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Resisting Reproduction: An Anthropological Analysis of Self-Induced Abortion in a Rural Ghanaian Village

Abstract

Unsafe abortions claim the lives of thousands of women every year. Globally, women in Sub-Saharan Africa face the highest risk of death and injury from abortion-related complications. Current global and national efforts to reduce incidences of unsafe abortion are highly ineffective in the rural Ghanaian community where this research was undertaken because programmes of action fail to address patterns of gender violence and patriarchal control by medicalising women's social suffering. Medical discourses and policy output about family planning and reproductive health, produced and reproduced at the level of the national body politic, in fact obscure more deeply embedded, powerful ideologies and social praxis about female sexuality and reproduction which are produced and reproduced within the context of popular interpretations of tradition and customary law. These aspects of the customary social structure and its current transformations, combine with economic hardship to dominate patterns of social relations in the village and thus, maintain the necessity for women to utilise a dangerous local plant in order to facilitate potentially fatal self-induced abortions as a means of resisting culturally-defined fertility patterns.

Introduction

This paper is an examination of the 1994 International Conference on Population and Development (ICPD) discussions and the emergence of the Millennium Development Goals (MDGs) in the year 2000 as policy direction for the global reduction of incidences of unsafe abortion. Frequently policy analysis concerns outcomes or impacts as the effect of decisions made or policy uptaken. However, factors which are not addressed or excluded from policy also continue to impact on individual lives. Accordingly, the absence of a specific commitment to women's reproductive rights within the framework of the MGDs, renders efforts to reduce unsafe abortion in Africa ineffective because current national and international efforts fail to acknowledge patterns of unequal sexual social relations which disempower women and lead to unwanted pregnancy. Medical discourses and policy output about family planning and reproductive health, produced and reproduced at the level of the national body politic, in fact obscure more deeply embedded, powerful ideologies and social praxis about female sexuality and reproduction which are produced and reproduced within the context of popular interpretations of tradition and customary law. These aspects of the customary social structure and its current transformation, combine with economic hardship to dominate patterns of sexual social relations in rural Ghana and thus, maintain the necessity for women to utilise a dangerous local plant to facilitate potentially fatal self-induced abortions as a means of resisting culturally-defined fertility patterns. The ethnographic accounts in this paper come from six months of research at a community clinic in a rural village in the Volta region of Ghana, West Africa.

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Abortion

Induced abortion is the oldest, and according to some, perhaps the most widely used method of fertility control (Royston & Armstrong). The majority of induced abortions performed in developed nations do not create negative health outcomes for women because abortion is a very safe medical procedure when performed hygienically and correctly. Globally, unsafe abortions however, claim the lives of thousands of women each year. The vast majority of these are performed in developing nations by the women themselves or by untrained and unskilled providers in unhygienic conditions. Every year the thousands of women who survive an unsafe abortion suffer serious health complications including sepsis, haemorrhage, uterine perforation and cervical trauma, which often lead to permanent physical impairment, chronic morbidity, infertility and psychological damage (Coeytaux 1990 & McLaurin 1991). The costs of unsafe abortion can also be measured financially. The necessity of treating the complications which arise from attempted abortions further strains the already stretched health budgets of developing countries. The World Health Organisation (WHO, 1990) claims that treating abortion complications may consume up to 50% of hospital budgets in the developing world. Although abortion law reform has been taking place slowly since the 1960s, for many years the practice of unsafe abortion remained little more than a silent statistical reality in the arena of global public health. However, the extent of the contribution that unsafe abortion makes to global maternal morbidity and mortality has more recently come to the forefront of the global public health agenda. Unsafe abortion has largely been recognised as a crisis issue since the 1990s.

Unsafe Abortion in the Global Political Arena

The response to the crisis was the 1994 International Conference on Population and Development (ICPD). The Programme of Action which resulted from the ICPD, became a key international consensus document detailing a comprehensive recognition of women's rights associated with sexuality, violence and unsafe abortion. The conference very much formulated a human-rights based discourse around sexual rights for women, including the right to say 'No' to unwanted, forced or unprotected sexual intercourse (Crossette 2005, p.171). The fact that thousands of women are denied this right, is a highly significant reason for many unwanted pregnancies globally. In 1995, the Fourth World Conference on Women renewed the commitments forged at the ICPD. Governments were urged to work in collaboration with non-governmental organizations (NGOs) and both national and international institutions to 'recognise and deal with the health impact of unsafe abortion' (Sai 200, p19). The United Nations General Assembly also held a progress review of governments implementing the ICPD Programme of Action and advocated the improvement of abortion health services. Moreover, the WHO developed technical and policy guidance for safe abortion for health systems addressing issues such as preferred methods, provision of skilled healthcare staff and reviews of legislative barriers to abortion provision.

