vacuum Aspirator (MVA), were provided at hospitals and at district level health centres (Health Centre IV) (Kananura et al., 2017). The rationale for this practice was not revealed. In Zambia too, the safer option of MVA has been ignored in face of an increasing trend towards the use of Dilation and Curettage (D&C), although the latter results in uterine injury (Benson et al., 2015).

Medical technology is categorised either as inherently risky or inherently safe. This conception negates the possible influence of a morally and legally restrictive context on the practice of care, whereby the delivery of abortion care services is shaped by the fear of apprehension for violating state law and societal morals (CEHURD, 2016). How these contexts affect the use of medical technologies for abortion care delivery remains insufficiently understood. The categorisation of medical technologies is assumed to be neutral, free of embedded interests. Material objects such as medical technologies do not merely convey particular meaning, however; they embody specific interests and inscriptions of power (Pylypa, 1998; Schmied & Lupton, 2001). Their meanings arise out of their application rather than existing prior to care practice. Theoretically, the premise that riskiness and safety are objective conditions embedded in medical technologies fails to account for risky outcomes from the use of medical technologies categorised as safe. Risky outcomes such as perforations of the uterus occur even where safe technologies are used (Bechem et al., 2016; Dao et

al., 2007; Sayami, 2019). Conversely certain technologies categorised as risky may produce safe outcomes for women with abortion care needs.

A focus on objective meanings inhibits the exploration of other meanings which such technologies may present for health workers involved in abortion care delivery. The discursive meanings that emerge from the application of technologies are ignored, while theoretical exploration on risk and safety focus on the organisation of care practice (Cooke, 2009; Flin et al., 2006; Flin, 2007), but not what happens during abortion care. A shift from the objective conception of material technologies to the actual processes of technological application during care delivery could help to illuminate the conditions and processes through which risk is enacted and reproduced in healthcare practice. Medical technologies for abortion care exist in a network of other material components of care practice (Groves et al., 2011). These are silenced when technologies are abstracted and singled out for analytical scrutiny.

Quality of Abortion Care

Quality of Care is defined as "the extent to which healthcare services provided to individuals and patient populations improve desired health outcomes" (Barker et al., 2016: 14). Quality of care is largely linked to delay factors at individual, community and health facility levels (Gutschow, 2016; USAID, 2018). Other studies stress the gaps in health system capacity (Aantjes, Gilmoor, Syurina, & Crankshaw, 2018; Gabrysch et al., 2019), while emphasising patient engagement during care delivery in order to achieve better health, better care and affordable care (Almaze & Beer, 2017; Sharma & Grumbach, 2017) to promote social justice in care and prevent medical errors (Davis et al., 2011; Sharma & Grumbach, 2017). Overall, quality of care improvement focuses on managerial and clinical interventions and stresses the need to improve health workers' competencies (Benson, et al., 2017), strengthen health systems (Leatherman, et al., 2010; Tetui et al., 2012), and ensure the accountability of health workers. Yet despite these interventions, in Uganda, quality of care is very poor even at hospital facility level (Cleeve et al., 2017; Namazzi et al., 2015). Across different low income societies, increasing numbers of health facility-based maternal deaths are linked to poor quality of care services (Adanikin et al., 2019; Barker et al., 2016; Izugbara et al., 2015).

The current conception of abortion care says very little about the care practice in which quality of outcomes is constituted and produced. Focusing on health workers' competencies and resources fails to explain how and why poor quality of care outcomes may result from the material assemblage that produces and constitutes care. Contexts and processes may affect quality of care, even when competencies and resources are availed. In addition, neoliberalism introduces an infrastructure of incentives which may shape the quality of care. Abortion care delivery may be shaped by both the need to appropriate neoliberal incentives and to evade the disciplinary state in a restrictive context.

Although the effect of law is recognised, the mechanisms through which law shapes the quality of care have been insufficiently investigated. However, studies in Uganda report the legal harassment of health workers in practices of abortion care. For example, a discourse analysis of Uganda's top print newspapers showed that health workers and women are victimised and are subject to arrest for procuring abortion (Larsson et al., 2015b). Like induced abortion, the provision of PAC sometimes leads to arrest as health workers and patients are charged with procuring abortion (Larsson et al., 2015;Mulumba et al., 2017). To avoid this, in neighbouring Kenya, health workers may obtain police or institutional approval before offering abortion care services (Izugbara et al., 2017). In Rwanda, health workers decline to offer care to woman with excessive bleeding because of the fear that the health facility would be closed for procuring abortion (Påfs et al., 2016).

The operational effects of the law on abortion care are least explored. Abortion care is imbued with restrictions, punishment and disciplinary consequences, for moral and legal reasons. Studies emphasise the need to liberalise the abortion law to create an enabling environment for abortion care delivery (Luedke & Logan, 2018; Kendal, 2017; Monte, 2015). This negates inquiry into tactics of manoeuvre used to navigate around legal restrictions and how this affects quality of care. Tactics of resistance and manoeuvre are present whenever restrictions occur (Egan, 2004; Romele et al., 2017). Yet the ways in which health workers resist the systems of control, and navigate forces of discipline and punishments, remain unexplored. Practices of resistance against and the navigation of restrictions could have adverse effects on the outcomes of abortion care, in much the same way that forces of domination may constrain and prohibit delivery of care. Examination of operations of power in abortion care may illuminate how and why obstetric violence emerges and is reproduced, and the conditions upon which this is contingent. Although concepts of biopower, discipline and punishment

have contributed to understanding institutionalised practices across different disciplines (Cummins, 2014; Martel, 2014; Tadros, 1998), these analytic tools are rarely applied in enquiries about quality of care and abortion care.

Meanings and interests embodied in abortion care delivery also remain insufficiently investigated. Institutionalised healthcare delivery is assumed to be always ethical, cognisant of the need and responsibility to care for another (Zembylas et.al, 2014). Discussion of what happens to ethics when abortion care is financialised yet legally restricted is ignored, yet there may be a contestation of whether to privilege the pursuit of individualised or collective goals (Horkheimer & Adorno, 2002). Complex interactions of ethics, the law, and market ideology complicate understandings of what care practice represents. Such meanings and representations could offer useful insights into why and how quality outcomes are shaped. Examining what abortion care delivery represents for health workers can help to illuminate the primary motivations for its delivery in a restrictive and financialised health system.

Policy Making Practice

Policy making is a critical tool for addressing systemic injustices. In Uganda, abortion care delivery is restricted to medically diagnosed conditions with potential risk to the life of a mother or the unborn child. Article 22(2) of the Constitution of the Republic of Uganda prohibits any person from terminating the life of an unborn child except as provided by law (GoU, 2006). Yet these circumstances are not explicitly stated, and no law exists to effect the operationalisation of the constitutional provision (CEHURD, 2015). Consequently, the penal code remains the basis for regulating abortion care. Section 143 of the code criminalises the unlawful supply of drugs or any other substance that can be used to procure an abortion (GoU, 2006). Equally, Section 141 criminalises attempts to procure an abortion. Legal restrictions disrupt family planning services, lower contraceptive use and result in unintended pregnancies, many leading women to seek unsafe abortion practices. Liberalisation of the law on abortion is assumed to be a means to counter unsupportive cultural norms and social attitudes.

Moral inscriptions may embody particular interests. Morality is conceptualised in an objective force that shapes and determines care delivery (Larsson et al., 2015; Verbeek, 2008; Weitz, 2010). This

has led to the neglect of the subtle ways in which it organises and orders policy making practice and regulates the discursive relationships involved. Society may retain the power to reconfigure policy priorities even when policy making takes on a participatory approach. Biopolitical studies indicate that moral structures may conceal certain realities in the process of illuminating others (Kotsila & Saravanan, 2017; Prajerova, 2018), and societal power may participate in suppressing any effort towards making a healthcare system responsive to the obstetric injustices experienced by women with abortion care needs. Binary concepts of 'immoral' and 'moral' need to be re-examined in terms of the ways in which they suppress or inhibit opportunities for prioritising abortion care delivery.

In addition, the ways in which moral restrictions affect policy formation remain inadequately understood. Some stakeholders disapprove of the liberalisation of abortion law and discourage policy allowing for abortion care on moral grounds, since abortion is regarded as evil (Moore et al., 2014; Al-Matary & Ali, 2014; Callaway, 2015). A qualitative study in Uganda showed that only half of the opinion leaders in local governments knew the law on abortion, and almost all were from Kampala, the capital city (Moore et al., 2014). Other scholars, however, argue for liberalisation of abortion law to create an enabling environment for abortion care delivery.

Policies serve as a means through which states govern specific populations. They reflect the interests of and the states' capacity to produce a population that serves its interest (Korkut & Eslen-Ziya, 2016). While both neoliberal institutions and the nation state have vested interest in maternal healthcare, little is known about how each governs the female population, via which technologies. Policy making is highly contentious. A comprehensive review of abortion in east Africa reports that contradictions among stakeholders in both Uganda and Kenya led to the withdrawal of the abortion care policy (Cleeve et.al, 2016). Multiple stakeholders (including religious bodies, the state, development agencies and non-government organisations) are involved, with differing interests, power and influence. Metanarratives about maternity, maternal healthcare, and motherhood are often used in discursive processes of policy making and may be implicated in effacing abortion care delivery from the national agenda.

Priority setting in maternal healthcare is shaped by global norms of 'universal health coverage' (UHC), 'quality of care' improvement, results-based financing (RBF), cost-effectiveness, and safe motherhood (Béhague & Storeng, 2013; Storeng & Be, 2016; Witter et al., 2017). It is organised

under global networks such as the current Reproductive Maternal, Neonatal, Child, and Adolescents Health network (Smith & Shiffman, 2016; Storeng et al., 2019). It is assumed that paying for performance results in improvements in provider performance (Meessen et al., 2011; Magrath & Nichter, 2012). This serves neoliberal interests in deepening the role of the private sector in delivering maternal healthcare services. Emphasising the benefits of performance-based payment focuses on measuring success indicators, ignoring the effect of entrepreneurship on quality of care. It privileges attention to individual level relationships involving patients, while ignoring the broader focus on health facility arrangements, situations and contexts within which care is delivered.

Decades of advocacy for safe motherhood, human rights and UHC have failed to reduce the number of maternal deaths associated with unmet abortion care needs. Even so, neoliberal expert knowledge has become normalised and remains unquestioned. Epistemic concepts such as universal health coverage, 'quality of care', Performance Financing or RBF, and cost-effectiveness may constitute and may be implied in the construction of priorities. Normalising narratives may embody forms of domination (Hope, 2016) and may justify social arrangements and reproduce dominant systems of governance (Alasuutari & Qadir, 2014a) that shape the appropriation of policy (Levinson et al., 2009; Walsh 2007). Epistemic concepts shape the construction of maternity, and determine what is prioritised and used to manage society, including holding recipient countries accountable to donors (Alasuutari & Qadir, 2014; Inda, 2005; Gul & Oren, 2017; Béhague & Storeng, 2013). Epistemes or ways of knowing may privilege dominant perspectives at the expense of others. Neoliberalism introduces a new system of values to assess everything in terms of economic benefits, and creates an infrastructure of incentives which shape the conduct of individuals, the population and states (Lorenzini, 2018). These have profound effects on policy choices and political consequences to address obstetric violence.

The performative effect of power in policy making practice also remains inadequately understood. Considerable attention has been paid to neoliberal effects in terms of the commodification of healthcare resulting from neoliberal ideological interest in deepening the private sector (Ferguson & Gupta, 2002; Parry, 2015). Forms of governance operate within policy-making processes (Thiel, 2019) in which individuals' subjectivities are constituted (Lorenzini, 2018; Paltrinieri, 2013; Alasuutari & Qadir, 2014; Pertti & Ali, 2014). Policy priorities emerge from local politics and may

be constrained or enabled by the wider regulatory and legislative framework. Neoliberal ideologies may also be countered by local national biopolitics, in which they have to be legitimated. Nation states may retain territorial power over neoliberal institutions and may use local norms and laws to counter the conduct of neoliberal institutions. Analysis of events, processes and discursive relations that characterise policy making practice could account for how policy makers negotiate, resist and are transformed by the macro forces of domination that underpin policy making. Such a perspective will also help to illuminate how wider societal forces of domination operate and allow for the exposition of technologies used by both the neoliberal state and the local state.

Neoliberal rationalities prioritise interventions that seek to advance individual freedom, negating the co-existing relationship between collective social welfare and individual wellbeing. Little investigation has been conducted on how such neoliberal rationalities affect the ability to address the local and collective condition that underpins unsafe abortion practices and obstetric violence in health facilities. Analysis of power operations may help to illuminate how states try to subvert attempts to address systemic injustices and, in the context of the focus of this thesis, obstetric violence. To illuminate what is hidden behind neoliberal rationalities of policy intervention, it is necessary to investigate the mechanisms in which knowledge construction and communication shape the framing and articulation of policy issues and influence the discursive relationships in which priorities are set. Such analysis is critical to illuminate how existing forms of neoliberal expertise and rationalities govern maternal healthcare priority setting, and so uncover how abortion care is rendered (in)visible, (in)calculable and (de)prioritised.

Summary of Gaps

The literature reviewed has illuminated both highlights and gaps relating to the policy and practice of abortion care. In terms of conceptualisation of practice, there are glaring consequences that come with the abstraction of care from the material assemblage, and conditions of contingency in which care is produced and evaluated for its quality. Gaps remain when policy making is reduced to the analysis of the evidence upon which decisions are determined. Both care and policy-making practices need to be conceptualised in a holistic way to offer a full account of the interlinkages, interdependence and contingencies. I have illuminated the narrow conception of neoliberal effect on policy making, which disguises its organising effect on society and policy making practice. Theoretically, I have

illuminated that normative and objective constructions of policy making and care practice silence the recognition of the performative effects and practices of resistance, negation and appropriations that actors may make. These gaps profoundly shape the conceptualisation and methodological design of this study, as I discuss below.

Conceptual Framework of Care and Policy-making Practices

Care Practice

As evidenced above, I have identified four major gaps: conceptual, theoretical, methodological and contextual gaps. The application of medical technologies in abortion care and the process of care, and how these may impact on outcomes, have largely been ignored. The isolation of care from the assemblage of things interdependently contributes and constitutes the care practice. Although care practice is nested within the broader institutional, social, political and ideological environment, studies on care have not investigated how care practices are linked to conditions of contingency. The conceptualisation of care and policy-making as normalised practices, conceals how power contestation, resistance, appropriation and self-governance occur. Even with a focus on domination, discipline and punishment, there has to date been little attempt to illuminate the mechanisms through which such power achieves its effect. Drawing from these gaps, my conceptual framework allows the illumination of care as an assemblage, as illustrated in Figure 1.

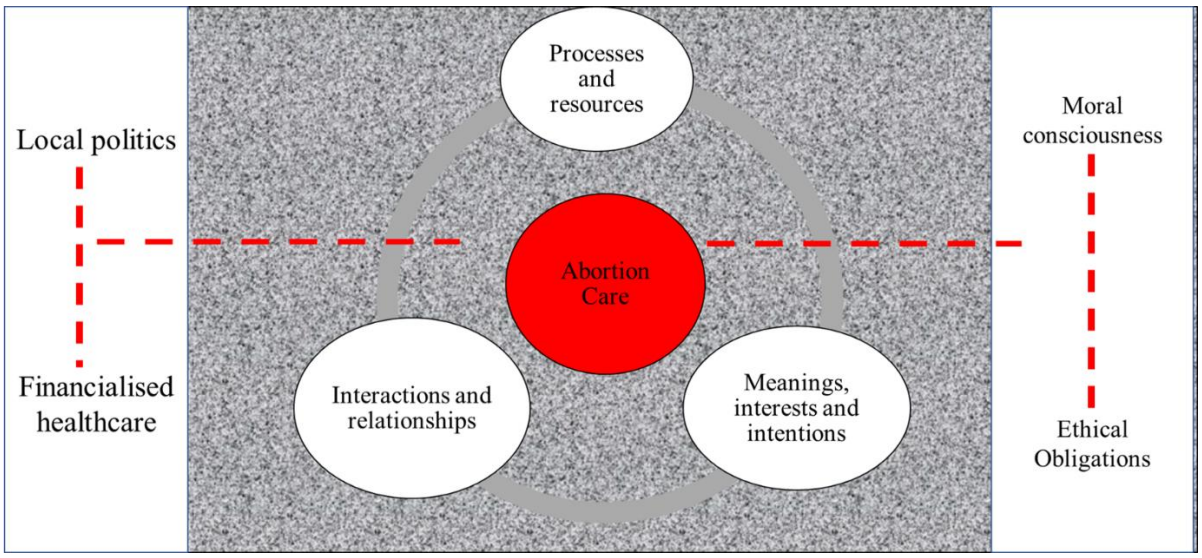

Figure 1: Conceptual structure of the abortion care

In Figure 1, abortion care is conceptualised as a practice comprising an assemblage of different components. These include health workers and their operations, abortion technologies and complementary materials like disinfectants, and health facility rules, law and its enforcement. My conceptual focus is not on an isolated unit, but rather on the system of things and their interconnections that result in obstetric violence for women with abortion care needs. While I retained the focus on meanings, individual health workers were conceptualised as having internalised structures of power which framed their construction of material objects and assigned meaning to abortion care.

Policy Making Practices

I have conceptualised policy-making practice as an enactment and contestation of power, through which nation states discipline, control and govern women's sexual and reproductive health behaviours. I have demonstrated the limited understanding of the effects of macro factors such as neoliberalism and biopolitical power on the organisational and the discursive relationships involved in setting maternal healthcare priorities. I have also illustrated how the current literature fails to illuminate the mechanisms through which biopolitical power and neoliberalism operates in policy-making practice, and how this may be linked to the social reproduction of obstetric violence. While retaining the conception of policy-making as an assemblage, I aim to investigate tensions and resistance involved in the complex practice, as illustrated in Figure 2.

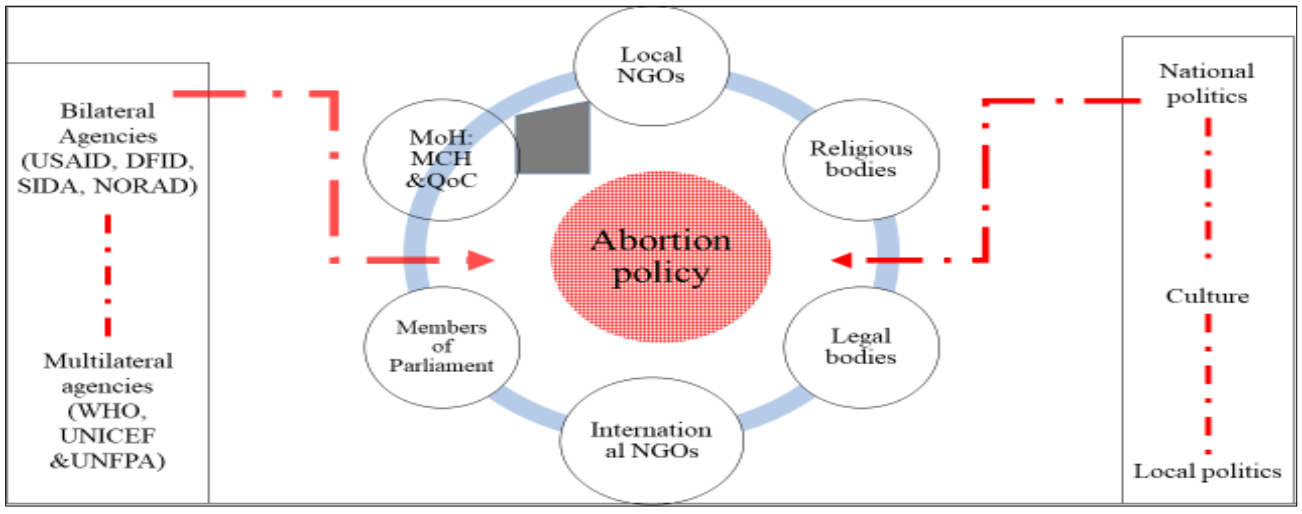

Figure 2: Conceptual structure of policy making practice

Material arrangements involved in spaces of policy making were examined to uncover the hidden interests of stakeholders, the strategies of domination used to silence competing discourses, the tactics of resistance, and contestation. Equally, neoliberal and moral narratives informing maternal healthcare policy-making, and epistemic knowledges, were examined for embodied inscriptions of domination. In so doing, I sought to uncover how the macrophysics of power enacted and reproduced women's vulnerability to poor abortion care outcomes.

Theoretically, I identified a clear gap in understanding the social reproduction of obstetric violence experienced by women with abortion care needs. In terms of care, I illustrated how risk is enacted and reproduced in abortion care. I also identified a conceptual gap, in the context of neoliberalism, of what abortion care delivery means and the performative effects of medical technologies. Such theoretical knowledge is critical to understand how obstetric violence is enacted and reproduced, and to explain why global interventions fail to result in better healthcare outcomes for women. To address this gap in this thesis, I use Foucauldian concepts of biopolitics, governmentality, and counter-governance to investigate what neoliberal epistemes and normalised metanarratives on maternity mean in relation to prioritising abortion care delivery.

Methodological Issues Central to this Research

The gaps identified above point to epistemological issues which ought to be addressed in relation to policy and practice of abortion care. Operations of power in policy and care practice are very fluid and mobile, eluding both interpretive and constructivist conceptions of reality. Traditional materials such as metanarratives, legal and policy texts emerge as important sites in which power occurs and is contested. Practice is situated in specific health facility sites and is contingent upon social, cultural and ideological conditions. Rather than focusing on concrete objects of care and policy-making, I focus on understanding practice in the assemblage of materials, rules, activities, skills, and linkages or processes, to capture the illusive realities of power operations.

Practice should be conceptualised as a means through which power operates. This helps to illuminate how health workers respond to, resist and/or disrupt the legal restrictions and medical rules. Likewise, medical technologies, care practice, law, morality, standards and guidelines were conceptualised as embodiments of particular interests of power. Normalised care practice and the categorisation of

medical technologies were conceptualised as sites of power contestation to uncover the hidden interests pursued by actors involved in policy and practice of abortion care. This helped to illuminate how such interests were masked, and how and why women's interests failed to be placed on the national agenda for maternal healthcare.

Knowledge is political and practices of knowledge production are never neutral (Goss et al., 2011; Henderson, 1994; Nairn, 2012). Rather than claiming objective knowledge and denying the presence of these interests, researchers need to firmly state their position. My commitment is to generate knowledge on policy and practice of abortion care to advance an emancipatory agenda to address obstetric violence. All discourses related to morality, law, practice, and abortion technologies were conceptualised as embodying interests of domination, stifling the freedom and wellbeing of women with abortion care needs while exploiting their vulnerability. I adopted a critical ethnographic approach to illuminate the ways in which power mechanisms account for obstetric violence against women with abortion care needs.

CHAPTER THREE

THEORETICAL FRAMEWORK

Under the fifth Sustainable Development Goal, the global community stresses its commitment to eliminate all forms of violence against women and girls (Binazzi, 2019; UNDP, 2019). Obstetric violence is one of the most neglected and silent forms of violence experienced by women. The failure to provide abortion care within and outside healthcare facilities is one aspect of this. In this chapter I examine the theoretical issues associated obstetric violence, illuminating the contributions and limitations in the context of abortion care in Uganda. I also illuminate how rethinking obstetric violence in macro politics enriches our explanatory, expository and emancipatory goals of theorising in maternal healthcare improvement. These are detailed below, starting with critical concerns in policy-making and care practice in the field.

Critical Concerns in Abortion Care Responses and Policy-Making Practice

Uganda witnesses a contradiction between the global commitment to universal healthcare coverage and the neoliberal influence to direct maternal healthcare investment to specifically high-impact interventions. This concern is illuminated and amplified by the continued deepening entrepreneurial spirit in care practice, and its convergence with the increased tendency towards low quality of care outcomes. Globally standardised guidelines to care practice, based on technically sound expert rationalities, fail to overcome local conditions that result in unsafe and risky abortions. The categorisation of medical technologies into ‘safe’ and ‘unsafe’, and expanding categories of health workers to deliver abortion care, have neither advanced the quality of care nor scaled up delivery of care practice (Bechem et al., 2016; Glenton, 2017; WHO, 2015a). Consequently, a crisis in healthcare has emerged.

Health workers are trapped between the ethical obligation to save a mother’s life and the duty to respect and abide by state moral and legal restrictions. Oftentimes, they navigate the restrictive moral and legal context to deliver abortion care to the poorest and most vulnerable young women. This has resulted in juridical practices in care delivery, which link to poor quality of care outcomes (Izugbara et al., 2015; Suh, 2019a). Consequently, obstetric violence against women with abortion care needs is systematically engrained in Uganda’s healthcare system, as is true for many other African societies

with restrictive legal and moral codes. Moreover, policy-making practice continues to efface the prioritisation of responses that ensure that the healthcare system is responsive to unmet abortion care needs. Yet policy-making is often seen as an avenue for transformation which could result in the public protection of vulnerable individuals. Uganda undertakes regular policy priority setting every four years, according to the Reproductive, Maternal, Neonatal, Child and Adolescents Health network, in which multiple stakeholders are involved. Although insufficiently applied, the strategic effects of power in institutionalised practices of care and policy making may offer useful insights into the social reproduction of obstetric violence.

Most theoretical explanations of obstetric violence hinge on the conscious practices of health workers that involve wilful violence in some cases intended to harm patients. In light of the context of abortion narrated above, three critical theoretical problems remain unanswered. How is obstetric violence produced? Under what conditions is obstetric violence reproduced and contingent? What performances do care practices and embedded obstetric violence represent in governing women's reproductive health behaviours? Answering these questions is critical to advancing the theoretical debate and stimulating transformational interventions to realise obstetric justice. In the following paragraphs, I critically examine the existing theoretical explanatory accounts, with the aim of illuminating the expository power and gaps in understanding the production, reproduction and performative effects of disruptive care practice. As I describe below, the production of obstetric violence is nested within the relational or interactive framework on one hand and the structural theory on another.

Interactive/Relational Framework

Using interactive theorisation, obstetric violence is conceived as an outcome of unequal power relationships between patients and healthcare workers. These hierarchies constrain the recognition and respect of women's agency, including the freedom to act, choose and freely express their feelings about care service. Obstetric violence is theorised as a conscious experience of women during labour and childbirth, and is often investigated from the lenses of birthing women (Borges, 2018; Barllet et al., 2014; Turkman 2019). It also attends to the discrete and self-conscious techniques that shape the interactive relationships of care (Mussawir & Parsley, 2017). Consequently, addressing obstetric injustices is oriented towards strengthening trust relationships in care practice and promoting

women's engagement (Turkman 2019; Barllet at al., 2014; Castro & Savage, 2019; Quattrocchi 2019). The premise of consciousness allows illumination of directly observed and recognisable injustices, such as verbal and physical abuses.

The premise of consciousness hides more than it illuminates. Reducing obstetric violence to consciousness obscures the recognition of and attention to forms of violence that individual women may suffer but of which they may be unaware (Shabot, 2020b). What goes on in healthcare practice is often based on biomedical expertise to which patients have limited knowledge. For example, women may not recognise recourse to caesarean section in private health facility settings as unnecessary, since they may not adequately perceive the medicalisation of birth as a form of violence (Sadler et al., 2016) . Invisible forms of violence built within biomedicine are often resisted by health workers since they conflict with professional ethos (Sadler et al., 2016). A woman's experience of obstetric violence is based on her interpretive lens inscribed by normative expectations of care practice (Bethlehem, 2016). Yet normative constructions and interpretive lenses are not captured under the relational framework.

The above theorisation abstracts obstetric violence from the contexts and circumstances that generate it. Obstetric violence does not occur in a vacuum and cannot be sufficiently attributed to individual health workers since it is mediated through meso and macro factors (Kavanagh, 2018). Health workers may find themselves in the dilemma of delivering abortion care as a professional ethical duty while trying to observe the moral and policy restrictions and the law on abortion and abortion care. Uteruses may be perforated and traumatised as health workers operate in a state of panic for fear of apprehension. Conscious of the legal consequences imposed by restrictions, a health worker's response to cases of obstetric trauma may further complicate healthcare outcomes, as they try to evade surveillance and the disciplinary state. Conditions of sepsis and excessive bleeding from both self-induced and assisted abortions may all indicate forms of obstetric violence, which traumatise the uterus but are unconsciously generated; their conditions of production are not captured by interactive theorisation. In the context of restrictions, the disciplinary consequences of reporting may not allow a woman to report injustices resulting from induced abortion. Obstetric violence is deeply embedded in relations of domination which govern and direct healthcare practice (Chadwick, 2017; Kavanagh, 2018; Marray, 2018; Bethlehem, 2016).

Conventional theorisation also ignores the role of government and counter governance conducts in enacting and reproducing obstetric violence. The concept of governmentality is important because several forms and levels of governance may be involved in producing obstetric violence. For example, local ideas, beliefs and norms about becoming a good mother shape how obstetric violence is reported and interpreted (Murray 2018). Normative values that define what it means to be a good patient, a good woman, and a good birthing body may all suppress critical thinking and the agency of individual women, and normalise obstetric injustices. Mode of discipline and punishment apply to health workers who offer abortion care services to women and so are considered to transgress collective norms and values. In Uganda, both patients and health workers risk apprehension due to abortion care delivery. Thus, obstetric injustices experienced in abortion care practices cannot be adequately explained without understanding the role of governmental procedures, logics and practices used to direct and regulate care practice.

Structural Foundations of Obstetric Violence

Structuralism perpetrates obstetric violence through the socialisation of men and women as objects of control and discipline for conducts deemed outside expected norms. Obstetric violence is built into the social fabric and this calls for attention to naturalised forms of violence that objectify, discipline and punish bodies in labour and birthing (Davis, 2019; Sadler et al., 2016). Since obstetric violence is an indicator of structural violence, its generative features can be traced to the institutional milieu which may be suboptimal to obstetric care (Lappeman & Swartz, 2019). Drawing on the implementation of laws against obstetric violence, structuralism focuses on micro level causes defined by the interaction of health facility conditions, which are humiliating and seek to discipline individual medical personnel and negate the institutions which they serve (Diaz-Tello, 2016). Obstetric violence may also stem from both the actions of individual medical professionals and structural healthcare issues which undermine the delivery of abortion care (Castro & Savage, 2019). This proposition allows illumination of how health workers participate in enacting and reproducing violent practices on women with abortion care needs, as a result of weaknesses in the healthcare system (Sadler et al., 2016).

Structural theorists often explain obstetric violence as a result of structural violence through normalising structures such as race, gender and poverty which condition women's submission to

subtle mechanisms of domination (Shabot & Korem, 2018; Shabot, 2020b, 2020a; Sadler et al., 2016; Sadler et al., 2016; Mihret, 2019; Perera et al., 2018; Davis, 2019). For example, poor and less educated women tend to report more experiences of obstetric violence than highly educated and high-income women (Mihret, 2019; Perera et al., 2018). Obstetric violence may be hidden in medicalised and normative values attached to good birthing bodies, being a good patient, and a good woman. Drawing on this premise, because of fear and shame, some women enact and perform some sort of docility as a strategy to avoid violence and obtain care (Chadwick, 2017). Obstetric violence, conceptualised from the perspective of women as victims, obscures understanding the conditions of its production, which health workers implicated in obstetric violence can expound. Unjust actions may be an emergent outcome of well-intentioned healthcare workers. Health workers are located at the intersections of class, race and gender and medical hierarchies, and thus operate from internalised positions within the power hierarchy (Chadwick, 2017). Structural accounts of why women are likely to be violated fail to account for why health workers are implicated. Health workers too attempt to defend the healthcare profession, asserting that there is no mistreatment in healthcare (Lappeman & Swartz, 2019), rather than acknowledging the complex dilemmas, contradictions and ambiguities in which they find themselves.

The second proposition relating to the production of obstetric violence hinges on the suppression of individual autonomy, agency and control of a woman over her body. Shabot (2020a) recognises that the neoliberal conception of the free and independent autonomous subject is a fantasy, since individuals are knotted together with others, who may construct and give meaning but also may destroy, suppress and objectify the individual. Collective identities nurture and perpetuate obstetric violence through shame-inducing myths about good motherhood (Shabot & Korem, 2018; Shabot, 2020b). This suppresses the possibility of resistance from women who suffer from shame. They are turned into objects, unable to experience their reproductive health as embodied, fulfilling experiences.

The turn from individual to normalising practice expands the explanatory account of the production of obstetric violence. However, this ignores the governing and controlling effect of power. As I have already argued, abortion care practice is highly sensitive, surrounded with and implicated in moral and legal restrictions which govern women's sexual and reproductive behaviour. Moral and legal

restrictions, together with neoliberal rationalities, direct the conduct of abortion care and policy making practice. Yet the mechanisms of influence remain insufficiently analysed in terms of their consequence to efface attempts to address obstetric injustices in maternal health. The government's policy to eliminate informal backstreet abortion by promoting formal healthcare facilities occurs within the biopolitics and neoliberal rationalities which govern and regulate care delivery and shape policy making practice and decisions. Similarly, the categorisation of medical technologies introduces a boundary in medical technologies classified as risky and as safe. Although categorisation serves a normative function, it may suppress the recognition of safe outcomes emerging from practices of care that are considered risky.

Categorical boundaries in care practices are fluid, but fluidity defies the easy classification that dominates in structural theorisation (Law, 2004; Law & Urry, 2005; Mol & Law, 2004). In accounting for obstetric violence, categorical concepts such as safety and risky, institutionalised care, metanarratives of maternity, and routine practices of care all need to be explored to unmask possible obstetric injustices. The policy boundary between permitted and prohibited abortion care introduces discrimination in abortion care services (Suh, 2018), and allows health workers to justify obstetric violence as a means of foetal protection (Diaz-Tello, 2016). This boundary, together with legal ambiguities, may be appropriated differently in a neoliberal context of deepened entrepreneurial spirit in care practice, based on specific health facility setting, internalised rationalities and the neoliberal structure of incentives for abortion care delivery. Although the effect of boundaries is explored, the tactics of resistance and ways of appropriating binary boundaries may also constitute, account for and complicate the problem of obstetric violence.

Comparison of relational and structural theorisation in the production of obstetric violence suggests that controlling and regulating power ensure that individual health workers are accountable for their conducts and responsive to women's obstetric needs. Control, discipline and punishment are embedded in moral and legal restrictions which seek to use women's obstetric or reproductive health to govern them. Such biopolitics together with neoliberal rationalities produce disciplinary, punitive and appropriative conduct among health workers and may result in practices of obstetric violence. The mechanisms of control and regulation also enact counter relational forces of resistance as power is ubiquitous, freely flowing in no definite direction (Deacon, 1998; Hope, 2016; Johnson, 2015;

Kelly, 2017), embedded in practices and normative structures such as language and technical knowledge, and contingent upon ideological, social, and political contexts (Deacon, 1998). Yet mechanisms of power may be invisible, and may strategically silence specific representations on abortion care while illuminating those which seek to perpetrate state interests.

The Problem of the Social Reproduction of Obstetric Violence

A neglected theoretical problem in obstetric violence studies is understanding the mechanisms of its social reproduction. Relational theorisation conceptualises obstetric injustice as a conscious objective condition and does not account for its mechanisms of reproduction. Structural theorisation follows the same objective in illuminating the hidden and unconscious structures that underpin obstetric violence. In both frameworks, the problem of the social reproduction of obstetric violence is not addressed. Yet obstetric violence continues to characterise care practices despite interventions designed to address structural and healthcare interactions. Many sociological and anthropological studies in healthcare address the problem of embodiment and power through the Foucauldian concepts of medical gaze, discipline and punishment, primarily from the accounts of patients (Fox, 2016; Reckwitz, 2002b). For instance, Reckwitz has argued for the exploration of practices as a system of interconnected components through:

> The embeddedness of the mental activities of understanding and knowing in a complex of doings, the analysis of the interconnectedness of bodily routines of behaviour, mental routines of understanding and knowing and the use of objects (2002b: 258).

My concern is that these are insufficient in illuminating the mechanisms of social reproduction in the context of interconnected systems of biopolitical and neoliberal governance. This concern relates to the power acted upon practice as an assemblage of things rather than on unitary actors and things, as the case is in interactionism and structuralism. Systems of knowing are fused with power (Lindsay, , 2013; Borch, 2005; Pylypa, 1998) and abstract concepts may stand in the way of gaining knowledge about the real world (Fox, 2016). Systems of knowing constitute the means through which authority can control and direct others, and all forms of knowledge underpin the claims of their proponents and are a means to their domination of others. In discourses on obstetric violence, the role of epistemic rationalities that guide policy decisions and everyday practices of care remain insufficiently examined

to assess their contribution to the reproduction of epistemic injustices. Epistemic rationalities may hide specific constructions of maternity and maternal healthcare conditions, and shape prioritisation toward constructed worldviews while hiding and silencing others (Alasuutari & Qadir, 2014a; Juntti, Russell, & Turnpenny, 2009; Russell, 2017).

The problem of social reproduction is examined from the relationships of the individual, society and practice. For instance, Butler (2009) asserts that the subject is not sovereign but is socially produced, with people's agency made possible through the language in which they are constructed, through power rather than its deterministic effects. The constitution of participants is presented as a mechanism through which social reproduction takes place. Such constitution occurs within specific areas of recognisability in which obstetric injustices may be rendered recognisable or not through epistemic rationalities. Equally, practices may produce subjects whose obstetric conditions are recognised and others whose are not.

Constitution occurs through practices, rationalities, and normative directives that sanction abortion care practice. Yet such constitutive mechanisms are often negated in the investigation of obstetric violence. This analysis invites us to attend to the political functions that are performed by disruptive practices in the political struggles for individual and collective obstetric justice. The constitution of subjects is variably accounted for in obstetric violence theories. According to Foucault, power operates with the strategic objective of enacting and reproducing the conduct of individuals and population (Allen, 2002; Foucault, 1977; Lemke, 2001). However, others propose that power enacts and reproduces the social through communicative and normative effects (Allen, 2002; Azeredo & Schraiber, 2017). Arendt's conceptions of power negate the strategic operations of power that seek to achieve specific outcomes (Allen, 2002). Foucauldian strategic effects represent the political or manipulative performances within organising and discursive arrangements in which both the normative and the political or organising effects of power are intimately connected. This is critical in the context of governmentality in which neoliberal rationalities and biopolitics organise the relationships and direct care and policy making practices.

Allen (2002) attempts to develop a third mechanism of social reproduction based on collectivism, and proposes that collective power acts as a resource for struggling individuals to resist constraining and disturbing power relations. She asserts that:

> One may well have to rely on communities of resistance and the collective power and normative resources that are generated in and through them in order to resist the normalising/disciplinary power about which he [sic] was so concerned (Allen, 2002: 144).

To illuminate this effect, Allen draws on operations of collective social movements that unify affected individuals into a single movement to challenge the status quo and drive transformation. Although these social movements may manifest out of resistance in which individuals are not stigmatised and ostracised, this context differs from the highly sensitive disruptive practices of abortion care. Collectivism also negates the possibility that such assemblies may be appropriated, organised and directed through highly subtle epistemic rationalities, through which actors may be made to self-regulate and constitute themselves as compliant subjects.

The Performative Role of Disruptive Conducts of Resistance in Care Practice

One of the least explored theoretical questions concerns the performative role of disruptive practices in the constitution of the social. Actions do not merely express the pre-exiting reality but also constitute the identity of the actor through the action itself (Allen, 2002). Participation in policy making on abortion care practice may disempower participants, and participants' responses may create new ways of obstetric oppression. Policy making is navigated through discourses which construct maternity and problematise maternal health conditions. Discourses have performative effects and are in constant flux, interdependent and inseparable from the constitutive factors of their existence (Talib & Fitzgerald, 2016). Discourses and discursive practices also produce particular elements of the social while excluding others, and embody ideological power formations which shape the representation of the social world (Greckhamer & Cilesiz, 2014). The examination of the performative effects of power may offer insights into the ways in which discursive practices condition injustices for women with abortion care needs.

Equally, participation in national policy making may legitimise the international agenda rather than merely address the conditions which underpin obstetric violence. Participation embodies the interests of the organisers of policy making practice. Participants may fail to recognise the nature of such interests and the ways their participation may legitimise dominant interests while suppressing their ability to articulate critical concerns preconditioning obstetric violence (Mumby & Stohl, 1991).

Performative effects operate through an assemblage of technical systems, communicative or discursive materials; local conditions need to be examined for their role in such performativity. Performativity can provide deeper understanding of the formation of obstetric violence in routine practices of resistance as well as normalised practices of policy making.

Theoretical Focus

My theoretical focus drew on the normalising, constitutive and performative effects of power in understanding obstetric violence. Anchored in critical social theory, in this thesis I explored the diverse forms of obstetric violence hidden behind normalised practices of care and policy making and the conditions that underpin them. Secondly, I drew on post structuralism to explore, describe and illuminate the ways in which obstetric violence is enacted and reproduced, and to describe and analyse how performances of power play out in social reproduction. Taking an ethnographic approach to institutionalised abortion care practice and maternal healthcare priority setting, I argue that practices are constituted in relational forces of governmentality embedded in organising epistemic rationalities and normalising conducts as well as counter conducts of resistance against such regulating power. Consequently, I argue that obstetric injustice is: (i) Embedded in normalising practices and epistemic rationalities; (ii) Emergent from the relational forces of biopolitical and neoliberal governmentality and counter conducts against such governance; and (iii) Reproduced through the productive and performative effects of governmentality.

Drawing on these premises, I illuminate the routine care practices that produce such tangible, embodied obstetric injustices such as uterine perforations, maladaptive emergency handling practices, and choices and decisions that maximise pecuniary interests embedded and silenced in abortion care practice. I also illuminate the organising effects of the metanarratives of 'birthing women', 'motherhood', and epistemic construction of maternity along the continuum of childbirth, in silencing the abortion care needs of women. These needs sit outside the normative expectations of motherhood. I contend that addressing obstetric justice must involve problematising normalised practices of care to unmask silenced obstetric injustices.

Second, using the second premise, I illuminate the processes of panic and fear of apprehension that underpinned risky abortion care outcomes, and triggered off maladaptive emergency handling

practices designed to counter the disciplinary effect of biopolitics and suppress the surveillance power of the state. I also illuminate how pecuniary interests underpinned decision making and choice of medical technologies for use in abortion care delivery. Finally, focusing on the performative and productive effects, I illuminate how tools of biopolitical and neoliberal governmentality acted upon health workers and participants in policy-making practice to produce compliant and self-regulating subjects. I describe how neoliberal epistemic rationality in policy-making practice created an infrastructure of self-interest for participants to prioritise national investment in maternal healthcare conditions with high-impact interventions. I also illuminate how biopolitics generates disciplinary effect, which then, conditions advocates for abortion care delivery to self-regulate through acts of silence to avoid detection, stigmatisation and ostracism by development partners.

CHAPTER FOUR

METHODOLOGY

The Ontology of Care and Policy-Making Practices

The current conception of abortion care is based on the normative categorisation of care practice, using binaries of ethical or unethical, safe or risky (Labandera et al., 2016; WHO, 2015b), including of medical technologies for abortion as safe and unsafe (Ganatra et al., 2017; WHO, 2015a). Such medical ontologies add to the normative emphasis on abortion stigma deriving from binary concepts of immoral and moral (Beynon-Jones, 2017; Cleeve, et al., 2017) and legal and illegal practice (Haaland et al., 2019; Mutua, Manderson, Musenge, & Achia, 2018). These serve to control women's reproductive choices.

Several concerns are overlooked by this focus. First, binary concepts serve as boundaries for care practice by defining what is allowable and what is prohibited or culpable (Suh 2018), so determining the conditions for health workers to terminate pregnancy and deliver care services (Marecek et al., 2017). These boundaries assume that abortion care practices divide according to the strict boundaries of risk and safety, in which the former embodies absolute poor outcomes and the latter embodies absolute good outcomes. However, the boundary between categorical binaries may not always exist, and unsafe healthcare outcomes remain prevalent in practices that are considered safe. Equally, the boundary negates the possibility that practices categorised as risky and medical technologies classified as unsafe may produce positive outcomes for women with abortion care needs. This conception thus fails to account for an increasing trend towards institutionalised maternal deaths resulting from poor quality of care and the increasing trend towards the use of medical technologies that are considered risky (Aantjes et al., 2018; Bechem et al., 2016; Benson et al., 2017). Equally, as noted earlier, abortion care remains low and poor even in contexts where the law is liberalised (Loi et al., 2015; Shah & Ortayli, 2014; Klugman & Budlender, 2001). The assumption that care practice is dependent on a combination of 'safe' medical technologies and skills (WHO, 2015a) fails to capture the specific situations in healthcare facilities and the conditions of care practice that may contribute to the healthcare outcomes.

Boundaries between 'safe' and 'risky' may not be always concrete, but normative constructions reify risks by failing to consider the continual re-negotiation of meanings, processes and performances of resistance, within care practice, through language-use and performances (Beynon-Jones, 2017). Conceptualising 'risk', 'safety', 'moral', 'immoral' and 'care' as objective and neutral negates the recognition of inscribed meanings on materials, objects, acting subjects, and care practice as potentially perpetuating specific interests (Payne, 2016; Law, 2004; Law & Urry, 2005). For instance, gestational limits on the use of medical technologies for abortion care may serve particular goals and interests which ought to be uncovered. The acceptance to deliver abortion care services in a restrictive environment may not always be immune to interests other than those of concern for a woman's health. Assuming that health workers always use technologies and handle patients as they are required by standards of care may blind us to recognition of maladaptive practices and the conditions that produce them. The application and use of medical technologies, and the performances that occur during care, may reflect but also enact and reproduce particular realities and silence others. Therefore, materials, technologies and care practices may not always be neutral and objective (Timmermans & Berg, 2003). Commitment to material aspects – skills, technologies, standards and guidelines, and health facilities – fail to account for on-going situations and processes that connect technologies to patients' outcomes. Moreover, risky outcomes may transit through processes of technological application, conditions during the operation, and rationalities which rule health workers in the process of care. Furthermore, mental rationalities that health workers internalise are also infused with power (Olson & Brosnan, 2017; Neal, 1971; Henderson, et al., 1994). Power has a performative role in governing the conduct of actors (Alasuutari & Qadir, 2014; Merle et al., 2018). Yet it may also invoke counter-governance practice, since power is ubiquitous, following no definite direction (Chairperson et al., 2015; Foucault, 1977; Hope, 2016; Kotsila & Saravanan, 2017). In addition, the effect and mechanisms of such power operations are hidden and may produce significant effects on policy and care outcomes. For instance, legal restrictions on abortion and the policy on abortion care may lead to appropriations, resistances and practices that counter regulatory mechanisms of the government. Normative constructions of care, risk, safety and practice negate the embodied and performative role of care practice and its categorical imperatives.

Normative roles are performed by neoliberal participatory networks such as the Reproductive, Maternal, Neonatal, Child, and Adolescents Health (RMNCAH) network and new partnerships for

maternal and neonatal healthcare (Storeng & Béhague, 2016). Although technically driven by expert knowledge, normative claims that assume the neutrality of expert knowledge fail to account for the continual de-prioritisation of care practices for women with unmet abortion care needs. Moreover, expert claims involve and constitute political technologies of governance (Alasuutari & Qadir, 2014a; Merle & Hellström, 2018), which privilege certain forms of knowledge at the expense of others (Daukas, 2019; Freeman, 2014; Quantz & Buell, 2019).

Neither the policy outcomes nor the discursive processes that produce maternal health priorities appear in vacuum; they are nested within neoliberal systems of thought. In addition, the political technologies through which rationalities construct maternity and abortion care can be analysed to demystify expert epistemes and their presumed neutrality. Maternal healthcare responses and the discursive practices through which they are identified are often infused with power linked to neoliberal ideologies (Springer, 2012; Wilson, 2017). These normative ontologies obscure performative, productive and politically embedded policy positions (Alasuutari & Qadir, 2014a). As in care practice, embodied interests, meanings and performances of communicative materials can be examined, including to determine what is silenced. Addressing these gaps helps to uncover the social reproduction of obstetric violence in health facilities.

In this study, my ontological focus is the normative categorisation of care practice, risk, safety, and policy. My goal was to uncover hidden, invisible, inaudible and silenced realities. By focusing on the performative role of materials, epistemic rationalities and language, I seek to uncover productive mechanisms and emergent realities, including contestation, control, appropriations and resistances. I attend to the performative effect of universal metanarratives, normalising discourses and participation, and the productive ontology that emerges through policy-making practice and policy-priority setting. I also focus on the representation and reconstitution of maternity and abortion care, and on women with abortion care needs in a neoliberal and biopolitical context. This focus brings life to the discursive and communicative materials, illuminating their performative role; in addition, it allows attendance to the emergent and concealed realities of the mainstream theorisation and prioritisation of processes and outcome. In doing so, I centre the debates on abortion care as a political ontology.

Epistemological Implications

Studies on care practice and policy focus on generating knowledge may be objective, offering universally generalising explanations (Larsson et al., 2015; Black et al., 2016; Macleod & Chiweshe, 2018), or subjective, based on lived experiences (Lafarge et al., 2014). Objective studies use an epistemological orientation attuned to normative care practice and normalising institutional policy-making practices. However, objective knowledge claims face the problem of certainty and struggle to explain conflicting empirical evidence of why risky outcomes result from institutionalised care. The danger of focusing on objective knowledge is that it may hide continuities through which social reproduction occurs (Eades, 2019).

Subjective interpretations that give meaning to objective conditions, and those based on lived experiences, are nested within institutional and normative sensibilities about care and policy-making (Cohn & Lynch, 2017). Furthermore, articulations of interpretive and subjective knowledge suffer from the inability to recognise that individual agency occurs within a pre-existing social frame outside our span of control (Charmaz, 2008). Individual agency detached from context and contingency may oversimplify neutrality and normalise structures of domination that individuals internalise. It thus becomes difficult to transform the macro structures that underpin agency. Attending to hidden realities is necessary to disrupt and unsettle both neutralising and normalising assumptions (Madison, 2012). Thus, both objective and subjective knowledge claims privilege the revelation of specific worldviews which guide the construction of care and policy-making practice. This renders other worldviews invisible, hidden and silenced.

In this study, my epistemological focus was on the generation of knowledge about the performative effects of care and policy-making practices, as an assemblage of embodied materials laden with power. In this frame, I illuminated the possibilities of acting with or without conditioned choices and freedoms, and the different worlds upon which care practice and policy-making are hinged. My concern was on unsettling the normalised and institutionalised practices of care and policy-making in order to reveal what is hidden behind normalising discourses, and the performances of taken-for-granted discursive materials in the interest of addressing the problem of obstetric injustices.

Truth is implicated in relations of power, since what qualifies as evidence depends on the researcher's theoretical position (Hardcastle et al., 2006; Gómez, 2016; Timmermans & Berg, 2003). Research may blur and reproduce practices of domination (Law, 2015), but alternatively, the privileged states of objective and subjective truths may be challenged and problematised in order to uncover the embodied worlds of power that inform and shape rationalities. In undertaking this study, I recognised that choice of data collection methods is inherently political (Beard et al., 2016; Law, 2004) and may disempower research participants (Irwin, 2018). Even the presentation of findings may privilege specific voices of participants and specific ideological positions (Madison, 2012). Knowledge emerges from practices that allow for a transparent account of how the researcher's bias results from his or her value orientations and commitments and theories (Hardcastle et al., 2006). Doing so helps to account for power and privilege created by such structures (Muhammad et al., 2015), and to escape the trap of legitimising and reproducing such forms of domination (Segall, 2001). Since realities are an effect and consequence of methods (Law, 2004; Miled, 2017), they cannot be independent. In this study, I also recognised that power runs through all stages of research and thus requires an iterative process about the conception, practice and presentation of findings. I engaged in a reflexive assessment of how my theoretical world, research practice, methods and presentation of findings could affect social justice towards especially vulnerable women with unmet abortion care needs.

Research Design

For this study I adopted a critical ethnographic approach. Critical ethnography is a method of study that investigates culture, knowledge and actions. It disrupts normative truth telling mechanisms, problematises normative ways of acting, and is open to scrutinise hidden agendas and power dynamics; it also questions common assumptions that inhibit, constrain and repress (Madison 2012; Panter-Brick & Eggerman 2018). It breaks away from traditional descriptive, explanatory and interpretive perspectives based on insider-outsider positions, and commits to the ethnographic exposition of and an emancipatory contribution to addressing systemic injustices (Miled 2017). My choice of this approach hinged on the understanding that policy making and the delivery of care comprise ethical, moral, legal and political standpoints, all of which are value-laden, non-neutral, and represent multiple constituencies. Thus, it was fundamental to explore the structure of meanings and interest embedded in the discourses of maternal and reproductive health interventions, while situating

them in their specific institutional, political, socio-economic and neoliberal ideological context. Critical ethnography also allowed me to resist being domesticated by a single world of either objective or subjective truths (Madison, 2012; Panter-Brick & Eggerman, 2018).

Care practice is captured as a system of interrelated components including biomedical and pharmacological technologies, health workers, women with abortion care needs, care operations, processes and knowledge expertise. All of these are coordinated to achieve positive outcomes for women with unmet abortion care needs. The ethnography offered a rich description of policy-making sites where maternal health priority setting occurred and the health facilities where care was delivered. This allowed me to illuminate local sites that shaped the practices and outcomes of care and policy-making. Using critical ethnography, the hidden, silenced realities operating behind normalised care practice were illuminated and the on-going and everyday political strategies and tactics of resistance, appropriation and self-rule in micro level practice were identified. Productive mechanisms and tools used to silence, hide and suppress or counter restrictions in care practice were also uncovered.

Considering that care practice and policy-making are contingent upon macro structures of power, the study included Critical Discourse Analysis (CDA). CDA focuses its analysis on "the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context" (Van Dijk, 2001: 352; Krzyzanowski, 2011). Several approaches to CDA exist. In this study I adopted a Foucauldian approach (Foucault, 1977) to uncover structures of domination embedded in global norms, technical organisation and language through which maternal health priority setting occurred. I used this to illuminate how discursive practice and materials constituted participants, privileged normalised maternal healthcare issues, and suppressed those that were considered outside global business interests, biomedical epistemes, and moral and legal boundaries.

Blending Critical Ethnography with CDA provided me with an opportunity to link macro global and local contexts, contents and practice together. Doing so allowed me to generate knowledge of the macro and microphysics of power, and an understanding of policy-making as a global practice of power. It also allowed me to uncover the hidden, silenced realities operating behind normalised,

universal moral standpoints and metanarratives, and to articulate how vulnerability to obstetric violence is reproduced.

Methods

Qualitative methods were used for this study because of the nature of the ontological realities under investigation. As highlighted in the preceding sections, I focused on investigating highly elusive operations of power which occur in ongoing care practice, normalised metanarratives and discursive processes of policy-making, embodied meanings inscribed on medical technologies, rationalities, appropriations, and resistances to restrictive policy and law on abortion. These realities are also contingent upon neoliberal ideology, local morality and biopolitics. Use of qualitative methods allowed me to observe the organisation of care and policy making practices, and illuminate the performances of different rationalities, material objects, and the self-governing activities of actors. This involved asking exploratory questions and iterative processing to transcend the observed occurrences and reported narratives of power in care and policy making.

The Context

Uganda's healthcare system is heavily donor-funded and characterised by a brain drain of highly-skilled health workers and the inadequate training and too few employed pharmacists (Imbi et al., 2019). Its maternal healthcare care responses and investment plans are shaped by global norms of universal healthcare coverage and health rights, and (in contradiction) neoliberal business norms of results-based financing and investment in high-impact interventions. The country gave political commitment to regional conventions relating to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo protocol), and the Maputo Plan of Action (MPoA) for the Operationalisation of the Sexual and Reproductive Health and Rights (SRHR) (2006). Uganda ratified it with a reservation to article 14(2) (c), which obliges states to commit to allowing medical abortion in cases of rape, incest, or when the pregnancy threatens the life or health of the woman, or when the life of the foetus is already compromised (Mulumba, 2016).

Uganda is a religious country, with strong value attached to the sanctity of life, and every day practice and institutional morality reinforces the restrictive law on abortion, limiting the possibility of abortion care delivery and seeking. Policy discourses on abortion in the country are always highly contentious.

For instance, the national guidelines and standards for the prevention of maternal mortality and morbidity due to unsafe abortion were launched in 2015, but were later withdrawn due to disagreements among stakeholders (Mulumba et al., 2017). Article 22(2) of the Constitution of the Republic of Uganda prohibits the termination of the life of an unborn child except as provided by the law (Government of Uganda, 2006). However, there is no statutory instrument enacted by parliament to enable the operationalisation of this provision. In its absence, the penal code is used by law enforcement to arrest and prosecute health workers caught in conflict with the law (Ngwena, 2014). The Uganda Penal Code criminalises any person who aids a woman to procure abortion and the person is liable for imprisonment for 14 years (Mulumba et al., 2017). Lack of harmonisation between the constitution and the penal code creates a legal vacuum, which consequently affects abortion care delivery.

For this study, as noted above (Chapter 1), data collection on the delivery of abortion care took place in Eastern Uganda, the region with the highest poverty density and the highest proportion of teenage pregnancies in the country (UBOS & ICF 2017). Occupied by the Basoga, a highly patriarchal society, polygamous marriage is very common, characterised with spousal violence and the abandonment of elderly women in favour of younger ones. Women in the region occupy a low position in decision-making, which exposes them to forms of gender-based violence. At a fertility level of 6.1 births per woman in a year, women in reproductive ages have a higher number of children than the national average of 5.4 children (UBOS, 2016). The high value placed on children explains both the low level of education among young girls and the high rate of school discontinuation around menarche. As elsewhere in the country, the provision of abortion care services is restricted to post abortion care and medically induced abortion services as the law may allow.

Study Sites

Conferences

The investigation of maternal healthcare prioritisation and policy-making practice was conducted at two national level conferences organised by the Ministry of Health: a two-day RMNCAH conference held from 20-21 August 2018, and a one-day conference held December 2018. The conferences were held in the national capital, Kampala, at the Imperial Royale Hotel, a high-class venue used for

various local and international conferences. Situated in an affluent suburb, the hotel has a main conference hall where the symposium was held, and other medium-sized halls for break-away sessions. The conference hall, air-conditioned with comfortable seats, offered an ambiance disconnected from the socio-cultural, political and economic contexts which underpin unexpected pregnancy and vulnerability to unsafe abortion. At the conference, people had snacks, morning and afternoon tea, and lunch, a form of comfort diametrically opposed to the women whose lives were being discussed.

In addition, I attended two regional meetings formally organised to discuss and enhance quality of care in family planning and harm reduction interventions in Eastern Uganda. The regional quality improvement meetings were organised by an NGO that promotes sexual and reproductive health in the region and were held in the same venue. The first was organised for health workers from profit and non-profit making health facilities in Eastern Uganda. The second meeting targeted health workers and administrators in public health facilities in the region. The meetings were situated in hotel rooms on the topmost floor (third floor) of one of the hotels in the region. The site of the conference offered an ambient environment for discussing issues related to abortion care delivery without eavesdropping from uninvited hotel guests.

Health Facilities

Data collection at health facility level was conducted at different sites to document how diverse health facility norms shaped the practice and outcome of abortion care practice.

Health Facility Site 1

Health facility one was a private for-profit health facility where most cases of induced abortions in the district take place. The health facility is located in one of the towns along the highway linking Uganda to Kenya, and is easily accessed. Throughout the study period, the facility was very busy, with many young men standing on the facility veranda, keenly observing passers-by to identify potential clients coming for the service and to keep watch for possible security persons.

The main entrance and a small door on the eastern side of the building linked the health facility to a corridor that led to a neighbouring building. Benches were positioned in the corridor, on which some

health workers sat; others stood and moved frequently to and from the front of the building, looking out for law enforcement officers. Health workers also moved frequently through the facility, passing through the small door. Some patients entered through the side door but exited through the main door. Each time a patient came close, health workers waiting on the veranda and in the corridor approached her and escort her inside the clinic, reinforcing my impression that they were able to spot potential clients.

Inside the room with the reception desk, posters of sexual and reproductive health education, and guidelines to care practices, were posted on a wall. Medical practicing licenses were framed in glass for 2016, 2017, and 2018. In addition, old, dirty and outdated materials communicated the maternal health services offered and the healthcare protocols of the Ministry of Health. Their dilapidation undermined the image of quality care services the health facility claimed to offer. Through the days of observation, no permanent person served as a receptionist. Instead, as a patient was brought in or was about to exit, a health worker appeared and attended to her. Except for one female nurse all these workers were male, aged around 25 to mid-50s. This facility was selected for this study because it is widely known that induced abortion services were provided there.

Health Facility Site II

This was a non-profit health facility, located about three kilometres outside the town. The health facility is founded on a Christian faith and is regulated by a regional coordinator for a religious institution. Here, maternal health services were offered by a midwife and a nurse on Mondays and Thursdays, when many women from rural areas came for antenatal care especially. Although not regularly used, the health facility in-charge indicated that ultrasound services were available once a week. The health facility also received technical and logistical support from an NGO that promoted safe maternal deliveries through a voucher scheme. Patients paid out of pocket if they did not have a maternity voucher card. This facility by policy did not offer induced abortion, although a few health workers explained that sometimes they provided termination secretly, with the patient discharged immediately afterwards. The facility offered post-abortion care services to women reporting with spontaneous abortions, which were attributed to malaria infection and domestic violence. This facility was selected because of the need to understand how abortion care practices here compared with those of other health facilities.

Public Health Facilities

The public health facilities comprised one Health Centre III and one district referral hospital. Health Centre III, located about ten kilometres from the town centre, was a high-volume facility in terms of the number of patients received. Induced abortions were not provided at the facility, but the health facility in-charge reported that induced abortions were possible for strictly medical reasons. However, several cases of spontaneous abortions were reported at the health facility, allegedly as a result of malaria, domestic violence, or sexually transmitted infections. The health facility also received training and logistical support for safe post abortion care and family planning services from an NGO operating in the region.

The district hospital served, in addition to the study district, about seven other neighbouring districts. The referral facility had a maternity ward, where most abortion care cases were received and treated, and a female ward where women with other health conditions were treated. Prior to admission, most women presented at the outpatients' department and were then directed to the maternity ward. Throughout my study, all departments were extremely busy, every day. Most of the time, health workers on night shift extended into the day while waiting for their colleagues to arrive. Weekly meetings were held at the health facility in the maternity ward to review quality of care delivered, including any maternal and perinatal deaths if they had occurred. The hospital received technical training from the WHO team in Uganda, and MVA equipment for quality abortion care service delivery from an NGO. Except for medical reasons, abortions were not provided in the facility because this was against government policy. However, in in-depth interviews, some health workers revealed that women who had had abortions at private health facilities were brought to them for post-abortion care. These two public health facilities were selected to offer perspectives on referrals.

Study Population

At the level of policy-making, participants comprised: technical officers from the Ministry of Health, religious institutions, non-government organisations working on women's sexual and reproductive health issues, and officers from bilateral and multilateral development agencies. At the level of abortion care practice, the study participants comprised health workers (doctors, nurses and midwives), health facility in-charges, quality assurance officers from non-governmental

organisations working on sexual and reproductive health matters in the region, and regulators from the district health team. Participants were also drawn from law enforcement and justice delivery departments, because of their stake in and experience of enforcing the law on abortion. Table 1 summarises the categories of participants in this study.

Table 1: Categories of participants interviewed

Name of Organisation	**Number of participants**
Technical staff from the Ministry of Health	05
Technical staff from multilateral development agencies	03
Technical staff from bilateral development agencies	03
Technical staff from international non-government organisations	04
Staff from local non-government organisations	04
Technical experts from professional bodies	03
Staff from religious institutions, Uganda	04
Government health workers	08
Private health facility workers	05
Non-profit health facility workers	03
Staff from law enforcement and judiciary	05
Total	**47**

Sample Size and Sampling Procedure

As indicated in Table 1 above, a total of 47 participants involved in the policy and practice of abortion care were interviewed. Participants in policy-making practice were identified through the national Reproductive, Maternal, Neonatal, Child and Adolescents Health (RMNCAH) conference. These included participants from the Ministry of Health, selected because of their positions of authority and oversight functions related to quality of care delivery, setting maternal health priorities and policy matters. Staff from development agencies occupying technical positions were selected because of their strong influence on government decisions and national maternal healthcare responses. Religious institutions were selected because of their strong voice on morality and their resistance, in 2015, to implementing the national guidelines on the prevention of maternal deaths and mortality due to unsafe abortion. Professional bodies were selected because of their technical expertise and ability to influence national maternal health priorities in Uganda. Participants from NGOs that operated in the area of sexual and reproductive health matters were selected because of their strong influence in advocating for reproductive health rights and justice, and implementing maternal health interventions in Uganda. The participants in these categories were chosen based on their technical positions in their respective organisations. Finally, participants from the Criminal Investigation Department (CID) under the Uganda Police, and from the Justice Department, were selected because of their stake in enforcing the law on abortion in Uganda.

In addition, health workers were selected from public, non-profit and profit-making healthcare facilities with high volumes of patients, because of their involvement in the delivery of abortion care services. All health facilities were determined according to records from the district health office, and were identified through an entry meeting with stakeholders at the district health office. Health workers from private for-profit and non-profit healthcare facilities were selected using snowball technique which began with known individuals identified through regional actors in sexual and reproductive health.

Snowball sampling was used because of the secrecy related to abortion as a result of legal and moral restrictions. There was a week-long time lag between scheduling and actually conducting an interview, enabling me to establish a relationship of trust before I conducted the interview. I hit a snag during my first two visits to the health facility to meet my informant. While he had invited me,

I was told by another health worker at the facility that he was not around and I was advised to leave the message. Worried that I would not succeed, I contacted the person who introduced him to me, who advised me to call him when I reached the health facility the following day. Following this advice, I was able to see my informant and to introduce myself to him in person. We related well but did not hold the in-depth interviews until after a week of frequent interactions. Participants selected a convenient public place where the interviews could be held privately and confidentially. Health workers from public health facilities were selected because of their position in the delivery of care services, and the regulation of the quality of care provided. Given their tight schedule arising from the high volume of patients, participants determined the time of the interview, but interviews were held within the health facilities.

Data Collection Techniques

Ethnographic Observations

Ethnographic observations were conducted at the national level conferences and regional quality of care improvement meetings. At the national conferences, observations focused on the organisational and discursive practices involved in setting national priorities for maternal healthcare responses. Observations focused on material objects, participants' activities, communicative materials, discursive relationships during plenary and group activity sessions, behavioural practices and the processes through which maternal priorities emerged. I also observed non-verbal interactions and responses such as the silences that ensued during discursive relations, the style of communication, the epistemic concepts and language used, and objects that were absent yet form critical aspects in maternal healthcare quality of care improvement. In making these observations, I took fieldnotes which were later developed into expanded notes. In addition, ethnographic observations were made at the health facility sites where care services were delivered; these observations were made only outside of the treatment rooms. I focused on everyday patient-health worker interactions and relationships among health workers, the material resources available, and observed and subsequently analysed the interactions in handling cases and dispensing care.

In-depth Interviews

In-depth interviews were used to explore issues linked to and in the (de)prioritisation of abortion care for Uganda and abortion care practice. At the level of policy-making practice, 27 in-depth interviews were conducted with participants identified in and through the conference, selected for their stake in influencing maternal health and prioritising abortion care interventions. The interview guide was developed following the conceptualisation of global discourses relating to maternal healthcare investment, and was adjusted in response to ethnographic observations. The interviews explored the rationalities, meanings and intentions of participants, and expert worldviews about maternity and abortion care. I also explored participants' desired policy actions and silenced positions at the conference. At the level of abortion care practice, I used in-depth interview (IDI) guides with health workers to explore the social organisation of abortion care practice, reveal the medical technologies used, the ways in which they are used, the rationalities behind their use, and how health workers navigated around the restrictive policy, law and morality to serve women with unmet abortion care needs. I also explored the experiences of health workers in using medical technologies in abortion care practice, and how medical technologies were talked about and represented by health workers in regional meetings and national conferences. Participants' responses were examined to identify the internalised worldviews that informed their choices, decisions and practices, and the meanings behind the practices they exhibited. All interviews were conducted in English, the official language commonly used in formal contexts. Interviews were audio-recorded with consent from participants.

Text Discourse Reduction

I reviewed legal and policy documents which regulated abortion and abortion care delivery. I focused on texts to identify biopolitical discourses and neoliberal metanarratives that shaped maternal healthcare responses and participants' behaviours in policy-making practice.

Blending observations with IDIs and text discourse analysis enabled me to deepen my understanding of observed occurrences such as participants' behaviours in discursive relationships at the conferences and silences on abortion care discourses during the national conference, and allowed me to inquire about these absences. It was revealed, for example, that the absence of and silence about abortion discourses, very obvious at the RMNCAH conferences, was a strategy consciously thought

about and executed, rather than the result of neglect of attention. I was also able to connect participants' choices, decisions, practices and discursive relations to multiple contexts, such as the sites of practice, ideological and biopolitical contexts.

Data Processes and Analysis

Preliminary analysis was undertaken in the field through debriefing sessions, when emerging issues were identified, research practice reflected upon, and areas for further enquiry identified. Through these sessions, issues identified were used to improve research practice the following day, broaden and focus in-depth interviews, and select participants who might help to address the gaps and triangulate perspectives.

Coding

All audio-recorded IDIs were transcribed by an independent person and edited by me. The transcripts were then exported into N-Vivo 11 software where I inductively coded out the data, generating a hierarchy of nodes. Coding, conceptualised from a quantitative perspective, focuses on generating relevant categories of data and capture patterns used to test the validity of specific hypotheses. Codes are often identified before the study and field transcripts are used deductively until saturation point is reached, when further coding does not add new codes (Alang, 2019; Furniss et al., 2019; Jalloh, 2019). However, drawing on codes deductively obscures the need to recognise narrative data about processes and performing materials, which are unimaginable prior to data collection and cannot be abstracted from the contexts in which they perform. Although inductive coding attempts to address the limitation by capturing emergent realities (Bechem et al., 2016; Maixenchs et al., 2019; Portacolone et al., 2019), it also fails to capture processes, performing realities and non-text data. Equally, in selecting abstract concepts to represent specific data, codes may reify existing normalised narratives about abortion care and policy making practice, since such concepts draw on the cultural values and orientation of the researcher. Such values and orientation may be implicit in reifying and producing hierarchies that underpin obstetric injustices. Concepts of objectivity and subjectivity in coding data are an obstacle to the development of critical scientific knowledge (Malighetti, 2019). It is necessary to consider the complex links among the researchers, the epistemes, the method, actors and the research practice.

In this study, I recognised that coding is informed by pre-existing knowledge, that every form of knowledge is imbued with power, and that power has a productive effect. Drawing on this background, my coding was built around the aim of this study. I sought to illuminate invisible, silenced and performing realities in much the same way as prescriptive textually visible realities. The aim of coding was to illuminate diverse rationalities, perspectives and performative effects exhibited in specific contexts of care and policy making practices. Coding began with an awareness of research as a practice of power and reflexively discounted the effects of my own cultural values and orientation, while reaffirming my position on illuminating injustice. Coding was informed by the analytical concepts of biopolitics and neoliberal governmentality together with counter governance or resistance at the apex of coding hierarchies; these several subcodes emerged as representative of performative effects of governmentality, resistance and appropriation. I generated process codes such as *silencing*, which illuminated on-going tactics of resistance in care practice. I also generated codes such as *silence*, which illuminated the invisible political strategy of staying unnoticed by the surveillance state.

During analysis, the nodes and sub-nodes were compared within and across health facilities, discussed and synthesised to generate major themes. During this process, preliminary findings from different categories of health workers and quality of care regulators were triangulated and similarities and dissimilarities identified. Finally, I triangulated findings from in-depth interviews with those from ethnographic observations. Doing so helped me to highlight the complementarity of in-depth interviews, observations and informal conversations to understand power operations in abortion care practice and the maternal healthcare priority setting at national level.

Analysis focused on understanding political technologies of power that governed healthcare delivery practice and maternal healthcare prioritisation, and the mechanisms through which they operated, were resisted, and appropriated. I also focused on the performances of physical objects (such as medical technologies, communicative materials and discursive practice) and non-verbal materials (such as silences in speech utterings, normalising and epistemic concepts) in enacting and reproducing forms of domination, resistance or transforming opportunities for addressing unmet abortion care needs. The technologies were then linked to the neoliberal business interests that shaped maternal healthcare investment, the global norms of universal healthcare coverage and human

rights, and the biopolitics embedded in restrictive morality and the abortion law. Theoretical concepts of biopolitics, governmentality and counter-governance facilitated the classification of emerging political technologies deployed during and post abortion care. This analytical approach allowed the illumination of the processes and conditions upon which risky outcomes emerged in abortion care delivery effaced from national responses for maternal healthcare improvement. I transcended beyond normative constructions of policy-making and care as moral and ethical practices to reveal the hidden and silenced mechanisms of governance and embedded tactics of resistance and methods of appropriations.

Credibility

In order to ensure that the study findings were credible and robust, I drew on critical reflections on technical concepts of saturation and positionality.

The concept of saturation has been overly conceived in terms of comprehensiveness of the data collected and analysed, a point at which more data yields no new information (Fusch & Ness, 2015). This conception often focuses on making knowledge claims that are generalisable (Fusch et al., 2018). It drives researchers towards focusing on volumes of data collected and triangulating sources of information, allowing the researcher to maintain control over the volume of data and its analysis. However, this does not free research of bias because the triangulation of sources of data may not uncover such highly internalised worldviews. Likewise, theoretical sampling used in the identifying participants presupposes certain worldviews which may misrecognise participants' internalised worlds of domination and self-regulation as their objective knowledge claims. Such claims fail to uncover conditions and mechanisms of domination and reproduction of vulnerability.

Similarly, conceiving saturation as an event obscures the processes through which quality in qualitative research is shaped. Reaching data saturation is a mysterious, subjective, non-directive, gradual, and unfixed process (Aldiabat & Le Navenec, 2018). While I recognise that failure to reach saturation point can negatively impact on the quality of the research conducted and hamper content validity (Fusch & Ness, 2015), I contend that saturation as a fixed point is an ideal and ignores the fact that researchers participate in the construction and representation of knowledge, and may choose whose voice is heard and whose is not. The production and representation of knowledge involves

cultural values, ideologies, and theoretical assumptions that may enact and reproduce expert worlds at the expense of others (Beard et al., 2016; Fusch & Ness, 2015). Saturation cannot address the embedded politics of production and representation, and cannot make research more credible in light of social injustices like obstetric violence. I affirm the conception of saturation as a process since participants may contribute to politics involved in representation (Charlesworth, 2017). Credibility of research findings requires also examining how meanings are imposed in research processes (Varpio et al., 2017a; 2017b).

Lack of awareness of researcher positionality can lead to a devaluing of community voice (Muhammad et al., 2015). Moreover, often times, scrutiny is put on the researcher rather than research practice, thus ignoring the fact that both the research participants and the researcher are embedded in the politics of knowledge construction, reproduction and representation of worldviews (Beard et al., 2016). In the representation of findings, ethnographers may inscribe certain worldviews in a selective manner (Segall, 2001). Incorporating participants' voices cannot be politically innocent and requires constant examination of how and whose worldviews are represented. Thus, looking inwards to the researchers and outwards to the discursive frames of research practice are both necessary to identify power entanglements, so to untangle them in knowledge representation (Beard et al., 2016).

With other scholars, I argue that saturation should be operationalised in a way that is consistent with the research question(s) (Saunders et al., 2018). Credibility of findings can be traced through four issues: (i) Adherence to the commitment to the ontological and epistemological roots that informed this research; (ii) The theoretical depth of the key concepts that emerged from the study; (iii) The research implications of the identification of obstetric violence among women with unmet abortion care needs; and (iv) The illumination of the findings from different sources of data. In committing to an ontology that is productive, this study allowed the illumination of different mechanisms in which participants in policy-making were constructed as compliant actors by both neoliberal forces and national biopolitics. It also illuminated how actors in care delivery contested and resisted forms of domination that macro forces placed on them, and identified the different ways in which obstetric violence was produced and sustained among women with unmet abortion care needs.

Positionality

Although several studies have discussed the concept of positionality from the perspective of a researcher (such as the influence of theoretical background and gender) little has been written about positionality that emerges from and or is brought to bear on a researcher during discursive research practice. Following the above critical reflections, I recognised the performative effect of power that operated through discursive relationships of in-depth interviews. Some participants attempted to shape the research direction by redefining what ought to be researched, and where to go for such information. Their institutional positions provided them with the privilege to define the presumed concerns that hindered delivery of abortion care services or the creation of an enabling environment for care delivery. The experience of interviewing high-level institutional actors thus counters claims that researchers are inherently in more powerful positions during an interview. Managing such politics required carefully treading the path of surrender, negotiation and assertion to fit within the power hierarchy. The terrain of power shifts depending on the level of authority assumed by either actor in the interview. What is critical therefore is an awareness of such power dynamics in an interview and a reflexive culture on the part of the interviewer in order to learn from all positionalities and tactfully navigate the terrain of power.

In some interviews, participants also navigated institutional power, sometimes offering their responses on record while in others preferring to express themselves off the record. In some interviews, viewpoints in conversations that occurred after the interview appeared to differ from the positions expressed during the interview. Without memory notes, narratives that flowed from the interview session could have easily eluded me. Yet such narratives extended the discourses into the broader contexts which were very useful in analysing the recorded findings. Such 'on record' and 'off record' information constituted and represented different worldviews about abortion and abortion care delivery in Uganda, and the latter appeared to be a liberated world in which the respondent felt free to express himself or herself. Analysing such data required recognition of both 'on' and 'off record' information as representations of different worldviews, rather than treating these as contradictory or privileging one view or statement of 'fact' against the other. This finding is in line with Nordstrom (2015), who asserts that recording devices, as normalised discursive materials, interact with humans and culture and breed diverse meanings and interpretations in a flux world.

Effectively, recording devices constitute part of the discursive power dynamic in which reality is navigated, embraced, and represented.

When studying abortion care, I was assigned different labels (an abortionist, a conservative and an academic) depending on what the participant felt that I represented. To some participants who represented religious institutions, I represented a liberalised international agenda that promotes immoral behaviour. Asking questions that transcend or question moral discourses attracted the label of an abortionist, and in subtle ways this labelling seemed to be designed to suppress and control the direction of the interviews. To counter this, I might invite the participant to reflect on what would happen if his or her daughter, sister, mother or wife was the person who desired to seek an abortion, or who needed post abortion care to avert possible death. This approach invited the participant to think about the implications of such moral positions or practices from an empathetic perspective.

To some of the actors from service delivery institutions, I was seen as an ally who could help make the situation better for both health workers and patients. Those who viewed me as an academic challenged me to transcend the normal conversations and offer alternatives that could help make things better. Overall, such positions reflected the expectations that different forces had on me as a researcher. Such positionalities created both an opportunity and a challenge that I had to navigate. Recognition of such positions helps a researcher avoid being trapped into producing moral scientific truths. My reflective practice with participants revealed to me that researchers' positional power is acted upon, negotiated and transformed during the interviews. Positionality is not static, with its influence flowing in a unilineal way from the researcher to the participant. On the contrary, it is contextual and its influence is ubiquitous in a discursive interview relationship.

In terms of gender of participants, among health workers, I interviewed seven males and nine female health workers. Among quality assurance officers, I interviewed five female and seven male participants, while at policy level, I interviewed ten males and nine female participants. Overall, the majority of the participants were male. Since I was a male Ugandan from the region of investigation, participants confidently talked about the subject with me, assuming that I shared their normative values about abortion. This made me invisible as an observer, and allowed me to access participants. In the quality assurance meetings, where I could easily have been noticed as a stranger, I was introduced to the participants by the convener, and my presence was interpreted in light of the sexual

and reproductive advocacy interventions which were promoted by the organisation. This too further demystified my strangeness. Given this introduction, some of the participants mistook me for a health worker during follow-up interviews, a fact which I clarified that I was a research student with keen interest in the practice of abortion care. This openness allowed me to inquire into and gain knowledge about the meanings of some of the medical concepts, participants used but to which I was not familiar.

During some IDIs, some midwives reproduced collective gender prejudices and power relations. For example, one midwife, in discussing why women came for induced abortion care services, expressed men's violent conducts against their wives, in statements such as "you know you men…" in which I seemed to be implicated. In other IDIs, female respondents expressed women's power in determining the father of the child, the basis upon which termination of pregnancy was resisted. For instance, in asserting that it was wrong for women to abort, one respondent said, "in Buganda, an outside intimate male partner does not father any child; that child has to belong to the husband who is known." They argued that women had the power to determine to allocate the foetus to the husband rather than terminating it. Outside these collective statements, my identity as a male researcher, as far as I know, affected neither relationships nor the outcomes of the study. As a male researcher investigating female reproductive matters of abortion and abortion care delivery, I was able to approach every information and practice with interest to learn more about it. Investigating practice through in-depth interviews allowed me to access conducts which only health workers had access to. There was, however, one male participant who asked me why I was interested in women's issues. In answering this participant, I narrated to him a story of a close relative who would be alive today were it not to be for complications from an unsafe abortion. In this exchange, the participant also opined that promiscuity among women as the driving force. However, his position also changed when I asked him how he would feel if it were his daughter. Studies on the social dynamics of interviews indicate the value of resolving differences between the interviewer and the interviewee (Manderson et al., 2006). Through this exchange, my experience in this study shows that empathy can be a useful tool in resolving differences, transforming gender positions and overcoming gender biases.

I was empowered by the recognition that ethnographic writing may constitute a political practice which researchers can use to illuminate neglected perspectives as well as extending theory and concepts. This thesis offers an ethnographic representation that highlights and exposes obstetric

injustice, illuminating hidden, neglected and suppressed realities across all perspectives and sources of data.

Methodological Reflections and Contribution

Ethnographic observations can be complex and difficult. In this study, working groups formed within the national and regional conferences created multiple social spaces, often occurring concurrently, in which focused discussions took place. This was not anticipated and the number of working groups could not be predetermined in order to have sufficient research assistants to support these observations. To adequately derive from these meetings discourses relevant to the study, prioritisation was made for those that included actors directly involved in abortion care delivery, while others were listened to during plenary sessions. Secondly, multiple communicative materials participated in the production of what was prioritised and silenced. An attempt to focus on one negates the contributory role of other communicative materials. The discursive relationships of interviews that involved high level participants in global institutions could be very tricky. Some participants may require a researcher to pursue lines of inquiry that fit institutional positions. There is no blue-print to navigating in such power relations. However, willingness to recognise the value of such positions and the ability to appear to surrender at one moment and insist in another helped me to have very fruitful discussions.

The use of a critical ethnography allowed me to illuminate and expose the linkages between macro structures of power and local practices of abortion care and maternal healthcare priority setting. I was able to expose maladaptive practices and pecuniary realities that were hidden behind the normative categorisation of care practice, tactics of resistance, and the navigation around restrictive regimes of law. In so doing, I was able to uncover the mechanisms that reproduced obstetric violence against women with abortion care needs. Equally, through recognition of the performative ontology, I was able to expose performance agency of communicative materials in silencing some worldviews about maternity and abortion care while illuminating others that fitted with normative frames. However, determining how the different communicative materials (texts, audio and video) linked together in this process was challenging because some textual materials existed prior to the conference, others emerged from the discursive process; some occupied a central position during the discursive practice; others were placed at specific tables of organisations at the edges of the conference hall. In this study,

videos proved to be very effective, appealing to the audience before and during break time. Studies indicate that 26% of maternal health deaths result from complications linked to abortion (Guttmacher, 2013), yet at the meetings I attended no video showed this in relation to the need for interventions on safe abortion and post abortion care. Future research in the performances of these communicative materials will help to expand knowledge of performative materials. Furthermore, I exposed how expert epistemic knowledge and normalised metanarratives on maternity healthcare responses were used to advance specific interests while effacing opportunities for illuminating local conditions that underpinned unsafe abortion care practice.

Ethics

Ethical approval was obtained for the study from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand (reference number M180466), the Uganda National Council of Science and Technology (UNCST) (reference number SS4677), and the College of Humanities and Social Sciences Research Ethics Committee of Makerere University (MAKSS REC 05.18.166). During field data collection, an information sheet tailored to specific categories of participants was shared prior to interview to ensure informed consent. For observed practices, consent was sought from the organisers of the conferences. Using an information sheet tailored to specific activity, the organisers of the conference and workshops granted me permission to participate in quality assurance and improvement meetings.

Investigating abortion care brought on me an ethical trilemma of having to respect the restrictive moral and cultural values, question normatively known ethical care practice, and do justice to individual health workers and women who found themselves entrapped in legal, moral and professional ethics. Considering that individual participants in this study were members of the collectivities, I took the first order obligation to protect their identities from possible legal, moral and ethical consequences. I identified with them to build their confidence and trust, and offered adequate protection while I explored their practice. Here, I aimed to do justice to the health workers and their patients, since they all seek liberation from a relationship of care in which they are constrained to act freely. I guided the participants to identify socially approved places that guaranteed confidentiality and privacy, where in-depth interviews were conducted. During the interviews, they were reassured of privacy and confidentiality. While audio recording was undertaken with permission, the audio

recorder was paused whenever a participant wanted to express an opinion or provide information off record. Equally, conducting in-depth interviews with stakeholders in quality of care assurance and policy-making practice raised a political and ethical stalemate, as some participants sought to shape the direction of research towards specific moral and political standpoints. I respectfully explored the moral and political implications of their orientation towards obstetric injustice and women's dignity, without appearing to disrupt their values.

After transcription, all personal identifiers were removed from the interview transcripts and the transcripts were then assigned unique identifiers. In presenting the results, I use pseudonyms for all participants to maintain their anonymity, and since health facilities might be identified, I have removed any ways of identifying them to maximise anonymity. Findings on induced abortion can be traumatising, especially reporting data on how emergency cases are handled and the ways in which foetal products of conception of varying gestation age are disposed of. I faced an ethical dilemma of first having to represent my research participants' perspectives and data in the same intensity as I received it, and my obligation not to traumatise my research audience. To resolve this dilemma, I toned down on the intensity with which the participants presented the data, in order to avoid what might be construed as traumatising findings, but without losing grip on critical aspects of the facts. Toning down the intensity may raise an ethical concern for research into criminal conduct since the practice under investigation is not represented with the same intensity in the report as it is in the raw data. In this study, toning down was deemed to be a useful strategy; future investigations into ethical issues in investigating criminal or borderline conducts in healthcare practices may offer useful insights to researchers in this field.

CHAPTER FIVE

POWER AND RESISTANCE IN POLICY-MAKING PRACTICE

This chapter explored and examined the influence of power (relational forces of domination and resistance) on effacing narratives of abortion care delivery from the national maternal health priorities for Uganda. I drew on ethnographic observations conducted at the RMNCAH conference, and on in-depth interviews with participants of the conference and other stakeholders in shaping national maternal healthcare priorities for Uganda. The infusion of neoliberalism with biomedical interventions worsens attempts to address obstetric injustices for women with abortion care needs in a morally and legally restrictive context for abortion care delivery. This chapter investigates and illuminates the mechanisms through which neoliberalism and biopolitics account for and are implicated in the effacing abortion care from national priorities. The chapter focuses on the processes and practices within the policy making conference in order to explore, examine and illuminate the operations and effects of power. I critique policy making as normalised institutional practice to uncover political technologies which neoliberalism and biopolitics use to govern the setting of maternal healthcare priorities.

The chapter is structured in three parts. The first part is an introduction in which I lay out the structure of the chapter, introduce the analytical concepts and summarise the major findings. The second part is an analysis of the major findings under theoretical concepts of governmentality and counter-governance in relation to the problem of obstetric violence for women with abortion care needs. The final part is a manuscript, accepted by and in press with the journal of *Health Policy and Planning*, which presents a detailed account of how biopolitics govern and direct the setting of maternal healthcare priorities in Uganda and the mechanisms used to efface abortion care from the national priority list. These appear hierarchically below.

The choice of the conference venue interfered with opportunities to illuminate drivers to abortion care. As noted above in Chapter four, the RMNCAH conference was held at the Imperial Royale Hotel, a high-class venue in which many other local and international conferences are regularly held in Uganda. Situated in an affluent suburb, the hotel is well organised with a main conference hall where the symposium was held and other medium sized halls, where break-away sessions were held.

The air-conditioned conference hall, equipped with comfortable seats, offered an ambiance which had little relationship with broader diverse and specific socio-cultural, political and economic deprivations which underpin women's vulnerability to unsafe abortion in Uganda. The gross region-specific vulnerabilities upon which unsafe abortion and poor maternal health services uptake were contingent were thereby muted. Without clear articulation of the underlying drivers to unsafe abortion and poor quality of abortion care services, the conference was destined to avoid addressing structural and institutional factors that underpin unsafe abortion and low-quality abortion care delivery.

The RMNCAH conference brings together multiple players representing forms of power which organise and direct the conduct of the conference. The selection of participants created a binary of privileged and unprivileged communities in framing maternal healthcare priorities. The majority of participants were technical actors involved in the delivery of maternity and women's health care services. These were drawn from district and national level government departments and services, and from implementing partner institutions. Participants from non-government organisations were inclined to biomedicine, although some were also motivated by concern for women's health as a human right. Other participants were from donor communities and development partners, who offer technical advisory services to the government on matters of national development and health system investment. Virtually all participants relied on biomedical understandings of the body to construct, problematise and identify priority interventions. Their focus aimed to strengthen the biomedical system to effectively respond to maternal healthcare issues. Complementary and alternative medical worldviews, constructions of maternity and women's health that relied on biopolitics, and qualitative evidence, were rendered invisible, or although discussed, were largely ignored or less influential in setting maternal healthcare priorities. Drawing on ethnographic data, I argue that the organisation of the conference privileged biomedical and neoliberal constructions and suppressed alternative constructions of maternity and women's health issues.

Second, the order of keynote addresses privileged particular outlooks. All keynote addresses were delivered by men. The first keynote addresses presented at the opening of the conference were rendered more influential than those presented towards the end of the conference, when some of the participants had already left. The conference began with an opening keynote addresses given by a representative of the World Bank, followed by a speaker from the World Health Organization. These

provided the framework within which maternity issues were discussed, problematised, measured and evaluated in quantifiable terms. The public health keynote address was presented last, on the second and final day, towards the closure of the conference. The public health expert articulated narratives of 'health system strengthening' and the interaction and coordination of the different components of 'health system', including 'human resources', 'health policy' and 'law'. The expert also addressed 'complementary linkages' between the political, social and economic conditions upon which maternal health is contingent. This keynote address articulated local structural and institutional issues which the first two keynote addresses did not. However, this last address was not a discursive component of the conference since it was the last event immediately prior to the closing of the conference. I argue that the ordering of keynote addresses renders last order addresses inconsequential to the work of prioritising maternal health issues.

Epistemic language comprised by concepts constituted a political technology of governing prioritisation of women's health issues. The language used at the conference relied on epistemic concepts largely drawn from the neoliberal keynote addresses and biomedical understandings of maternal healthcare interventions. Such concepts included global norms of universal health coverage; quality of care improvement; neoliberal ideological concepts like 'high-impact interventions', cost-effectiveness, and Results- or Performance-Based Financing; and demographic dividends. These epistemic concepts provided the boundaries within which maternal priorities were identified, problematised, articulated and measured with statistical evidence, which indicated the potential impact for investing in a maternal health condition. Consequently, alternative constructions of maternity conditions from other epistemic communities were silenced and excluded from the national agenda. This epistemic rationality suppressed abortion care delivery since it did not have statistical power, but it also created epistemic injustice for those communities whose ways of constructing and measuring maternity lay outside the epistemic boundaries. The epistemic concepts embodied tacit knowledge used to think about maternity and women's health, and so constituted the power which framed the choice and priority options for investment in maternal health. For instance, by internalising notions of 'high-impact interventions' and results-based financing, participants acquired self-interest in prioritising maternal health issues which would yield increased health funding to their facilities. In this context, policy-making participants reflected on the financial status of their health facilities, obscuring the conditions in which women of reproductive age find themselves vulnerable

to biopolitics regulating their sexual and reproductive health behaviours. Epistemic rationality therefore governed the construction of women's health issues, production of self-interested and compliant participants, and suppressed alternative constructions and the problematisation of maternity and women's health issues.

In addition, maternity and women's health issues were framed normatively. Such framings included maternal healthcare issues as occurring along the continuum of birth (antenatal, labour, delivery and postnatal care), and common reference to 'motherhood' and 'women giving birthing' during articulation of maternal healthcare issues. Maternal health care issues which occurred outside the continuum of childbirth were suppressed; this included abortion care delivery issues which lacked strong statistical evidence, and policy and legal reforms which would not yield tangible impact on investment. Participants also found vindication in moral and legal provisions which govern female sexual and reproductive bodies.

Analysis of the discursive relationships during the conference further indicated that conference practice is regulated by ruling relationships. These were constituted in both textual and oral interactions, created boundaries in maternal and women's health issues, and introduced hierarchies among participants. Policy and legal texts, to begin with, defined the boundaries of prohibited and permitted maternal health conditions. During plenary sessions, there was almost no discussion about the delivery of safe abortion services or the conditions that suggested this might be necessary. During follow-up, interviewees revealed that the presence of participants from state institutions made it difficult for them or others to openly articulate rationales for abortion care delivery. Abortion care issues were mainly discursively engaged in inaudible micro level discussions where there was little chance of recognition of their merits and urgency by the general audience or the conference rapporteur. Thus, knowledge of prohibited and permitted care practices defined what could be articulated for inclusion in and exclusion from national priorities for maternal health. Observation data indicated that advocates for abortion care delivery adopted silence as a strategy to avoid being noticed by participants from the political and regulatory institutions. Participants regulated themselves in interactive relationships to avoid exposure and vulnerability to possible scrutiny at a future date. In follow-up in-depth interviews, some participants from organisations that championed safe and comprehensive abortion care in Uganda reported that fear of being ostracising, isolated,

labelled and bracketed invoked self-censorship. Thus, the silence observed in the conference was a strategy to evade state surveillance.

Another finding related to discursive practice was the power of communicative materials. Several materials were used in the conference: side-video clips, audio and conference screens, and texts. Texts comprised the agenda booklets and literary information material from different organisations, which articulated their scope of work and specific services delivered. Videos were very effective in appealing to the audience before and during the interlude and fed deep into informal discussions during tea breaks. Video clips and printed and PowerPoint visual materials constituted points of reference during discursive engagements, and maternal health issues visualised on screens attracted attention and discussion. Screens also projected maternal health issues that emerged as priorities from discursive engagements. Abortion care discourses constituted in texts embodied all conversations on safe abortion and post abortion care services and products available. They included family planning, safe abortion, and post-abortion care technologies such as pills and Misoprostol delivered by specific organisations. However, abortion narratives did not appear in any visualising material used in discursive engagements. They were only at specific organisations' tables at the edges of the conference hall. Although unsafe abortion is a major contributing factor to maternal death in Uganda, no video clips illuminated the severity of the situation nor was cause of death analysed. Abortion care delivery issues were not made visible, and these issues lacked quantitative qualities to reflect the magnitude, scope and scale of associated problems. Drawing from ethnographic observations, discourses on safe abortion care delivery were hidden in plain sight. I argue, therefore, that communicative materials mediate information but also participate in the silencing narratives linked to abortion care delivery.

Policy-making practice is an embodied assemblage of material components whose organisation and coordination direct the production of a desired population. In this study, policy making practice comprised an array of communicative materials, activities, participants, epistemic rationalities, ruling relationships, and discursive processes, all of which embodied specific ways of governing the setting of maternal priorities. As indicated, communicative materials actively participated in silencing abortion care discourses in the process of illuminating maternal healthcare issues along the continuum of birth. Communicative materials are not merely objects used in communication: they perform

certain functions in the process of communicating about maternity issues. Equally, symbolic expression such as silence, and the framing of discourses as 'post abortion care' in discursive relationships, constituted performances of counter conduct designed to evade state recognition of actors involved in abortion care delivery. I therefore argue for a shift of attention from the cultural symbolic meanings to performative effects of power in a relational conduct of domination designed to govern priority setting and counter conducts against such governmentality.

Two forms of governmentality shaped the setting of national maternal healthcare priorities: neoliberalism and national biopolitics. Neoliberal governmentality occurred through three tools desired to ensure that maternal healthcare priorities were directed towards the deepening of the private healthcare investment. As indicated, neoliberal epistemic language comprised epistemic concepts such as demographic dividends, results-based financing, high-impact interventions, and cost effectiveness. These concepts were embedded in the keynote addresses of the World Bank, UNFPA and WHO, and constituted the framework within which women's health and maternity conditions were constructed, thought about and articulated during the conference. Additionally, statistical evidence was used to measure and identify women's health issues and maternity conditions that meet the investment criteria of high-impact interventions. Individual participants reconstructed their relationships to and reasoning on maternity conditions toward potential financial consequences. Thus, maternity conditions become objects for furthering pecuniary interest and seen as investment opportunities. Equally, the order of keynote addresses provided neoliberalism with the opportunity to direct the entire conference towards its agenda. First keynote addresses came from global institutions and the Ministry of Health, as noted, while the national public health expert keynote address was scheduled last, towards the end of the conference. This ordering rendered the public health address inconsequential to the outcomes of the conference. Third, participant selection also privileged biomedical epistemic communities to shape the constructions and problematisation of maternity conditions, following statistical evidence. This consequently created cognitive injustice to other communities which construct maternity outside biomedical interventions. Effectively, neoliberal tools of epistemic governance succeeded in silencing abortion care since there was lack of statistical evidence to illuminate its magnitude, and participants were self-interested in prioritising maternity conditions which would attract more funds to their areas of jurisdiction.

Biopolitical governmentality, constituted by restrictive morality and the law on abortion, aimed at securing a female population whose obstetric system functioned to further motherhood roles of child bearing and caring. Biopolitics governed through reference to normalising metanarratives of motherhood, reference to birthing women, and the construction of women's health as associated with childbirth. Normalisation effectively made visible the maternity conditions that affected women in their roles as mothers and child bearers, and directed priority setting towards strengthening the healthcare system to respond to such issues. Normalisation also concealed other maternal healthcare conditions resulting from and contingent upon unsafe abortion practice, which disrupted the expected normative conduct of women. Biopolitical governmentality also effectively worked through fear of disciplinary effects, such as stigmatisation, labelling and ostracising, to produce compliant and self-regulating participants. Counter conducts of silence and framing abortion by normalising the concept of post abortion care further stifled the articulation of a transformative agenda for abortion care at the conference. Such counter conducts transform individual agency into an internal tool of self-discipline and direction.

Policy making practice should be conceptualised in the realm of population and reproductive governance in Uganda. Focus on policy making practice and processes enables the illumination of the embodied performative and productive effects of biopolitics and concealed realities, which the vaunted emancipatory power of network participation cannot uncover. Through the lens of critical social theory, I illuminate what is concealed behind the normalised routine activities, epistemic concepts, ordering of things, and interactive engagements. Through concealment, and locking out alternative constructions of maternity and women's maternal health issues, I illustrate how policy making practice is able to efface abortion care from the national agenda. The productive effect of discursive relationships remodels individual agency into an instrument of self-control and direction, and how counter conducts are inconsequential to the possibilities of addressing structural and institutional foundations of obstetric violence among women with abortion care needs. The following publication provides a detailed account of power contestation in policy making practice in Uganda.

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Tools of governmentality in priority-setting

Key messages

1. Insufficient attention has been paid to the ways in which abortion delivery is deprioritised from national maternal healthcare responses.
2. We highlight the organising and performative effects of neoliberal rationality in directing priority setting and effacing abortion care delivery from the national maternal healthcare priorities.

3. We illuminate how neoliberal rationality actively produces compliant and self-regulating participants. It creates an infrastructure in which participants find self-interest to prioritise maternal healthcare issues with high-impact interventions, while normalising metanarratives of motherhood and fear of the disciplinary effects of biopolitics compel advocates of abortion care delivery into self-regulating conduct.
4. The organising effect, epistemic governance, and production of compliant and self-regulating participants suppress opportunities to illuminate structural and institutional conditions which underpin unsafe abortion care; and undermine reforms for quality abortion care delivery.
5. By focusing on the performative and productive ways in which neoliberalism, the state and the health institution govern the conduct of policy makers, we uncover how abortion care delivery discourses are silenced.

Abstract

Unsafe abortion practices remain the major contributor to maternal death in Uganda, impeding the achievement of universal health care coverage and quality of maternal health care. Using an ethnographic design and critical discourse analysis, we explored the operations of power in setting maternal healthcare priorities, using the 2018 Reproductive, Maternal, Neonatal, Child, and Adolescents Health (RMNCAH) Conference as a case. Data were collected using ethnographic observation of the policy-making activities, processes and events, and key informant interviews with 27 participants. We describe how neoliberal and state governance through the structure and organisation of policy-making, epistemic governance, and universal concepts of 'high-impact' interventions, results-based financing, cost-effectiveness, and accountability, all converge to suppress the articulation of local conditions that underpin unsafe and risky abortion. Further, by defining maternity along the continuum of birth and emphasising birthing women, priority-setting was directed towards interventions that promoted women's normative role as mothers and suppressed unmet abortion care needs. Finally, discursive and communicative materials produced actors and

institutional behaviours that controlled the reproductive conducts of women of reproductive age in Uganda.

Introduction

Maternal deaths due to unsafe abortion area continued concern in both restrictive and liberalised legal contexts. Each year, globally, between 4.7–13.2 percent of maternal deaths are attributed to unsafe abortion (Say et al., 2014; Ganatra et al., 2017), with increasing numbers of these deaths occurring in health facilities due to poor quality of care (Namazzi, Waiswa, Nakakeeto, Nakibuuka, Namutamba, Najjemba, Namusaabi, Tagoola, Nakate, Ajeani, Peterson, & Byaruhanga, 2015). In many African countries, comprehensive abortion care delivery is not included in national responses for maternal healthcare improvement. In Uganda, in order to align national maternal health priorities to the Sustainable Development Goals, global networks like Reproductive, Maternal, Neonatal, Child and Adolescents Health (RMNCAH) have taken centre stage to identify priority packages of technical interventions for investment (Ministry of Health, 2016). RMNCAH is an area of maternal healthcare programming which brings actors together into a network through which maternal healthcare issues are identified to assist in developing responsive and preventive interventions.

In Uganda, although policy-making is technically the responsibility of the Ministry of Health (MoH), identifying national priorities for maternal healthcare investment is done through the RMNCAH Stakeholders' Conference. Stakeholders' participation in the policy making network is assumed to be an effective tool for advocacy, empowering actors to articulate neglected maternal health problems and increasing government accountability (Klugman, 2008; S. L. Smith & Shiffman, 2016). However, networks may activate intercountry tensions (Storeng, et al., 2019), and participation may become a means by which individual participants self-direct their discursive conduct (Lorenzini, 2018).

Maternal healthcare priority setting occurs within the context of neoliberal ideology. Neoliberalism, in this article, refers to a distinct form of reason or rationality that organises everyday life, and shapes or governs the conduct of individuals in relation to others in the image of economic rationality. This context encourages individuals to take a specific entrepreneurial form and introduces techniques of self-regulation (Lemke, 2001), although this is not always successful (Inda, 2005). The prioritisation

of policies is informed by inscriptions of worldwide views and the cultures that legitimate them (Alasuutari & Qadir, 2014a). In this context, neoliberal meta-narratives that privilege reproduction may hide questions of abortion care. How neoliberalism shapes national maternal health prioritisation processes and outcomes has not been well explored.

Priority-setting in maternal healthcare is shaped by the demand for universal health coverage (UHC), quality of care improvement, results-based financing (RBF), and cost-effectiveness, due to the influence of neoliberal market forces in public health and global norms of safe motherhood (Béhague & Storeng, 2013; Storeng & Be, 2016; Witter et al., 2017). The concept of motherhood is assumed to be neutral in policy-making, despite that decades of safe motherhood, human rights and UHC have failed to reduce the number of maternal deaths resulting from unmet abortion care needs. Normalising narratives may constitute forms of domination (Hope, 2016) and may justify social arrangements and reproduce dominant systems of governance (Alasuutari & Qadir, 2014a), but they also shape the interpretation and appropriation of policy issues (Levinson, et al, 2009; Walsh 2007).

Evidence used to justify policy priorities often casts an image of rationality (Parkhurst et al., 2018), making interventions that are easier to measure and evaluate more attractive than structural reforms (Walls et al., 2018). This supports technologies and mechanisms in which knowledge production and communication shape how policy issues are understood and how priority setting occurs (Merle & Hellström, 2018). We refer to this as a form of epistemic governance which may privilege dominant perspectives at the expense of others (Freeman, 2015). Epistemic governance is used to manage society. It shapes the perceptions of the world, and determines what gets prioritised and is used by donors to hold recipient countries accountable (Inda, 2005; Gul & Oren, 2017;Béhague & Storeng, 2013; Alasuutari & Qadir, 2014). Specific epistemic stances define what is possible regarding women's health and maternity. In this context, policy priority setting based on existing statistical evidence bases, in which qualitative evidence is undervalued, may constitute an epistemic injustice (Moes et al., 2020). Equally, communicative relationships draw on accumulated knowledge of specific communities (Hook, 2001) and may involve struggles for control (Emmons, 2009), since knowledge bestows power to those who generate and use it (Hook, 2001;Emmons, 2009; Dalglish et al., 2017; Koduah et al., 2016). Analysis is necessary of the existing forms of knowledge, expertise, and means of reasoning which govern maternal healthcare prioritisation, and of how specific

constructions and communication of knowledge renders abortion care invisible and deprioritised is necessary.

Elsewhere, we have described how (post)abortion care in Uganda occurs within a restrictive state law on abortion and morality (Kagaha & Maderson, 2020a). In 2015, stakeholders developed and launched national guidelines and standards to prevent maternal mortality due to unsafe abortion, but following resistance, they were withdrawn six months later (Cleeve et al., 2016). Policy making on abortion is clouded in moral discourses of abortion as evil and immoral (Larsson et al., 2015). Abortion care delivery is often framed in medical, legal and moral lenses (Rowbotham et al., 2019; Fraser et al, 2019), and 'normalising judgements' may be used to produce compliant behaviours (Thiel, 2019). In addition, Christian morality shapes which policy priorities are conceivable and politically possible (Haaland et al., 2019), affecting the legitimation processes (Korkut & Eslen-Ziya, 2016) through which global norms direct the state's behaviours (Cortell, 2000). Further, communicative materials hide specific realities while making others visible (Rudrum, 2016). Maternal health priority setting involves the control of individual behaviours. Discursive relationships produce compliant individuals who are complicit in their self-rule (Merlingen, 2011; Thiel, 2019). Without attending to such technologies that exclude abortion care from national maternal health responses, obstetric violence against women with abortion care needs remain a significant problem.

The national RMNCAH conference to prioritise areas of intervention for better health outcomes in Uganda was held in August 2018. The two-day conference, organised by the MoH with multiple sources of donor support, included district health officers, local and international non-government organisations working in maternal, sexual and reproductive health matters, development agencies and donor organisations. The RMNCAH conference is the platform on which maternal health issues were problematised and articulated, and constituted in a sharpened plan for maternal healthcare improvement. The plan is anchored within the national health sector strategic development plan, and constitutes the overall approach used to accelerate national progress towards maternal healthcare improvement (Ministry of Health, 2016). Before the conference, a trend and bottleneck analysis study was conducted by the MoH and critical issues were identified. During the conference, a summary of the Ministry of Health's analysis was distributed for discussion. After the conference, the technical

working group within the ministry consolidated the conference report into strategic 'high-impact' interventions for national prioritisation.

In this article, we draw on ethnographic research of maternal health priority setting to investigate how the (de)prioritisation of abortion care discourses was effaced from the national agenda for maternal healthcare investment. We sought to answer three questions: (1) What happens during policy-making in the legally restrictive context in Uganda? (2) How do the discursive interactions shape opportunities to prioritise abortion care delivery among maternal healthcare responses? (3) How do questions of expanding the quality, scope and scale of delivery of abortion care get lost? In answering these questions, we blended institutional ethnography and critical discourse analysis to examine the link between policy and legal text discourse, including language in relation to language, contents and contexts (see Krzyzanowski 2011).

The Legal and Moral Context of Abortion Care Delivery in Uganda

Inducing abortion is restricted in Uganda, allowed only on medical grounds for the purposes of saving the life of a mother or the unborn child (HRAPF, 2016). However, there are no statutory instruments to operationalise this provision. Law enforcement agencies continue to use the Penal Code, which criminalises the procurement of abortion and aiding a woman to do so (Mulumba et al., 2017). Although the Government of Uganda ratified the African protocol on the rights of women, it did so with reservation to article 14(2)C on reproductive health and abortion (CEHURD, 2016). The status quo is therefore unchanged and the government has resisted supporting an enabling environment to advance the rights of women with abortion care needs. The restrictive law provides the framework within which national policy responses are made. Consequently, Uganda's sexual and reproductive health guidelines only provide for the provision of post abortion care services. Eighty percent of the Ugandan population are Christian (Larsson et al., 2015), and faith-based institutions, particularly the Catholic Church, strongly influence abortion discourses. In 2016, policy reforms aimed at preventing maternal deaths and mortality due to unsafe abortion were withdrawn due to contention among stakeholders (HRAPF, 2016; Mulumba et al., 2017; Cleeve et al., 2016).

Restrictions impact on both health workers and on women and girls who are harassed, intimidated, arrested, and convicted and imprisoned (HRAPF, 2016). This may lead many women to self-induce

or seek support in unsafe environments, with people who lack adequate skills and expertise; as a result they are at elevated risk of perforation, sepsis and death (Aantjes et al., 2018; Kagaha & Manderson, 2020a). In Uganda, an estimated 54 unsafe abortions per 1000 women of reproductive age occur annually (Moore et al., 2014). Legal restrictions impair the ability of state and non-state actors to develop health system capacities to respond to abortion care needs, and result in discrimination against women with abortion care needs other than PAC as permitted by policy (Mutua et al., 2018).

Methods

Study population and participant selection

This study focused on the policy-making practice. This comprised the organising institution - the Ministry of Health -with participating institutions and individuals from donor and development agencies, implementing partners, local and international non-government organisations, and District Health Officers. Individual participants in the study in these categories were selected based on ethnographic observation in order to explore, from their experiences in the RMNCAH Conference, how maternity and abortion care issues were shaped. The Table below summarises the categories of participants interviewed in this study.

Table 2: Categories of participants interviewed

S/N	Categories of participants	Number
01	Ministry of Health	09
02	Implementing nongovernmental organisation	04
03	Professional bodies (public health experts and Uganda Obstetric and Gynaecological Association	05
04	Religious bodies	04
05	Development agencies	05

	Total	27

Data Collection

Data were collected by observations, in-depth interviews and text discourse analysis. Non-participant observations were made at a two-day RMNCAH conference held from 20-21 August 2018, and at a one-day conference held December 2018. We used an observation guide, developed following the theoretical conception of policy making as an assemblage of activities, actors, processes, materials and ways of knowing (Reckwitz, 2002a), but also as a governmental practice which controls, directs and produces compliant individuals (Foucault, 1977; Lorenzini, 2018). Using this guide, we observed the way the conference was organised, the setting of the venue, seating arrangements, the ordering of events, the communicative material (PowerPoint visualisation, audio microphones, loudspeakers, video clips at the sides of the conference hall, and text materials), and how these factors combined to influence outcomes. Participant interaction in both open sessions and group sessions was observed, as were the technical terms and language used, and communicative materials performed. Brief notes were taken during the conference and expanded as fieldnotes at the end of each day.

The first author conducted 27 in-depth interviews with stakeholders identified in and through the conference, selected for their stake in influencing maternal health and prioritising abortion care interventions. The interviews explored the rationales, meanings and intentions of participants, and explored their epistemic worldviews about maternity and abortion care, their desired policy actions, and silenced positions at the conference. The interview guide was developed following theories of policy-making processes and global discourses relating to maternal healthcare investment, and adjusted in response to ethnographic observations.

Lastly, we reviewed legal and policy text documents which regulate abortion and abortion care delivery. International covenants and documents containing global development norms on maternal healthcare investment were reviewed. We focused also on national laws and moral discourses on abortion to identify bio-political discourses, and explored international and local institutional rules shaping mental, behavioural and discursive choices of participants in policy-making practice. We

also consider the maternal health choices deemed possible or not from the perspective of local and foreign institutions.

Data Analysis

The first phase involved identifying, processing and organising data. As noted above, emerging issues from ethnographic observations were explored in interviews, which were audio recorded and transcribed independently. Expanded field observation notes, transcription, and editing were undertaken by the first author, and were then all imported into N-Vivo software. Data were inductively coded and categorised into themes and subthemes, with text data also categorised into meta or general and specific or local discourses. The second phase involved meaning-making from the themes and subthemes from specific data sources; these included: ordering of events, epistemic technical language, selection of participants and ruling relationships, and the relation of this to the low priority given to abortion care delivery.

We then focused on what the discursive materials, processes and practices at the conference performed, and how participants deployed, appropriated and negotiated power within the micro-space of policy-making. We also examined the link between discursive behaviours and global neoliberal ideology shaping maternal healthcare investment and financing. In doing so, we identified mechanisms in which neoliberalism and national biopolitics hid and silenced opportunities to place abortion care delivery on the national agenda.

Results

In this article, we present findings generated from the accounts of critical ethnographic investigation, in which normativity is disrupted to reveal hidden conditions that underpin the silencing in abortion care discourse. First, we describe and analyse the RMNCAH Conference and critique the normative ways of organising as a means to order and direct policy making toward specific outcomes. We then examine the discursive practices involved in policy making, the play of power, and the constitution of participants into compliant subjects. Finally, we discuss these findings in relation to the ways in which abortion care gets effaced from the national agenda and the implications to addressing obstetric concerns of women with abortion care needs.

The Organisation and Structure of the Policy Making Practice

Policy-making was structured according to and situated within global neoliberal ideological context that shape maternal healthcare investment. Uganda's moral and legal restrictions which regulate women's sexual and reproductive health behaviours also impacted on policy-making. Three structures emerged as shaping maternal healthcare prioritisation: (1) Organisation of the conference, (ii) epistemic governance, and (iii) normalising discourses. We discuss these below.

Organisation of the Conference

The conference was organised to give priority to dominant maternity conditions and 'high-impact' interventions such as improved antenatal care and delivery and postnatal care services. Abortion care was dismissed as having low measurable impact. The RMNCAH Conference began with rapid participatory activities through which maternal healthcare issues were identified. These constituted the main discursive material from which critical maternal health issues were discussed and enlisted for prioritisation. There was recognition in the document containing preliminary maternal healthcare priorities that teenage pregnancy and unsafe abortion disproportionately affected impoverished communities, resulting in preliminary recognition of the need for interventions to address unsafe abortion. However, the location of the conference contributed to effacing abortion care from national priorities.

The conference was held at the Imperial Royale Hotel, a high-class venue at which many other local and international conferences are held. Situated in an affluent suburb, the hotel has a main conference hall where the symposium was held, and other medium-size halls for break-away sessions. The conference hall, air-conditioned with comfortable seats, offered an ambiance disconnected from the socio-cultural, political and economic contexts which underpin girls' and women's vulnerability to unsafe abortion. This, we suggest, dissipated individual and collective capacity to argue for equitable access to and the delivery of abortion and post-abortion care.

The selection of participants emphasised the biomedical epistemic governance over maternal health issues. Most participants were technical actors in the field of health: District Health Officers and delegates from the Ministry of Health, implementing partners from international and local non-government organisations; and donors and development agency staff. Other technical perspectives

that might link maternal health care to the broader biopolitics and social and cultural context were not included. Moreover, maternal morbidity and mortality associated with unsafe abortion involve political, socio-cultural and moral reasoning that inhibited an enabling environment to discuss abortion care delivery. Although some young people were invited, their perspectives were mediated through and limited to family planning discourses articulated in the keynote addresses: that is, they were unable to make comments on these addresses. As the medical participants focused on medical aspects of maternity, prioritisation tilted towards biomedical responses. Discussions on how restrictive biopolitics make healthcare systems unresponsive to critical abortion care needs were consequently suppressed.

Even the order of the keynote addresses silenced debates on abortion care. The opening keynote addresses set the style, framing and content of discussions. In contrast, the public health keynote address that attended to interrelated maternal health issues was presented last, at the end of the second day. The speaker of the closing keynote address articulated narratives of 'health system strengthening,' the interaction and coordination of the different components of 'health system' components, including 'human resources', 'health policy' and 'law'. He also drew attention to complementary linkages between the political, social and economic conditions upon which maternal health is contingent. This keynote address articulated local structural and institutional issues overlooked by earlier keynote addresses, but by the time of this address, some participants had already left and there was little opportunity for participants to engage with the issues. This meant too that the subject matter was rendered inconsequential to the processes that shaped maternal health priorities. Hence policy and law reform, and attention to underlying drivers of unsafe abortion, constituted neither part of the discursive contents nor its outcomes.

Epistemic Governance

Epistemic governance refers to the mechanisms in which knowledge production and communication shape how policy issues are understood and how priority setting occurs (Merle & Hellström, 2018). We analysed the epistemic concepts and principles were used within the RMNCAH Conference to define maternity priorities in terms of 'high-impact' interventions, using statistical data, graphical trends and maps. The keynote addresses given by the representatives of global institutions provided

the paradigm that shaped the way maternal health was problematised, measured and prioritised. Table 2 below summarises the main talking points of keynote addresses at the opening session.

Table 3: Epistemic concepts and statements of keynote addresses at the opening of the RMNCAH Conference, Kampala, 20-21 August 2018.

Organisation	Keynote messages
World Bank representative	Focus should be put on high impact, cost-effective interventions and results
	Support transition to long-term sustainable domestic financing of RMNCAH and scaling up financing from both domestic and international, and private and government sources.
	Smart financing to ensure evidence-based, high impact interventions are prioritising and delivered in efficient results focused way. Prioritise interventions with strong evidence base demonstrating impact
World Health Organization (WHO) Representative	Improve Quality of Care for maternal and new-borns along the continuum of pregnancy, ANC, labour, delivery and postpartum period, and increase access to post-partum family planning
	Mainstream accountability at all levels by addressing capacity gaps in management, administration and overall governance.
	Improve mothers' child birth experience
	Global commitment to universal access to sexual and reproductive health care
	Scale up the evidence based/ high impact interventions for children and maternal healthcare improvement.

UNFPA Representative	Uganda's teenage pregnancy accounting for 25%, the highest in the world. Adolescents' pregnancy account for 28% of maternal mortality and contraceptive use the lowest in the region, at 35%. All these result in a high population growth of 3% per annum.
	Increase the domestic financing of the health sector and improve the implementation rate and accountability for funds
	The need to address commodity stockouts at all levels including the service points
Ministerial speech	The need for investment in the health system (human resources, medicines and supplies, infrastructure development, civil registration and vital statistics, data collection and reporting for evidence-based programming.
	The need to focus on high impact interventions in order to realise RMNCAH indicators
	Universal health coverage to reduce unmet needs for modern contraceptives, ANC, institutional deliveries, PMTCT, comprehensive obstetric and new-born care.
Uganda National Population Council representative	Demographic transition: problematising how median age at marriage, low uptake of modern contraceptives.
	Aim to accelerate family planning, public-private partnerships, human resources for health, and commodities and supplies.
	Effective and efficient service delivery (health, education), strong legislative framework, and zero corruption

As illustrated in Table 2, the agenda for maternal healthcare improvement was set on principles of 'evidence-base' and impact. 'Evidence-based' was aligned to the statistical representation of maternal health issues. Abortion and abortion care delivery issues were not statistically represented

as such data are not collected by national statistical institutions. In Uganda, the national information management systems of the Ministry of Health and the Uganda Bureau of Statistics (UBOS) do not gather data on abortion care delivery. The case for integrating abortion care delivery into a maternal health policy therefore was not visible in statistical and graphical trend analysis, reflecting the restrictive legal and policy environment and shaping what was prioritised. The conception of quality attuned to quantifiable units silenced the chance for illuminating processes and mechanisms through which poor abortion care outcomes emerged. Consequently, abortion care discourses were suppressed using epistemic means to define evidence.

Prioritisation was also steered through metanarratives characterising maternal healthcare issues (Table 2, above). The representative of the World Bank emphasised the investment paradigm, and spoke of 'investment returns', 'demographic dividend' 'results-based/performance-based financing', cost-effectiveness, efficiency, and accountability in maternal healthcare delivery. This discourse provided the framework within which quality of care was defined, quantified and evaluated to enable results-based financing monitoring. This meant that the focus of participants was predetermined. Yet interventions that address abortion care hinge on the policy and legal reforms whose impact cannot be presented in measurable terms since they influence practice indirectly. Moreover, the implementation of abortion care interventions in Uganda is shaped by the existing neoliberal funding regime:

If you now go to check inside the details of many of the funders, this component [abortion care delivery] is left to us. Because many of them [non-government organisations implementing maternal healthcare responses] receive money from USAID, us who may receive money like from the Koreans, we can afford to buy technological equipment for abortion care (in-depth interview with a participant from an international development agency).

Securing funds to implement abortion care delivery interventions is further compromised by the international funding guidelines from the United States of America, known as the Mexico City Policy. This policy prohibits non-governmental organisations receiving funding from USAID to provide abortion care services or to advocate for the liberalisation of abortion laws (Mavodza et al., 2019). Many organisations involved in safe abortion care delivery withdrew from providing the service

because of financial constraints and the fear of losing USAID, the major funder. Thus, advocacy organisations with funding linked to the USAID cut down most of the activities:

> Today, the USAID for instance, which is our biggest funder, cannot put money into procuring equipment for post abortion care because of their gag rule and policy. It is not a Ugandan policy, people [implementing partner organisations] are trying to see that these people [women with abortion care needs] are being managed but their government is having the capacity. They have withdrawn all the funding for such services (in-depth interview with a technical officer from a development partner organisation).

As illustrated, the withdrawal of funding for abortion care service delivery compromised health facility capacities and staff preparedness to provide care for patients with unmet abortion care needs. Although some organisations access funding from alternative and anonymous funding, under the umbrella of the "She decides" movement — a global solidarity movement for gender equality, adjusting in the short term becomes very difficult. Moreover, although resistance against the global gag rule created the movement as the alternative funding mechanism, this does not transform local biopolitics that operate through the restrictive law on abortion and an unclear policy environment for abortion care delivery as one respondent noted:

When they are giving you the funding, they say their activities should be only carried out in countries where abortion is legalised. So, our work is to try and change people and fight for the rights of woman. So that the policy is changed but for them in their phrase they put that, if the country does not support them; they can't give you the money. That is how we failed (In-depth interview with participant from an international implementing partner organisation).

This makes it difficult to have interventions which enable abortion care, including post-abortion care, in Uganda. Moreover, without such reforms in the legislative, policy and normative environment, translating global commitment for universal health coverage of maternal health services becomes difficult:

> We do a lot of dialogue meetings with ministry especially on highly level, like the ambassadors and the minister of health, and other ministers as well. But I think bringing the global commitment into the policies and regulations in the country so that they [the state

> institutions] are following what they are committed to, is a general challenge. It is much more difficult to try to get them implementing their commitments than for them to sign documents (In-depth interview with a participant from a development agency).

Metanarratives at the conference also focused on normalised maternal conditions. For instance, the ministerial statement on maternal healthcare addressed improvement along the continuum of birth (pregnancy, antenatal care, labour, delivery and postpartum). This helped attune the RMNCAH participants to prioritise maternal healthcare responses along women's expected roles of motherhood, and did not allow or discuss ex-nuptial pregnancies and births, infertility, miscarriage, stillbirth or abortion. Although abortion care services would be addressed through interventions aimed at articulating the needs of mothers, many unmarried women and adolescents also often experience abortions care needs but do not appear along the continuum of motherhood. Moreover, even among married women, abortion care needs may arise outside the normative roles. Consequently, women outside a normative identity as mothers with abortion care needs were neglected and their concerns were neither articulated nor prioritised. Even so, at the end of the conference, delegates called for the integration of "harm reduction in the implementation guidelines in PAC e.g., MVA, FP and managing complications" (RMNCAH, 2018). This integration focused on PAC (post-abortion care), so ignoring comprehensive abortion care delivery and the conditions in which poor quality of abortion care outcomes occur at health facilities.

The Discursive Practice

Discursive practice refers to the way people explain their experiences through a system of communicative relationships in which they are embedded (Clarke et al., 2012; Hook, 2001; Kwon et al., 2009; Macgilchrist & Van Hout, 2011; Wodak & Meyer, 2008). The analysis of discursive practices allows us to describe and explore the social structures and the environment through which maternity is constructed and its responses framed, and to illuminate the role of communicative materials, including policy and law. In this study, the analysis of discursive practices focused on the dominant actors – that is, health professionals and policy makers.

Ruling Relationships

Ruling relationships here denote the ways in which hierarchical relationships structure and control individual behavioural practices in maternal healthcare priority settings. In this study, we examined the performance of relationships at the RMNCAH Conference. Discursive relationships shaped the behaviours of participants. First, participants sought to maintain and exhibit the social image of the first lady, who was patron of maternal healthcare interventions. In follow-up interviews, advocates for safe abortion care delivery stated that the presence of participants from state institutions made it difficult to openly articulate rationales for abortion care delivery, and some people preferred to stay silent. Some participants felt that they were being watched and would be sanctioned, ostracised or labelled. This affected how abortion care was articulated during priority setting engagements:

> We were not ourselves, it was an engagement, even…especially the Ministry [of Health] officials, I think was the biggest problem. So, we were very careful on the language we used, how we packaged these issues [abortion care]. This is how we have been there for all these years. If it means using a wrong language that you really don't mean, then do that. If it means calling abortion, post-abortion, then do that; so that you know everybody is comfortable (In-depth interview with a respondent from an NGO).

As above, advocates for abortion care services carefully negotiated morality and law in their articulation. Packaging the need for safe abortion as post-abortion care silenced any conversation around the critical issues that relate to and affect induced abortion that continue to be unsafe and risky for young girls and women. Advocates used silence as a strategy to avoid being noticed by political and regulatory institutions, and being ostracised in development interventions, stigmatised and labelled abortionists. However, in their bid to avoid state surveillance and their self-regulation, their expressive agency for abortion care delivery was suppressed.

The relationships of resistance extended beyond the conference to the abortion care landscape, where advocates provoked state responsibility. They worked behind development agencies to have their advocacy issues articulated, and had unsuccessfully funded a private member's bill in parliament to bring about law reform. However, where advocates pursued legitimate legal reforms, the government deployed the common discursive statement, "we are working on it," without any meaningful

response. In some cases, state institution representatives simply ignored public statements of the need for abortion care, which activists had designed to provoke response. For instance, research reports that articulated the vulnerability of young girls to unsafe abortion in one of the districts in South-Eastern Uganda targeted to provoke response from both the Ministry of Health and the national legislature. This did not enlist input from the government, despite media coverage and the invitation of key government actors. Thus, silence as a tactic of power was used by both the state and activists. However, activists expressed a defeat, as government silence meant failure to transform the policy regime to advance abortion care delivery. To counter state control, some advocates turned to donors to advance their agenda:

> The other nice thing to do is to push it through the development partners, because Uganda is highly donor dependent. If a major donor said it, the government would listen; it would, you know, push back and say 'donors will not tell us what to do' but in the long run they do what they are told to do (laughter) (Key Informant, International NGO).

This option was challenged by some advocates who constantly engaged with members of the donor community. While they recognised the power of development agencies, for example, they also recognised that they had to work within the national law:

> We do not have the back up from the UN bodies. You know, a UN body has the power to twist the arm of the government but let me tell you, all these UN agencies that we work with, UNFPA, UNICEF, what … will never do anything that they feel it is against the laws the country. So that is why we are hanging; we kick the ball this way, we hit a wall and we come back. The UN women for them they go fighting gender-based violence, they go fighting these FGM, but they will never be tough on any area of abortion (In-depth interview a respondent, international NGO).

International development agencies also self-regulated to fit within the government's law on abortion. In follow-up interviews, participants from international organisations and development agencies expressed the fear that their organisations would be expelled from the country if they contravened the national law, and adhered to national priorities to advance their own maternal health programmes.

Fear of the consequence of not doing so successfully suppressed any efforts to include abortion care among national maternal healthcare priorities.

Communicative Materials

Communicative materials also silenced discourses on abortion. Video clips, texts and textualised and visualised material (such as conference screen visualisation) excluded abortion care while other maternity issues were presented. Only maternal conditions amplified by these materials appeared to be considered important by the organisers. While unsafe abortion is a major contributing factor to maternal death, no video clips addressed this, while videos on fistula, health facility infrastructure, and family planning were very effective: they appealed to the audience before and during the session breaks and fed into informal discussions during tea breaks. Video clips and visual materials constituted points of reference during discursive engagements. Maternal health issues represented on screens attracted attention and discussion, and they reflected emergent and prioritised discourses on maternal health.

Discourses on safe abortion care delivery were hidden in plain sight. Texts on safe abortion and post abortion care services and products, available in the conference at specific organisations' tables. Such texts contained discourses on family planning, safe abortion and post-abortion care technologies including abortifacients (used for medical abortion) that specific organisations delivered. These discourses were not included in visual material not in discursive engagements on maternal healthcare improvements in plenary sessions, despite their presence at the tables of specific organisations, located at the periphery of the main conference hall. Even in break-away working groups where the range of maternal health issues generated through pre-conference activities were assessed, abortion care was rarely discussed. Each break-away working group identified, discussed and documented the maternal health issues they considered to be critical for the national response, and these were presented in the plenaries. Moreover, working groups sessions were constituted in afternoons, had fewer participants, and maternal health issues received more critical reflections in the main conference sessions than in break-away groups.

Discussion

Our interest was in understanding the mechanisms through which abortion care delivery was effectively obliterated from Uganda's national maternal healthcare priorities. Our findings reveal that abortion care delivery was effaced through tools of governmentality including both (i) the structure and organisation of the conference and (ii) the discursive relationships through which maternal healthcare priorities were made. Epistemic governance constituted through neoliberal concepts of results-based financing, cost-effectiveness, efficiency and accountability tilted the prioritisation towards identifying maternal health conditions that would advance the growing role of the private sector in maternal healthcare delivery. To effectively achieve this goal, epistemic governance relied on statistical data, graphs, and charts of maternal health trends and maps, as measurement tools that constituted the evidence-base to measure and determine 'high-impact' interventions. There was no national statistical data on abortions or abortion care. Its prioritisation requires reforms in restrictive policy, law and morality to ensure that interventions have a measurable impact. Epistemic governance also operated through normalising biomedical concepts that defined maternal healthcare problems along the continuum of birth (pregnancy, antenatal care, labour, delivery, and postpartum care). These normalising technologies effaced abortion care discourses since they occurred outside the continuum of birth.

During discursive interactions, neoliberal governing institutions and the Ministry of Health combined to shape maternal health priorities. The organisation of the RMNCAH Conference prioritised biomedical participants, locking out non-medical perspectives which could have articulated the need to address underlying conditions for poor maternal health in general and abortion care in particular. The ordering of keynote addresses rendered the public health keynote address powerless in shaping the outcomes. State governmentality operated by silencing discourses on abortion care using vague and dismissive statements in response to (rare) questions, suggesting action to abortion care advocates but without any meaningful response. Fear of being excluded in the network of development actors, and being labelled as an abortionist, also suppressed discourse and ensured compliance and complicity in ignoring abortion as a health issue. Ministerial emphasis on birthing, safe motherhood, maternal and child health all combined to hide abortion care narratives which contradicted the expected roles of women as mothers.

Discursive practice was mediated through normalising narratives that controlled the prioritisation of maternal healthcare issues. Metanarratives of 'women giving birth', 'safe motherhood', and 'maternal and child health' characterised discussions in the conference. These led to pre-occupation with strengthening health systems capacity to respond to the needs of birthing women. The metanarrative of 'women giving birth' fitted with societal expectations of women as mothers. Consequently, the unmet abortion care needs of women seeking to terminate pregnancy were absent. Discursive engagements could not deal with the everyday challenges in abortion care practice which health workers confront within a legally restrictive environment. The primary, almost exclusive, narrative of motherhood drew attention to the reproductive function of women and de-emphasised abortion care needs. Abortion practice was seen to vandalise the moral, legal and spiritual norms, values and beliefs, and women with abortion needs, and those caring for them, are considered transgressive of the collective norms and values society uses to control women's reproductive health behaviours.

Neoliberalism shaped how maternal health was conceptualised, thought about and discussed. From the global development perspective, the narratives of achieving 'demographic dividends' characterised and led to family planning as the foremost national maternal healthcare priorities. This fitted neatly within the national response to the prevention of unsafe sex and the need for abortion, was embraced by conference participants., and matched global priorities that advance increased government expenditure on family planning supplies. During discussions, measurement of quality of care focused on the statistical strength of data, ignoring the processes and conditions that underpin quality care practice. In the context of a culture of investment impact, abortion care constituted a marginal health concern: it lacked critical representation in terms of statistical data on its magnitude, scope and scale. These neoliberal terms acted upon and produced compliant entrepreneurial actors, who were conscious of the economic incentives produced by the Results-Based Financing and found vested interests in following 'high-impact' maternal health interventions. This meant that women of reproductive age became a means towards financing health facilities. In this context, policy-making participants reflected more on the financial status of their health facilities, then on the conditions affecting women of reproductive age. Women accordingly find themselves vulnerable to a biopolitics that regulated sexual and reproductive health behaviours.

The neoliberal and state governmentality produced compliant subjects, uncritical and unconscious of the local conditions and realities women with abortion care needs face, and the institutional obstetric violence. Participative freedom also limited and regulated what people could speak about. Participants' behaviours were governed by formal and informal ruling relationships, and an infrastructure of self-interest embedded in the neoliberal concepts that shape maternal health investment. In addition, participants engaged in self-constituting practices as a result of fear of stigmatisation, labelling and ostracised. Advocates used silence as a strategy to avoid being detected, but this meant that they were complicit in not discussing abortion. Although some participants attempted to counter this by provoking state response and undertaking litigation, the state deployed subtle tools such as silencing and using discursive statements that gave hope without any response.

Many scholars argue that lack of policy guidelines impedes abortion care delivery and inhibits quality improvements that could be facilitated by healthcare training (Mandira et al., 2016; Mutua et al., 2018; Cleeve et al., 2016). Our findings deepen this analysis to illuminate how restrictive contexts limit attempts at policy reforms. We have examined power as exercised in the constitution of subjects through practices, discursive styles (Nunes & Lotta, 2019) and ordering of behaviours (Levinson, 2009). We have argued that advocates and opponents to abortion care often use economic, legal and moral, practical and ideological frames (Rowbotham et al., 2019) and social political drivers (Kienzler, 2019). But here, we have also illuminated how operations shape outcome. While supporting the discursive operations of power, we acknowledge the epistemic effect of evidence-based policy-making (Moes et al., 2020). However, in the context of abortion care, the effect occurs through the creation of an infrastructure of self-interest to prioritise interventions that fit neoliberal interests. Thus, the productive nature of power contingent upon macro-economic and political economy suppresses the struggle for discursive agency (Kimberly, 2009).

Our findings amplify Rudrum's argument (2016) on the need to recognise and scrutinise texts as materials of power that may hide some realities while presenting others. This is critical because policy-making is text-mediated and embodies ruling relations (Bisaillon and Rankin 2013). In this study, however, we add to this by highlighting the power of national governments to govern global interests using local biopolitics. Studying biopolitics as practices of governance helps to uncover how global development interventions and norms fail to enter into the political processes of national

priority setting. We challenge the development imperative of participation as a means to addressing marginal maternal health issues (Klugman, 2008). Rather than a solution, we see that participation serves as a political process that legitimises the growing global influence of business norms within maternal healthcare investment (Jasmine and Porter 2016). This is at the cost of addressing the local conditions that result in women's vulnerability to unsafe abortions and unmet abortion care needs. For this reason, we suggest, neoliberal reforms for decades have failed to put abortion care delivery on national maternal health priorities in many sub-Saharan African countries.

We highlight the need to attend to the organising effect of power in policy-making through ordering keynote addresses and selecting participants. Seemingly neutral activities including choice of venue constitute symbols of domination which successfully hide local conditions which, in this case study, underpin unsafe abortion and fail to acknowledge the need to prioritise abortion care delivery. We unexpectedly identified the active role of communicative materials in organising, silencing and making present specific narratives. These findings point to the intricate ways in which communicative materials constitute ways of governing participants and self-governance. We have illuminated the performative effect of the conference practice, and the mechanisms of power operation by linking micro practices in the conference to national biopolitics and global force of neoliberalism. This was a result of triangulating ethnographic observations and in-depth interviews with critical discourse approach.

Conclusion

At all levels, women's sexual and reproductive health occurs in a political environment, operating through epistemic governance, the structure and organisation of the policy conference, and discursive relationships. As illustrated, neoliberal technologies govern policy-making, and may stifle abortion care delivery. In advancing debates towards the prioritisation of abortion care delivery among national maternal healthcare improvement responses, there needs to be a move away from normative moralities, law and policy to the ways in which neoliberal ideology, the state and health institutions govern the conduct of policy-makers. This distracts attention from the intractable local structural and institutional violence that creates vulnerability to unsafe abortion.

CHAPTER SIX

POWER RELATIONS AND MEDICAL TECHNOLOGIES FOR ABORTION CARE DELIVERY

Considering that unsafe abortion is a major contributor to maternal mortality and morbidity, global efforts have turned to expanding the categories of health workers involved in abortion care delivery and scaling up the use of medical technologies that are classified as safe. Medical technologies have acquired an important position and have been classified into those which are risky and those which are safe for use. Medical technologies are assumed to have known capabilities to secure either risky or safe outcomes, and their categorisation is intended to direct how abortion care delivery is conducted. This direction occurs in a broader biopolitical framing of moral, policy and legal restrictions which regulate abortion care practice. Medical technologies are therefore not objective instruments, but are nested within the political technologies which govern women's sexual and reproductive health practices.

Although unsafe abortion and the withholding of care to women with abortion care needs are recognised as important maternal health issues, there is no critical investigation on the role of medical technologies in accentuating the system that governs female bodies. Nor is there attention to the implications of this for obstetric injustices. Much of the debate focuses on the normative functions and institutional barriers and capacity gaps in accessing and using medical technologies, overlooking the extent to which obstetric injuries continue even with the increased use of safe and appropriate medical technologies.

Uganda's Penal Code prohibits induced abortion and punishes both the women and health workers who abet abortion. The value of human life is particularly influenced by dominant adherence to Christianity in the country, and this has led to equating an abortion to killing an innocent life. Even so, women continue to seek abortion care services. Health workers, as citizens are however, constrained by both moral and legal restrictions in the use of medical technologies for abortion care delivery. In this chapter, I focus on the problem of biopolitics, medical technologies and abortion

care practice. I am concerned with how health workers relate to biopolitical restrictions that govern and direct the choice and application of medical technologies and abortion care delivery practice in general. I examine how they circumvent moral and legal restrictions to offer abortion care service.

How do we account for the risky outcomes of institutionalised abortion care practice when standard guidelines on use of safe medical technologies and biomedical technical expertise both exist? In this chapter, I use the post-structural conception of power as embodied and material, with both productive and constraining effects, and illustrate how the exercise of power enacts counter relational forces of resistance and appropriation. I examine health workers' conduct in relation to the biopolitics restrictions that direct abortion care practice. Using an ethnographic approach, I explore the application of medical technologies in abortion care practice in Uganda's restrictive context and examine the consequences on healthcare outcomes. My aim is to illuminate how biopolitics govern and direct the choice and application of medical technologies, and how health workers evade state surveillance and its punitive effects. Specifically, I describe medical technologies used in abortion care service delivery, explore the meanings and constructions health workers attach to medical technologies and the rationalities that inform choice and application.

The findings presented in this chapter are generated from ethnographic observations of two regional meetings on quality of care improvement. The meetings were funded and conducted by an independent organisation working in the field of sexual and reproductive health in Eastern Uganda. The first meeting was organised for health workers in private healthcare facilities and facility owners, while the second was organised for health workers and administrators in public health facilities in the region. Through these meetings, I identified the overall issues relating to the use of medical technologies for abortion care delivery, and explored these in in-depth interviews. In the meetings, I documented the medical technologies discussed, the discursive interactions between facilitators and participants, and narratives about abortion care, the law and medical technologies. In addition, gestures and speech style – silences, laughter and various facial and body expressions – were documented.

In-depth interviews were conducted with health workers (nurses, midwives and doctors) in private for-profit, private but non-profit, and public health facilities in Eastern Uganda (Iganga district), and with district level regulators of health practice. Corroborative narrative conversations with auxiliary

staff who support healthcare workers in clinical environments were also conducted to gain detailed accounts into the everyday care practice in which these medical technologies were used. Interviews were used to follow-up with health workers on what happens during abortion care and how they navigate the restrictive legal context. In addition, I explored how members of the quality assurance team regulated abortion care practice and critical concerns relating to regulation of abortion care. All interviews were conducted in English, in sites that guaranteed privacy; they were audio-recorded and then transcribed by an independent person. I reviewed the transcripts; all personal identifiers were removed and unique identifiers assigned to the transcripts.

During the analysis, I situated the use of biomedical technologies in the overall performance of the health system in Uganda to locate how practices of abortion care are contingent upon and reflect the macro realities therein. I inductively coded all the data using N-Vivo software.

Healthcare Technologies Used Across Different Health Facilities

Health workers were asked about the medical technologies used in abortion care practice, as summarised in Table 4:

Table 4: Categories of medical technologies used across different health facilities

	Manual Vacuum Aspirator	Dilation & Curettage	Misoprostol	Mifepristone (Divabo combination drug therapy)
Public health facility				
Private profit-making health facility				
Social franchise (non-profit making) health facility				

As illustrated in Table 4, health workers in public health facilities used manual vacuum aspirators, Dilation and Curettage (D&C) and Misoprostol. In private for-profit health facilities, health workers mainly used D&C technology and Misoprostol. Non-profit making health facility workers used MVA, Misoprostol and Divabo – a combination drug therapy comprised of Mifepristone and Misoprostol. Most cases of induced abortion were conducted in profit making private health facilities, using D&C technology, which is considered risky and discouraged in the national policy guidelines. In non-profit health facilities, Misoprostol and Divabo were used to induce abortion. In cases of incomplete abortion, across all healthcare facilities, Misoprostol was used to complete the removal of products of conception. According to in-depth interviews, Divabo could not be promoted in public health facilities as it is explicitly intended for inducing abortion, while in profit-making health facilities, health workers reported that this technology was too expensive.

Manual Vacuum Aspiration Technology

I explored what informed the choice and application of specific technologies across different categories of health facility workers. Many health workers in public health and non-profit health facilities emphasised the internalised safety of MVA technology. However, I observed in Health Centre III that MVA technology was covered, with dust accumulated over it, without any signs of use. Some of the health workers explained that the technology was supposed to be used only by the doctor, who was the 'in-charge' of the facility; they were not allowed to use it. Others reported that there were no cases of patients who appeared with complications where the technology might be used. In general, MVA was applied in higher level health facilities – Health Centres IV and the district referral hospital. Across in-depth interviews with health workers in public and non-profit health facilities, use of MVA was based on the recognition of its safety for women, as informed in the trainings. However, among private healthcare workers, non-use of MVA was attributed to its ineffectiveness, which challenged narratives of its safety.

Besides choice, the application of MVA required a lot of time, about an hour to complete an abortion. Where many clients were seeking induced abortion, only a few could be cared for, and both patients and health workers were mindful of time spent, since time-consuming technology increased the risk of apprehension. In addition, MVA restrictions meant that the technology could only be used on women with pregnancies of 12 weeks or less. However, health workers received clients whose

pregnancies were often above this gestational age, who would be lost if they followed this restriction. Estimation of gestational age was often inaccurate and health workers reported that this technology could not effectively aspirate all products of conception from the uterus. Thus, although MVA was categorised as safe, the application of the technology if transgressing gestational age increased the risks to the woman.

In addition, the use of MVA was reported to be cumbersome and many health workers lacked the skill to disassemble and reassemble the equipment. This gap was evident during the regional quality of care improvement meetings, when health workers failed to adequately reassemble the MVA after disassembling the parts. Full disinfection of the technology required skills of first disassembling the components for total immersion into the disinfectant for cleaning, then reassembling them. Lack of adequate skills can increase the risk of infection. According to quality assurance officers, health workers lacked this capacity and knowledge about the time needed for disinfection. Health workers did not have timers in their health facilities to guide them, and they had to guess sufficient time; this could be compromised when there was a steady demand to use the equipment. In the referral hospital, the use of MVA was further constrained by a limited supply of disinfectant. Health workers were forced to transfer the cost of this to the patients, increasing their financial burden.

Dilation and Curettage (D&C) Technology

D&C was the main technology used to induce abortion in private for-profit healthcare facilities. It was also used by doctors in emergency operations in the district referral hospital. As discussed in the article below, health workers who used D&C revealed the political interests of evading state apprehension, securing financial benefits and increasing the scope of women for whom induced abortion could be conducted. Non-use of this technology was attributed to the strict adherence to the standards and guidelines from the government and the riskiness associated with the technology. These concerns were also shared by health workers who used the technology but attributed the riskiness to both lack of experience and knowledge about the reproductive system among some health workers who, as a result, traumatised women when undertaking abortions.

Pharmacological Technologies

The use of abortifacients such as Misoprostol was reported across all categories of health facility workers. Misoprostol was used to induce abortion and was used in post abortion care to complete the removal of retained products of conception from the uterus. Misoprostol was considered a master drug for the complete removal of retained products after abortion, especially after the use of MVA. However, if Misoprostol failed, MVA was used to clear all retained products of conception: "There is a time I gave (it), then it failed; then I did MVA, that is when it came out. It can also fail but the failures are fewer" (Rose, non-profit health facility respondent). Misoprostol was also used to induce abortion, as a precondition for accessing PAC. Health workers reported that Misoprostol was used outside the clinic to induce contractions of the cervix to initiate abortion, allowing women to claim the right to post abortion care at public health facilities. Patients were able to access the drug on the open market, as an over-the-counter drug in private pharmaceutical shops, due to gaps in regulation. According to the quality assurance team at district and national level, Misoprostol is licensed in Uganda as a drug for managing post-partum haemorrhage, a critical condition contributing to maternal deaths. Accessing Misoprostol over the counter increased risks of underdose, overdose and misuse, as acknowledged by health regulators. At pharmacies, the drug is provided openly, although neither clients nor the dispenser wanted this known publicly. Health workers argued that pharmacological technology removed the need for surgery, so reducing risk of infection, and made the complicated abortion care procedure easier, with little risk of apprehension since patients could induce an abortion at home. Divabo, the combination drug therapy of Misoprostol and Mifepristone, effectively worked to induce abortion, and was used mainly by health workers in non-profit health facility. Divabo was considered very effective in securing a safe abortion, but public health facilities health workers did not use it because of the restrictive law. In Eastern Uganda, Divabo was supplied without charge by an international NGO working the field of sexual and reproductive health to the non-profit health facility, but not to the profit-making health facility, which would then make money out of the service:

> Divabo is for sale not for free, and you know, you cannot go there [in public health facility] for sale who will pay? In the private [health facility], we think we should not give something for free to somebody [a facility] who is going to make money out of it. If they were offering

> free services, then it would be justifiable to give free products. The procedure [abortion] he is doing; he is charging it about 200,000/= [two hundred thousand Uganda shillings]. So, it really does not make sense; a procedure for management of PAC or MA, someone can even charge you 300,000 and because these are patients who are desperate, for those procedures, they will pay (Mercy, NGO respondent).

Ultrasound Technology

Ultrasound was reported as a valuable technology in abortion care, although only the hospital had the technology on site. The non-profit health facility offered ultrasound services once a week, on days allocated specifically for maternal health care. Ultrasound technology was not accessible to most of the health facilities in the region and accessing it required extra costs on the part of the patient. Ultrasonography was reported across different health facilities as a necessary component in abortion care, especially in cases of emergency, to help ensure accurate assessment. Without the technology, health workers relied on physical examination of the patient to identify conditions of incomplete abortion and perforations of the uterus, and on scanty details in history-taking:

> First of all, getting the information from them [patients] is tricky. Remember they are young people; they would not like to disclose that they are getting such conditions from this [abortion] problem. History taking become very tricky, they will never disclose. If someone is not very good at doing physical examination, she/he may miss out. You need a scan to be sure that are the products were completely removed.

Some health workers, however, considered ultrasound scanning a waste of time and considered experience was enough to ensure complete evacuation or to assess the necessary steps in care. During quality of care improvement meetings, health workers were trained to use ultrasound but not to interpret ultrasound images.

Post Abortion Family Planning Technologies

Post abortion care services entail a package of information and services on family planning. Promotion of family planning services emphasised the use of long-term methods such as the intrauterine device (IUD). Health facilities were given financial incentives based on the number of

clients recruited on long-term methods of family planning, and health workers from both private and government health facilities were trained on how to administer different family planning methods. Even at the district level, it was reported that family planning was high on the agenda: "We have a very big drive for family planning, those unwanted pregnancies will be reduced; we have to tell people how to use the method they are availed with" (Henry, public health facility respondent). Among health workers from Catholic-founded health facilities, only natural methods of family planning could be promoted. In the main hospital, women who expressed the need for (or interest in) family planning were referred to another department due to human resource shortages. However, the choices and use of family planning technologies was very limited. While some information was offered after abortion care procedures in all facilities, many patients indicated the need to consult their spouses before accepting family planning, and many were wary of the side effects of the technology. In addition, in some facilities, family planning services were simply neglected in post abortion care service delivery. Consequently, many women returned a few months after post abortion care, again with the need for care following an incomplete abortion or wanting to procure an abortion.

Drawing on the findings above, I argue that the choice and application of medical technologies used in abortion care are informed by and contingent upon biopolitical technologies. The use of medical technologies was shaped and directed by rationalities about safety and effectiveness. The markings of gestation age limits to MVA, and in determining the dosage of Misoprostol, represented forms of control embodied in medical technologies. This embodied restriction directed health workers' conduct. Embodied power establishes boundaries between prohibited and permitted induced abortion, and indirectly personified foetuses above the gestation age as bodies with inter-uterine citizenship to be protected. Many health workers internalised foetuses as persons whose lives had to be protected, and many attached this to their professional duty to save life, not kill. Restrictive power based on the categorisation of medical technologies acted upon health workers to produce positive effects, as many health workers exercised self-restraint from choosing medical technologies which they considered risky. Secondly, through criminalisation, health workers chose specific technologies to minimise the risk of exposure of practices conflicting with national abortion law. In health facilities where abortions were induced, health workers relied mostly on D&C technology because it was regarded as time-saving and effective.

These forms of power are often challenged, contested and transformed during care practice, particularly in private healthcare facilities. Health workers reconstructed meanings of efficiency in relation to the complete removal of all products of conception, time-saving capabilities to evade state apprehension, and ability to transgress any gestation limitation in order to care for women needing induced abortion. Equally, consciousness of the criminalised nature of their conduct increased the fear and tension in operations, thus affecting the efficiency and increasing the risk of an incomplete abortion and uterine perforation. Health workers operated by stealth, limiting the possibilities of consultation when complications emerged. This deprived patients of the opportunity to benefit from wider specialist consultation, and increased the risks of severe morbidity, emergency surgery (such as hysterectomy), and death. Emergency case handling practices were designed to enable a health worker to escape the law, with the patient's health and life apparently secondary. Thus, criminalisation compromises the ability of district health teams to monitor, supervise and regulate the use of medical technologies and practices of abortion and post-abortion care.

Biopolitical governmentality induces counter conducts to render the juridical practices of the surveillance state ineffective. Abortion care is conducted in secrecy. As already argued, other conducts transgressed restrictions by applying technologies on pregnancies above the gestation age restriction. Navigation around state surveillance mechanisms, and modes of framing rationalities for transgression of embodied restrictions in medical technologies, legitimised conducts considered outside permitted boundaries, and extended the pursuit of pecuniary interests through abortion care delivery practice. The transgression of normative restrictions induced panic during care practice which increased the risks of perforations, incomplete abortion, excessive bleeding and death. However, patients who recovered through such practices of technological transgression did not necessarily understand the source of the risks and extended the referral network, thus reproducing obstetric injustices in abortion care practice. Risks emerged, therefore, from the conducts of technological application in panic and fear of being apprehended, and comprises in quality of care (such as poor disinfection protocol) after abortion care. I therefore argue that categorisation of medical technologies into risky and safe technologies does not guarantee safer outcomes, since the risks are emergent outcomes of technological application, rather than a result of the technologies themselves.

As indicated in Figure 3 below, both conducts of obedience to and resistance against state regulations, on the use of medical technologies and abortion care practice, involve possibilities of obstetric justice and injustices. By adhering to state disciplinary boundaries, health workers create boundaries and discriminate against patients with induced abortion care needs, outside the permitted condition. Those women who are discriminated against often resort to seeking alternative avenues for inducing abortion in panic, which results in increased possibilities of risk of having retained products of conception, perforations and excessive bleeding. The article which follows, published in *Social Science & Medicine*, illustrates in detail the effects of power on the application of medical technologies in abortion care delivery.

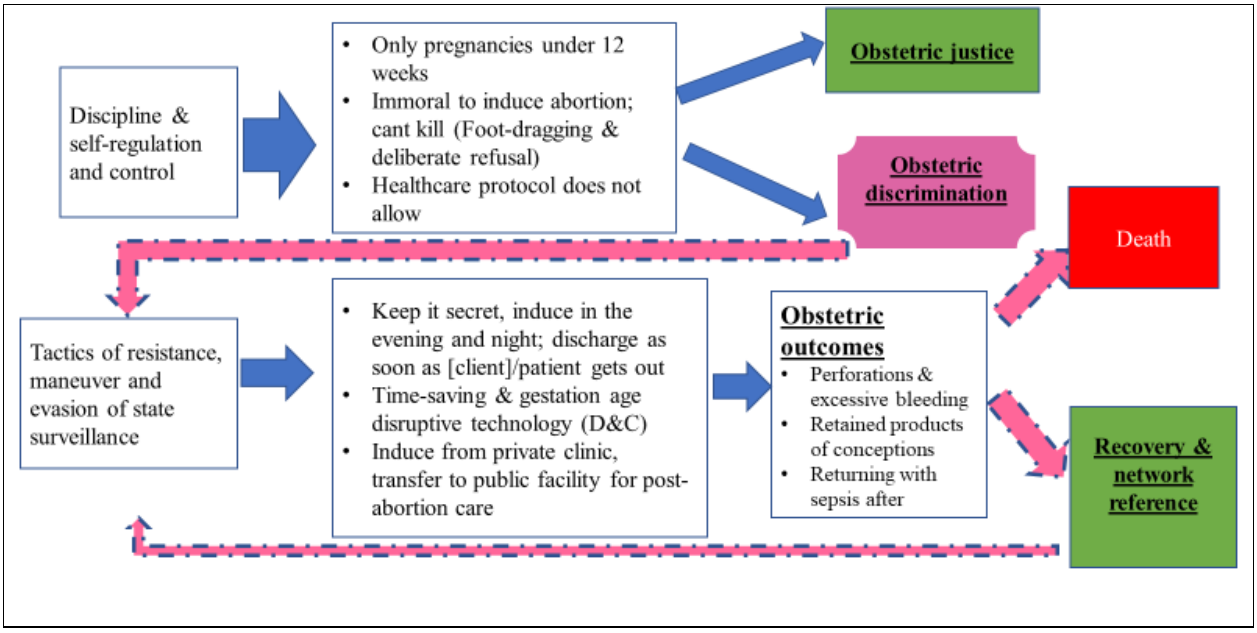

Figure 3: Health workers' responses to restrictions on medical technologies and abortion care

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Abstract

Manual Vacuum Aspirators (MVA), Dilation and Curettage (D&C), and medical abortifacients (Misoprostol, Mifepristone and Divabo) are available in clinical settings that offer abortion and post-abortion care in Uganda. While these technologies imply appropriate and safe abortion care, legal and policy ambiguities impact health outcomes. In this article, we draw on an ethnography of abortion care delivery practice conducted in one district in Eastern Uganda between August 2018 and March 2019, with data from interviews and observations, both of interactions and during quality of care improvement and training meetings. We illuminate how, in the context of a financialised healthcare system and legal restrictions, the meanings and use of medical technologies and abortion care vary across different health facility types. In public health facilities, health workers become state agents in the control of women's bodies. In private health facilities, they become transgressors, who use medical technologies to help women attain termination surreptitiously. Health workers offset risks associated with any involvement in termination, such that pecuniary interests dominate their motivation. Normalised and disciplinary power enact and reproduce unsafe and risky conditions, leading to poor abortion care outcomes. We illustrate the mechanisms of domination and tactics of resistance in abortion care, and expose conditions upon which unsafe and risky outcomes are contingent.

Keywords: Uganda, Abortion, Categorisation, Criminalisation, Domination, Instrumental Reason

Safety and riskiness in abortion care practice are contentious in debates on how to scale-up quality abortion care service where medical technologies occupy centre stage. Many scholars assert that the use of technologies which are classified as 'safe' reduces risks and produces better maternal and infant outcomes (Ganatra et al., 2017; WHO, 2015a). Others argue that better outcomes are contingent on scaling up the capacities and broadening the levels of health workers involved in abortion care (Abdella et al., 2013; WHO, 2015a). A third group advance the need to liberalise restrictive laws to allow safe abortion practice (Mishtal, 2018). In sub-Saharan Africa, law reform, medical technologies and the integration of nurses and midwives in abortion care delivery can all be critical in reducing poor maternal health outcomes.

What is inadequately understood, however, is what 'safety' and 'riskiness' represent in abortion care and the conditions that produce them. Some studies classify medical technologies as 'safe' and others as 'risky' and inappropriate to use in primary care settings (Ansari & Abbas, 2017; Ara, et al., 2018; Benson et al., 2017; WHO, 2015a; Ganatra et al., 2017). However, even safe technologies can result in risk and injury such as perforations of the uterus (Bechem et al., 2016; Dao et al., 2007; Sayami, 2019). Moreover, not all practices involving 'risky' technologies, such as Dilation and Curettage (D&C), actually result in poor abortion care outcomes, and in eastern and southern Africa, D&C remains the preferred method of post-abortion care in hospitals (Aantjes et al., 2018). What is also missing is knowledge about how risk and safety arise in abortion care practice. Many studies in this field ignore the choice and application of medical technologies in healthcare practice. Although the notion of neutrality and objectivity in reproductive technology has been questioned (Eklund 2017; Payne 2016; Powell-Jackson et al., 2015), how technologies shape abortion care practice remain unknown.

In addition, there has been little work on how elusive structures of power play out in abortion care practice in legally restrictive environments. Foucauldian scholars show that power is highly complex and perpetually in motion, and normalised in ways which require neither fuel nor direction from those holding it (Deacon, 1998). Power is also hidden in language, formal knowledge and text (Anonymous et al., 2015), in the form of mental dispositions and discursive practices in which tension plays out, transgressing social norms and values (Hodge, 2014; King, 2013). Although the disciplinary effect of the law is considered a barrier to the access to and delivery of abortion care (Suh, 2014), the

mechanisms through which power operates in abortion care, and how these interact with power tied to class, remain underexplored. Thus, in both its normalising and disciplinary effects, the mechanisms and conditions by which power shapes technological outcomes need to be adequately examined.

Although the integration of midwives and nurses in abortion care delivery, in many contexts, lead to better abortion care outcomes (WHO, 2015b; Cleeve et al., 2016; Bain & Kongnyuy, 2018; Mandira et al., 2014), their practices are not immune to unsafe and risky conditions, particularly in legally restrictive environments, within institutions as well as outside of health facilities. Yet this may help uncover conditions and mechanisms through which risky outcomes emerge even when 'safe' and 'appropriate' technologies such as Manual Vacuum Aspirators (MVA) and D&C are applied in a timely fashion. While abortifacients are effective for the medical termination of pregnancy, MVA and abortifacients have gestational age restrictions, and the meanings and interests they represent for health workers involved in abortion care are inadequately understood. If institutionalised, abortion care is immune to risk, how do we explain the poor health outcomes which some researchers report (Bechem et al., 2016; Ganatra et al. 2017)? Why would there be a decline in the use of medical technologies which are classified 'safe', and a shift towards those known to be 'risky' (Cook et al., 2017; Odland et al., 2014)?

In this article, we examine how medical technologies and abortion care are shaped in a restrictive legal context, drawing on research conducted in southeast Uganda. In exploring the factors that influence the high rate of maternal deaths from abortion (Ahmed et al., 2018; Ziraba et al., 2015), we show that safety and risk are emergent features of healthcare practice. This is institutionally dependent and contextually contingent on Uganda's restrictive moral and legal context and the financialised healthcare system. We transcend the normative classifications of 'safe' and 'risky', 'legal' and 'criminal' to uncover hidden meanings and interests. These classifications, together with medical technologies and the law, are conceptualised as embedded with inscriptions of power but are also contested through healthcare practice. In this article, abortion care is conceptualised comprehensively to capture both 'safe abortion' and post-abortion care practice in which medical technologies are used.

Methods

Study Sites

The findings we present below draw from a larger ethnographic study of abortion care delivery practice in one district in Eastern Uganda between August 2018 and March 2019. Ethical approval was obtained for the study from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, and the Uganda National Council of Science and Technology (UNCST).

The study was conducted in four health facilities in Iganga district, Eastern Uganda. The selected facilities were identified through an entry meeting when the study was introduced to key actors in the delivery and regulation of sexual and reproductive health services in the district. During this meeting, stakeholders identified one public health centre (level III) and one private, non-profit health centre (also level III), both with a high volume of maternal reproductive health cases reported to the district. The latter facility, located about 3 km out of the town, did not provide induced abortion, but offered post-abortion care for women who had attempted a termination elsewhere and required follow-up care. We also included one private profit-making health facility located in the town, where most cases of induced abortion were reported to take place, and where cases of incomplete abortion were referred and managed. Finally, the district referral hospital was selected to specifically explore the referral and handling of patients with post abortion care needs. The selected sites represented the different categories of health facilities in Uganda, and allowed inquiry into induced abortions, post abortion care and the referral pathway.

Study Participants

Within each health facility, the different categories of health workers directly involved in abortion care delivery, including nurses, midwives and doctors, were identified by the health facility in-charge. In total, 16 health workers (seven female, nine male) were selected because of their involvement in delivering abortion care services. In addition, eight participants from government, and local and international non-government organisations working on sexual and reproductive health matters in the region, were selected because of their stake in quality of care regulation. In total, 24 participants participated in this study.

Data Collection

Ethnographic Observations

The first author conducted participant observation in two regional training and quality of care improvement meetings organised for health workers, private health facility owners and district health administrators. The first meeting comprised health workers in and owners of private health facilities; the second regional training meeting comprised health workers in public health facilities and district health administrators. Both meetings were organised and facilitated by a non-government organisation (NGO) working in sexual and reproductive health. In these meetings, the first author documented the medical technologies discussed, the discursive interactions between facilitators and participants, and narratives about abortion care, the law and medical technologies. In addition, gestures and speech style – silences, laughter and various facial and body expressions – were documented. In-depth interviews were used to follow-up on some of the issues observed.

In-Depth Interviews

Interviews were conducted to explore with health workers what happens during abortion care, and how they navigated the restrictive legal context. In addition, we explored how members of the quality assurance team regulated abortion care practice and what they regarded as critical concerns relating to regulation. All interviews were conducted in English at sites that guaranteed privacy; these were audio-recorded and then transcribed by an independent person. The transcripts were reviewed by the first author and all personal identifiers removed and unique identifiers assigned to the transcripts.

Data Processes and Analysis

Transcripts from in-depth interviews were imported into N-Vivo 11 software, where data were inductively coded, generating a hierarchy of nodes. From this we developed subthemes for each technology used in abortion, then merged similar subthemes to generate themes that were both exhaustive and mutually exclusive for analysis. We compared data from transcripts of health workers from the same health facility and analysed findings within the specific health facility conditions. We then compared findings on the different technologies across health facilities and analysed those findings within the broader moral and legal restrictions, and a financialised healthcare system.

Results

The Context

Ugandan institutions and everyday morality attach strong value to the sanctity of life. Article 22(2) of the constitution of the Republic of Uganda prohibits the termination of the life of an unborn child except as provided by the law (Government of Uganda, 2006). However, in the absence of a statutory instrument enacted by parliament to enable the operationalisation of this provision, the penal code is used by law enforcement officers to arrest and prosecute health workers caught in conflict with the law on abortion (Ngwena, 2014). Under the penal code, both the health worker and the woman who terminates pregnancy are criminalised. The Uganda Penal Code criminalises any person who aids a woman to procure abortion, and that person is liable for imprisonment for 14 years (Mulumba et al., 2017). Lack of harmonisation between the constitution and the penal code creates a vacuum in abortion care delivery, which consequently occurs in a misty legal environment.

Uganda's law on abortion is anchored in secular English common law codified in the penal code (HRAPF, 2016) and in traditional moral precepts, both of which have historically regulated women's sexual and reproductive health. However, religion strongly influences the legal and policy context. Uganda is predominantly a Christian country, with eighty percent of the population being Christian (Larsson et al., 2015), and this has shaped how actors respond to and represent abortion. In 2015, the guidelines on the prevention of maternal mortality due to unsafe abortion were withdrawn after strong resistance from the religious bodies (Cleeve et al., 2016; Mulumba et al., 2017). Similarly, "teachers' manuals on safer sex to avoid abortions were withdrawn from school curriculum in the face of advocacy" (Larsson et al., 2015:2).

Nevertheless, the provision of post abortion care is allowed under the national health guidelines for sexual and reproductive health (MoH, 2016) and complications from induced abortion may qualify women to access post abortion care service. Yet even within this policy provision, "women and girls, and health workers remain vulnerable to law enforcement personnel and face arrest, prosecution and imprisonment" (HRAPF, 2016:5). A significant portion of women who seek abortion care delivery services are young, with restrictions on their movement from both schools and home. In addition, many private clinics and drug shops are operated by attendants with varying backgrounds, experience

and medical knowledge. Although the Council of the Pharmaceutical Society of Uganda is expected to regulate pharmacy practice, Uganda's health system is characterised by a "brain drain of highly-skilled health workers, low uptake of trained pharmacists into jobs" (Imbi et al., 2019: 608). In this context, we examine how medical technologies shape and are shaped in abortion care practice.

Gestation and Ultrasound

Gestational age is key to understanding the choice of technology for abortion. Gestational age is conventionally estimated as the number of completed days after the onset of the last normal menstrual period, and this is important for two reasons. First, the medical technologies accessible at primary care level are designed to induce and complete abortion of a fetus under 12 weeks. Although the concept of abortion is used for terminations of pregnancy up to 28 weeks in Uganda (Kiggundu et al., 2008), fetuses above 12 weeks are, personified as human beings and are protected by the state. This point was reiterated by health workers in in-depth interviews: "For me, it is worse when it is more than 12 weeks because I feel it is a real human being in existence but the other one [under 12 weeks], it is still in formation and some things are not yet" (Agnes, midwife, health centre III). According to many health workers, fetuses above 12 weeks represent bodies closer to full humanity and need to protected, and accordingly, gestational age serves a moral as well as technical control limiting the application of medical technologies for abortion. However, determining gestational age is challenging as most health workers rely on patients' reports. Ultrasound technology allows for greater certainty of gestational age (Kimport & Weitz, 2015; Wanyonyi et al., 2017), but only two of the four health facilities had ultrasound technology on site; and health workers from one of these had access only once a week, on the day allocated for maternal healthcare.

In general, ultrasound was used for emergency abortion care rather than prior to abortion to determine method of termination. Patients were referred for ultrasound as an out-of-pocket expense to detect retained products of conception and uterine perforation, conditions associated with the prior use of MVA and D&C respectively. Ultrasound was also used to complement history notes in emergency cases where concealment of information was suspected. As one health provider noted, it was "tricky" to solicit information from women seeking abortion care: "Remember they are young people; they would not like to disclose that they are getting such conditions from this [abortion] problem. History taking becomes very tricky, they will never disclose. And if someone is not very good at doing

physical examination, they may miss it [the complication resulting incomplete abortion]" (Kizza (pseudonym), medical worker, district hospital). Without access to ultrasound, health workers relied on physical examination to identify possible incomplete abortion and uterine perforations. Some health workers also felt that scanning was a waste of time and money for already impoverished patients, and they preferred to rely on experiential knowledge: "You go and do an abdominal ultrasound to see whether it is this or that, so those investigations take time. With my experience I can say this one, no, let us just go direct to evacuation" (Dembe, health worker, district hospital).

Drugs

Three pharmacological drugs are used in abortion care: Misoprostol, Mifepristone and Divabo. Misoprostol in Uganda is licensed to manage post-partum hemorrhage, to treat ulcers, and for abortion. Misoprostol is intended to be used independently and was most commonly reported by health workers as ideal for completing abortion and removing retained products of conception, especially after MVA: "When she has just been bleeding, that is when you give Misoprostol so that it clears all products" (Peace, medical officer, public health centre III). Health workers across different health facilities and participants in the regional training meetings all supported its use.

Misoprostol and emergency contraceptive pills were accessible through the open market. Many women purchased Misoprostol from a pharmacy for personal use to secure an abortion. However, purchase was constrained by lack of privacy at access points, as one respondent explained: "Remember a pharmacy is an open place. People who come for Panadol are also listening to somebody asking for them. It is a problem both to the clients seeking for it and to the dispenser giving that service, because he/she wouldn't want to be known to provide the service" (Sarah, regional quality assurance officer). Once a woman had self-initiated termination by taking the drug, she would then seek post abortion care at a public health facility. Some health workers considered this a misuse of the drug: "We got Misoprostol for managing PPH [post-partum hemorrhage] which is the biggest cause of maternal mortality here, and if we used it that way then it would be OK. Unfortunately, people are using it for abortion" (district health official).

Mifepristone and Divabo are used together as a combination drug therapy for termination. These were less commonly reported, but were said to be very effective. One health worker recounted that

she had "administered the first tablet and before the client came for the second dose, the thing [conceptus] was already out, meaning it works effectively" (Teddy, regional quality assurance officer). However, government facilities were not supplied with Divabo because of the government policy on abortion, and it was available only in private health facilities and social franchise clinics, the latter a network of health facilities established and supervised by non-governmental organisations to scale-up quality and cost-effective sexual and reproductive healthcare.

Complications in Abortion

Misoprostol was associated with failure to complete abortion after induction, sometimes due to errors in dosage: "It does not actually complete the abortion; it stops on the way because the dosage is not right. So, many clients are ending up with incomplete abortions resulting from use of Misoprostol" (Jane, regional quality assurance officer). Errors in dosage were associated with lack of adequate knowledge about the correct dosage by women self-administering the drug. In addition, although health workers – enrolled nurses, clinicians, and pharmacists – insisted that they had adequate knowledge about dosage, this was not always the case: "Okay, Misoprostol is very effective in inducing abortion, but what I have found is that people [health workers] do not know the right dosages of Misoprostol to give to induce abortion. A lot of Misoprostol is being used wrongly" (Jane, regional quality assurance officer). Complications from the unsuccessful use of Misoprostol led to the need for other technologies.

Manual Vacuum Aspiration (MVA)

MVA was mainly used in public health facilities and the non-profit health facility, and was regarded as very effective for pregnancies under 12 weeks, especially with an incomplete abortion with retained products. Private health facility workers, however, felt that it was ineffective and that the available technology lacked aspiration capacity, particularly when gestational age was over 12 weeks: "For us, we go for Continuous Medical Education (CMEs) and they want us to use MVA for abortion. But MVA cannot work well if the pregnancy is over three months. We do not use this system because it cannot aspirate the contents from the uterus" (Suzan, nurse, private health facility). Health workers relied on information provided by patients to establish gestation age, and when this was inaccurate, the outcomes of the MVA were compromised.

On the other hand, MVA was considered very inexpensive for both the health facility and patients, since no drugs are used and a patient does not need hospitalisation. However, some health workers considered it to be time-consuming, tedious and inefficient. Most reported that it took from 30 minutes to an hour, depending on whether tissue was retained in the uterus. Without adequate time and patience, the abortion would remain incomplete, with the risk of septicaemia. Some patients returned to the health facility with complications as a result:

> You may think everything has been sucked out but you may find three to four days later, a patient comes back with lower abdominal pain, with labour-like contractions, and says that 'I am bleeding things which are clots'. If there are no retained products, the patient would not have labour-like contractions (Walter, medical officer, private health facility).

Health workers also reported serious concerns relating to the sterilisation and use of MVA equipment, as some could not assemble the MVA to create the vacuum needed for aspiration. At regional quality assurance trainings, there was no discussion of signs of incomplete evacuation of products of conception from the uterus, and very few participants could assemble, use and disassemble the MVA to the satisfaction of the quality assurance officers. This was despite that this was follow-up training on skills which, in theory, health workers already possessed. If MVAs were sterilised according to the protocol, infection would be avoided, but this also required experience and adherence to a systematic process: "If one misses one step, then infection arises. If someone is not experienced in doing that, then incomplete abortion occurs" (medical worker, district hospital). Some health workers sterilised the MVA by boiling. According to the quality assurance team, high level decontamination following the standards requires letting the instrument stay in a highly concentrated disinfectant for at least 20 minutes, and then washing it in sterilised or boiled water. However, few health workers could conduct adequate high-level decontamination to ensure that the MVA was safe to use on the next woman. They did not use timers when disinfecting and, at times, MVAs were left for too long in boiling water or in *jik* (disinfectant). Consequently, the plastic technology lost its effectiveness: *"*Last week when we went for an outreach in a public facility, I saw a health worker trying to heat [the MVA] and then it was shrinking" (Sarah, regional quality assurance officer). Further, in public health facilities, sterilisation was contingent on the availability of disinfectants, but supplies were irregular and well below facility needs based on activities: "Here, we are expected to use at least five

litres of *jik* every day because we have to decontaminate everything; because you find we are having fluids and blood all the time. But we are given only two litres. Sometimes you get five litres in a week" (Loy, medical worker, district hospital). Consequently, health workers sometimes asked patients and their caregivers to bring their own supplies, thereby transferring the maintenance costs to the women.

Dilation and Curettage (D&C)

D&C is a surgical procedure that involves the use of a set of instruments to remove the products of conception from the uterus. A health worker uses a dilator to open the cervix and then a curette to scrape the walls of the uterus and scoop out the products of conception. In social franchise health facilities, health workers had phased out this technology and did not use it for abortion care. In public health facilities, D&C was undertaken only by medical doctors, and at health centre III level, interviewees reported that it was used before MVA was introduced. Like the MVA, its effectiveness was contested. Health workers in the private health facilities considered the technology effective because it could be used regardless of gestational age, in contrast to MVA which should only be used on first trimester pregnancies. D&C was also considered speedy and effective: "It is faster and it removes tissues very well" (midwife, private health facility). Time-saving was critical in induced abortion services for several reasons:

> We have many of these cases because, to tell you the truth, we welcome them because we expect, to be straightforward, to get a lot of money. There is a lot of money in these cases more than other cases; we would not handle these cases if it were not for money, but because of the conditions in which we live, they bring money and we handle the cases. But when we begin to operate, you find that they are very difficult cases, what we expected it to be is not what it is (Jacob, medical officer, private health facility**).**

Another respondent added:

The reasons for doing this on side of health workers is money. This is a very big issue. Not that I am helping her just to abort. But a way of helping, hoping that you are going to get something [money]. Those who come, we do not call them, no. They also come when they have their burdens, which they would like you to help them offload. So even you who is helping her to offload the burden, you also

expect something in return. This, in a way, I am earning a living (Dan, male nurse, Private health facility).Health workers who provided induced abortion care services did so for financial reasons, despite the risk of arrest and loss of their practicing license. Although induced abortions were solely reported in the private health facility, health workers from public health facilities transferred patients with induced abortion care needs to their own private health facilities, where they delivered the service. In the private health facility, a patient's financial ability also determined the medications received. For poor patients, painkillers were given and they were told to buy other medications from pharmacies once they had money. "After the removal of the 'things', we treat the patient and give her all the necessary help. But this depends on the ability of the patients" (James, medical officer, private health facility). Records of payments by a patient were used to determine if complete treatment with drugs could be provided; however, many young girls who presented for care had no money.

Perforations

The use of D&C in abortion care risked uterine perforation, depending on the competency of the health worker. Without adequate knowledge of the anatomy of the uterus, chances of perforation were very high, particularly because the depth of the uterus was difficult to determine: "You do it blindly; you do not do it in unaided way, you use a curette, push it inside, you scrub and remove the things from the uterus" (Henry, medical officer, public health centre III). Perforation was reported even when an abortion was performed by a highly skilled doctor: "We normally have these cases. They are very many. Even now we have a case on our ward. And it was done by a doctor who we know was trained ... when they did an ultrasound, they realised she had perforations" (Jacob, medical officer, private health facility). Perforations resulted in poor health outcomes, depending also on timely detection and identification of signs. Clients typically returned home after the operation, leading to delayed reporting with sepsis and necrosis, when the uterus then had to be removed to prevent loss of life. Often delayed cases were very young women who feared reporting, could not easily get permission from their parents, and lacked the resources for medical attention. During the study, vivid cases of the consequences of perforation presented at the district referral hospital. The following case is illustrative:

> This was a 16-year-old girl. She got pregnant. But she went and had an abortion from wherever she went and she kept quiet, not knowing that the person who did it was maybe not skilled in it and they perforated the uterus. I think she stayed in the village for around a week. By the time she came here, she was discharging pus down her [vagina]. The uterus was perforated. She came with signs of intestinal obstruction, because, I think, in the process of conducting it [abortion], the *thing* (curette) passed through the uterus and someone pulled the guts. And by the time we intervened, she was already toxic. They resuscitated her, and they did an operation on Monday but she passed away yesterday. Part of the gut was cut off. It was terrible!" (Faith, midwife, district hospital).

Managing Adverse Events

Many health workers stressed that they helped a woman abort only because of the money. Financial motivation meant that the more cases they handled, the greater the financial benefits to both the facility and the provider, and this changed how abortion care delivery was understood. Some health workers at public health facilities transferred patients to private health facilities where they were able to deliver services. In the private health facility, abortion care was seen as a business and health workers were paid based on the number of patients received.

Although considered efficient, D&C was linked to excessive bleeding, and all health workers in the private health facility saw this as a real challenge: "What disturbs us most in this thing [abortion] is excessive bleeding. It is a very big issue. (The patient) has left school without parent's knowledge. So, when she begins to bleed so much, it is our problem to handle" (Suzan, nurse, private health facility). In some cases, bleeding needed immediate attention. Where caregivers had money, clinic staff used local networks to secure blood for transfusion at the private health facility. However, some health workers were concerned about this strategy:

> You cannot do blood transfusion. You have not done grouping and cross-matching; you have not done HB or a complete blood count to know the parameters of the hemoglobin, and yet things have gone beyond this. She will not stop bleeding and maybe there are some injuries in the uterus (Jacob, medical officer, private health facility).

If a patient could not be managed at the local health facility, she would be referred to the district referral hospital, but typically without formal documentation of her history and medical care. Informal interactions with non-medical workers at the facility indicated cases where patients in severe condition were whisked from the private facility on a *boda-boda* (motorcycle) to the gates of the main hospital, where they would be left to find their own way to receive care.

In the event of death from complications at the primary facility, sometimes – respondents reported – the body would be left at the gate of the mortuary: "Others even can just be dumped on the roadside when somebody on who she was conducting abortion died. Things didn't turn out the way they expected" (Moses, medical officer, private health facility). Corpses of women who had died before intervention were similarly handled:

> *"*In the process of giving the drug, the anesthesia, if somebody has a heart problem, they may just die in the process, even before the abortion had been conducted. Somebody gets a cardiac arrest and now how are you going to answer for that? So, you may end up just dumping the body. Yeah! (Sam, medical officer, private health facility).

Throughout the data collection time, the private health facility was very busy, with many young male health workers hanging around on the facility verandah, hoping to identify potential patients but also on alert for possible law enforcement officers. The facility building, with both a main entrance and a narrow side exit, allowed for the ready escape of women and providers in the event of a police raid.Discussion

Our findings show that discourses of safety and risk offer international legitimacy for scaling-up the production and use of economically viable technologies while suppressing others. We highlight that pecuniary motives drive the delivery of particularly induced abortion care services in a restrictive legal environment. We also argue that medical technologies have a double effect on structures of domination, sometimes reproducing them and in other cases, disrupting and transforming them in women's interests.

Ultrasound was not a technology for which health workers received training in quality assurance and training meetings; nor was there training on the interpretation of ultrasound images despite recognition of its sensitivity in diagnosing retained products of conception or confirming completion (see also Tasnim et al., 2014, Ansari & Abbas, 2017). Although ultrasound is not needed for outcome

assessment when treating incomplete abortion (Shochet et al., 2012), clinical examination is inadequate (Kurmi et al., 2015), and ultrasonography is an effective method to evaluate tissue retention in patients with post-abortion bleeding (Iqbal et al., 2019: 93). Our interviewees considered ultrasound a critical technology in improving maternal health outcomes.

The medical technologies for abortion and abortion care are inscribed with restrictions on gestational age, local moralities and legislation. While some health workers adhere to the restrictions, others transgress them as they transgress the law on abortion. This increases risks and can lead to poor outcomes. Medical technologies and health worker actions are both interpreted according to the social and legal context in which they are used, and this explains health workers' emphasis on financial gains from abortion. That is, because abortion is criminalised, health workers offset the risks of terminating and providing care for complications by direct financial gain. As we have illustrated, power and resistance operate when abortion is criminal(ised). Thus, normalising and disciplinary power were evident, and influence abortion care outcomes though several mechanisms, as we now explain.

Categorisation

Categorisation refers to the classification of medical technologies into classes of safe and appropriate technologies and risky technologies. Categorisation is exercised by the World Health Organization and scholars through global guidelines and global standards for abortion care delivery, national policy and quality of care standards (Ansari & Abbas, 2017; Ara et al., 2018; Benson et al., 2017; Tasnim et al., 2014; WHO, 2015a). According to the guidelines, MVA, Misoprostol, Mifepristone and Divabo are safe and appropriate technologies for use in abortion care delivery, while D&C is considered a risky, unsafe and inappropriate technology primarily because of the possibility of uterine perforation, although also via risks related to anaesthesia. Misoprostol is further classified according to differing levels of safety (less safe and least safe), within the spectrum of unsafe abortion (Ganatra et al., 2017). This classification, it is argued, reflects the transition from the use of dangerous technologies to the use of Misoprostol outside healthcare practices. However, although studies report a high level of effectiveness when such technologies are used (e.g., Warriner et al., 2019), health workers reported several examples where MVA and Misoprostol had failed to aspirate and evacuate all products from the uterus, resulting in incomplete abortion. This necessarily required D&C. At the

same time, not all cases of the use of D&C technology resulted in excessive bleeding and perforations, nor complications from anesthesia.

While risk and lack of safety are viewed as outcomes of using unsafe technology (Unnithan & De Zordo, 2018), our findings show that risk may occur even in technologies dubbed as safe. Equally, conceptualising risk and safety as strategies used to govern and regulate healthcare practice (Unnithan & De Zordo, 2018) misses understanding how such concepts are appropriated by health workers in a restrictive legal context. We argue that riskiness and safety are rather outcomes of technological application, contingent on specific health facility conditions, economic and legal contexts. Healthcare risk and safety theory stress the effect of interpersonal communication with patients and among professionals to prevent adverse events and improving patient safety (Severinsson et al., 2015; Tucker et al., 2008). However, this abstracts healthcare risk and safety from the restrictive legal regime governing abortion, upon which abortion care practice is contingent.

The cultural safety perspective focuses on the organisational or institutional preparedness to guarantee safety and risk-free healthcare (Groves et al., 2011). However, conceptualisation of risk and safety from normalised healthcare and fails to explain and account for risks and safety issues in abortion care delivery, a practice considered to transgress institutional values, policy and legal norms regulating women's sexuality and reproductive health behaviors in Uganda. Conceptions of safety and risk abstracted from context negate the effect of global events and processes upon which local healthcare practice is contingent. Without questioning the view that health workers are always keen to deliver safe, competent, compassionate and ethical care (Harrowing et al., 2010), our findings reveal that communicative, interactive and cultural theories insufficiently account for risky and unsafe healthcare practices which are offset by panic, fear and decision-making that seek to evade state control. Definitions of risk and lack of safety depend on the exercise of power and counter-governance practices used to evade state power. Global emphasis on using medical technologies as standard instruments (Klugman & Budlender, 2001; Warriner et al., 2019;Tasnim et al., 2014) overlooks ways that health workers appropriate and apply technologies, the (in)adequacy of disinfection practices and the different health facility values and rules that condition abortion care delivery. Yet as indicated in this study, these constitute critical avenues through which risky outcomes arise in abortion care practice. We argue that safety and risks are contingent upon the way medical

technologies are interpreted amidst the struggle to evade the disciplinary effect of institutional norms and the law. Risks and safety are outcomes of an assemblage of things (material technologies), activities, rules and mental dispositions mediated through biopolitics. Such a conception helps to uncover the social reproduction of risk and the conditions of possibility that generate them. Categorisation uses the discourses of safety and risk to offer international legitimacy to scale up the production and use of economically viable technologies while suppressing others. This level of legitimacy is reinforced by national abortion care standards which institutionalise technologies for safe abortion care. Economically viable medico-technological innovations are accorded international legitimacy to scale-up their production and use in healthcare practices. In this context, the 'riskiness' and 'lack of safety' which arise from the use of a 'safe' technology are hidden and cease to be relevant, provided the technology promotes the instrumental needs of dominant forces in both global and local health arenas. Consequently, categorisation enacts and reproduces economic interests without necessarily correcting the mechanisms through which risk is generated in abortion care practice.

Criminalisation

Criminalisation shapes abortion care outcomes in multiple ways in Uganda. First, health workers choose specific technologies which minimise the risk of exposure of practices that conflict with national abortion law. In health facilities where abortions were induced, health workers relied mostly on D&C technology because it was regarded as time-saving and effective. But criminalisation increased the fear and tension in operations, thus affecting the efficiency and increasing the risk of an incomplete abortion or uterine perforation. Due to fear, health workers operated by stealth, limiting the possibilities of consultation when complications emerged. These surreptitious conducts deprived patients of the opportunity to benefit from wider specialist consultation, and increased the risks of severe morbidity, emergency surgery (such as hysterectomy), and death. Emergency case handling practices were designed to enable a health worker to escape the law, with the patient's health and life apparently secondary. As described above, practices such as abandoning patients, whisking them to and leaving them at the gates of hospitals, and bodies at morgues, reflect how patients are handled when abortion care is criminalised. Many young patients present to health facilities for care without

the knowledge of or permission from home or school. Health workers from the private health facility acted in fear and designed strategies to evade apprehension.

Even when Misoprostol was used, open market access did not guarantee a dose appropriate to gestational age, because prescribing the drug to induce abortion is also criminal. While drug shops may be keen to avoid serious complications after abortion (Shannon, Brothers, Philip, & Winikoff, 2004), without adequate regulation, many categories of workers dispensing medicines in private health facilities may not have adequate knowledge of the risks involved. In Kenya, Liambila and others report that "only about half (49%) of providers whose facilities stocked Misoprostol mentioned the correct regimen for pregnancies of various gestational ages" (page 27).

Criminalisation compromises the ability of district health teams to monitor, supervise and regulate the use of medical technologies and practice of abortion and post-abortion care. The women and health workers act in collusion against state law and healthcare policy. Consequently, neither party reports the district health team, except when a woman's health condition deteriorates dramatically; and quality of care is not regulated since there is no evidence of the practice. In the private health sector where induced abortion was most common, facility norms relating to terms of payment shaped the choice of technologies, again with limited regulation, supervision and monitoring. In contrast, in the social franchise clinics and public health facilities where the practice was supervised, there were positive outcomes. Therefore, while a restrictive legal regime increases the financial value of abortion care for health workers involved in its delivery, it deepens women's vulnerability to poor health outcomes.

Motives and Pecuniary Interests

Financial motives shift attention from patient care outcomes to health worker interests. In applying medical technologies for induced abortion and managing complications from abortion, health workers have a range of motives and interests, including monetary. Contrary to the idea that medical technologies are favored because of their efficiency (Bain & Kongnyuy 2018), health workers from private health facilities preferred to use technologies with the greatest financial benefit. In this regard, despite the risk of uterine perforation, D&C was preferred. Health workers in the private health facility were paid according to the number of patients attended to per day. In addition, a patient's care

package was determined based on ability to pay. Health workers employed in public health facilities transferred patients to their private clinics for financial reasons, as well as to protect the privacy of patients and to avoid their apprehension for criminal practice. In this context, spontaneous miscarriages within private and public health facilities were treated as health conditions which attracted fewer financial returns.

Financial motivations create opposing forces in abortion care practice as the duty to provide care was considered secondary to the material benefits to health workers providing abortion care. Many health workers saw service delivery as an instrument to meet financial goals, and accordingly women's bodies were objectified as a means for financial benefits. Equally, medical technologies were subjectified and interpreted in terms of their value for financial gain. The assertion that "there is no health condition which is more financially rewarding than abortion" (Suzan, midwife, private health facility) vividly illustrates that material conditions dominate the delivery of abortion care service. Financial incentives as a means of quality of care improvement have been institutionalised in maternal healthcare, through results-based financing and the introduction of voucher schemes (Ekirapa-Kiracho et al., 2011; Pariyo et al., 2011). In private healthcare facilities, institutionalisation occurred through remuneration, based on the number of patients served in a day. Within the broader social and economic environment, health workers' identities were evaluated according to their ability to meet personal, familial and collective responsibilities, less so their loyalty to medical professional ethics and values. These internalised conditions were invoked in abortion care, and the restrictive environment offered health workers an opportunity to exploit women in need of care.

Control

Control refers to the internalised knowledge system relating to the law and technology that govern the self in the application of abortion care technologies. Criminalisation shaped outcomes of medical technologies in subtle ways. First, gestational age ceilings determine when medical technologies can and cannot be used. Once internalised, health workers exercise self-regulation in abortion care, observing the gestational age restriction. Second, fetuses above the gestational age ceiling are made visible as human beings via the use of ultrasound, or in its absence, through discourse. Such fetuses are given entitlement to citizenship rights in the womb, which the mother is obliged to protect. This consciousness of the body invokes acts of self-regulation by health workers, which operates through

their fear of contravening state regulations on technology application. Thus, normalised power turns health workers into objects of the state, which is able to regulate the rights of personified fetuses (and so act in the case of its violation). Equally, the state uses ultrasound to visualise the womb ecology and ensure that it is conducive for a healthy fetus and mother. Although personification of the growing fetus shifts attention away from the mother to the fetus (Manderson, 2016; Zechmeister 2001), there is, in the application of the technology, the intent of a symbiotic effect from which both the fetus and the mother benefit. Studies in South Africa indicate that focusing on the fetal environment places blame on mothers, limits responsibility for the outcomes to her body, and thereby further objectifies women (Manderson, 2016; Pentecost and Ross 2019).

In our study, we highlighted that health workers did not merely exist as objectified bodies on whom systems of control are inscribed and reproduced. In some cases, they induced abortion in pregnancies when the gestational age exceeded the legal limit, in pursuit of financial gains. Thus, medical technologies not only carry and exert systems of control, but are used to disrupt inscribed power. This increases the risk of direct injury to the woman and the risk of an incomplete abortion, leading to the need for further medical care and further risks. Thus, since abortion addresses the needs of women who do not wish to carry a pregnancy, medical technologies have a double effect on structures of domination: sometimes reproducing them and in other cases, disrupting and transforming them in women's interests.

Conclusion

We have challenged the idea that the tensions of riskiness and safety are inherent features of reproductive medical technologies, and have shown that these are emergent outcomes of abortion care practice. We have also discussed how instrumental reason shifts the consciousness of health workers, from offering abortion care as a duty to offering it for personal financial gain, notwithstanding that this is a way of managing their own risks. We suggest that focus on integrating health workers to expand access to and promote quality outcomes in abortion care can only be useful if the instrumental reasoning of health workers is addressed.

We challenge the objective interpretation of medical technologies as having normative value, since this obscures the practices, processes and mechanisms that shape technologies' meanings, choice and

application in abortion care. Equally, we challenge a subjective interpretation, since this inhibits exposing the internalised conditions of domination and resistance which lead to unsafe and risky outcomes and compromise women's health. As we have described, inscriptions written on medical technologies, and the narratives of health workers who use them, represent particular interests. Women are objectified in all discourses surrounding the choice and application of medical technologies. Rather than asking what medical technologies constitute, greater value lies in inquiring into what they represent to different actors in the field.

Finally, we have shown various dimensions of domination and tactics of resistance in abortion care. These include both normalising powers hidden in the categorisation of medical technologies and self-regulating practices of health workers, and the disciplinary power which operates through the restrictive law on abortion. While normalised power controls health workers, the disciplinary dimension of power escalates medical and legal risks for women and health providers, offsetting dangerous tactics of evasion which compromise abortion care outcomes.

Study Limitation

Our focus was on quality of care improvement meetings and abortion care practice was explored through the perspectives of health workers. Future studies could undertake health facility ethnography and incorporate perspectives of women into understating the abortion care practice, and the construction of risky outcomes.

CHAPTER SEVEN

POWER OPERATIONS AND QUALITY OF ABORTION CARE SERVICES

In the previous chapter, I discussed the complexities involved in delivering abortion care services. I particularly examined the embodied power of medical technologies, the ruling regimes of knowledge, and the biopolitical restrictions inscribed in moral, policy and moral codes. In this chapter, I extend this discussion into understandings of quality of abortion care services. Abortion care practice is often wrapped within general discussions of care, and considered as a purely ethical practice when conducted in institutionalised health facilities by health workers, using technologies considered to be safe and risk-free. But abortion care is nested within the real world of moral and legal restrictions, and it touches on sensitivities and moral rationalities which construct the identity and affect the conduct of health workers in relation to the self, to women with abortion care needs, to colleagues in the profession, and to the state. There is, however, very little investigation of what happens during abortion care delivery in this context and how these factors affect quality of care outcomes. Anthropological concern with what happens in this practice is critical because restrictions establish a system of conduct that makes abortion care unique while often concealing other care practices. In this chapter I make visible what is silenced behind normalised care practice and describe the tactics of counter conduct used to silence prohibited performances.

Much of the debate on quality of care emerges from biomedical constructions and relates to institutional health systems functioning. Other debates focus on the individual, family and community readiness and responsiveness to health facility-based care services. These accounts offer good breeding points for neoliberal interventions aimed at deepening the role of private sector in maternal healthcare delivery, scaling up the infusion of medical technologies into healthcare, and increasing the biomedical surveillance of women's bodies. Without questioning the rationality, I argue that these interventions conceal the unique injustices and violence against women with abortion care needs, which are embedded in health care practices in restrictive contexts. Abortion care delivered in a restrictive context cannot be the same as care conducted without restrictions. In Uganda, restrictions govern the conduct of health workers and women who procure abortion services outside the law, but abortion care continues despite the restrictions. Equally, as a professional

practice, abortion care is nested within ethical rules of conduct, to which a health worker may be subjected if her or his conduct falls short of expectations. Thus, restrictions are often transgressed in much the same way as they are obeyed in care practice. This presents care practice as a site in which forces of domination and control on abortion care practices are reproduced, appropriated, contested and transgressed.

In this chapter, I focus on three concepts of biopolitics, care and resistance which are bound together in the practice of abortion care delivery. I am concerned with political technologies used to direct and govern the conducts of health workers and their counter conducts against such forms of governance, and the implications on the quality of care delivered. I examine practices of power in everyday routine activities and processes displayed by health workers across different categories of health facilities. In the following section, I summarise the major findings of this chapter and offer a general analysis of these findings in the context of the biopolitical concepts of discipline, punishment and resistance.

Abortion care practice in the study setting was always conducted in panic and fear of apprehension. Health workers preferred to offer their services for all pregnancies, regardless of gestational age, late in the evening and at night time, using technologies designed to save time. Abortion care delivery was considered the most profitable maternal healthcare service and pecuniary interests drove the practice. For fear of apprehension, patients were discharged as soon as the operation was completed, with medication that fitted within their financial capacity. Those who could not afford the complete dosage of recommended drugs were discharged with pain killers and told to buy the complete prescription of antibiotic drugs once they had sufficient money. In public health facilities, where strict adherence of the policy and law on abortion was observed, health workers transferred patients to private healthcare facilities for abortion, and the private facility then returned them to the public facility for post-abortion care. Although regular quality improvement meetings were held in public health facilities, health workers organised pre-meetings to sieve through what should and should not be reported and discussed with health facility administrators for fear of sanctions. Most health workers in public health facilities regarded abortion care delivery to be immoral and illegal except for post abortion care or abortion induced on purely medical reasons. Consequently, lower-level health workers engaged in foot-dragging and complete refusal to support medical doctors who chose

to contravene the policy. Throughout the study, abortions were performed in secrecy, with no room for consultation in care emergency for fear of apprehension.

Abortions involved several risks and complications. Some women haemorrhaged heavily during the operation, and although a patient left the health facility with telephone contacts of the health worker with advice to call should complications arise at home, many returned or were referred with sepsis, anaemia and other obstetric complications. Emergency handling practices exacerbated the risks. Operations of abortion were framed as another similar maternal health condition such fibroids or pelvic inflammatory disease. Patients were coached on these conditions as the cause of seeking care, were an enforcement officer to apprehend them. The health facility owner, the health worker and the patient all had self-interest in suppressing the actual practice of abortion since they would all be culpable before the law. This resulted in subterfuge at all levels. In cases of excessive bleeding beyond the capacity of the health facility, health workers carried the patient on a motorcycle and left her at the district public hospital, without medical records.

Post abortion care handling practices involved techniques of evading state surveillance and disciplinary effects. In the case of death, health workers relied on their networks within the law to ferry the body to the hospital morgue or drop it along the roadside. Through these emergency handling practices, both the healthcare facility and woman's condition were silenced. During community funeral ceremonies, cause of death was labelled as a common illness such as malaria. Thus, reported cause of death silenced the risk consequences of abortion care practice. The deceased's family had self interest in attributing the death to a common illness as this saved the family from community stigmatisation. Only in exceptional circumstances where the family and the health workers had not agreed was abortion reported as the cause of death at a funeral ceremony.

Drawing from these findings, abortion care practice enacts and reproduces a social order that directs the conduct of health care workers. Decision making based on moral, policy and legal reasoning discriminates against women with abortion care needs, bringing punitive impact on women for their transgressive reproductive conduct. Health workers reconstruct themselves as obedient subjects and state agents who monitor, report and extend the state's capacity to punish disruptive actors. Within this context, governmentality also induces conducts of counter governance designed to weaken state surveillance and its disciplinary and punitive power. Health workers design juridical conduct and

secretive conduct to conceal prohibited abortion care services, enabling them to stay unnoticed by the health and police system. Health workers also engage in silencing dead bodies by not revealing the conditions of their death, and by dumping dead bodies at the morgue and along roadsides. This practice was reported by many health workers and auxiliary staff who worked in the private health facility. Secretive conduct, juridical practice and silencing dead bodies comprise technologies of counter governance through which women with abortion care needs received care. As I illustrate, abortion care practice is appropriated in a restrictive context, and women with abortion care needs are used as instruments in the pursuit of pecuniary interest. Abortion care delivery was considered the most profitable maternal health condition, and care practice (including treatment) was mediated through financial abilities and benefits. Detailed accounts are summarised in the manuscript presented hereafter.

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Title: Quality of Care and the Silencing of Dead Bodies Post Abortion in Eastern Uganda

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Abstract

As focus on maternal deaths has shifted from community to institutional settings, so the premises that guide current Quality of Care (QoC) interventions are being questioned. This is particularly in the context of restrictive abortion care delivery, requiring an exposition of what happens during care practice and how QoC might be improved. Using a critical ethnographic approach, we investigated what happens in Eastern Uganda during and post abortion care practice, with attention to how legal, moral and policy restrictions operate, are appropriated, resisted and reproduced. From August 2018 to March 2019, we collected data through in-depth interviews, observations in QoC improvement meetings, analysis of policy documents, and informal conversations. In this analysis, we draw on the biopolitical concepts of governmentality and counter-governance as analytic tools. We illustrate that health workers' choices, decisions and care practices are conditioned and contingent upon local morality, health policy guidelines, national law and a financialised healthcare context. Health workers counter governmentality using 'silencing' as both a tactic and strategy of power, but in doing so they constitute, enact and reproduce obstetric violence against women. Surreptitious practices, framing and panic in the provision of care produce poor outcomes while disrupting and weakening state regulation and surveillance power. We call for reimagining QoC in a framework of power to rethink the law, policy and practice as constitutive elements.

Keywords: Uganda, abortion care, epistemic governance, juridical practice, prioritisation, self-governance

Background

In recent years, the proportion of avoidable maternal and perinatal deaths in health facilities rather than the community have increased (Bohren et al., 2015), and unmet abortion care needs and poor QoC related conditions following induced abortion continue to contribute significantly to preventable maternal mortality in many low- and middle-income settings (Adanikin et al., 2019; Barker et al., 2016). In Uganda, despite a general decline, the number of maternal deaths occurring in health facilities has increased: from 119 per 100,000 in 2015/16 to 148.3 per 100,000 in 2016/17 (MoH, 2018; MoH, 2016). Quality of maternal care is low even in higher-level health facilities (Namazzi, Waiswa, Nakakeeto, Nakibuuka, Namutamba, Najjemba, Namusaabi, Tagoola, Nakate, Ajeani, Peterson, Byaruhanga, et al., 2015), despite the general improvement in maternal health conditions from 2000 to 2016 (UBOS, 2016). Many abortions in Uganda are initiated outside health facilities. Women present at facilities with post-abortion complications. However, abortion care practices within health facilities are generally ignored, on the assumption that institutionalised abortion care practice is always safe. Addressing QoC in relation to abortion could contribute significantly to ending preventable mortality.Abortion care practice in Uganda is subject to legal and moral restrictions (CEHURD, 2016; Cleeve et al., 2017; HRAPF, 2016; Larsson et al., 2015b). Article 22(2) of the constitution prohibits the termination of the life of an unborn child except as may be authorised by law (Government of Uganda, 2006). However, there is no enabling legislation to facilitate operationalising this provision. The penal code criminalises "any person who unlawfully supplies drugs or any other substance necessary for the procurement of an abortion (Section 143) or "attempts to procure an abortion" (Section 141). Health policy guidelines operate within the law, and can only provide post abortion care services (Atuyambe et al., 2015). Legal restrictions thus create boundaries, in which only post-abortion care (PAC) is allowed, making other forms of abortion immoral and illegal as in Senegal (Suh, 2019b) and stigmatise care practices (Larsson et al., 2015). However, how health workers navigate the restrictive legal context, and its effect on QoC and its outcomes, is largely unknown. Both the policy and law are inadequately

understood by healthcare workers (CEHURD, 2016). Even when staff operate within the law, fear of prosecution and stigma characterise abortion care practice (Aantjes, et al., 2018).

Current QoC studies offer little information about how risky outcomes emerge and are reproduced. The World Health Organisation (WHO) defines Quality of Care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes" (Barker et al., 2016: 14). Critical issues impacting QoC are largely linked to delayed response to maternal health conditions (Gutschow, 2016; USAID, 2018), limited health system capacity (Aantjes et al., 2018; Gabrysch et al., 2019), and lack of patient-centred care. Consequently, QoC improvement largely focuses on managerial and clinical interventions, focusing on improving health workers competencies (Benson, et al., 2017), strengthening health systems (Leatherman, et al., 2010; Tetui et al., 2012), and ensuring the accountability of health workers. However, care practice, processes and contexts may also affect outcomes, and the use of 'safe technologies' does not always result in good QoC outcomes (Kagaha & Manderson, 2020a). Interpersonal healthcare practices may also contribute to poor outcomes through obstetric violence against women with abortion care needs (Suh, 2019b; Unnithan & De Zordo, 2018). Consequently, in this article we inquire into the social production of risks and poor QoC as both process and outcome.

Institutionalised care practice may be conditioned by and contingent upon macro level realities. but how these affect abortion care practice, processes and outcomes is also poorly understood (Waring, et al., 2016). Global response to QoC in relation to maternal morbidity and mortality has attuned societies to select high-impact interventions that improve maternal and child survival (Black et a., 2016; WHO, 2015b), while they also deepen global state surveillance of healthcare practice. Consequently, specific interest on QoC negates large-scale processes and factors which may underpin poor quality of abortion care. Yet, emergent risks and unsafe conditions upon which poor QoC is contingent cannot be understood from individual elements that constitute the health system (Salway & Green, 2017). Although maternal and perinatal death surveillance and responses in clinical practice have reversed maternal deaths in 'normalised' maternal health conditions (MOH, 2017; Nkurunziza, 2018; USAID, 2018), there is no evidence of the effectiveness of these interventions to address unsafe and risky practices and outcomes in abortion care, which is considered disruptive and transgressive.

Forces that regulate abortion care practice are often dialectically related to tactics and strategies of resistance, with subversive practices of resistance and the evasion of state regulation reported (Egan, 2004; Romele et al., 2017). Driven by fear of reprisal and disciplinary action, health workers may engage in inaccurate and incomplete data recording and falsification of data (Nkurunziza, 2018; H. Smith et al., 2017). These practices may nullify the entire process of Maternal and Perinatal Death Surveillance and Response (Gutschow, 2016; Smith et al, 2017), while making their practice invisible to the state. In addition, care practices, choices and decisions may constitute forms of obstetric violence against women, contributing to maternal deaths. A focus on practices of domination and resistance in care may illuminate how and why obstetric violence emerges and is reproduced, and the conditions upon which this is contingent. Using an ethnographic approach, in this article we explore what happens during abortion care in health facilities and the relationship of this to QoC outcomes.

Theorising Abortion Care Practice

Foucault's analytic tools of power, knowledge, discipline, punishment and governmentality have contributed to understanding institutionalised practices across different disciplines (Cummins, 2014; Martel, 2014; Tadros, 1998). However, there has been limited application of these analytic tools in enquiries into QoC and abortion care practice. Here, we firstly use 'governmentality' and 'counter-governance' as analytic tools, and attend to the use of political technologies to govern the conduct of the self and others (Foucault, 1977; Lemke, 2001). We use ideas of governmentality to illuminate how individual health workers are regulated and how they participate in their 'self' governance during and post abortion care. We also show how health workers are taught to govern others and to be governed in delivering abortion care services.

Secondly, we use the concept of 'counter-governance' to understand the power struggles and activities of resistance, appropriation and navigation around the restrictive context of abortion care delivery. Counter-governance recognises the will of individuals to be (or not) governed (Lorenzini, 2018), and in applying this concept, we investigated, uncovered and analysed the hidden and silent activities, tactics and political technologies used by health workers against regulation of their practice. This focus included our attention to the capacity of individuals to frame, package and represent abortion care in order to evade state surveillance.

Methods

Drawing on ethnographic data from Uganda, we investigate what happens during and after abortion care delivery, and uncover how health workers appropriate, negotiate and/or resist legal, policy and moral restrictions on abortion. A critical ethnographic approach, with multiple methods, was used to explore the health practice, its settings and processes, institutional norms and rules, and the mental dispositions that informed the choices, decisions and practices of health workers during and post abortion care.

Study Sites

The study on which we draw was conducted in Eastern Uganda, a region with high rates of teenage pregnancy, high poverty density, and an array of private health facilities operating alongside public and non-profit making health facilities. Data were gathered from three health facilities: one private for-profit health facility, selected because it offered all services including induced abortion; one non-profit health facility, which offered neither abortion nor post abortion care; and one government health facility, which provided post abortion care and referral services for obstetric emergency. The three sites reflected the diversity in which the restrictive surveillance of abortion care delivery was navigated. Data were also collected from two institutionally organised regional meetings facilitated by quality assurance officers from non-government agencies and aimed at developing approaches to improve QoC in family planning and abortion care delivery. The first meeting comprised private health facility owners and health workers; the second comprised health workers in public health facilities and district health administrators.

Study Population

Participants were recruited purposively, were experienced in quality regulation and assurance, and we hypothesised their responses might offer insight into the perspectives of health workers. Twenty health workers were recruited using snowball technique through known individuals involved in sexual and reproductive health, and included nurses, midwives and clinicians who had been directly involved in everyday abortion care delivery for at least five years. They were recruited from government, private for-profit and non-profit healthcare facilities with high volumes of patients according to the records from the district health office. In addition, ten quality assurance officers

from national and district level government and non-government institutions were selected because of their technical competence on quality of abortion care issues, capacity building, supervision and QoC regulation.

Data Collection

Prior to data collection, relevant information was provided to each participant, on which basis informed consent was sought. Carefully reviewed and pretested in-depth interview guides, tailored to health workers and policy implementers, were used by the first author to gather data. Interviews were conducted in secure environments determined by participants, and were audio recorded with consent, independently transcribed, and edited by the first author. During data collection, informal interviews were held with auxiliary staff working in health facilities to generate further in-depth information about everyday abortion care practices, and select cases were identified for further enquiry and to illustrate power dynamics. Using an observation guide, the first author observed and noted the discursive relationships between health workers and quality assurance trainers, and between private health facility owners and facility workers. Discourses (including silences and laughter that punctuated the different narratives), abortion care technologies, and technical know-how of health workers were noted. Institutional norms, rules, values and routine practices of healthcare workers were also documented. Participants who raised critical issues relevant to understanding operations of power in abortion care practice were identified and followed-up for interview.

Data Analysis

All transcripts from in-depth interviews were imported into NVivo software, allowing data to be categorised and coded into nodes. Coding was undertaken inductively by identifying key nodes and sub-nodes. These nodes and sub-nodes were compared within and across health facilities, discussed between the first and second author, and synthesised to generate major themes. During this process, all preliminary findings from different categories of health workers and QoC regulators were triangulated, and similarities and dissimilarities identified. Finally, we triangulated findings and highlighted the complementarity of in-depth interviews, observations and informal conversations to illustrate how power operated in healthcare practice.

Ethics

An information sheet on the study and the rationale for participation was provided to the convenors of the quality assurance and improvement meetings for permission to observe. An information sheet tailored to specific categories of participants was shared with in-depth interview participants prior to interview to ensure informed consent. Participants were regularly reassured of privacy and confidentiality during the interviews. In the text that follows, we use pseudonyms for all participants to maintain anonymity.

Results

Inside Abortion Care Practices

During in-depth interviews, health workers were asked to narrate, from their experience, what happens from the time a woman presented to a facility until she left. Pre-abortion counselling, safe abortion, and post abortion care (PAC) were provided in all health facilities, while induced abortion was provided mainly through the private for-profit health and non-profit health facilities. Post-abortion care was provided across all facilities. Health workers paid strict adherence to the government's policy on delivery of abortion care services, and thus they restricted their services to PAC as allowed under government policy:

For sure, abortion, for me I cannot do it. Even by law, a midwife, to induce someone's pregnancy to cause abortion, I cannot. What I can easily do for you is to refer you to another health unit which is higher than this one, to go and discuss with the doctors from there" (Barbara, midwife, public health facility). A number of health workers objected to the delivery of induced abortion as this would be acting against their religious beliefs. They argued too that inducing abortion would bring shame and negative sanctions from colleagues, and some suggested that those who induced abortion were acting to prevent those women from having children in the future. When young women presented for PAC, health workers sometimes called their colleagues into the examination room to witness what had happened:

The attitude outside there is that abortion here in Uganda is illegal; yet the policy environment is clear, it allows [it] under listed conditions. But because the people [health workers] have not

familiarised themselves with the policy guidelines, they feel securing an abortion is like completely illegal. People [health workers] don't tend to read and appreciate the policy environment (James, Quality Assurance Officer). The general moralising attitude from health workers in public health facilities contributed to women seeking induced abortion outside of a health clinic but then presenting there for post abortion care. Abortion care practices were subjected to varying degrees of supervision across the different facilities. Supervision and monitoring QoC practice was limited in the private health facility, whereby the facility owner only appeared very early in the morning and late in the evening to attend to complicated cases and monitor financial records. Here, health workers received payment based on the number of cases they handled, and this stimulated their willingness to perform abortions. Health workers preferred to use D&C technology to perform abortion, which they defined as time-saving and efficient, although also, some health workers noted, treatment depended on the amount of money a patient had. Those with adequate money could afford all necessary treatment, while poorer women were discharged with pain killers and told to buy antibiotics once they had money:

> We normally give them antibiotics and pain killers if they are there [in the health facility]. So, we give them telephone contacts and say in case of any problem contact us in time for medical advice. But we hope that they may reach there [home] and don't bleed. And this is very common. She leaves the health centre when very normal but reaches there [patient's home] and starts to bleed very seriously. Yet she left without any sign of bleeding. But when she reaches the village, she bleeds very seriously and she gets very risky to manage. Sometimes they call saying the person you worked on is in very bad condition. And by the time she reaches [returns] here, she has lost blood and become anaemic.

Cases of abortion were often neither recorded nor reported, making it difficult to determine the nature of service delivery:

> It is a secret *thing* [abortion care practice]; for us to regulate it, it is not easy. It is privately arranged; it is done and then. Of course, when somebody has a clinic and you know abortion cases are going there but you see, this is a clinic and they will not tell you. Even when you ask informally, they will say, "I don't have any patients here, I am not doing anything that it is even illegal, I am not doing those abortions," he will tell you. So, they cannot report that

they do even evacuation officially (Robert, Health Services Regulator). Health workers in the non-profit private health facility reported that they were regularly checked and monitored by quality assurance officers from the non-government agencies that supported them. But this does not affect how people end up at a particular facility, and by the time of a death, a patient with induced abortion complications may have passed through a number of health facility sites. With death, the state surveillance system is able to capture the site of death, but not the various sites to which a person presented and nor the kind of care provided that preceding the death. In the event of a death from an induced abortion, a health facility will not provide medical records, and its involvement is usually unable to be traced or proven. Consequently, specific conditions in different health facility sites remain unknown.

At public health facilities women pass through several points prior to receiving treatment. Patients were screened on presentation at the out-patients' department, and here it was determined whether they needed to be referred to a maternity ward or general female ward. Records are kept at every department, and regular quality assurance meetings are held at facility level to review performance. Thus, institutional arrangements in public health facilities include multiple actors and departments, each holding records for patients. However, in private for-profit and non-profit health facilities and departments, processes were summarised through a one-off encounter with a health worker who assessed the need and offered care. In the private health facility, health workers also kept personal details of patients separate from the formal record book, to enable them to contact their patients without being implicated in abortion procedures.

Specific treatment guidelines were followed in delivering abortion care. However, different levels of adherence to the treatment protocols were followed across the different facilities. These were strictly followed in public health facilities, but not in profit-making health facilities:

> You know, here [in the public health facility], we follow protocol. Here, when you have had an incomplete abortion, I can ask to have a cheap CBC [complete blood count] to see the parameters are ok, or to have an abdominal ultrasound to see whether it is viral or what…but somebody is in pain as you are doing those investigations. Yet when you come to the clinic,

> with my experience, I can say this one no, let us just go direct to evacuation (rather) than requiring a patient to put in more money. People do not have money (Denis, Clinical Officer).

As indicated, health workers often considered a patient's health condition and financial status in deciding whether or not to follow the protocol or bypass certain steps during abortion care delivery. In the non-profit making health facilities, health workers reported similar responses.

Quality of care in PAC delivery, which Uganda's health policy allows, was also governed through maternal death review meetings. In the non-profit health facility, health workers only met when a death occurred because of the need to report to the regional non-government agency supporting maternal health services delivery. The person in charge of the health facility would report directly to the non-government agency, which would respond with an immediate audit. In public health facilities, in contrast, health workers met weekly to discuss QoC issues. The committee, constituted by health workers and administrators, oversaw the reporting and review of maternal death medical records and identified actionable points.

Therefore, health workers self-regulated. They monitored their own conduct in accordance with policy restrictions that prohibited abortion but allowed PAC to be provided, and they were mindful of the law and healthcare treatment protocol and guidelines. Some health workers also governed themselves through internalised moral values that equated induced abortion with killing an innocent person. Health workers in private health facilities reported their fear of recording and reporting cases of induced abortion, and their awareness of the law shaped the methods they used for abortion and PAC. In the quality assurance meeting, facilitators asked participants why there were limited reports on induced abortion care cases, despite that the demand and stock-out rate for the abortifacient medicines Misoprostol and Divabo were so high; participants decline to answer.

Counter Governmentality and Surreptitious Practice

Given their fear relating to abortion, health workers were asked how they navigated the strict regulatory and legal context. In private health facilities, patients sought health care in highly secretive ways and health workers induced abortions usually late in the evening and at night to reduce the risk of detection. Health workers generally used D&C technology as this was considered time-saving and effective for both early pregnancy and pregnancies above 12 weeks of gestation: "When a girl comes

wanting to abort, we also get disturbed because this *thing* [abortion] is done secretly. We do not want people to know because the law does not allow us to conduct this *thing.* So, it stays in us" (Rehema, nursing officer, private-for-profit health facility). In addition, health workers ensured early patient discharge to evade the law and avoid disclosure.

Neither patients nor health workers were willing to report on seeking or delivering abortion to higher health authorities since the practice made them all legally culpable. Consequently, regulating institutions found it difficult to supervise; district health quality assurance and regulators reported that they had the health facility inspection tools but lacked resources for effective monitoring and supervision. In some cases, health workers in public health facilities transferred patients to private health facilities to allow them to access induced abortion, and they would then be referred back to the public health facilities for post-abortion care, since this was within policy boundaries. Women then returned home.

In the event of death due to complications of a private hospital or out-of-hospital procedure, health workers would use social networks with the police to transfer the corpse to the hospital morgue. This was possible only when death occurred during day. At night, a corpse would be left at the gate of the morgue or along the roadside for discovery the next morning. Health workers gave examples, as in the following reconstruction:

Case 1: The missing sister

> Robert [pseudonym] woke up to news of the death of his sister. She had disappeared from her home, pregnant with a man outside of her marriage. She sought an abortion from a private healthcare clinic. During surgery, she began to haemorrhage, and died at the clinic. The health workers approached a police officer, who brought the police van to the clinic and transported the body to the hospital morgue. At the morgue, the body was reported and recorded as having been found by the roadside. After two days, the woman's family begun to search for her. A person who worked at the clinic and knew the family suggested that they search the morgue, and there they found her body. Her husband noticed that there were no signs of pregnancy, although she had been four months pregnant. This led to a post-mortem that determined she had died while trying to abort.

In this example, the name of the health facility where death occurred was replaced with "roadside" in the report, making follow-up and detection of the circumstances of death difficult; usually it would be less easy to notice a pregnancy loss. In private health facilities, where induced abortions were conducted, health workers and the health facility owners shared an interest in not reporting a death because both were acting against the law. In addition, health workers from the non-profit facilities noted, deaths at a health facility undermined the reputation of the facility. Where a patient's condition has deteriorated, therefore, staff generally referred her for emergency care at a higher-level facility rather than intervening.

Juridical Practice in Abortion Care

Medical Records

In official records, health workers reported conditions such as fibroids, pelvic inflammation disorder and unspecified bleeding to disguise terminations. This ensured that if a death were investigated, health workers could evade control, since the symptoms with which a woman presented could indicate multiple conditions.

> Much as they talk about it that it is illegal abortion; people have learnt how to legalise it. You know there are conditions where you can say, general diagnosis like pelvic inflammatory disease, other things like the fibroids, fibroids are like swelling on the uterus. Now the management of fibroids in most case is through surgery by cutting. So, somebody can carry out an abortion in a health setting, and report that this person had fibroids (Richard, medical doctor, private but for-profit health facility).

In some cases, induced abortion resulted in criminal prosecution. This occurred for one young woman whose parents investigated her death:

> Police come in, of course, but they are not going to do that examination for induced abortion themselves. Now in a setting like ours [South-Eastern Uganda], the police do not have their own doctors to carry out investigation. They take you to the government facility to carry out the tests. … So, they on rely on the very same profession of health workers (who assisted with termination). So now how will the medical profession take a medical doctor if he implicates a fellow member? So, the health worker will say ok, we are going to see, and they will delay the process or if you do the scan, of course, you will find wounds on the uterus. But the

> wounds on the uterus could have been caused by the removal of the fibroids. Fibroids are just like any swelling (Grace, medical doctor, private not-for-profit health facility).

Verbal Autopsies

People referred to various conditions to disguise death from poor abortion care. Under the MPDSR guidelines, maternal deaths are surveilled through verbal autopsies, in which a community member – often a sister or mother – is asked to narrate the circumstances that led to the death of a pregnant woman. In most cases, deaths were reported to have occurred due to malaria, the most common illness in the region, so safeguarding the social reputation of the family. During burial ceremonies, too, cadavers were assigned a common cause of death to disguise abortion-related death. This protected the health facility where the death occurred, the health workers involved in inducing or intervening in an incomplete abortion, and the family seeking to avoid shame:

> The most important thing is to have good relations with the parents and relatives of the person. And what is true is that when parents and relatives get to know that she was aborting, they also do not want to speak openly about it in the community. They also even want you to talk to the mourners that she died of malaria. They do not want people to know that she died while terminating pregnancy. They only say so at the sides. No one wants it [abortion] to spread, [so] normally [they] keep it quiet (Suzan, health worker, private-for-profit health facility).

Both health workers and the family of the deceased have vested interests in silencing deaths from abortion, so to evade the disciplinary effect of the law and the moral judgement of the community. This applied also to cases when attempts to abort using local herbs resulted in death. Deaths were only reported in exceptional cares when the health worker disagreed with the family of the deceased, and in general verbal autopsies failed to capture cause of death.

Rehearsing

In the health facility where maternal deaths were reviewed, health workers noted that sometimes internal micro-level meetings were held among ward health workers prior to review meetings with health facility administrators:

> Yesterday we held [a meeting] but the turn-up was not very good. The night shift was very busy, people were very tired. So, we postponed it, but we will have it. But first within ourselves. We don't want the administrators. It is a family meeting [laughter…]. We want to air out the rubbish within (Sandra, health worker, public health facility).

Before review meetings, therefore, health workers at lower levels discuss among themselves what issues to present to and discuss with facility administrators. Although our respondents hesitated to talk about these issues and the processes of screening they used, they clearly reported only on issues they felt were appropriate for administrators to hear. Maternal death reviews therefore embody strategies to evade culpability, and health workers were wary of when and with whom to discuss sensitive issues relating to professional conduct. Yet they also felt that review meetings enabled them to improve on the practice and QoC delivered to mothers by reflecting on what went wrong, and to take corrective measures.

Coaching

Strategies aimed at evading the legal and professional consequences of detection also involved patients. Health workers coached those who wished to procure an abortion on how to respond should they be asked:

> Sometimes when *things* go bad, astray, the relatives want to turn on you. However, we counsel these people that what we are going to do is illegal and we cannot give *assurance* on life … a hundred percent you will be okay … because that one we left it to God. But in case *things* go astray for me, they are going to arrest me and even take my documents; for you [her] they will just arrest you [her] and put in prison so you [she] have [has] to save me as I am saving you [her]. So, in case *things* go bad, you say I came to *Musawo* [health worker] when I was bleeding in case, they ask you why you decided to make abortion? You say I was bleeding. That means she has no case to answer and I have no case to answer in that order (Dorothy, Clinical Officer from a private health facility).

Foot Dragging

In public health facilities, health workers also reported resistance to deliver abortion care services. Sometimes, nurses objected for fear of the legal consequences or because abortion countered their faith: "Last time… I will not assist that doctor. This was a real abortion. It was an abortion not even a miscarriage. Me, with my faith, I will not assist next time. At least I will pretend as if am so busy with other things" (Fatuma, nurse non-profit making health facility). Nurses are protected since the practice is not legal:

> When I was practicing, I was a general nurse, there came this doctor, telling me that he wants to carry out an abortion. I told him doctor, before God, I am not going to assist you. I am not going to release any equipment for you. Do it on your own but I am not participating. Then he reported me to the head of the institution that I had refused to assist him to carry out that procedure. I told the head of the institution that he told me he wanted to do abortion and I was not consenting to abortion, and I was set free (Rose, Midwife, public health facility).

In refusing their services, nurses and midwives drew on legal restrictions as well as moral constraints, noting the absence of any framework that would protect them in case of arrest and prosecution. As illustrated in Table 1, practices of counter governance occurred across all health facilities. However, private health facilities reported more tactics than public health facilities, arguably because health workers in private health facilities reported both induced and spontaneous abortion practices.

Table 5: Tactics to counter the governmentality of abortion care delivery

Category of health facility	Evasive tactics applied
Private for-profit health facility	• Non reporting of cases of induced abortions handled • Referral without medical records • Framing induced abortion as haemorrhage, or pelvic inflammatory disease

	• Carrying and abandoning emergency cases at gate of public health facility • Using social networks to take dead bodies to hospital morgue • Assigning common illness (malaria) as the cause of maternal death • Framing dead bodies as resulting from common sicknesses in the community
Non-profit /social franchise health facility	• Framing induced abortion conditions as pelvic inflammatory disease • Non-reporting • Recording cases of induced abortion as post-abortion care
Public health facility	• Transferring patients from public to private health facilities for induced abortions. • Rehearsal and editing of case reports prior to maternal death review

Quality of Care Outcomes

Abortion care in registered health facilities can be as dangerous as abortions conducted outside them. Institutionalised abortions were typically provided in haste in fear of legal intervention. Consequently, there were at times complications such as perforations in the uterus and retained products of conception, which resulted in excessive bleeding. These complications triggered panic, by both health workers and patients' attendants, as indicate below. Sarah untimely death illustrates how a young woman in need of abortion care must navigate moral and legal restrictions, family constraints, and the complexities of abortion care delivery.

Case 2: A visit that never was

Sarah, a young woman in her teens, told her mother, Alice, that she wanted to visit a friend in one of the towns in the South-Eastern region. She did not know the exact location, she explained, but the house was near a particular health facility. Her mother knew the location and provided directions. Sarah left for town that afternoon. Later that day, her mother received a phone call from an unknown person, telling her that Sarah was in a critical condition at the health facility; she had presented with severe bleeding and they were trying to manage it. Alice rushed to the clinic to see her daughter, and agreed with health workers to transfer Sarah to the district referral hospital for emergency care. Unfortunately, Sarah arrived too late and died. Alice was well connected politically and used her influence to demand an immediate investigation. An investigation team was dispatched to the area and ordered the health facility to be closed. However, before the team had left the town, the facility had reopened. Angered by this neglect of the order, the investigating team ordered the arrest of the health facility owner and health workers.

Health workers conduct abortion operations in haste, and this increases the risk of perforation and discharging patients with retained products of conception. Fear of the legal consequences of inducing abortion triggered maladaptive emergency action. Once complications develop, health workers conceal them, preventing consultation with other medical doctors. Although health workers referred to positive cases of improved maternal healthcare for women with abortion care needs, care was compromised by fear of legal, moral and policy consequences, resulting in hasty operations to avoid detection and apprehension.

Discussion

We have focused on what happens during abortion care practice in health facilities, and how health workers navigate restrictive legal, policy and moral contexts. First, patients in need of induced abortion are transferred to private health facilities and later returned to a public health facility for post abortion care. These transfers allowed health workers to circumvent institutional policy restrictions, since PAC is permitted. Second, early referral (prior to stabilising treatment) to avoid a maternal death being associated with a facility undermines policies meant to improve QoC and surveillance. Third, various tactics are used by health workers to counter state governmentality, leading to

maladaptive practices, rendering invisible induced abortion practice in health facilities, and hiding risky processes and conditions. Figure 6 shows the mechanisms through which QoC outcomes are shaped by the existing regime of governmentality, discipline and punishment:

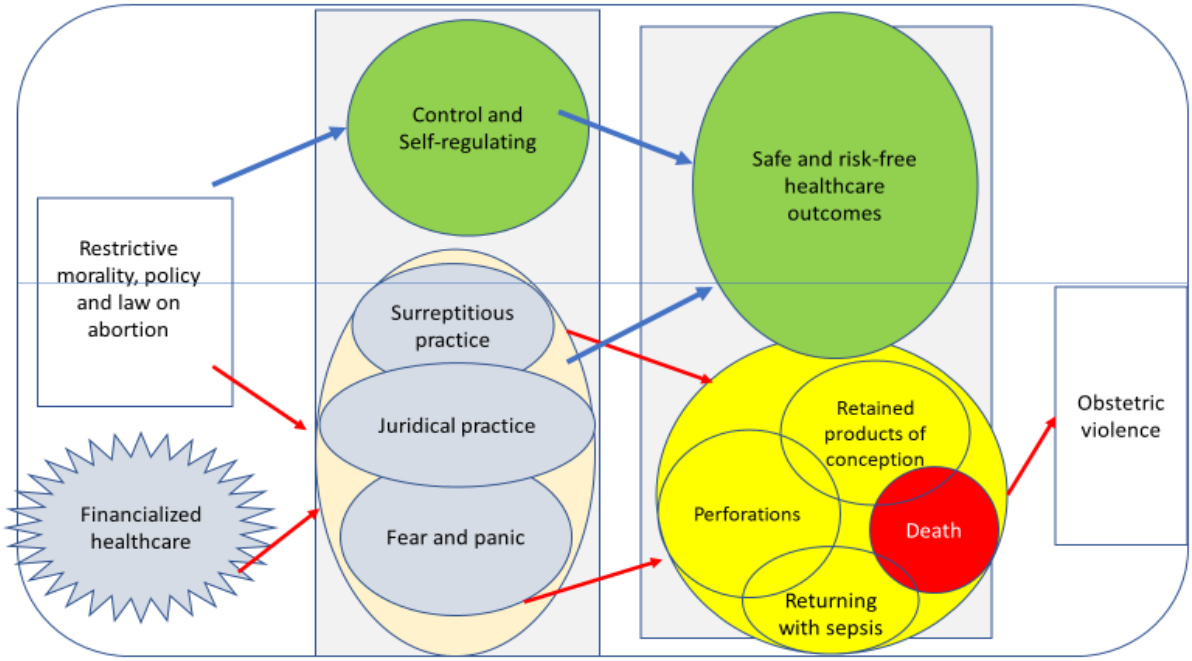

Figure 6: Mechanisms of governmentality controlling abortion care practice

As illustrated, counter-governance operations such as surreptitious practice, fear and panic, and juridical practices in emergency case handling, contribute to risky outcomes for women. Juridical practice such as framing induced abortion as inflammatory pelvic infection or fibroids; and surreptitious practice and fear interact as counter- governance practice to induce poor QoC outcomes.

Silencing as Counter-Governance

Silencing tactics and strategies are used to counter governance in abortion care delivery. Silencing emerged as a set of practices and technologies employed by health workers to keep secret their practices. Silencing is characterised by: high levels of surreptitious practice, juridical practices, and disruptive practices resulting from panic and fear. This disrupted regulation and so constituted and produced poor QoC outcomes. The fear for the disciplinary consequences for disrupting policy, clinical protocols and state law on induced abortion trigger panic and increases the risk of harm to

women. In addition, it encouraged health workers to concealment the practice, so inhibiting the possibilities of consultation should the woman's condition deteriorate.

Silencing prevents governments and institutions from addressing maladaptive care decisions, choices and practices, and it allows both the enactment and reproduction of obstetric violence. Studies on obstetric violence identify acts of abuse, dehumanisation and appropriation by identifiable perpetrators (D'Gregorio, 2010). The boundary between victim and perpetrator may fail to appear because sometimes the health worker finds herself or himself trying to support a woman with abortion care needs. Our study findings support Chadwick's conceptualisation of obstetric violence in that it transcends the individual victim-perpetrator relationship and embraces interrelationships of disciplinary, bodily and material factors (Chadwick, 2017) in specific biopolitical contexts. Obstetric violence is therefore built on the foundations of structural violence in institutionalised healthcare. Through counter-governance technologies, health workers keep secret the transgressive practices in which they are involved. As argued elsewhere, secrecy is enables "people (to) form social relationships and construct collective identities ... regulate social interaction, and frame institutional practices" (Manderson et al., 2015: 184). Thus, contrary to the view that surveillance practices make messy practices understandable (Hope, 2016), silencing technologies confound and complicate abortion care practice. Health workers are not docile individuals, but retain the power to counter regulatory systems of governance.

Global neoliberal reforms rely on hard evidence-based reporting to detect and prioritise interventions (Bohren et al., 2015). However, reports that silence, falsify and mislabel conditions obscure abortion in national healthcare statistics. Consequently, abortion-related deaths are made invisible and are not included in health care interventions.

Governmentality, counter governance and obstetric violence are dialectically related. Technologies such as rehearsing and editing review information; referral without a patient's medical records; framing and representing induced abortion cases as conditions such as inflammatory pelvic infections or fibroid, all silence abortion care. As noted, common illnesses such as malaria were reported in verbal autopsies to cover up induced abortion. In private health facilities, technologies of counter governance enabled health workers to pursue pecuniary interests through institutionalised abortion

care delivery. Silencing thus hides maladaptive practices used in emergency case management, creating vulnerability and resulting in further poor health outcomes.

In private health facilities where induced abortions are initiated and some deaths occur, the health workers and health facility owners colluded not to report cases to avoid the facility being closed. Consequently, the potential effect of surveillance power on their actions, attitudes and everyday practices (Galič et al 2017) is reduced; the health workers cease to be passive data subjects and are also creators of data (Hope, 2016). As indicated elsewhere, health workers may be unwilling to acknowledge maladaptive care practices in their own facilities (Gutschow, 2016). Despite contrary arguments (Haggerty & Ericson, 2000), in Uganda at least state surveillance fails to control elusive and evasive individuals and acts in healthcare institutions.

Conclusion

Our findings amplify the voices of other scholars in sexual and reproductive health who have articulated problems associated with individualising collective forms of vulnerability. In antenatal care, for instance, structural vulnerabilities are individualised and responses do not address the root causes of health problems (Clark, 2014; Manderson, 2016). Abortion care interventions need to attend to counter-governance practices as well as the biopolitics linked to the governance of individuals and the population (Ormond & Nah, 2019).

Restrictions in abortion care produce techniques of self-regulation but also induce practices of appropriation, negotiation and resistance among health workers. In this way, sovereign institutions and individual health workers are co-produced through care practice. Quality of care responses thus need to take into consideration ways to strengthen institutionalised technologies of governmentality to support adherence to quality of care protocols while identifying technologies of counter-governance. Our focus on health workers' perspectives is concerned with the current practices and biopolitics of neoliberal and local biopolitics, and while it does not include women's voices, it supplements other accounts of women and their experiences. Future research using an historical or genealogical approach could help identify how the practices of counter governance have changed over time and uncover the historical conditions upon which they are contingent.

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CHAPTER EIGHT

REPRODUCTIVE GOVERNANCE AND REPRODUCTIVE JUSTICE FOR WOMEN WITH INDUCED ABORTION CARE NEEDS IN EASTERN UGANDA

In this chapter, I present reproductive health matters and justice for women with abortion care needs. I aim to illuminate why and how reproductive injustices exist for women with abortion care needs, and how injustices are concealed, normalised and perpetuated through reproductive health interventions. Considering the complexity of biopower and biopolitical mechanisms involved in constructing and directing women's reproductive bodies, the findings presented in this chapter emerge from observations of quality of care improvement meetings and policy priority settings, as well as in-depth interviews with health workers, law enforcement officers and policy makers. To analysis the findings, theoretical concepts of reproductive governance, biopower and biopolitics are used.

In the text that follows, I illustrate the three major forms of biopower operating on women's bodies: biomedical, biosocial and bioeconomic power, which produce risky bodies, birthing women, and reproductive health consumer bodies respectively. I illustrate how each form of biopower operates as a strategy to produce its desired female population and touch the individual woman's body. I argue in this chapter that the way women's reproductive bodies are constructed conceals and makes invisible the relationships, family and community structures that violently exploit women and precondition their need for induced abortion. I also illuminate the way in which reproductive violence is normalised and rendered invisible and difficult to target. Across all forms of biopower, the idea that abortion is a woman's problem is retained with the view of controlling her reproductive bodily conducts and desires without seeking to address the concerns that may render her incapable of living to the standards desired by society. Within biosocial and biomedical forms of power, awareness of the punitive effects of the state law and policy against disruptive health workers, who transgress reproductive health norms, mobilise counter tactics of resistance. Such tactics include working surreptitiously to avoid being detected. However, surreptitious practices, as illuminated in Chapter six, exacerbate the risks for obstetric violence.

The findings show that reproductive policies and legal ambiguities in Uganda exist and are variably interpreted. The lack of clarity on the law and policy on abortion care in Uganda creates an ambiguous environment, making regulation difficult. Individual activists, health workers and NGOs interpreted the restrictive contexts of law in ways that allowed them to justify their conducts aimed at scaling up service delivery. For instance, participants argued that the law provides for the right to health, which they defined to be consistent with the UN definition as a complete state of physical, mental, social, economic, political and psychological wellbeing. Working behind and with this interpretation, NGOs and activists justified abortion care delivery as legally permitted. Through such an interpretation, they expanded the delivery of reproductive health services by building capacities of health workers:

> The law is restrictive, but not prohibitive but not all people know that it is just restrictive. So, that one depends on which provider or which institution is doing it. One thing I have to tell you now is that am quite happy that many players have come on board, we have the safe abortion action fund, who have trained providers. Those are now working with government facilities here in Kampala. What they do, they have even trained providers to do PAC, at the same time when they do, they are using our style, they are trying to use harm reduction model. But they have trained the providers how to manipulate on MVA kit and all these. (Irene, respondent from an international NGO).

In some instances, ambiguous policy regimes can be expanded to enable the delivery of reproductive health services, build the capacities of health workers and justify abortion care delivery. Legal ambiguities can both enable access to reproductive health justice and constrain access to care due to fear of arrest (Haaland et al., 2019). The boundary between induced abortion, miscarriages and post abortion care delivery was not clearly understood by the health workers who performed post abortion care.

In this chapter, I use the concept of reproductive materialism to theorise the problem of reproductive justice in the context of neoliberalism and restrictive care. I argue that the interface between neoliberal rationality and restrictive care changes the ways that women are related to in healthcare, law enforcement and priority settings. In health care practices, women are represented as material beings used in pursuit of pecuniary interests, and in the process, are stripped of dignity. In addition,

health workers' rationality for care changes from ethical to entrepreneurial motivations, in which context care becomes a means for pursuing profit. Women with induced abortion care issues are discharged immediately, and care packages depend on the financial capacity of the patient. Reproductive health advocacy also becomes a means of justifying access to donor funds and social factors that underpin the reproductive health needs are concealed, used as grounds for social entrepreneurship but not to eradicate these factors. Detailed accounts of these findings are illuminated in the following manuscript.

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Title: Reproductive Governance and Justice for Women with Abortion Care Needs In Uganda

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Key Messages

1. Biopolitical interests normalise reproductive injustices against women.
2. Bioeconomic technologies of power strip care practice of its ethics and replace this with materialist motives.
3. Reproductive materialism strips women of dignity in their receipt of care, and increases their vulnerability in relationships with partners and family.
4. Reproductive health interventions should adopt local approaches which ensure women's dignity.
5. It is critical to address how an assemblage of normalised reproductive interventions, practice and reason which conceal, escalate and sustain health injustices.

Abstract

Women's reproductive bodies are central in global and national development politics, and a constellation of institutions converge on and govern their conducts. In this article, we reveal how the biopolitical construction of women's reproductive bodies, produce, conceal, and normalise reproductive health injustice. Using an ethnographic approach, we explore how women's reproductive bodies are represented, and examine how women are related to in the delivery of healthcare, through law enforcement and in policy priority settings. We reveal three different women's bodies: a risky body produced by biomedical power; a birthing and maternal body constructed by biosocial power; and a consumer body targeted for new reproductive technologies and an autonomous life. Biopolitical strategies discipline disruptive health workers and punish women, and embody mechanisms of concealing and normalising reproductive injustices. We use the concept of *reproductive materialism* to illuminate the effects of the interface between bioeconomic norms and institutional practices in a restricted context for abortion care delivery. *Reproductive materialism* strips care of its ethic, and women of dignity. Reproductive health interventions that focus on women's bodies perpetuate the framing of abortion as a woman's problem, and make invisible the violent, appropriative and disruptive conducts and rationality to which women are subjected and on which they are dependent for reproductive health and justice.

Keywords: Uganda, abortion care, biopolitics, biopower, reproductive materialism

Women's reproductive bodies are placed at the centre of global development discourses. Since the launch of the safe motherhood initiative, in 1987, women's status as womb 'owners' has formed the basis of reproductive health interventions across developing countries, using biomedical discourses to characterise them as risky, and reducing their reproductive health to biomedical conception, pregnancy and birth (Hardee et al., 2012). Reconstruction of women's reproductive bodies under the discourses of universal health coverage signal inclusion of all women's reproductive health needs (Ganatra et al., 2017). It enhances reproductive health justice, based on individual responsibility, choices, and medical risk discourses (Stone, 2014). Yet in many sub Saharan African societies, women's reproductive health rights and justices remain centred around foetal politics and women's normative roles of childbearing (Manderson, 2016; Paltrow, 2002; Pentecost & Ross, 2019). Aligning national health programmes and policies to ensure universal reproductive health rights protection remains a challenge.

Human rights claims shift attention from the punishment of women's reproductive bodies and disruptive health workers to the delivery of abortion care practice in medical health facilities (HRAPF, 2016; Ngwena, 2014). However, framing abortion on the basis of medical professional expertise creates ambiguities about the reproductive autonomy of women when medical expertise prevails over women's bodies (Macleod et al., 206). Equally, rights-based interventions raise tensions between global and national interests in relation to reproduction (El Kotni & Singer, 2019; Singer, 2016; Singer, 2017). Such tension and ambiguities render reproductive justice elusive particularly for women with abortion care needs, as abortion discourses are muted (Steinfield et al., 2018), in much the same way that global and national discourses continue to conceal the circumstances of pregnancy, abortion and unsupportive family relationships (Chiweshe & Macleod, 2018b; Chiweshe et al., 2017; Mavuso et al., 2020). In the contestation and reconciliation of these tensions, reproductive health and justice as experienced for some women may be misrecognised, neglected and suppressed. In this study, we examine the biopolitics involved in the constructions of women's reproductive bodies and how this shapes opportunities for reproductive justice.

In general emergency obstetric care and post abortion care guidelines, reproductive health policies and programmes seek to align national resources to strengthen health systems by deepening the private sector's role in reproductive health and family planning (Cisek et al., 2019). Financial rewards

of care may minimise or overlook the reproductive care needs for women who are very poor or in other ways marginal. Financial motives drive interventions towards areas of donors' resource prioritisation, while suffocating those where there are no financial incentives (Odekunle & Odekunle, 2016; Seims & Khadduri, 2012). However, insufficient investigation has been directed to understanding how this changes the practice of care. Economic rationality may change how reproductive health issues are interpreted and how material objects are linked to consequent care. Money and markets may produce corrosive effects which turn patients and their ills into dollar signs (Timmermans & Almeling, 2009). The interactions between biopolitics and economic rationality may intensify disparities of access and disregard therapeutic efficacy (E-Murshid & Haque, 2020; Giorgio et al., 2020; Mac-Seing et al., 2020). In this article, we use the concept of reproductive materialism to illuminate the effects of the interface between economic rationality and healthcare practice in restricted contexts, and to illustrate the implications of this to women's reproductive health justice.

The use of safe abortion technologies, with the promotion of greater skills and expertise of nurses and midwives, may improve the quality of post-abortion care (Ganatra et al., 2017; WHO, 2015a). Even so, injustices have persisted particularly in relation to induced abortion (Aantjes et al., 2018; Bukenya & Golooba-Mutebi, 2019; Mutua et al., 2018). Standards and guidelines may narrow the scope of services (Mac-Seing et al., 2020; Storeng et al., 2019), and how these are adhered to may be shaped by global biopolitics as well as local social and legal boundaries (Obrist & Van Eeuwijk, 2020; Jaffre & Suh, 2016). Public discourses concerning the delivery of induced abortion care services affect how health workers are viewed within and outside the profession (Macleod et al., 2016). Restrictions and economic rationality may impute different meanings on women's reproductive bodies and affect how women are positioned in care, law enforcement, and policy priority setting practices.

Care practice is a charged space in which multiple actors are involved, and care is mediated by personal, social, and institutional conditions (Boydell et al., 2019; Singer, 2016; Yirgu et al., 2020). In Uganda, induced abortion care is incompatible with dominant social, religious and legal norms (HRAPF, 2016; Izugbara et al., 2015; Ngwena, 2016). How health workers position themselves and the women in relation to care practice, reflect power and privileges and control based on notions of risks and criminality. Although studies underscore the positive role of clinical officers and health

surveillance assistants in deepening access to family planning service (Banerjee et al., 2015; Cates & Maggwa, 2014), health workers may force women to take long acting family planning methods against their desire, and actively prevent women using methods of their choice (Senderowicz & Higgins, 2020). The boundaries set by guidelines may be transgressed (El Kotni & Singer, 2019; Suh, 2019b) in pursuit of political goals and strategies which are often taken for granted (Sangaramoorthy, 2012). These may also mobilise counter resistance, appropriation, and mechanisms of navigating restrictions, all of which may produce reproductive injustice. By rendering these effects of power invisible or power inequalities normal, the need to reform institutional practices of abortion care delivery is overlooked.

Below, we explore the construction of women's reproductive bodies and investigate the way institutions relate to them in care and through law enforcement impact care choice. We step aside from binary normative categories, so to uncover the concealing, normalising, productive and performative effects of biopower and to describe how these sustain reproductive health injustice. Our aim is to illustrate how and through what mechanisms continuities in reproductive health injustices are sustained.

Methods

We draw on ethnographic data from a study of policy, priority setting and the delivery of health services of national maternal healthcare responses and quality of care improvement in Eastern Uganda from August 2018 to March 2019. At the national conference for priority setting, the first author observed and documented how women's bodies were framed and constructed in keynote addresses and discursive processes (Author and Author, 2020). These data were supplemented through in-depth interviews (48), with people involved in abortion care and law enforcement, to explore how women's bodies were represented in institutional practice. These participants, the majority male, were from development agencies, non-government organisations, faith-based organisations, law enforcement agencies, Ministry of Health, and health workers from three health

facilities where induced abortion and post abortion care services were delivered[1]. With health workers, we explored the institutionalised arrangement of abortion care and how this influenced health worker conduct. This included health workers' adherence (or not) to the law, policy and treatment protocols, including the microphysics of navigating around the law on abortion and policy on post abortion care delivery, and evading state disciplinary effects. The first author observed in quality of care improvement meetings how health workers applied MVA and D&C technologies on dummies under the keen supervision of the quality assurance team, and so how the intervention influenced the abortion care conducts of health workers. At the magistrate's office in Eastern Uganda, the first author reviewed the records of criminal cases of procuring abortion and aiding abortion and explored the judicialised processes of securing justice.

All interviews were conducted with informed consent in the English language, the official and commonly used language in formal settings, by choice of the interviewees. Audio recordings were transcribed by an independent person and reviewed, edited and allocated pseudonyms. Transcripts were then exported into N-Vivo software, where the first author inductively coded the responses then analysed the data drawing on theoretical concepts of biopolitics. The authors then analysed the results, and synthesised these under four themes of reproductive: (1) birthing bodies and autonomy (2) control, resistance and concealment in care practice, and (3) retribution for disruptive health workers and women, and (4) reproductive materialism. In discussing these findings, we develop the concept of reproductive materialism to reflect the effects of the interface between economic rationality and and restrictive care practice. Given the moral and legal sensitivities surrounding induced abortion, the specific health facilties and district where data were gathered are not specified in this manuscript; we use Eastern Uganda to refer to the study area.

[1] The distribution of participants across the different institutions was as follows: donors and technical development agencies (n=4), Ministry of Health (n=5), faith-based organisations (n=6), non-government organisations (n=7), district level quality assurance team (n=5), health workers (n=16), law enforcement officers (n=05).

Results

Birthing Bodies and Autonomy

Development actors argue that governments invest in birth control interventions to harness the demographic dividends of countries with very young populations. Uganda has an especially young and sexually active population. About 52 percent of the population is below 15 years, teenage pregnancy accounts for 25% of all births (Dlamini et al., 2019), and the fertility rate is estimated to be 5.4 children per woman (UBOS, 2016). Modern birth control methods have been promoted within the framework of family planning since 1957, but development actors and the Catholic Church still disagree over the use of modern contraceptives, with the church continuing to advocate for natural birth control methods. Christian and cultural values on women's bodies render young women especially vulnerable to unsafe sex. Although Uganda has a sex education programme in schools, religious institutions oppose this for fear of secularisation. Contraceptive use outside family planning (that is, within marriage) is regarded by both communities and religious institutions as antithetic to women's sexual role, in which reproduction is privileged, and the spiritual purpose of sex. Accordingly, women explore their sexuality clandestinely, and once pregnant, seek abortions to avoid victimisation of pregnancy outside marriage.

In contrast, rights-based discourses represent women's bodies as autonomous entities, and argue that women have the right to control their fertility and reproductive health. In this context, abortion is brought into the realm of health rights. Reproductive health rights inscribed in legal instruments, international human rights treaties and the African Charter on Human and People's Rights and the Maputo Protocol all oblige nation states to provide an enabling environment for women to exercise their rights over fertility decisions; this includes abortion (CEHURD, 2016; HRAPF, 2016). However, there is considerable tension over the construction of a woman's reproductive bodies as autonomous, and these instruments are silent on the right of a woman not to have a child. This suggests the influence of African constructions and everyday moral logics which conceptualise abortion and fertility choice in the context of birth, with women's reproductive desires determined by local standards of what is morally right and desirable. Along with intentional choice not to reproduce and the non-intentional birthing of children, abortion is framed as disrupting women's maternal identity, unless occurring spontaneously and regrettably as a miscarriage.

Uganda's guidelines for post abortion care (PAC) set out the boundary between permitted and prohibited abortion care practice. In public health facilities, attention was paid to women with post abortion care needs, but not to women seeking induced abortion. Women perceived with signs of having induced abortion, or assumed to have resorted to abortion because of young age, are stigmatised by health workers. Women's bodies are constructed to carry babies, to protect them until birth and to nurture them thereafter. One male respondent described women's bodies, without irony, as containers:

> People were saying women have a right to decide what to do with their bodies, but you don't have a right to kill yourself. So, why should you even kill your baby? Yes, you have a right to do anything to your body but not to your baby. Your baby is an independent entity [laugher]. So, you have no right to kill a baby. This baby is just in your body, you are just a container (Alfred, participant from Catholic Church).

In Christian faith-based organisations (FBOs), termination at any gestational age is considered evil, as life is considered to begin at time of conception. In Islam, it was reported that termination of pregnancy is acceptable if conducted before ensoulment, understood to occur at about 12 weeks. However, in limited circumstances, some FBOs allowed abortion to save the life of the mother:

> There is a situation where abortion is conducted to save the life of a mother; if there are complications and it is the only way they can save a mother, which with me as a public health practitioner, it's fine and it is an acceptable position. So, it is acceptable if an abortion is medically done with the purpose of saving the life of a mother and evidence is there, that one is acceptable. Right even here, it is acceptable because even our bosses have wives, they have daughters, they could get pregnant tomorrow and if there is a complication, they have to terminate. So, under those circumstances it is also acceptable (Emmy, respondent FBO).

As indicated, all FBOs allow those whose lives are at risk to secure abortion safely, but punish women who transgress normative gendered expectations of reproduction. In the event of inability to care for a child, both state policy and Christian groups advocate for women to carry the pregnancy and then admit their new-born infants to orphanages or adoption agencies. The responsibilities of male partner,

the woman's family and other community members are invisible. Further, induced abortion is often not possible because of the lack of support particularly for poor young woman (Guttmacher, 2013).

Universal reproductive healthcare coverage and reproductive rights for women stand in contrast with the desired national reproductive identities of women and reproductive health rights outside the birthing roles. In particular, young women's sexual and reproductive health desires are misrecognised and women with unwanted pregnancies are expected to carry them against their will, to grapple with life-long guilt of conceiving an unwanted child, sometimes in violent circumstances, or to raise them amidst unsupportive social relationships. Further women's sexual desires are tied to childbearing, and the right not to have a child is generally dismissed.

Control, Resistance and Concealment in Abortion Care Practice

Bringing abortion care practice under the control of legal and medical authority introduces a theoretical boundary between unsafe and unsafe abortion, based on the environment in which abortion is conducted. In most countries, medicalised abortion is now standardised care with an expanded categories of health workers, within the constraints of medical abortion technologies and gestation age (Glenton et al., 2017; WHO, 2015a). During quality of care meetings conducted at a regional level, health workers were educated on the limits, possibilities, and challenges of using different medical technologies for induced and post abortion care delivery. Under the new classification, manual vacuum aspiration (MVA) stands out as safe and risk-averse. However, MVA is restricted to pregnancies in the first trimester ($\leq$ 12 weeks gestation), and excludes abortions from 12 weeks gestation. But termination is only available in private health facilities. In public health facilities, women with induced abortion needs are subject to often discrimination. Health providers willing to support women often transferred them to private clinics, and these clinics then returned them to the public health facility for post-abortion care (PAC), thus evading state surveillance while ensuring women's access to safe induced abortion. Poor women who cannot afford private health facilities were, according to interviewees, advised by public health facility staff to self-induce and then to access PAC service at the facility. However, most health workers believed that termination, no matter the circumstances, was prohibited and morally reprehensible. Health workers who aided women to procure abortion, both in the public sector and in faith-based organisations, were ostracised by colleagues. In some cases, inducing abortion led to tense relations between midwives and medical

doctors, with foot-dragging and resistance by midwives and nurses because they considered this to be criminal of itself and because it would compromise women's ability to reproduce in the future. Restrictions therefore produced compliant health workers while producing fear in women:

> You see at the end of the day there is that fear. We had interns here but I can tell you, the university students fear pregnancy so much, more than HIV. That is why they are now abusing this tablet of the emergency pills. You take it once a month. But for them, once they expect to have sex, they take it whether after one day, two days, or every week. They just keep taking. (Denis, participant from the network of religious organisations).

PAC Standardised Guidelines, issued by the national Ministry of Health, normalised discrimination against women with induced abortion care needs. However, limited state capacity to monitor care practice across different categories of health care facilities offered room for induced abortion for women willing and able to pay for private services. Very poor women, however, were unable to access financial support and received care commensurate with their financial capabilities rather than objective treatment. Thus, guidelines without effective mechanisms of supervision do not translate into better outcomes for vulnerable communities.

In public health facilities, the unreliable supply of disinfectants and work overload compromised the quality of PAC services, and placed stress on health workers. They in turn would vent their frustration on patients. Health workers who worked night shift often worked until late in the morning, waiting to be relieved, and under such stress, women who seeking PAC and assumed to have induced abortion received scant attention. Local politicians and patients interpreted this as instances of rudeness and alleged malpractice; health workers however saw their behaviour as reactions to limitations of the facility. In the private health facility, treatment to patients depended on their financial resources. Health workers operated independently most of the time, in panic, with little time for informed decision, information sharing and post abortion care counselling. In case of emergency, there was no room for consultation, due to panic and fear of apprehension and the consequent risk that their practicing license would be terminated. Non-profit health facilities on the other hand were regulated through periodic training and continuous medical education tailored towards standardised technology use and quality of care.

Restrictions mobilise resistance in which systems of reproductive control are disrupted. Some health workers used MVA on pregnancies above 12 weeks, resulting in failure to aspirate all products of conception. D&C meanwhile was used to induce abortion, although discouraged, resulting in perforation, haemorrhage and sepsis. As we have reported elsewhere, the classification of medical technology ignores the risks of incomplete abortion and infection (Authors, 2020). Many international NGOs intervened to build the capacity of nurses and midwives to use safe medical technologies to deliver post abortion care, thus increasing access to reproductive health care services:

> I have been picking data from Mulago, Kawempe and Kiswa, and all these [shows figures] are induced abortion cases from November. So, these are the numbers of mothers they have seen and they are even complaining that they have run out of medicine. They do it vey confidently. We have given them the data collecting tools and we provide them with that support. So, much as the law is there, our providers have realised, it's better to save life and risk the law than go and attend the funeral of a woman whom we could have saved. Definitely aborting is very restricted, at national and at district level; it is not acceptable. But at an operational level, everything is going on very well (Irene, NGO respondent).

The training sessions offered NGOs in sexual and reproductive health matters in the region targeted health workers in social franchise and public health facilities, but not profit-making health facilities where most cases of induced abortions occurred. It was assumed that women who sought care services from private health facilities were highly educated, relatively wealthy, and could afford the services; and that the services were safe. NGOs sought to integrate abortion care delivery as one of a range of services in public health facilities. Some NGOs introduced Value Clarification and Training (V-CAT) courses as a form of harm reduction, to reconfigure health workers' and justice department officers' attitudes toward induced abortion and abortion care delivery. Others scaled up the supply and use of medical technologies for abortion care. However, given the restrictions on inducing abortion, the abortifacient Divabo – a combination drug therapy of Misoprostol and Mifepristone – was only supplied by the NGO to social franchise health facilities. Public health facilities were not supplied this since the government policy prohibited it, and instead, they were supplied only with Misoprostol, which was available to treat postpartum haemorrhage.

Risky conditions of abortion care were reported in practices conducted by professional doctors and health workers, including those trained on the use of medical technologies. To health workers in the referral health facility, abortion care injuries were constructed as outcomes of practicing without competency, using risky technologies and operating in unsound clinic environments.

Retribution for Disruptive Health Workers and Women

Most cases of procuring or aiding procurement of abortion against the law occurred through word of mouth, with stories that circulated within the community that emphasised danger and risk. This includes cases of pregnancy in young women, resolved birth the pregnancy came to term; cases of young women haemorrhaging; and foetal tissue found in the community. Hearsay activated community suspicions and invoked disciplinary conducts, with both health workers and women reported to the police. A review of records in the study area identified several cases of procuring and abetting abortion. To prove culpability, however, the cooperation of the patient as a witness is needed. No woman willingly testified against the health workers since they would also be implicated. Even when there were complications, women remained silent to avoid the law. Criminal cases rarely reached courts of laws, therefore, suggesting lack of evidence on the file, incomplete investigation or the absence of a witness, and most cases were dropped because of lack of evidence to link the accused to the offense and to prove the offense

> Yes, most of these [aiding procurement of abortion and procuring an abortion] are dismissed because there is no evidence. They cannot go through the entire process of trial because the prosecutor was not able to produce sufficient evidence. You see in trials of criminal offense; someone is supposed to prove beyond doubt, so most of them are dismissed for want of prosecution. Want of prosecution means that, the case has been going on and for every time you come to court, it is postponed because there is no file, or investigations are still on going, or you do not have the witness to be produced in court (In-depth interview, advocacy officer).

Despite the constraining effect of the law on abortion (CEHURD, 2016; HRAPF, 2016), individual health workers and women are therefore rarely penalised. According to a legal advocate for health workers and women, only one case had succeeded in her experience, when a woman was compelled to confess in the hope that she would get a lighter sentence. However, the effects of the law are

realised through normalising mechanisms of enforcement. First, fear of prosecution disciplines health workers and rights advocacy workers. For advocacy organisations and activists, the abortion law meant that a person involved in sensitising communities to abortion care services was at risk of being held for incitement or aiding a woman to commit the crime of terminating pregnancy. Second, the boundary between prohibited and permitted abortion care services was incomprehensible to most law enforcement officers. Induced abortion care occurs outside of the law, and opens healthcare practice to public scrutiny, subjecting health workers and women to humiliation by the police and media coverage. Sometimes humiliation occurred in practices of PAC, as indicated above, when care was provided to a young woman who presented to the clinic with an incomplete abortion. According to some health workers, when there is conflict with the law, the public begins to ostracise health workers and avoid the clinic, eroded their moral integrity to serve:

> I had such an incident somewhere in Tororo, where I was arrested on charges of aiding procurement of abortion for girls. I really went through a lot and my clinic actually closed for quite some time because, everyone was starting to label me as an abortionist and yet I was actually trying to offer post abortion care. A girl had tried to abort and it was incomplete. She came to me and I helped her complete the abortion. But then her parents got to know of it, I was instead arrested for inducing the abortion. I was only released after giving money to the police officers. I am an elderly woman, you know, a mother with a family. It was shaming, being seen as a murderous person yet I was saving life (Irene, public health facility worker).

The restrictive law also limits scale up of positive interventions for reproductive health promotion, and to support the defence for health workers and women in conflict with the law. Few lawyers were willing to assist, and those available were usually too expensive for many health workers to afford. Because of the social stigma attached, not all lawyers understand the concepts surrounding human rights issues involved in abortion. The same is true with other issues that are considered controversial or illegal: sex work, drug abuse, and homosexuality. Lawyers opt to avoid the social politics that accompany these issues (Diana, advocacy officer, NGO).

Tonnestrom and Al-Nagar (2019) argue that health workers exercise "Hippocratic disobedience" in order to secure the reproductive health of women. But criminalisation has both concealing and

productive effects by directing attention to individual health workers. The professional intentions of health workers to secure the reproductive health of women is concealed. Prosecution does not interrogate the motivations behind induced abortion but searches for incriminating evidence. Consequently, a health worker and woman are victimised for asserting professional responsibility, reproductive rights and political resistance against what they perceive to be an injustice. Fear of the law and its execution reinforces adherence to the law even if in contravention to health judgements. At the same time, working under fear of apprehension triggers panic in practice, driving surreptitious conducts and making regulation even more difficult:

> Where I am working, I have spent like 3 or 4 years without seeing a member of the council [Uganda medical professionals and dentists' council] coming here to even check how services are being provided. That's part of their mandate. And so, there are many even private hospitals that they have never supervised at all. No body checks on what is taking place, why? Because at times the resources are not there (Esther, quality assurance officer).

Fear of retribution also undermines the articulation of issues for reproductive justice, and advocates carefully tread the line to avoid detection:

> The packaging language matters a lot. Walking to the Ministry of Health and talking about abortion, they will not listen. When you walk in Ministry of Health and talk about post abortion care, they will listen to you, even when you may be talking about the same things you understand. We are careful when dealing with it [reporting on induced abortion]

Reproductive Materialism

We use the concept of reproductive materialism to draw attention to the effects of the interface between neoliberal goals, and reproductive technologies and practice, on women at the centre of development strategies. Reproductive materialism refers to the way in which neoliberal rationality and values transform institutional practices and women's reproductive bodies into materials and instrumental subjects for the global reproductive health industry. In this study, we examined how the use of abortion technologies, and the delivery of induced abortion may be emancipatory (Cleeve et al., 2017) but also may transform women into material instruments used in pursuit of financial

motives. Using the concept of reproductive materialism, we examine how this interface relates to reproductive health justice for women with induced abortion care needs in Uganda.

In Uganda, neoliberal rationality, facilitated by the infrastructure of global financing, directs national priorities for reproductive health investment toward interventions which generate high impact rather than meet holistic reproductive health needs. In quality assurance meetings, the quality assurance team emphasised the importance of allowing women to choose which family planning method to use. However, there were no incentives for health workers to provide short-term family planning methods. Directing women towards uptake of long-acting contraception was motivated by the financial incentives that NGOs used to reward health facilities that promoted long-term methods. This also involved manipulating women's reproductive agency by discouraging and devaluing short-term family planning contraceptives while advancing rationalities that privilege long term methods. Thus, knowledge and information packaging were tailored towards instrumental goals rather than offering professional care. Yet drawing from interviews, women countered such tactics by promising to return to the clinic after consulting with their mothers-in-law and partners. Most women did not return.

Among health facilities which relied on donor support, sometimes records about the number of clients served, the number of family planning and abortifacient technologies were exaggerated to magnify the number of cases handled in order to elicit more funding to scale up healthcare activities. This was particularly the case in public health facilities that received funding from donors and NGOs in the region. Where the supporting institution detected falsified records, verification exercises were instituted to allow data checks and transactions were reversed as a penalty. In Uganda, reproductive health interventions, including abortion care, are based on donor funds and so local conditions were interpreted and appropriated consistent with the funding regime. In private health facilities, induced abortion care was interpreted within the law to support women, but with financial gain emphasised. The service was considered the most lucrative of maternal and reproductive health services. As we have illuminated elsewhere, pecuniary motives increased the risks to women's reproductive bodies, with the attending provider discharging patients immediately after the procedure to avoid possible apprehension (Authors, 2020).

Reproductive materialism stratified patients according to financial ability to pay for the service, and so reproduced inequality. NGOs extended reproductive health services but only in economically

viable regions of central, east-central and western Uganda, and so side-lined the chronically impoverished regions of north and eastern Uganda:

Our clinics are pay centres. these are *'people pay'* for services. A network of them in the central region, and then in Western Uganda all the way to Kabale (bordering with Rwanda). We have in Eastern, Tororo-Soroti and in Mbale (Uganda's border with Kenya). Its only in North-East (Karamoja region) where we are not. We used to have a clinic in Karamoja but we closed it because I think Karamoja are still far away on the spectrum of family planning and post abortion care. So, we closed that one in 2016. Our clinics vary depending to the level of economic development of the region and you know where people have money, the private sector tends to stay. So, you find lots of these clinics in South West and Western. So, it's about purchasing power because these are private clinics. So, the more you have economic development, the more you are likely to have clinics that can meet the stand for accreditation (In-depth interview, NGO participant). This logic of intervention emerged as an effect of commodified healthcare in which monetary values transform relationships of care into economic mediations. In these relationships, patients became customers, health workers became healthcare entrepreneurs, and advocacy organisations became social entrepreneurs for institutional financial survival. Across the three relationships, women's bodies and reproductive health conditions were reduced to material objects for profit. Yet under restrictive condition, surreptitious care practices further endangered women's reproductive health. Both the transgression and appropriation of regulations on induced abortion care were conducted in the prism of saving life. Risks were constructed as unavoidable circumstances that befall any care practice juxtaposed against those that arise in regulated practice.

In law enforcement, criminal prosecution affects only poor health workers and women who cannot buy their way out of prosecution or compensate the family whose image is in social disrepute as a result of induced abortion. According to interviewees, the parents of young woman reported cases to police only to force the offender or his family to compensate for the crime (of parenting).

Discussion and Conclusion

The production of risky, birthing and maternal bodies, and consumer reproductive bodies normalises reproductive injustices and makes invisible certain reproductive health issues while privileging

others. The way in which women's bodies matter behind concealed strategies of reproductive governance, creates inequalities, in which some reproductive health bodies cease to matter. In this study, unmarried women, and women without interest in reproduction, are subject to reproductive injustice. The need for induced abortion care, contraceptive use outside of marriage, and the desire to not have children are all suppressed in privileging reproductive needs along the continuum of birth. Drawing from this, we argue that this forms the foundation on which women's reproductive bodies matter in healthcare practice. We agree with the view that the different articulations of the body destine women to reproductive injustice (Gibbon, 2017). The articulation of the consumer reproductive body intensifies reproductive health inequality, by aligning services to economically powerful women and regions of economic viability. This means that women have to overcome social, legal and economic barriers to secure induced abortion from private health facilities. We disagree with singular notions of reproductive rights, and public health discourse cannot advance reproductive justice (HRAPF, 2016; Ngwena, 2014). Instead, we suggest that promoting reproductive justice lies in addressing the interactive effect of the different articulations of the reproductive body.

Although standards and guidelines are promoted to ensure quality healthcare (Amanda Cleeve et al., 2016; Glenton et al., 2017), they can also embody injustice and normalise discrimination against women . If adhered to strictly, guidelines and standards justify institutional injustice against those who are considered disruptive of the normative standards (Suh, 2019b). If the PAC guidelines and the law did not enact boundaries for disrupted and permitted abortion care practice, health workers would have little basis for discriminating against women with needs for induced abortion.

Everyday healthcare practices are deeply implicated in reproductive health injustices. We have illuminated elsewhere that restrictions that seek to regulate abortion care practice mobilise counter conducts of resistance, and surreptitious practice under conditions of panic (Authors and Authors b), which escalate risks of obstetric injuries and yet are difficult to regulate. Equally, retributive justice against health workers who provide induced abortion services increases costs of accessing services, and the risk of self-induced abortion to qualify PAC services. Normalised practices and reasons enter into political realm in which they perform instrumental goals. Besides the restrictions, we have shown that a new value system based on materialism replaces the normative values, and this established boundary of moral and immoral, legal and illegal, permitted and prohibited practices. This generates

different levels of care for poor and economically privileged women, and criminalises poor health workers who cannot compensate family of the woman or buy their way out of prosecution.

Reproductive justice is located in an assemblage of materiality in which reproductive health issues, women's reproductive health issues, conditions of their vulnerability are linked together through policy priority setting and care practices. Through this assemblage of materials is appropriated for instrumental purposes by a network of health workers, NGOs activists and policy entrepreneurs. This conception introduces new meanings and interpretations in which such materials, conditions and practices are no longer seen as evil to be eradicated but as opportunities for financial gain. Reproductive materialism has transformed the role of reason from being an objective measure of the desired conduct to serving an instrumental purpose in which logic is used to justify and pursue instrumental goals through specific reproductive health interventions and conducts. We argue that to address reproductive justice, the problem of materialism in institutional practices must be confronted. Normalised reproductive health interventions, standards and rationalities must be reconceptualised to uncover the concealed mechanisms through which reproductive health injustice is perpetuated.

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CHAPTER NINE

INTEGRATED NARRATIVE

I used a critical anthropological approach to understand how women's reproductive bodies and population are produced and controlled through policy priority setting, abortion care delivery, and the enforcement of the law on abortion. I have examined the biopolitical strategies used to govern individual women's reproductive bodies and the conduct of health workers to produce the desired conducts and desires, and determine the possibilities available to care for women with abortion care needs. The biopolitics that produce and control women's reproductive bodies involve a triad relationship of the economy, biomedicine and medical technologies, and the society. Through these relationships, various discourses about the beginning of life, cultural roles of birthing and nurturing children, and reproductive rights, all in the image of reproductive health consumerism, are used to produce and control the reproductive health desires and desired bodies. Through the different chapters, I have illuminated the ways that women's reproductive bodies are constructed, and the knowledge about them, the institutional practices of care, discipline and punishment, and the relationship to the self, and I have identified how these have increasingly become materialised. Understood as a transformation from ethics and norms, reproductive materialism represents a change in the configuration of biopolitical interests in women's reproductive bodies, supplanting ethical and normative interests with pecuniary interests.

Methodological Integration

In this study, I adopted a critical ethnographic design in which ethnographic observations were blended with in-depth interviews and document review. Ethnographic observations offered a valuable tool for accessing the discursive effects of power in priority setting in a naturally flowing manner, and highlighted tactics of countering and navigating around legal restrictions on induced abortion. Through observation, I was able to account for how individuals constitute themselves in the image of the different forms of biopower. I was however mindful of the field of contestation and power dynamics, and thus noticed the ways in which conducts and language, including silences, are deployed strategically in concealing surreptitious conducts which occur against the law, and imposing rationalities of domination.

I was able to account for the performative effects of communicative materials, beyond normative and objective constructions. I showed how material technologies are deployed in the discourse of setting reproductive health priorities. I illuminated the specific performances at a point in time and accounted for the entire processes of effacing abortion care from the national agenda, as opposed to merely outcome-based results. In effect, I was able to illuminate the emergent realities and the processes that produce them. Ethnographic observations brought the everyday context of practice together with data, thus offering a situated knowledge of how power effects the different biopolitics which converge on and produce women's reproductive bodies.

However, ethnographic observation cannot uncover that which is inherent in the mental dispositions of participants, as institutionally organised observations offer no room for mental exploration at the same time. To cover this gap, follow-up in-depth interviews were used to explore the intentions and meanings behind observed conducts, and to document and analyse non-observable performances like silence in the RMNCAH conference. In exploring power and reproductive health issues, in-depth interviews offer data which provide a perspective on and broaden understanding of the different ways in which different categories of participants construct reproductive bodies, relate to them, resist, contest and/or appropriate the forms of control imposed on them. In-depth interviews also offer site specific realities about situated conducts such as abortion care delivery, thus deepening the understanding of how and why practices may produce different outcomes despite the fact that they are under the same policies and regulation. In this study, in-depth interviews illuminated clearly how abortion care practice differs across health facilities, and also presented how risks can be variably represented by health workers across different health facilities. In-depth interviews present a unique challenge in which research participants from particularly high-level institutions may seek to tilt the interview towards issues which they consider to be important. This brings about power contestations which may facilitate or frustrate the attainment of the research goals.

The document review also offered an opportunity to understand the pre and post conference rationalities that mediated both epistemic power and power of the established rules that regulated discursive relationships. This review revealed how ruling relationships were internalised in ways that mediated but also shaped the discursive conduct of participants, for fear of being recognised as transgressors of the national law on abortion. Documents also contained discourses, which although

present may not be articulated in discursive engagements of the conference. This research design required adequate preparation in my field of inquiry, including the understanding of research practice and methods as inherently political, with potential to mystify my own influence on the findings. Critical ethnographic research design provides an opportunity for contexts, contents, practices and perspectives to come together in ways that capture stable and objective realities, the fluid, the emergent realities, the situated and contingent, and the performative social realities. Three forms of biopower operate on women's bodies. The first is biosocial power, which produces women's reproductive bodies in the image of pregnancy, birthing and maternal roles of childrearing. The chapters on reproductive justice and governance and policy priority setting (chapters five and eight) showed how the state law on abortion and morality are used to produce birthing women's bodies and desires, and how the law directs institutional cultures toward punishing and disciplining disruptive reproductive conducts. Second, biomedical power constructs women's reproductive bodies as risky and directs national priority setting toward strengthening the health care system to protect women against risky and unsafe conditions. In chapters 5, 6 and 7, I have shown how biomedical power secures women's reproductive health through the use of safe medical technologies, trained health workers and health facilities operating according to health service standards and guidelines on post abortion care. Finally, bioeconomic power organises and produces women's reproductive bodies in the image of economics, producing them as consumers of reproductive health technologies and medicines. In chapters five, six and seven, I have shown how care for women is determined in pecuniary terms, with the provision of induced abortion care and post abortion care, law enforcement, and maternal and reproductive health policy prioritisation all determined by balancing risk and remuneration.

The convergence of these three forms of biopower on women's bodies weakens, erodes and suppresses women's reproductive agency. The convergency effect intensifies the biopolitical strategies of controlling, directing and producing the desired individual bodies. The biopolitical interest of producing consumer women's reproductive bodies employ technologies through which women self-constitute by desiring to be compatible with free world identities of reproductive empowerment. Equally, national biopolitical attempts to produce a birthing female population employ weaponries in which women desire to become subjects of moral and legal surveillance. At the level of healthcare, health workers are constituted as agents of medical and state surveillance, and

as entrepreneurial agents of a consumer biomedical world order. NGOs and advocacy agencies are also transformed into social entrepreneurs, exploiting local contexts and vulnerabilities in the image of the financialised world to get donor funds. The intensification of global and national regimes of biopower converge on women's bodies to produce multiple subjectivities of women's bodies, which change how women relate to their reproductive bodies, and influence how they are treated and cared for in healthcare conducts and policy priority setting. In each form of biopower, a woman self-constitutes differently. Each form of biopower creates sensibilities of a synthetic life and being, which are incompatible with the local realities in which women live and from which they are indivisible. Such sensibilities conceal the real sources of injustice while exposing women to other injustices concealed within newly acquired sensibilities.

I argue that the way women's reproductive bodies are constructed and treated under the current neoliberal context indicates that women's reproductive bodies have been turned into materials. Reproductive materialism involves a new set of valuing women's reproductive health issues including abortion in terms of material gains resulting from care and the central paradigm of birth appropriation in reproductive health interventions. The turn from normative and ethical bodies to reproductive materiality strips care of its ethic and turns reason into an instrument to be used in pursuit of pecuniary interests. Reproductive materialism accommodates the oppressive conditions such as violent and unsupportive intimate partner and family relationships, which precondition the need for induced abortion. It appropriates women's vulnerability. While women's embodied reproductive power is adapted to birthing consciousness for patriarchal control, the same reproductive power is appropriated for material gains.

Women's reproductive bodies are in a flux of normative expectations to material or pecuniary interests, which produce new relationships based on an entrepreneurial spirit in which health workers transform into health entrepreneurs and women hitherto referred to as patients become customers/clients. The new relationship based on the entrepreneurial spirit strips care practice of its ethic, replacing it with material value. Women with induced abortion care needs are treated according to their ability to pay rather than in terms of what is ethically expected. Those without sufficient financial resources are likely to suffer more reproductive injustice. Consequently, the boundary in medical practice between categorical imperatives of safe and unsafe technologies, and permitted and

prohibited practices, become meaningless as all categories are appropriated by an entrepreneurial spirit. Thus, PAC and law, based on normative values, discriminate against women with induced abortion needs, and reproductive materialism also normalises and intensifies discrimination against poor women with induced abortion care needs.

Reproductive materialism transforms the ways by which institutions relate to women's reproductive bodily needs. Chapter 8 showed that law enforcement against criminal prosecution for procuring and abetting abortion becomes effective in apprehending poor health workers and women without economic resources. This normalises injustice, as crime is transformed into a means toward material interest. Criminality is no longer a morally or ethically determined injustice but an action based on material capabilities and the lack thereof. This, I argue, deepens the marginalisation and vulnerability of poor health workers in conflict with the law, together with poor women with induced abortion care needs. Reproductive materialism also retains and implicitly extends the idea that abortion is a woman's healthcare problem, thus ignoring the need to address the structural and institutional foundations of gender-based violence and men's role in reproduction. Bioeconomic power effectively transforms rationality in reproductive health from an ethical and moral purpose, as evidenced in biosocial and biomedical power, to an instrumental one in which reason serves to extend the attainment of material interests. This too was illuminated in Chapter five, in the neoliberal emphasis on investing in high impact interventions. Consequently, reproductive health conditions which are economically inviable cannot attract national prioritisation, and in health care, women with abortion care needs cannot be cared for beyond their financial capabilities.

In the face of reproductive materialism, I argue that anthropological enquiry needs to transcend normalising universal and categorical claims in order to uncover the continuities and intensification of injustices in reproductive health interventions targeting women's reproductive lives in Africa. Women's reproductive bodies and the rights that are inherent are constantly in flux, according to the material interests at stake. This analysis can help to demystify the view that postmodern reproductive health interventions liberate women from injustices and obstetric violence, and illuminates the ways in which reproductive health injustices are sustained.

Inside and Beyond Binary Categorisations in Reproductive Health Matters

Scholarship in abortion care matters still stresses the emphasis on binary constructions of safe and unsafe medical technologies, permitted and prohibited abortion care practice, illegal and legal abortion. These categorical imperatives represent different ethical values but retain the problem of normativity. I have shown in Chapters six, seven and eight that these binary categories normalise injustices in those considered ethical and moral conducts, and vilify those that are considered prohibited, illegal and immoral conducts.

These categories are at best descriptive entities that reflect the desired but not necessarily the real conditions. This study has shown that there can be no universal and unidirectional outcomes of what the category describes. Risks can emerge in practices where safe technologies are used, in much the same way as safe outcomes can emerge from use of medical technologies which are considered unsafe and risky, and from medical practices that are prohibited. Consequently, the violence and the risks that emerge from practices which are categorised as safe are concealed, in much the same way that good health outcomes that emerge from prohibited practices and technologies are suppressed, suffocated and overlooked. Normative categories of safety may reflect an attempt to justify neoliberal and biomedical reproductive health interventions but conceal the tyranny of the neoliberal order that crafts the reproductive industry around women's reproductive bodies. This can be evidenced in the classifications of abortifacients as safe, less safe and least safe. Under this categorisation, risk is acknowledged and accommodated as better than no use of abortifacients at all.

Categorisation, typical of biomedical and social power, retains the belief that conducts can be inherently good, but ignores the effects of specific conditions and circumstances of care on the quality of care practice and its outcomes. Binaries negate the interconnectedness and embeddedness of reproductive health matters like unsafe abortion, obstetric violence and other reproductive health injustices. Equally, it fails to account for the effect of an assemblage of things, materials, processes and the embedded power which gives agency to medical technologies and communicative materials. Consequently, binary analysis fails to recognise the emergent things, the transitory processes, and the mechanisms through which reproductive health issues arise and are sustained. Relying on time-tested experiences of the use of these technologies and the observed outcomes without scepticism risks turning reproductive health interventions into the realm of the unquestioned, and yet they fail to

account for why the same interventions can produce different outcomes, sometimes even diametrically opposed to those observed in areas in which they worked. Categorisation is deceptive, and normative analysis fails to uncover the true mechanisms that produce risky outcomes. I argue that investigation in reproductive health matters demands transcending binary constructions in order to reveal the concealed, account for the emergent realities, and problematise that which is normalised.

Governing Health Workers and Women's Reproductive Bodies

Governmentality is one of the core concepts in this study. I have illuminated diverse ways in which biopower governs national policy priority setting, abortion care practice and the delivery of justice. In particular, I have revealed the constraining effects, the productive or constitutive, the performative and concealing effects of governmentalities in reproductive health matters. The constraining effect of power occurred through the law regulating abortion in Uganda. Although punitive measures such as the withdrawal of practicing licenses were reported, this study did not reveal any specific effect on the performance of health workers in the study areas. Performative effects of power were embedded in restrictions on medical technologies based on the limit of 12 weeks of gestation age, beyond which the use of MVA was prohibited.

Within the macro anthropological analysis which I retained for the study, I undertook a sociological examination of the microphysics of power in policy and priority setting and abortion care practices. Through this analysis, I have shown the mechanisms of power through which health workers and policy making participants constitute themselves as subjects of both neoliberal and state control. I have shown in Chapters five, six, seven and eight how prioritisation in policy making, abortion care and abortion law enforcement practices reproduce health workers subjectivities, women's bodies, and reproductive health injustice (Kagaha & Manderson, 2020a, 2020b).

In Chapters six and seven, I illuminated the microphysics of power in three different avenues. First, through the conducts of fear and panic, health workers constitute themselves as obedient subjects to avoid negative consequences such as ridicule, ostracism and stigmatisation. This prevents them from inducing abortion against PAC guidelines and the law on abortion. Health workers also reconstitute self-interest to appropriate an infrastructure of neoliberal incentives for financial goals. Their reasoning in care activities, processes, choices and material components involved in abortion care

becomes an instrument towards the attainment of pecuniary goals. Induced abortion care delivery was considered to be the most profitable maternal health condition but patient care depended on the amount of money available, shaping choice and location of procedure. Poor patients who had pregnancies terminated were discharged after operations without antibiotics, in the hope that they would buy them when they were able to get the money; choice and application of medical technologies aimed at cost-saving and profit maximisation. All these conducts of economisation in care reproduce injustice. Health workers transformed into entrepreneurial actors and patients with unmet abortion care needs were both subjects (reliant on health workers for better healthcare outcomes) and objects (necessary for the appropriation of financial motives). Thus, abortion care practice turns into an instrument, rather than an end in itself, whose satisfaction lies in the perfect care of the women with unmet abortion care needs without expecting anything in return.

Secondly, health workers also resist forms of governing their conducts. As illustrated in Chapter 6, the effectiveness of medical technologies for abortion was defined in terms of amount of time taken to effect operation; time-saving technologies considered more effective; time wasting technologies were considered ineffective. Second, surreptitious practice, including the transfer of patients from public to private health facilities for inducement of abortion, constitutes an effective means for patients to be re-admitted and provided with PAC. I have illustrated the maladaptive conducts such as falsification of reports, non-reporting and misrepresentation of cases, rehearsal and coaching patients, which were used to save both patients and health workers from the disciplinary effects of the state (Kagaha & Maderson, 2020a). In weak healthcare systems, the entrepreneurial constitution of health workers increases women's vulnerability to obstetric violence since healthcare aspects are concealed and removed from regulation.

Chapters five, six and seven have shown that the biosocial constitution of health workers into compliant subjects occurred through internalised moral values that equated inducing abortion to killing innocent life, leading to adherence to treatment protocol. These resulted in foot dragging and outright resistance among nurses in their relationships with doctors. In this context, biosocial technologies that governed health workers' conduct mobilised micro conducts of resistance and navigation around restrictions. These resulted in the total subjugation of women's bodies in care practice, misrepresentation of their concerns and needs in health system records, and in post-mortem

records. Surreptitious practice, juridical measures (like the falsification of records, framing death, coaching and rehearsal before maternal death reviews, and referral without a patient's medical records) aimed to disrupt and weaken institutional regulations.

Power can also operate through organising and performative effects. In Chapter five, I have illuminated how the organisation of the policy-making practice (setting the stage, epistemic governance, participants' selection and ordering of keynote addresses) directed the discursive conduct toward neoliberal interests. I also illuminated how the communicative materials participated in the silencing of reproductive health issues. However, in policy priority settings, the communicative material performances reinforced epistemic power embedded in concepts of high impact interventions, demographic dividends and results-based financing. I argue that the organising and performative effects of neoliberal power violates concerns raised from other epistemic communities. Chapters five and eight illustrate how the epistemic concepts used to produce desired women's bodies are also involved in deciding what matters to women's reproductive health.

Epistemic power creates a realm of possibilities and impossibilities in reproductive health matters where those who decide on what can be provided or performed are assumed to be more knowledgeable about women's bodies than the women themselves. At the level of care practice, it defines what is normal, abnormal, safe and unsafe. In priority setting, maternal and reproductive health intervention areas of lesser investment impact were defined in terms of those with high-impact on investment, as defined using statistical data. In Uganda's terrain of epistemes on reproductive bodies, the law is defined through the stipulation of what is criminalised. In effect, epistemic governance reflects the control of the most powerful, determining what should and should not be invested in, who should be cared for, or discriminated against. Overall, global institutional rationalities bring a world of realities into being that direct the thoughts and desires of participants in policy-making and care delivery practice. These rationalities offer epistemic privilege to global institutions which are then used to secure and perpetuate global interests and goals over the female population, while mystifying pressing institutional, structural concerns for women's reproductive health improvement.

Linking anthropological and sociological lenses together, I see the social reproduction of obstetric violence as a function of multiple forms of biopower and biopolitical strategies that are designed to

produce and govern women's reproductive bodies and regulate the conducts of health care. I have illuminated the different forms of biopower that converge on women's reproductive bodies and the concealing, productive, normalising, and performative mechanisms through which they operate. All current reproductive health interventions may appear empowering and transforming for women. I have argued through this analysis that bioeconomic power relies on highly subtle mechanisms which are very difficult to detect, and this power also perpetuates the idea that abortion is a woman's problem, ignoring the constellation of biopolitical strategies in which women's bodies are governed. What appears evident is an attempt to ignore the indivisibility of women's reproductive bodies from the local conditions in which women live. I argue that a transformation in women's reproductive health requires a holistic understanding of women in their localised setting. This highlights the need to craft interventions that act upon the concealed, normalised, productive and performative effects of power across all spheres of women's lives.

Through this study, I have contributed to understanding why women with reproductive health issues related to abortion are criminalised instead of being care for, and contributed to understanding why women remain vulnerable to unsafe abortion and its consequences despite the prevalence of emergency contraceptives in Uganda. I have stressed the importance of the centrality of women's reproductive bodies to the global reproductive health industry which relies on women as consumers of neoliberal health technologies. Given highly subtle biopolitical tools, women's vulnerability and neoliberal scientific epistemes are likely to render women incapable of realising their full reproductive wellbeing.

Theoretical Contribution

In examining the conduct of abortion care and the application of medical technologies, I have critically examined reproductive healthcare risks in Uganda's restrictive context. Risks are manifested in abortion care practice conducted in concealed, prohibited, permitted and regulated practice. In concealed and prohibited conducts, risks emerged as outcomes from panic, triggered by fear of apprehension. Fear and panic can be experienced by both skilled and unskilled health workers working in health facility settings. In addition, risks arose from the application of medical technologies (D&C and MVA), including from failure to disinfect medical instruments. Thus, risks were embedded in both permitted and prohibited abortion care practice. Drawing on these findings,

I argue that risks are emergent products that involve an assemblage of materials, processes, and conditions of contingency in which care is provided. I argue against the normative and objective conception of risk in which it is assumed to be embedded in specific technologies (D&C) and located outside biomedical expertise. Equally, conceptions of risk and safety as effects of interpersonal communication with patients and among professionals, as a way of preventing adverse events and improving patient safety (Severinsson et al., 2015; Tucker et al., 2008), fail to account for the productive processes and mechanisms in which risks are generated. Such a theoretical framework fails to account for the effects of the restrictive legal regime upon which abortion panic and fear in care practice are contingent. Furthermore, even the cultural safety perspective which places focus on the organisational or institutional preparedness to guarantee safety and risk-free healthcare delivery (Groves et al., 2011) also obscures the multiple material arrangements, processes and practices that mediate risks in healthcare.

Without questioning the view that health workers are always keen to deliver safe, competent, compassionate and ethical care (Harrowing et al., 2010), I argue that communicative, interactive, cultural safety theories insufficiently account for risky and unsafe healthcare practices which are offset by panic and fear, and support decision-making that seeks to evade state control. Risky and unsafe practices depend on the terrain of power governing and the counter-governance practices used to evade state power, which induce panic and fear in care practice. Healthcare risks are contingent upon the way medical technologies are interpreted as health workers struggle to evade the disciplinary effects of the law on abortion. Healthcare risks and safety need to be reconceptualised within an assemblage of things (material technologies), activities, rules and interpretive perspectives mediated through national biopolitics and neoliberal normative constructions of efficiency.

I have articulated the theoretical problem of reproductive materialism, in which women's objective and subjective bodies are constituted into materials and appropriated for material interests. Reproductive materialism can be conceptually useful in investigating how neoliberalism intensifies the vulnerability for women of reproductive age in low-income societies. Beyond governance and resistance, reproductive materialism opens up possibilities of understanding how binary categorisations can be appropriated without transformation. It illuminates how health care, infused with new forms of rationality based on materialism, can affect the organisation of care and transform

patient-health worker relationships. I have illustrated how realities – considered irrational on the basis of ethics and norms – become transformed into instruments to seek pecuniary interests. Reproductive materialism explains how and why structural and institutional bases of vulnerabilities are no longer eradicated but sustained as means towards social entrepreneurship.

Conclusion

The overall aim of this study was to uncover the operations of power and its effects in policy making and abortion care practices. I argue that policy priority setting and abortion care practices are sites of enacting, contesting, reproducing and transforming the terrain of biopolitics. I have indicated that such power is productive: it produces compliant and obedient subjects who adhere to the policy and legal restrictions on abortion care practice. Specifically, I have articulated the three biopolitical forces that produce risky reproductive bodies, birthing women, and women who are reproductive health consumers. Each category embodies within it forces that conceal and yet also normalise reproductive health injustices. In institutional practices of care, power also mobilises practices of resistance and tactics of navigating the restrictions and weakening the state's ability to regulate care conducts. This increases the risks for obstetric violence. In addition to resistance, power has a concealing effect, which suppresses the articulation of the structural and institutional factors which underpin unsafe abortion care practices. The way that current bioeconomic power operates in Uganda's restrictive context for abortion care delivery, I argue, produces women as reproductive health materials whose conditions and bodies are appropriated for pecuniary interests. Thus, current biopolitical interventions render women permanent bodies of subjugation, incapable of realising their reproductive health lives with dignity. Transforming this trend will require conceiving reproductive health beyond women's bodies and transforming the relational, social and political structures to respect and support women in their reproductive lives.

As evidenced in the findings, restrictions in abortion care produce techniques of self-regulation but also produce surreptitious practices of induced abortion through private care facilities, and resistance among health workers in public health facilities. Risks and risky outcomes emerge from panic during care, which is triggered by fear of apprehension for disrupting state policy and legal norms. The desire for pecuniary interests in care lead to choices and the application of medical technologies designed to maximise profit, save costs, and reduce time taken for procedures. Thus, risks in healthcare are not

inherent in specific technologies but in conditions of panic and fear of apprehension amidst the desire for pecuniary interests in unregulated practice. The theoretical boundaries established in reproductive health care mystify and conceal more than they can illuminate, and they cannot guarantee quality healthcare outcomes. Categories of permitted and prohibited practices, safe and risk technologies, immoral and moral conducts, illegal and legal boundaries, only exist theoretically. In real everyday practices of caring, enforcing the law on abortion, these boundaries are transgressed. The obstetric risks and reproductive health injustices women experience are emergent outcomes of an assemblage of things interconnected and coordinated through processes and practice. Medical technologies have no meanings on their own, but they are assigned them through their application. This explains why technologies considered to be unsafe can be used even against the policy. Fear of apprehension triggers panic in care practice, thus increasing the risks of having obstetric trauma, which also triggers maladaptive emergency handling practice. Thus, categorisation serves biopolitical intentions of disciplining disruptive health workers and women, and giving legitimacy to disciplinary action, while also legitimising the scaling up of abortion care technologies considered to be safe.

Although policy and legal boundaries constrain practice, this does not happen directly through the punitive effects that are intended to touch the body of a disruptive health worker or a woman who induces abortion. The effect of punitive measures fails to condition practice where state surveillance power is weak. In public health facilities where health workers were obedient and complied with policy boundaries, it was because they internalised positive effects of acting within policy boundaries, but not because of punitive measures. Law and policy can be very effective when health workers constitute themselves as agents of state law and societal morals. Restrictions mobilise acts of counter conducts and surreptitious conducts, in which the state is rendered weak and unable to regulate healthcare practice. In private health facilities where most induced abortions occurred, health workers transgressed even the embodied restrictions in medical technologies. Thus, given its productive and performative effects, law is also an instrument of obstetric violence.

I thus 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. Yet the problems in each binary reasoning cannot be resolved by abandoning this. Based on the findings from this ethnographic research on social practice,

reproductive health matters are complex assemblages of things, with embodied productive and performative meanings and power, which cannot be reduced to either structure or agency, dialectics or hegemony. Coming to terms with this challenge requires methodologies and theorisation that can 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.

CHAPTER TEN

RECOMMENDATIONS

Drawing on the complexity, fluidity and materiality of induced abortion care practice and policy-making revealed in this study, prescriptive ways of addressing reproductive health injustice risks that enact these very problems have been revealed. The recommendations made hereunder are merely suggestive:

Health Facility Level Recommendations:

1) Health facility owners and health facility in-charges should procure and train health workers on the effective and effecient use of the recommended technologies (MVAs, and abortifacients) for induced abortion care delivery, in line with post abortion care guidelines.
2) Health facility in-charges should facilitate participatory continuous monitoring, evaluation and learning from abortion care delivery expereinces, and cultivate a culture of continuous learning from everyday practices.
3) Health facility in-charges should undertake regular reorientation of health workers on healthcare ethics and conduct participatory discussion with health workers of how to mitigate ethical challenges and dilemma in everyday abortion care practice.
4) Health facility owners and health facility in-charges should procure ultrasound scanners to increase guidance and support health workers' decisions in choosing appropriate technologies for induced abortion based on the gestation age of the pregnancy, and in making decisions related to retained products of conception, detecting perforations and determining the best options for completing abortion.
5) Health facility in-charges should consider partnering with non-government organisations that support women in sexual and reproductive health, to ensure timely consultations, referral of emergency cases, ensure regular quality of care improvement and quality assurance monitoring, evaluation and learning.
6) Health facility in-charges should secure and create awareness, among health workers, of the post abortion care guidelines and the law, to minimise individual health worker's legal risks of being apprehended for contravening the law on abortion

Regional level recommendations:

1) District and regional health teams should undertake a regional survey of private health facilities where cases of induced abortion take place, and offer targeted training for quality of abortion care improvement capacity building.
2) District and regional health teams should take action to raise awareness among health workers and health facility administrators about the processes, practices, and conditions that increase and result in unsafe and risky outcomes of abortion care practices
3) District and regional health teams should develop process-based indicators and conditions underpinning safe abortion care practice, and should take action to facilitate learning about these all categories of health facilities.
4) District and regional health teams should explore ways to widen and deepen qualitative inquiry into experiences of health workers' handling of induced abortion care cases, generate in-depth accounts, conditions and contexts of emergency cases and their handling in order to contribute to national dialogue on policy and regulatory interventions.
5) District and regional health teams should work with politicians, religious leaders and law enforcement agencies to increase awareness about the the role of health workers in securing the rights to sexual and reproductive health of women with abortion care needs, even within the restrictive moral and legal environment.
6) District and regional quality of care improvement teams should conduct a stakeholder mapping of formal and informal institutions, analyse their power and influence of each stakeholder and develop a partnership strategy aimed at increasing aceess to, delivery and use of quality abortion care care services.
7) District and regional health teams should adopt a community-based communication strategy aimed at increasing and strengthening intimate partner, family and community support towards girls and women with abortion care needs to secure medical attention.
8) District and regional actors should vulnerability mapping and assessment to identify high-risk categories of female population to sexual abuse and risky abortion practice, and partner with local governments to design and implement a robust preventive strategy.

National Level Recommendations:

1) NGOs advocating for sexual and reproductive health justice should take action to create awareness among stakeholders, about the injustices hidden and normalised by key the technical language terms used in policy-making, and design concrete acctions to address them.
2) Advocates for women's sexual and reproductive health and wellbeing should work with the Ministry of Health to highlight the concealed reproductive injustices and develop an action plan for making comprehensive abortion care visible and prioritised in health policies.
3) In order to develop a national level programme to monitor and prevent risks associated with care practice, national health teams and NGOs advocating for sexual and reproductive health justice should generate national level qualitative and quantitative data on how unsafe and risky cases, and the reasons for them.
4) National health teams and NGOs should spearhead a national level discussion with religious institutions, the parliamentary committee on sexual and reproductive health, and political leaders, on the dangers of fear and panic created by moral, legal and professional ethics on quality of care improvement, the steps needed to prevent maternal deaths and morbidity resulting from induced abortion as health matters.

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APPENDICES

Appendix I: Co-Author's Declaration Form

Declaration: Student's contribution to article(s) and agreement of co-author(s)

I, Alexander KAGAHA, student number 1834444, declare that this Thesis is my own work and that I contributed adequately towards research findings published in the article(s) stated below which are included in my Thesis/Dissertation/Research Report.

Signature of Student **Date**.....11th November 2020.

Name of Primary Supervisor: Prof. Lenore Manderson...

Signature of Primary Supervisor **Date** 11 November 2020

Agreement by co-authors: By signing this declaration, the co-authors listed below agree to the use of the article(s) by the student as part of his/her Thesis/Dissertation/Research Report. In cases where the student is not the 1st author of a published article, the primary supervisor must explain (under comments) why the student is entitled to use the paper for his/her degree purposes.

Article 1: Title: Medical technologies and abortion care in Eastern Uganda.

Journal name, year, volume and page numbers: *Social Science & Medicine*, 2020, Volume 247, February 2020, 112813, Doi: https://doi.org/10.1016/j.socscimed.2020.112813

Authors	Name	Signature	Date
1st author	Alexander Kagaha		11th November 2020
2nd author	Lenore Manderson		11 November 2020

Comments by primary supervisor: Nil

Article 2: Title: Power, Policy and Abortion Care in Uganda

Journal name, year, volume and page numbers: *Health Policy and Planning*, accepted for publication [20-Sep-2020] under print (Manuscript ID HEAPOL-2020-Apr-0289.R2)

Authors	Name	Signature	Date
1st author	Alexander Kagaha		11th November 2020
2nd author	Lenore Manderson		11 November 2020

Comments by primary supervisor: Nil

Article 3: Title: Silence and concealment during and post abortion care in eastern Uganda.

Journal name, year, volume and page numbers: *Women and Health.* (Under review), manuscript number WWAH-2020-0333.

Authors	Name	Signature	Date
1st author	Alexander Kagaha		11th November 2020
2nd author	Lenore Manderson		11 November 2020

Comments by primary supervisor: Nil

Article 4: Title: Reproductive governance and justice for women with abortion care needs in Uganda.

Journal name, year, volume and page numbers: *Anthropology & Medicine.* (Under review), manuscript number CANM-2020-0099.

Authors	Name	Signature	Date
1st author	Alexander Kagaha		11th November 2020
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Comments by primary supervisor: Nil

Appendix II Ethics Approval Letter from the Uganda National Council of Science and Technology

Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Below is a list of documents approved with this application:

	Document Title	Language	Version	Version Date
1.	Research proposal	English	N/A	April 2018
2.	Consent forms	English	N/A	N/A
3.	In – depth interview guides	English	N/A	N/A

Yours sincerely,

Isaac Makhuwa
For: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Copied to: Chair, Makerere University School of Social Sciences, Research Ethics Committee

LOCATION/CORRESPONDENCE
Plot 6 Kimera Road, Ntinda

COMMUNICATION
TEL: (256) 414 705500

Appendix III Ethical Clearance Letter from the Human Research Ethics Committee (HREC), Medical, of the Faculty of Health Sciences of the University of the Witwatersrand, South Africa

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R14/49 Mr Alexander Kagaha

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M180466

NAME: (Principal Investigator)	Mr Alexander Kagaha
DEPARTMENT:	Public Health Namungalwe Health Centre III St. Peter Clever Busu Health Centre III Iganga hospital
PROJECT TITLE:	Policy and practice of abortion care in Eastern Uganda
DATE CONSIDERED:	04/05/2018
DECISION:	Approved Unconditionally
CONDITIONS:	
SUPERVISOR:	Prof Lenore Manderson
APPROVED BY:	Professor CB Penny, Chairperson HREC (Medical)
DATE OF APPROVAL:	24/08/2018

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

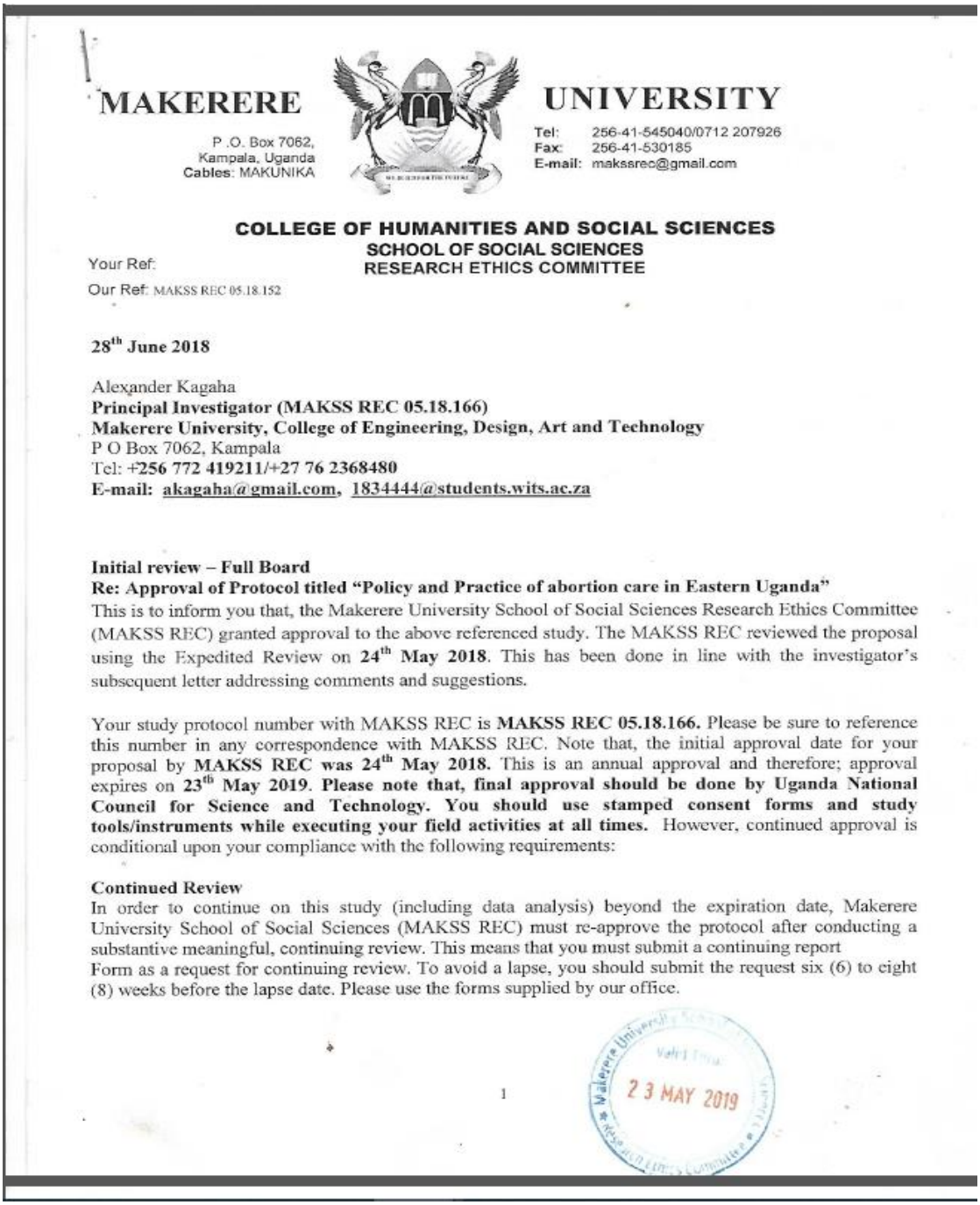
To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **April** and will therefore be due in the month of **April** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date 30th/08/2018.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix IV Ethical Clearance Letter from Makerere College of Humanities and Social Sciences Research Ethics Committee



MAKERERE UNIVERSITY

P .O. Box 7062,
Kampala, Uganda
Cables: MAKUNIKA

Tel: 256-41-545040/0712 207926
Fax: 256-41-530185
E-mail: makssrec@gmail.com

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
SCHOOL OF SOCIAL SCIENCES
RESEARCH ETHICS COMMITTEE

Your Ref:
Our Ref: MAKSS REC 05.18.152

28th June 2018

Alexander Kagaha
Principal Investigator (MAKSS REC 05.18.166)
Makerere University, College of Engineering, Design, Art and Technology
P O Box 7062, Kampala
Tel: +**256 772 419211/+27 76 2368480**
E-mail: akagaha@gmail.com, 1834444@students.wits.ac.za

Initial review – Full Board
Re: Approval of Protocol titled "Policy and Practice of abortion care in Eastern Uganda"
This is to inform you that, the Makerere University School of Social Sciences Research Ethics Committee (MAKSS REC) granted approval to the above referenced study. The MAKSS REC reviewed the proposal using the Expedited Review on **24th May 2018**. This has been done in line with the investigator's subsequent letter addressing comments and suggestions.

Your study protocol number with MAKSS REC is **MAKSS REC 05.18.166.** Please be sure to reference this number in any correspondence with MAKSS REC. Note that, the initial approval date for your proposal by **MAKSS REC was 24th May 2018.** This is an annual approval and therefore; approval expires on **23th May 2019. Please note that, final approval should be done by Uganda National Council for Science and Technology. You should use stamped consent forms and study tools/instruments while executing your field activities at all times.** However, continued approval is conditional upon your compliance with the following requirements:

Continued Review
In order to continue on this study (including data analysis) beyond the expiration date, Makerere University School of Social Sciences (MAKSS REC) must re-approve the protocol after conducting a substantive meaningful, continuing review. This means that you must submit a continuing report
Form as a request for continuing review. To avoid a lapse, you should submit the request six (6) to eight (8) weeks before the lapse date. Please use the forms supplied by our office.

Makerere University
23 MAY 2019

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Please also note the following:

- No other consent form(s), questionnaires and or advertisement documents should be used. The Consent form(s) must be signed by each subject prior to initiation of my protocol procedures. In addition, each research participant should be given a copy of the signed consent form.

Amendments

During the approval period, if you propose any changes to the protocol such as its funding source, recruiting materials or consent documents, you must seek Makerere University School of Social Sciences Research and Ethics Committee (MAKSS REC) for approval before implementing it.

Please summarise the proposed change and the rationale for it in a letter to the Makerere University School of Social Sciences Research and Ethics Committee. In addition, submit three (3) copies of an updated version of your original protocol application- one showing all proposed changes in bold or "track changes" and the other without bold or track changes.

Reporting

Among other events which must be reported in writing to the Makerere University School of Social Sciences Research and Ethics Committee include:

i. Suspension or termination of the protocol by you or the grantor.
ii. Unexpected problems involving risk to participants or others.
iii. Adverse events, including unanticipated or anticipated but severe physical harm to participants.

Do not hesitate to contact us if you have any questions. Thank you for your cooperation and commitment to the protection of human subjects in research.

The legal requirement in Uganda is that, all research activities must be registered with the National Council for Science and Technology. The forms for this registration can be obtained from their website www.uncst.go.ug

Please contact the Administrator of Makerere University School of Social Sciences Research and Ethics Committee at makssrec@gmail.com OR bijulied@yahoo.co.uk or telephone number +256 712 207926 if you counter any problem.

Yours sincerely,

Valid Thru
2 3 MAY 2019

Dr. Stella Neema
Chairperson
Makerere University School of Social Sciences Research and Ethics Committee

c.c.: The Executive Secretary, Uganda National Council for Science and Technology

Appendix V List of Study Participants

	POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA: SOURCES OF PRIMARY IN-DEPTH INTERVIEWS CONDUCTED ALEXANDER KAGAHA, (PhD Student) University of the Witwatersrand.				
S/N	**Respondent's Unique ID**	**Name of Organization**	**Position of the respondent**	**Gender**	**Duration of Interview**
1	MOH 01	Ministry of Health	Commissioner for nursing and midwifery	Female	0:45:30
2	MOH 02	Ministry of Health	Focal person for family planning, MCH department	Male	0:30:05
3	MOH 03	Ministry of Health	Monitoring and Evaluation Officer, MCH Department	Male	0:53:38
4	MOH 05	Ministry of Health	Commissioner for sexual and reproductive health	Female	0:12:49
5	MOH 05	Ministry of Health	Emergency Obstetric and Gynaecological Services (EMOC) Director	Male	1:03:52
6	MDA 01	Multilateral Development Agency	Programme Manager (Maternal and reproductive health)	Male	0:42:59
7	MDA 02	Multilateral Development Agency	Programme Analyst (Midwifery, maternal health, sexual and reproductive health)	Female	0:51:40
8	MDA 03	Multilateral Development Agency	Family Health and Population Advisor	Female	1:15:47
9	BDA 02	Bilateral Development Agency	National Programme Officer, sexual and reproductive health and rights	Female	1:04:16
10	INGO 01	International NGO	Country Director	Male	1:02:54
11	INGO 02	International NGO	Regional Manager	Male	1:05:09
12	INGO 03	International NGO	Technical Research Officer	Female	0:21:32
13	INGO 04	International NGO	Country Director	Female	0:48:28
14	LNGO 01	Local NGO	Legal Advocate	Female	1:45:37
15	LNGO 02	Local NGO	Youth Advocate	Female	1:04:21
16	LNGO 03	Local NGO	Advocate	Male	0:59:51
17	LNGO 04	Local NGO	Director of Programmes	Male	1:02:20

18	PB01	Association of obstetricians and Gynaecologists in Uganda	Member	Male	1:14:24
19	PB02	School of Public Health, Makerere University	Public Health Specialist in Uganda	Male	0:39:54
20	PB03	Uganda Nursing and Midwives Association	Member and former chairperson	Female	0:49:10
21	RO 01	PFNP facilities Umbrella body, Eastern Uganda	Coordinator PFNP Facilities, Eastern Region	Male	1:22:30
22	RO 02	Uganda Muslim Supreme Council	Technical Advisor and Researcher	Male	0:34:48
23	RO 03	Uganda Muslim Medical Bureau	Quality Assurance Specialist	Male	1:03:45
24	DHT 01	District Health Office	District Health Officer	Male	0:57:25
25	GHWHC4 01	Public Health Centre IV	Health Facility In-Charge	Male	0:30:33
26	DHT 02	District Referral Hospital	Medical Superintendent	Male	0:42:36
27	DRH 02	District referral hospital	Senior Nursing Officer	Female	0:51:18
28	DRH 03	District referral hospital	In-Charge Maternity ward	Female	0:58:55
29	DRH 04	District referral hospital	In-Charge Female ward	Female	0:55:56
30	PPHW 01	Profit making health Centre III	Health Facility In-charge	Male	1:07:57
31	PPHW 02	Profit making health Centre III	Nurse	Male	1:30:52
32	PPHW 03	Profit making health Centre III	Clinical Officer	Male	0:44:54
33	PnPHW 01	Non-profit making health facility centre III	Health Facility In-charge	Male	1:12:56
34	PnPHW 02	Non-profit making health facility centre III	Nurse	Female	1:01:29
35	PnPHW 03	Non-profit making health facility centre III	Midwife	Female	0:44:15
36	GHWHC3 01	Public Health Centre III	Health Facility In-charge	Male	0:31:12
37	GHWHC3 02	Public Health Centre III	Nurse	Female	0:55:52

38	GHWHC3 03	Public Health Centre III	Midwife	Female	0:16:47
39	LA01	Uganda Police, eastern Region	Head of the Criminal Investigation Department	Female	40:00
40	LA02	Uganda Police, eastern Region	Head of Sexual and Gender based Violence desk	Female	47:00
41	LA03	Office of the district Resident State Attorney	State Attorney	Male	41:25
42	LNGO 1	District local government	Chairman Local Council V	Male	57:34
43	LNGO	Inter-religious Council of Uganda	Programme Manager (HIV/AIDS and Public Health Programme)	Male	44:51
44	INGO	International NGO	Quality Assurance Officer	Female	52:09
45	INGO	International NGO	Quality Assurance Officer	Female	1:10:34
46	INGO	International NGO	Medical products detailer	Male	40:51
47		Faith-Based Organisation	Programme Coordinator	Female	53.00

Appendix VI Information Sheet, Consent Forms and In-depth Interview Guide for Health Workers

SCHOOL OF PUBLIC HEALTH

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – INFORMATION SHEET FOR HEALTH WORKERS

Introduction

Good morning/afternoon to you. I am Alexander KAGAHA, a PhD student from School of Public Health at the University of the Witwatersrand, South Africa. Thank you for accepting to learn about my study. I hope you will find merit to be part of it.

Please kindly receive and read this information sheet and make an informed decision.
This is your copy to keep.

What is the study about?
This study is about understanding the policy and practice of abortion care in Eastern Uganda. The study is part of the tasks I have to do in order for me to earn a grade at the School. It has been approved by the Human Research Ethics Committee (Medical) of the University and the Uganda National Council of Science and Technology (UNCST).

Who is doing the study?
This study is done by Alexander KAGAHA, a PhD student in the School of Public Health at the University of the Witwatersrand, South Africa.

Why me?
I have selected you because you are a health professional and I think you have the relevant experience of delivering abortion care. I would like to particularly learn from about your personal experience and the setting in which you deliver abortion care.

What will I be asked to do?
I am inviting you to participate in this study. If you accept, I will be asking you questions about abortion, the policy and practice of abortion care. I will be particularly interested in learning about your experience of delivering abortion care. I will thus, be asking you to have some time for an interview with me. This could take about 45-60 minutes and could be done at any time of your convenience.

I will also be asking you for permission to allow me record the interview, to enable me to capture all the data without missing any of the very useful experiences you share with me. I want to pledge to you that the recording is purely for this study and no one else will listen to what we discuss here. I will transfer the recording on my laptop and develop a transcript. Thereafter, I will destroy the recording.

How do I benefit?
There is nothing to offer to you directly in this study. However, the responses you offer will be very

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useful in helping to understand how healthcare delivery can be improved. This could be useful to create an enabling environment for the delivery of quality healthcare in Uganda.

How will my confidentiality be protected?

Given the sensitivity surrounding abortion, I am very mindful about the protection of your identity in this study. I undertake to keep what you share with me confidential. I have three ways of doing this. The first, during the interview, I plan to interview you from a secure and safe place where you are comfortable and no one else is listening to our conversation. I will ask you to choose which place is convenient for this to happen.

Second, I have assigned unique identifiers to people I interview based on the type of health facility. I plan to use the unique identifier instead of your name when reporting. This means that all the transcripts will be edited and where your name appear, it will be replaced by the unique identifier. Here, no one can tell that it was you talking, except me who developed the unique identifier. The third option is for me to use first name. if this is done, one can read your first name in the transcripts but will not know that it is you since many people share our first names. When writing the articles for publication, I may quote you verbatim, to enable be put emphasis on some points I will be making but reference will be made using either the unique identifier or your first name.

All the data will be protected with a password, only known to by my supervisor and I. this means that only authorised persons will be access to this data. All printed files will be kept under lock and key and stored according to the rules of the University of the Witwatersrand.

What are the risks involved?

Sometimes interviews remind us of horrible experiences we have had in the course of delivering abortion care. This can be sensitive and distressful. In case you experience this, and you would like to discontinue the interview, please let me know. Also, if there is any information you share but later feel it should be removed from the transcript, please tell me and I will do so before using it.

How will I receive feedback?

I plan to write a book from these findings. The book will be ready by the end of 2020. This book will be open in university library. I also plan to public academic papers on online journals. You will be able to access them once you log in.

What if I don't want to participate?

Taking part in this study is fully at your will, and nothing will happen to you if you do not. Even after you choose to participate, you are at liberty to opt out any time. If you choose to do so, just let me know and I will instantly end the interview.

Where can I get further information?

In case you have any concerns, or would like to get more information about this study, please feel free to contact my supervisor on the address hereunder:

1. Professor Lenore Manderson — Tel: +27(0)117171000, Email: lenore.manderson@wits.ac.za
2. Professor Anne Katahoire — Tel: +256 772 723729, Email: annekatahoire@yahoo.co.uk

How do I agree to participate?

If you have made an informed decision to take part in this study, I will kindly ask you to indicate so by signing on the form provided hereafter. I will also offer you a separate form for you to sign if you allow me to record the interview.

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT FORM

Verification of consent:

I agree to be a participant this in study and that:

1. I understand the purpose and what the study is about.
2. I understand why I have been selected.
3. I understand that I can opt out of the study if I feel like
4. I understand that an interview will be conducted with me.
5. I understand that it's up to me to have the interview recorded or not
6. I understand that nothing happens to me if I do not participate in the study
7. I understand that my information will be kept confidential
8. All I want to know about the study has been explained to me and I understood.

I agree to participation in the study on the condition that:

1. I can choose an appropriate place to have the interview from
2. I can withdrawal from the study at any time if I feel like so and without any adverse consequence
3. I have a right not to answer any of all
4. The University of the Witwatersrand Human Research Ethics Committee (Medical), the Uganda National Council of Science and Technology (UNCST) have approved the study
5. My responses will be kept and treated with strict confidentiality.
6. I am treated with respect and dignity through the interviews.

PARTICIPANT:

_____	_____	_____
Name (Printed)	**Signature**	**Date**

RESEARCHER:

_____	_____	_____
Name (Printed)	**Signature**	**Date**

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT TO RECORD

I have read and understood the study and the purpose for which it is being conducted.

I understand that it is at my will to have the interview recorded or not. I understand that nothing adverse happens to me if I choose not to have the interview recorded.

I also understand that I can have the recording stopped, halted, if I decide to.

I understand that my interview recording will be kept in the strictest sense possible and that my data will be treated as confidential.

Once the interview recordings are transcribed, the transcript will be kept and audio recording will be destroyed at an appropriate time following the university of the Witwatersrand regulations. The recording will be kept on only one central computer to allow comparing the transcript and the audio recording during the analysis of the data. No any other person outside the study will have access to listen to the audio recording.

☐ Yes, I give permission for the discussion to be tape recorded

☐ No, I do not give permission for the discussion to be tape recorded

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW GUIDE- HEALTH WORKERS

Introduction

Hello Sir/Madam. Good morning/afternoon to you, I am here for the meeting we planned to have today. Are you ready for it? (If yes, get ready and start the interview. Otherwise, ask to rearrange the interview).

I thank you for giving this chance to learn from you on issues which are at the centre of maternal and reproductive health. Again I would like to stress that this is purely an academic work, not activism for any group. I thus, thank you in advance for all the responses I will get from you.

Section One: Narratives and Place on the Abortion

1.1. Share with me about the status of women's health in this area. Probe for reproductive health concerns, ANC uptake, timing and health facility birth

1.2. What is your stand on abortion? Probe for:

a. Attitudes on abortion in Uganda?

b. Attitudes on the law of abortion?

1.3. What is your comment on the women who seek abortion care services? Probe for:

a. Values used to talk about the women.

b. Relationship between with health worker and the women

c. The requirements for a woman have abortion care

1.4. What is the position of the health care institution on abortion and abortion care? Probe for:

a. Policy on delivering abortion care services (including safe abortion)

b. What happens to women with needs of abortion care who come to the centre?

1.5. How prepared is your health facility in creating an enabling environment for delivery of abortion care services? Probe for:

a. Availability, obstacles and opportunities in procurement and access to necessary resources for abortion care?

b. Availability of safe and secure clinical sites for delivering abortion care

c. The safety and welfare of patients and health workers

1.6. Share with me, your experience in delivering abortion care services? Probe for:

a. Motivations for delivering abortion care services

b. Demotivation against delivery of abortion care service

c. Interaction with the law of abortion in your experience of offering abortion care services

1.7. Does delivery of abortion care affect the way you relate to others? Probe for:

a. relationships with other staff at the health facility

b. Relationships with patients seeking healthcare

c. Relationships with the community?

1.8.Does the law of abortion influence the way abortion care is delivered? Probe for:

a. Perception about the law of abortion
b. Perception about the policy of abortion care
c. How do you navigate around the institutional position?

1.9. How comprehensive is the abortion care service delivered? Probe for:

a. Scope of abortion care services provided (Abortion, post abortion care, counselling, and sexual and reproductive health information).

1.10. What critical factors affect the quality of care given to pregnant women in this health facility? Probe for:

a. The effect of the health facility environment on delivering quality and comprehensive abortion care
b. The rules of the healthcare facility and how the respondent navigates around them.

End of the Interview, thank you so much, 😊

Appendix VII: Information Sheet, Consent Forms and In-Depth Interview Guide for Participants from Development Agencies

SCHOOL OF PUBLIC HEALTH

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – INFORMATION SHEET FOR PARTICIPANTS FROM DEVELOPMENT AGENCIES

Introduction

Good morning/afternoon to you. I am Alexander KAGAHA, a PhD student from School of Public Health at the University of the Witwatersrand, South Africa. Thank you for accepting to learn about my study. I hope you will find merit to be part of it.

Please kindly receive and read this information sheet so that you can make an informed decision. **This is your copy to keep.**

What is the study about?

This study is about understanding the policy and practice of abortion care in Eastern Uganda. The study is part of the tasks I have to do in order for me to earn a grade at the School. It has been approved by the Human Research Ethics Committee (Medical) of the University and the Uganda National Council of Science and Technology (UNCST).

Who is doing the study?

This study is done by Alexander KAGAHA, a PhD student in the School of Public Health at the University of the Witwatersrand, South Africa.

Why me?

I have selected you because of your important role in facilitating maternal and reproductive health development interventions in Uganda. I am also interested in talking to you because your technical and policy positions influence the local and national level responses in relation to abortion care delivery policy and practice. In addition, I know that this development agency supports many, different actors in the promotion and implementation of maternal or reproductive health in Uganda. I would like to learn from you on these matters.

What will I be asked to do?

I am inviting you to participate in this study. If you accept, I will be asking you questions about the policy and practice of abortion care. I will be particularly interested in learning about your experience in influencing the policy and practice of abortion care. I will thus, be asking you to have some time for an interview with me. This could take about 45-60 minutes and could be done at any time of your

convenience.
I will also ask you for permission to allow me record the interview, to enable me to capture all the data without missing any of the very useful experiences you share with me. I want to pledge you that the recording is purely for this study and no one else will listen to what we discuss here. I will transfer the recording on my laptop and develop a transcript. Thereafter, I will destroy the recording.

How do I benefit?
There is nothing to offer to you directly in this study. However, the responses you offer will be very useful in helping to understand how to protect and promote women's maternal and reproductive health through both the policy and practice. This could be useful to create an enabling environment for a healthy, safe and secure population of women in Uganda.

How will my confidentiality be protected?
Given the sensitivity surrounding abortion, I am very mindful about the protection of your identity in this study. I undertake to keep what you share with me confidential. I have three ways of doing this. The first, during the interview, I plan to interview you from a secure and safe place where you are comfortable and no one else is listening to our conversation. I will ask you to choose which place is convenient for this to happen.

Second, I have assigned unique identifiers to people I interview based on the category to which they belong. I will use the unique identifier and assign a pseudonym instead of your real name when reporting. This means that all transcripts will be edited and where your name appears, it will be replaced by the unique identifier. Hence, no one other than me will know that it was you talking. When writing the articles for publication, I may quote you verbatim to emphasize some points I will be making, but you will not be identifiable.
All data will be protected with a password, only known to by my supervisor and I. This means that only authorised persons will be access to this data. All printed files will be kept under lock and key and stored according to the rules of the University of the Witwatersrand.

What are the risks involved?
Sometimes interviews remind us of horrible experiences we have had in the course of deliberating on abortion care policy. This can be sensitive and distressful. In case you experience this, and you would like to discontinue the interview, please let me know. Also, if there is any information you

share but later feel it should be removed from the transcript, please tell me and I will do so before using it.

How will I receive feedback?
I plan to write a book from these findings. The book will be ready by the end of 2020. This book will be open in university library. I also plan to public academic papers on online journals. You will be able to access them once you log in.

What if I don't want to participate?
Taking part in this study is fully at your will, and nothing will happen to you if you do not. Even after you choose to participate, you are at liberty to opt out any time. If you choose to do so, just let me know and I will instantly end the interview.

Where can I get further information?
In case you have any concerns, or would like to get more information about this study, please feel free to contact my supervisor on the address hereunder:

1. Professor Lenore Manderson Tel: +27(0)117171000
   Email: lenore.manderson@wits.ac.za
2. Professor Anne Katahoire Tel: +256 772 723729
   Email: annekatahoire@yahoo.co.uk

How do I agree to participate?

If you have made an informed decision to take part in this study, I will kindly ask you to indicate so by signing on the form provided hereafter. I will also offer you a separate form for you to sign if you allow me to record the interview.

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT FORM

Verification of consent:

I agree to be a participant this in study and that:

1. I understand the purpose and what the study is about.
2. I understand why I have been selected.
3. I understand that I can opt out of the study if I feel like
4. I understand that an interview will be conducted with me.
5. I understand that it's up to me to have the interview recorded or not
6. I understand that nothing happens to me if I do not participate in the study
7. I understand that my information will be kept confidential
8. All I want to know about the study has been explained to me and I understood.

I agree to participation in the study on the condition that:

1. I can choose an appropriate place to have the interview from
2. I can withdrawal from the study at any time if I feel like so and without any adverse consequence
3. I have a right not to answer any question
4. The University of the Witwatersrand Human Research Ethics Committee (Medical), the Uganda National Council of Science and Technology (UNCST) have approved the study
5. My responses will be kept and treated with strict confidentiality.
6. I am treated with respect and dignity through the interviews.

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT TO RECORD

I have read and understood the study and the purpose for which it is being conducted.

I understand that it is at my will to have the interview recorded or not. I understand that nothing adverse happens to me if I choose not to have the interview recorded.

I also understand that I can have the recording stopped, halted, if I decide to.

I understand that my interview recording will be kept in the strictest sense possible and that my data will be treated as confidential.

Once the interview recordings are transcribed, the transcript will be kept and audio recording will be destroyed at an appropriate time following the university of the Witwatersrand regulations. The recording will be kept on only one central computer to allow comparing the transcript and the audio recording during the analysis of the data. No any other person outside the study will have access to listen to the audio recording.

☐ Yes, I give permission for the discussion to be tape recorded

☐ No, I do not give permission for the discussion to be tape recorded

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW GUIDE- DEVELOPMENT AGENCIES

Introduction

Hello Sir/Madam, good morning/afternoon to you. I am here for the meeting we planned to have about my study. Are you ready? If yes, sit down and start the interview. Otherwise ask for a postponement. Again I would like to stress that this is purely an academic study, not an advocacy for any group.

I am glad to talk to you about maternal and reproductive healthcare issues here in Uganda. I appreciate the commitment of DFID/USAID/SIDA/NORAD/WHO/UNFPA/UNICEF towards supporting interventions aimed at promoting maternal and reproductive health. I will first ask you some general questions about maternal and child

1. Share with me your understanding of the reasons for the global shift from safe motherhood to Maternal and Child Health (MCH). Probe for:
    a. Critical factors that the shift in approach is intended to address
    b. Any shift in the position globally on matters of abortion care and if so, why?
2. The position of the agency on the abortion and abortion care in Uganda. Explore the
    a. The concerns of the agency on abortion care policy and how they shape national and local policy and practice?
    b. Dialectic between the position of the development agency and the law and policy of abortion in Uganda,
    c. The dialectic between the position of the agency and the local normative narratives on abortion and abortion care in Uganda
    d. The place of young women in particular in the way the agency of talks about abortion and abortion care.
3. Your understanding of the country's commitment to meeting the targets of Sustainable Development Goal number 3 on maternal health
    a. The mechanisms for effective and equitable delivery and access to quality abortion care (the effect of liberalized and financialized abortion care on reproduction of inequity in access to abortion care)
    b. The effect of standardized abortion care to Uganda's health care system
4. The strategic linkages between the development agency and the government in promoting maternal and reproductive health care, specifically abortion care services.
    a. The funding regime and the commitment to full realization of health care needs of women in Uganda
    b. The interactions or cooperation between this agency and other development agencies in matters linked to delivery of abortion care
5. I would like to learn from you about the relationship between the Ministry of Health and the development agencies in the context of delivering comprehensive abortion care policy. Explore:
    a. The obstacles and chances available for strong and effective partnership

End of the Interview, thank you so much, ☺

Appendix VIII Information Statement, Consent Forms and In-Depth Interview Guide for Participants from Law Enforcement Organisation

SCHOOL OF PUBLIC HEALTH

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – INFORMATION SHEET FOR PARTICIPANTS FROM LAW ENFORCEMENT

Introduction

Good morning/afternoon to you. I am Alexander KAGAHA, a PhD student from School of Public Health at the University at the Witwatersrand, South Africa. Thank you for accepting to learn about my study. I hope you will find merit to be part of it.

Please kindly receive and read this information sheet and make an informed decision.
This is your copy to keep.

What is the study about?
This study is about understanding the policy and practice of abortion care in Eastern Uganda. The study is part of the tasks I have to do in order for me to earn a grade at the School. It has been approved by the Research Ethics Committee (Medical) of the University and the Uganda National Council of Science and Technology (UNCST).

Who is doing the study?
This study is done by Alexander KAGAHA, a PhD student in the School of Public Health at the University of the Witwatersrand, South Africa.

Why me?
I have selected you because of your huge role you play in implementing the law of abortion in Uganda, and facilitating the processes leading to the dispensing of legal justice. I also selected you because in executing these roles, you interact and relate to multiple stakeholders whose interests shape the processes and outcomes of the law but also those who are affected by such outcomes. I would like to learn from you on these matters.

What will I be asked to do?
I am inviting you to participate in this study. If you accept, I will be asking you questions about abortion, the law and policy of abortion care. I will be particularly interested in learning about your experience

in influencing the policy and practice of abortion care. I will thus, be asking you to have some time for an interview with me. This could take about 45-60 minutes and could be done at any time of your convenience.

I will also be asking you for permission to allow me record the interview, to enable me to capture all the data without missing any of the very useful experiences you share with me. I want to pledge to you that the recording is purely for this study and no one else will listen to what we discuss here. I will transfer the recording on my laptop and develop a transcript. Thereafter, I will destroy the recording.
How do I benefit?

There is nothing to offer to you directly in this study. However, the responses you offer will be very useful in helping to understand how to protect and promote women's maternal and reproductive health through both the policy and practice. This could be useful in creating an enabling environment for the a healthy, safe and secure population of women in Uganda.

How will my confidentiality be protected?

Given the sensitivity surrounding abortion, I am very mindful about the protection of your identity in this study. I undertake to keep what you share with me confidential. I have three ways of doing this. The first, during the interview, I plan to interview you from a secure and safe place where you are comfortable and no one else is listening to our conversation. I will ask you to choose which place is convenient for this to happen.

Second, I have assigned unique identifiers to people I interview based on the **category to which they belong**. I plan to use the unique identifier instead of your name when reporting. This means that all the transcripts will be edited and where your name appear, it will be replaced by the unique identifier. Here, no one can tell that it was you talking, except me who developed the unique identifier. The third option is for me to use first name. if this is done, one can read your first name in the transcripts but will not know that it is you since many people share our first names. When writing the articles for publication, I may quote you verbatim, to enable be put emphasis on some points I will be making but reference will be made using either the unique identifier or your first name.

All the data will be protected with a password, only known to by my supervisor and I. this means that only authorised persons will be access to this data. All printed files will be kept under lock and key and stored according to the rules of the University of the Witwatersrand.

What are the risks involved?

Sometimes interviews remind us of horrible experiences we have had in the course of implementing the law of abortion. This can be sensitive and distressful. In case you experience this, and you would like to discontinue the interview, please let me know. Also, if there is any information you share but later feel it should be removed from the transcript, please tell me and I will do so before using it.

How will I receive feedback?

I plan to write a book from these findings. The book will be ready by the end of 2020. This book will be open in university library. I also plan to public academic papers on online journals. You will be able to access them once you log in.

What if I don't want to participate?

Taking part in this study is fully at your will, and nothing will happen to you if you do not. Even after you choose to participate, you are at liberty to opt out any time. If you choose to do so, just let me know and I will **instantly** end the interview.

Where can I get further information?

In case you have any concerns, or would like to get more information about this study, please feel free to contact my supervisor on the address hereunder:

Professor Lenore Manderson Tel: +27(0)117171000
Email: lenore.manderson@wits.ac.za

Professor Anne Katahoire Tel: +256 772 723729
Email: annekatahoire@yahoo.co.uk

How do I agree to participate?

If you have made an informed decision to take part in this study, I will kindly ask you to indicate so by signing on the form provided hereafter. I will also offer you a separate form for you to sign if you allow me to record the interview.

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT FORM

Verification of consent:

I agree to be a participant in this study and that:

1. I understand the purpose and what the study is about.
2. I understand why I have been selected.
3. I understand that I can opt out of the study if I feel like
4. I understand that an interview will be conducted with me.
5. I understand that it's up to me to have the interview recorded or not
6. I understand that nothing happens to me if I do not participate in the study
7. I understand that my information will be kept confidential
8. All I want to know about the study has been explained to me and I understood.

I agree to participation in the study on the condition that:

9. I can choose an appropriate place to have the interview from
10. I can withdrawal from the study at any time if I feel like so and without any adverse consequence
11. I have a right not to answer any of all
12. The University of the Witwatersrand Human Research Ethics Committee (Medical), the Uganda National Council of Science and Technology (UNCST) have approved the study
13. My responses will be kept and treated with strict confidentiality.
14. I am treated with respect and dignity through the interviews.

PARTICIPANT:

_____	_____	_____
Name (Printed)	**Signature**	**Date**

RESEARCHER:

_____	_____	_____
Name (Printed)	**Signature**	**Date**

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT TO RECORD

I have read and understood the study and the purpose for which it is being conducted.

I understand that it is at my will to have the interview recorded or not. I understand that nothing adverse happens to me if I choose not to have the interview recorded.

I also understand that I can have the recording stopped, halted, if I decide to.

I understand that my interview recording will be kept in the strictest sense possible and that my data will be treated as confidential.

Once the interview recordings are transcribed, the transcript will be kept and audio recording will be destroyed at an appropriate time following the university of the Witwatersrand regulations. The recording will be kept on only one central computer to allow comparing the transcript and the audio recording during the analysis of the data. No any other person outside the study will have access to listen to the audio recording.

☐ Yes, I give permission for the discussion to be tape recorded

☐ No, I do not give permission for the discussion to be tape recorded

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW GUIDE- IMPLEMENTERS OF THE LAW OF ABORTION

Introduction

Hello Sir/Madam, Good morning/afternoon to you, I am here for the meeting we planned to have today. Are you ready for it? (If yes, get ready and start the interview. Otherwise, plan ask for reschedule of interview).

I thank you for giving this chance to learn from you on issues which are at the centre of the law and maternal and reproductive health. Again I would like to stress that this is purely an academic work, not activism for any group. I know how important this faith is on matters of maternal health. I thus, thank you in advance all the responses I will get from you.

1.1. Let me learn, your office in the body? Probe for the obligations handled and for how long have you been serving this capacity?

1.2. What is the stand of this body on abortion? Probe for:
   a. Attitudes on abortion in Uganda?
   b. Attitudes on the law of abortion?
   c. Explicit meanings and interests expressed by the attitudes on abortion?
   d. How women are situated in the narratives on abortion
   e. Implications of attitudes and positions assigned to woman have on their reproductive and maternal health outcomes?

1.3. What are your experiences of prosecuting cases of abortion? Probe for:
   a. Experiences of gathering evidence against assumed cases of abortion, and witnesses in courts of law.
   b. Defending the government position on abortion as a criminal offense in light of the reproductive and health rights over a woman's body

1.4. What is your comment on the equality of justice among women of different social, economic and political classes before the law of abortion? Probe for:
   a. Cases of abortion successfully prosecuted among women from poor economic and social and political background, and those from rich and politically connected background
   b. The dialectic between reproductive health justice to a woman and legal justice to the state.

1.5. Does the implementation of the law serve the intended purpose?
   a. Probe for what the law of abortion is intended to heal/address
   b. Probe if it really addresses the intention
   c. The relevancy of law in light of the rights of women to decide what to do with their bodies and the healthcare needs,
   d. What do you think about abortion?

End of the Interview, thank you so much, ☺

Appendix IX Information Statement, Consent Forms and In-Depth Interview Guide for Participants from Non-Government Organisations

SCHOOL OF PUBLIC HEALTH

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – INFORMATION SHEET FOR PARTICIPANTS FROM NON-GOVERNMENT ORGANISATIONS

Introduction

Good morning/afternoon to you. I am Alexander KAGAHA, a PhD student from School of Public Health at the University of the Witwatersrand, South Africa. Thank you for accepting to learn about my study. I hope you will find merit to be part of it.

Please kindly receive and read this information sheet and make an informed decision.
This is your copy to keep.

What is the study about?
This study is about understanding the policy and practice of abortion care in Eastern Uganda. The study is part of the tasks I have to do in order for me to earn a grade at the School. It has been approved by the Research Ethics Committee (Medical) of the University and the Uganda National Council of Science and Technology (UNCST).

Who is doing the study?
This study is done by Alexander KAGAHA, a PhD student in the School of Public Health at the University of the Witwatersrand, South Africa.

Why me?
I have selected you because of your important role in supporting the government in implementing maternal and reproductive health interventions in Uganda. I also chose because of your experience in dealing with multiple actors at different levels on matters relating to the policy and practice of abortion care delivery. I would like to learn from you on these matters.

What will I be asked to do?
I am inviting you to participate in this study. If you accept, I will be asking you questions about abortion, the policy and practice of abortion care. I will be particularly interested in learning about your experience in influencing the policy and practice of abortion care. I will thus, be asking you to have some time for an interview with me. This could take about 45-60 minutes and could be done at any time of your convenience.

I will also be asking you for permission to allow me record the interview, to enable me to capture all the data without missing any of the very useful experiences you share with me. I want to pledge to you that the recording is purely for this study and no one else will listen to what we discuss here. I will transfer the recording on my laptop and develop a transcript. Thereafter, I will destroy the recording.

How do I benefit?

There is nothing to offer to you directly in this study. However, the responses you offer will be very useful in helping to understand how to protect and promote women's maternal and reproductive health through both the policy and practice. This could be useful to create an enabling environment for the a healthy, safe and secure population of women in Uganda.

How will my confidentiality be protected?

Given the sensitivity surrounding abortion, I am very mindful about the protection of your identity in this study. I undertake to keep what you share with me confidential. I have three ways of doing this. The first, during the interview, I plan to interview you from a secure and safe place where you are comfortable and no one else is listening to our conversation. I will ask you to choose which place is convenient for this to happen.

Second, I have assigned unique identifiers to people I interview based on the category to which they belong. I plan to use the unique identifier instead of your name when reporting. This means that all the transcripts will be edited and where your name appear, it will be replaced by the unique identifier. Hence, no one other than me will know that it was you talking. When writing the articles for publication, I may quote you verbatim, to enable be put emphasis on some points I will be making but reference will be made using either the unique identifier or your first name.

All the data will be protected with a password, only known to by my supervisor and I. this means that only authorised persons will be access to this data. All printed files will be kept under lock and key and stored according to the rules of the University of the Witwatersrand.

What are the risks involved?

Sometimes interviews remind us of horrible experiences we have had in the course of delivering abortion care. This can be sensitive and distressful. In case you experience this, and you would like to discontinue the interview, please let me know. Also, if there is any information you share but later feel it should be removed from the transcript, please tell me and I will do so before using it.

How will I receive feedback?

I plan to write a book from these findings. The book will be ready by the end of 2020. This book will be open in university library. I also plan to public academic papers on online journals. You will be able to access them once you log in.

What if I don't want to participate?

Taking part in this study is fully at your will, and nothing will happen to you if you do not. Even after you choose to participate, you are at liberty to opt out any time. If you choose to do so, just let me know and I will instantly end the interview.

Where can I get further information?

In case you have any concerns, or would like to get more information about this study, please feel free to contact my supervisor on the address hereunder:

1. Professor Lenore Manderson Tel: +27(0)117171000
   Email: lenore.manderson@wits.ac.za
2. Professor Anne Kataboire Tel: +256 772 723729
   Email: annekataboire@yahoo.co.uk

How do I agree to participate?

If you have made an informed decision to take part in this study, I will kindly ask you to indicate so by signing on the form provided hereafter. I will also offer you a separate form for you to sign if you allow me to record the interview.

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT FORM

Verification of consent:

I agree to be a participant this in study and that:

1. I understand the purpose and what the study is about.
2. I understand why I have been selected.
3. I understand that I can opt out of the study if I feel like
4. I understand that an interview will be conducted with me.
5. I understand that it's up to me to have the interview recorded or not
6. I understand that nothing happens to me if I do not participate in the study
7. I understand that my information will be kept confidential
8. All I want to know about the study has been explained to me and I understood.

I agree to participation in the study on the condition that:

1. I can choose an appropriate place to have the interview from
2. I can withdrawal from the study at any time if I feel like so and without any adverse consequence
3. I have a right not to answer any of all
4. The University of the Witwatersrand Human Research Ethics Committee (Medical), the Uganda National Council of Science and Technology (UNCST) have approved the study
5. My responses will be kept and treated with strict confidentiality.
6. I am treated with respect and dignity through the interviews.

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

4

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT TO RECORD

I have read and understood the study and the purpose for which it is being conducted.

I understand that it is at my will to have the interview recorded or not. I understand that nothing adverse happens to me if I choose not to have the interview recorded.

I also understand that I can have the recording stopped, halted, if I decide to.

I understand that my interview recording will be kept in the strictest sense possible and that my data will be treated as confidential.

Once the interview recordings are transcribed, the transcript will be kept and audio recording will be destroyed at an appropriate time following the university of the Witwatersrand regulations. The recording will be kept on only one central computer to allow comparing the transcript and the audio recording during the analysis of the data. No any other person outside the study will have access to listen to the audio recording.

☐ Yes, I give permission for the discussion to be tape recorded

☐ No, I do not give permission for the discussion to be tape recorded

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW GUIDE- NON GOVERNMENT ORGANISATIONS

Introduction

Hello Sir/Madam, good morning/afternoon to you. I am here for the meeting we planned to have about my study. Are you ready? If yes, sit down and start the interview. Otherwise ask for a postponement. Again I would like to stress that this is purely an academic study, not an advocacy for any group.

Section One: framing of abortion

1. What is the stand of this body on abortion? Probe for:
    a. Attitudes on abortion in Uganda?
    b. Attitudes on the law of abortion?
    c. Explicit meanings and interests expressed by the attitudes on abortion?
    d. How women are situated in the narratives on abortion
    e. Implications of attitudes and positions assigned to woman have on their reproductive and maternal health outcomes?

Section Two: The law of abortion

2.1. I would like to learn from you, what do you think about the law of abortion in Uganda? Explore:
    a. The knowledge about the law of abortion
    b. The meanings and interests the law represents for women from the perspective of the actor.
    c. The efficacy and equity in the enforcing the law of abortion across different categories of women (like the very poor, the rich, the educated and the non-educated)
    d. Linkages between the law of abortion and women's health?

2.2. Does your organisation conduct anything aimed at affecting the law of abortion in Uganda? If no, explore why. If yes, explore:
    a. The critical issues in advocacy
    b. The plan undertaken to shape the law,
    c. The obstacles and chances to exploit

Section Three: Abortion care policy

3.1. What are the concerns of the body on abortion care policy and how do they shape national and local policy and practice? Probe for:
    a. The meanings and interests the policy represents for women
    b. How women are situated in the policy
    c. Links between equity and the context of the law and culture

3.2. Does the abortion care policy address the user-needs of women (mainly the young women)? probe for:
    a. The way of delivery (private cost fee service or free of cost fees)

b. Quality of care issues during delivery (privacy, safe, secure sites, stigma etc.).

3.3. Does the policy address the concerns of health workers in the delivery of abortion care services? Probe for:

a. The stigma and mental needs of health workers delivering abortion care services

b. Protection of health workers whose conscience does not allow them to deliver abortion care services

c. Capacity building for health workers to offer quality and safe abortion care?

Section Four: influencing the abortion care policy

4.1. Does/(did) your organisation join in any activities leading to the creation and operation of the abortion care policy? Probe for:

a. The processes in which the organisation participated

b. the priority settings and interests of the organisation in the abortion care policy?

c. The plans used to shape the policy?

d. The combative and consensual issues in the policy

e. Experience of turning women's issues into national policy issues

4.2. Share with me your experience, of influencing the policy? Probe for:

a. The critical issues advocated for in the policy and why (ask if public health framing was used).

b. The plans used to advocate and influence the policy outcomes

c. the organisational activities (meetings, conferences and workshops) used and their effect.

i. How the specific organisational structure (meetings, workshops, conferences etc.) relate to the outcomes

ii. The critical issues of stiffness, clash and agreement felt in the process

iii. The ways differing accounts were opposed, gained or lost power or were fought

iv. Local contexts informing the positions on abortion care policy?

d. Experiences in networking with other actors (the legislators, Professional medical bodies, and Global donor agencies) to shape policy?

i. The influence of the macro context (like global funding regime) on the activities of the organization

End of the interview, thank you so much😊

Appendix X Information Statement, Consent Forms and In-Depth Interview Guide for Policy Makers at National and Local Government Level

SCHOOL OF PUBLIC HEALTH

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – INFORMATION SHEET FOR PARTICIPANTS FROM POLICY MAKING AND IMPLEMENTING INSTITUTIONS

Introduction

Good morning/afternoon to you. I am Alexander KAGAHA, a PhD student from School of Public Health at the University of the Witwatersrand, South Africa. Thank you for accepting to learn about my study. I hope you will find merit to be part of it.

Please kindly receive and read this information sheet and make an informed decision.
This is your copy to keep.

What is the study about?
This study is about understanding the policy and practice of abortion care in Eastern Uganda. The study is part of the tasks I have to do in order for me to earn a grade at the School. It has been approved by the Research Ethics Committee (Medical) of the University and the Uganda National Council of Science and Technology (UNCST).

Who is doing the study?
This study is done by Alexander KAGAHA, a PhD student in the School of Public Health at the University of the Witwatersrand, South Africa.

Why me?
I have selected you because of your important role you play in both formulating and implementing the policy and national guidelines and standards for delivery of quality abortion care. I also selected you because in executing these roles, you interact and relate to multiple stakeholders whose interests shape the policy making processes and implementation. I would like to learn from you on these matters.

What will I be asked to do?
I am inviting you to participate in this study. If you accept, I will be asking you questions about abortion, the policy and practice of abortion care. I will be particularly interested in learning about your experience in influencing the policy and practice of abortion care. I will thus, be asking you to have some time for an interview with me. This could take about 45-60 minutes and could be done at any time of your convenience.

I will also be asking you for permission to allow me record the interview, to enable me to capture all the data without missing any of the very useful experiences you share with me. I want to pledge to you that the recording is purely for this study and no one else will listen to what we discuss here. I will transfer the recording on my laptop and develop a transcript. Thereafter, I will destroy the recording.

How do I benefit?

There is nothing to offer to you directly in this study. However, the responses you offer will be very useful in helping to understand how to protect and promote women's maternal and reproductive health through both the policy and practice. This could be useful to create an enabling environment for the a healthy, safe and secure population of women in Uganda.

How will my confidentiality be protected?

Given the sensitivity surrounding abortion, I am very mindful about the protection of your identity in this study. I undertake to keep what you share with me confidential. I have three ways of doing this. The first, during the interview, I plan to interview you from a secure and safe place where you are comfortable and no one else is listening to our conversation. I will ask you to choose which place is convenient for this to happen.

Second, I have assigned unique identifiers to people I interview based on the category of participants to which they belong. I plan to use the unique identifier instead of your name when reporting. This means that all the transcripts will be edited and where your name appear, it will be replaced by the unique identifier. Hence, no one other than me will know that it was you talking. When writing the articles for publication, I may quote you verbatim, to enable be put emphasis on some points I will be making but you will not be identifiable.

All the data will be protected with a password, only known to by my supervisor and I. this means that only authorised persons will be access to this data. All printed files will be kept under lock and key and stored according to the rules of the University of the Witwatersrand.

What are the risks involved?

Sometimes interviews remind us of horrible experiences we have had in the course of making and implementing the policy of abortion care. This can be sensitive and distressful. In case you experience this, and you would like to discontinue the interview, please let me know. Also, if

there is any information you share but later feel it should be removed from the transcript, please tell me and I will do so before using it.

How will I receive feedback?

I plan to write a book from these findings. The book will be ready by the end of 2020. This book will be open in university library. I also plan to publish academic papers on online journals. You will be able to access them once you log in.

What if I don't want to participate?

Taking part in this study is fully at your will, and nothing will happen to you if you do not. Even after you choose to participate, you are at liberty to opt out any time. If you choose to do so, just let me know and I will instantly end the interview.

Where can I get further information?

In case you have any concerns, or would like to get more information about this study, please feel free to contact my supervisor on the address hereunder:

1. Professor Lenore Manderson — Tel: +27(0)117171000 Email: lenore.manderson@wits.ac.za
2. Professor Anne Katahoire — Tel: +256 772 723729 Email: annekatahoire@yahoo.co.uk

How do I agree to participate?

If you have made an informed decision to take part in this study, I will kindly ask you to indicate so by signing on the form provided hereafter. I will also offer you a separate form for you to sign if you allow me to record the interview.

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT FORM

Verification of consent:

I agree to be a participant in this study and that:

1. I understand the purpose and what the study is about.
2. I understand why I have been selected.
3. I understand that I can opt out of the study if I feel like
4. I understand that an interview will be conducted with me.
5. I understand that it's up to me to have the interview recorded or not
6. I understand that nothing happens to me if I do not participate in the study
7. I understand that my information will be kept confidential
8. All I want to know about the study has been explained to me and I understood.

I agree to participation in the study on the condition that:

1. I can choose an appropriate place to have the interview from
2. I can withdrawal from the study at any time if I feel like so and without any adverse consequence
3. I have a right not to answer any of all
4. The University of the Witwatersrand Human Research Ethics Committee (Medical), the Uganda National Council of Science and Technology (UNCST) have approved the study
5. My responses will be kept and treated with strict confidentiality.
6. I am treated with respect and dignity through the interviews.

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

4

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW – CONSENT TO RECORD

I have read and understood the study and the purpose for which it is being conducted.

I understand that it is at my will to have the interview recorded or not. I understand that nothing adverse happens to me if I choose not to have the interview recorded.

I also understand that I can have the recording stopped, halted, if I decide to.

I understand my interview recording will be kept in the strictest sense possible and that my data will be treated as confidential.

Once the interview recordings are transcribed, the transcript will be kept and audio recording will be destroyed at an appropriate time following the university of the Witwatersrand regulations. The recording will be kept on only one central computer to allow comparing the transcript and the audio recording during the analysis of the data. No any other person outside the study will have access to listen to the audio recording.

☐ Yes, I give permission for the discussion to be tape recorded

☐ No, I do not give permission for the discussion to be tape recorded

PARTICIPANT:

Name (Printed)	Signature	Date

RESEARCHER:

Name (Printed)	Signature	Date

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

IN-DEPTH INTERVIEW GUIDE- POLICY MAKERS AT NATIONAL AND LOCAL GOVERNMENT LEVEL

Introduction

Hello Sir/Madam, Good morning/afternoon to you, I am here for the meeting we planned to have today. Are you ready for it? (if yes, get ready and start the interview. Otherwise, plan ask for reschedule of interview).

I am glad to talk to you about the abortion care policy and practice, considering the national target of ensuring that 85% of cases with post abortion complications are "appropriately managed". Before we get there, I would like to learn from you, about the current status of abortion in Uganda.

1. Probe for known nature of abortion (safe/unsafe), most affected age group
2. How prepare in the health system preparedness to deliver abortion care services to the patients in need? Explore for:
    a. Plans of action in place for capacity building of staff to deliver quality abortion care services
    b. The resources and facilitation necessary for healthcare centres to deliver services
    c. Mechanisms for equitable access to abortion care services (across population categories and spaces)
    d. The chances and obstacles met in delivering abortion care services
3. What standards and guidelines exist at national and local level to ensure:
    a. Universal health care?
    b. Equality of access to abortion care?
    c. Delivery of safe and quality abortion care service?
4. Share with me your experiences of monitoring to ensure quality abortion care services across regions? Probe for:
    a. The institutional mechanisms in place and the effectiveness in monitoring adherence to the standards at local government level
    b. Protection of health workers unwilling to offer abortion care based on their conscience
    c. Monitoring the private health care facilities that offer abortion care services
    d. The ethical encounters between medical termination of pregnancy and legal abortion
    e. Obstacles in ensuring equitable access to quality abortion care in Uganda.
    f. In a context of plural healthcare market for abortion and misty legal contest, how are standards and guidelines monitored?
5. I have learnt through literature that the abortion care policy made by the ministry was withdrawn after it had been made. I would to learn from you what really happened? Probe for:
    a. What the policy was intended to achieve?
    b. The critical concerns that brought disagreements among stakeholders about the policy
    c. What the ministry plans to do about the policy
    d. The implications of withdrawing the policy document on comprehensive abortion care delivery
6. We have come the end. I would like to learn from you about the relationship between the Ministry of Health and the development agencies in the context of delivering comprehensive abortion care policy. Explore:
    a. The obstacles and chances available for strong and effective partnership

End of the Interview, thank you so much, ☺

Appendix XI Guide to Making Observations in Conferences/Meetings

UNDERSTANDING THE POLICY AND PRACTICE OF ABORTION CARE IN EASTERN UGANDA

OBSERVATION GUIDE

Context:

Observe and describe the context (including the surrounding social, economic and politically related issues in which the conference/meeting is nested. Observe the venue setup, facilities and materials availed

Organisation

Observe, note and describe the organisation of the conference/meeting in terms of sitting arrangements, order of activities, hierarchies, rules, materials facilitating the conference, meals, refreshments, and anything issues

Discursive Interactions and relationships

Observe and note the way in which people relate within the conference; the forms of micro groups and micro conversational issues, broader issues of consensus. Highlight the major frames used to articulate priority issues, the language and major concepts.

Note the centres of power, resistance, and ways in which different stakeholders respond. Note also what is at stake in moments of contention, and resistance or cooperation.

Observe potential silences, absences of some conversations within the conference, including those that appear only in passing.

Reflections

Make own reflections each day on the following: how abortion is framed, articulated, and the major narratives presented. Reflect on how advocates for reproductive health rights respond to state power in the conference.

Identify key issues emerging for follow-up in in-depth interviews

Appendix XII Plagiarism Declaration Form and TurnItIn Cover Page

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

I ALEXANDER KAGAHA (Student number: 1832444A) am a student registered for the degree of PHD (PUBLIC HEALTH) in the academic year III.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

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1	Alexander Kagaha, Lenore Manderson. "Medical technologies and abortion care in Eastern Uganda", Social Science & Medicine, 2020 Publication	13%

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