Opposition and Policy Outcomes

Unsurprisingly, these advances in international health policy were hotly contested and there was fierce opposition from some official delegations with Vatican support or the backing of conservative governments. While this opposition did not succeed at the ICPD, it did impact on the formulation of the Millennium Development Goals in the year 2000. Despite the progress made at the ICPD and the Fourth World Conference on Women, an explicit commitment to the reproductive rights of women was absent from the MDGs. Reproductive rights for women were replaced instead with more general promises of gender equality and a commitment to improving maternal health – goals 3 and 5. Crossette (2005) states that reproductive health and women's sexual rights were not adopted as millennium development goals because the issue became too contentious and the United Nations Secretariat was required to cede to political pressure. The progress attempts at reducing the health burden from unsafe abortion have thus been largely directed through the MDG 5 of improving maternal health and, in a practical sense, have focused on the provision of contraceptives and family planning solutions. There has also been attention given to the expansion of abortion services and the training of health care staff. This focus very much positions the issue of unsafe abortion as being largely solved by medical and technical means and minimises global attention on the significant role that unequal sexual social relations play in the health burden of unsafe abortion.

It must be acknowledged that current policy output and international commitment to reducing the incidences of unsafe abortion have seen positive results in some geographic regions. Overall the global number of unsafe- abortion-related maternal deaths has reduced by one-third since 1990 (Ahman & Shah 2011, p.123). However, there has been little change in Africa where the WHO reveals that the trend in the unsafe abortion mortality rate has reduced by just 1% (Ahman & Shah 2011, p.123). This is particularly concerning considering that the risk of death from unsafe abortion is the highest in the world in Sub-Saharan Africa (Wolf 2004, p.99).

Ghana's Response to Unsafe Abortion

Ghana, a signatory to the ICPD and the Fourth World Conference on Women, has demonstrated commitment to reducing its unacceptably high number of unsafe abortion related deaths. In 1985, the Ghanaian government liberalised national abortion laws changing the previously prohibitive and punitive stance on abortion to legislation which allowed abortion under specific circumstances; when performed in registered Government hospitals or clinics by qualified persons.1 Moreover, Ghana responded to the 2007 African Union Conference of Ministers of Health by agreeing to 'adopt strategies to reduce unsafe abortions by providing abortion services to the fullest extent that national laws would permit (Hill et al 2009, p.2017). Ghana upgraded its services as far as its health budget would allow and it was hoped that results would be seen as a reduction in the number of induced abortions. Indeed, the fact that there are still numerous incidences of unsafe abortions throughout Ghana does not escape the watchful eye of the state health services. A recent article in a Ghanaian newspaper reports the frustrations of the Asante-Mampong Municipal

[1] See Morhe & Morhe (2006, p.81)

Health Director. She has called on women 'to take advantage of safe family planning methods, to avoid unwanted pregnancies, unsafe abortions and preventable deaths [and she] regretted that in spite of the numerous government interventions to safeguard their reproductive health, women are still dying from unsafe abortions, *due to ignorance and non-patronage of available family planning methods*'.[2] Similarly well-intentioned the Medical Superintendent of the Mampong Government Hospital, advised women to 'desist from engaging in self-induced abortions, which could easily kill them [and to utilise] safe abortion services provided at hospitals. In many respects, Ghanaian efforts to reduce incidences of unsafe abortion have followed the guidelines of the WHO and the Millennium Development Goal number five of improving maternal health. The approach has been predominately medical and technical, focusing on the provision of contraceptive products and the improvement of hospital and clinic abortion service provision.

There is however, a price to be paid for the compromised policy trajectory of the MDGs. A commitment to reducing the health burden of unsafe abortion which fails to directly address women's reproductive rights cannot hope to be truly effective. Ethnographic accounts from my qualitative study of self-induced abortion in rural Ghana demonstrate that rural women's sexual experiences are often coerced and violent and exact a high toll on their physical and mental well-being. A key reason for all the women interviewed to have performed a self-induced abortion was a lack of control over sexual experiences. Both married and unmarried women stated that most of the time they felt that they did not have the right to say 'No' to unwanted sexual intercourse or unprotected intercourse. Frequently these situations lead to a pregnancy which they terminated by a potentially fatal self-induced abortion.

Marriage in Ewe Customary Law

Turner's (1984) theory states that within any society there is a discourse which determines appropriately sexed beings and organises their relations (p.14). In the rural Tongu-Ewe village in Ghana this discourse is expressed within customary law. The law specifies that correct sexual unions are those formulated within the institution of marriage. A marriage is considered valid if the appropriate customary rites have been performed. A man wishing to legally marry in a customary way must supply a bridewealth payment. After the ceremony the woman is henceforth seen as the property of the husband. This notion of property was confirmed by a Tongu Ewe elder:

B: *The wife can only become the husband's property if you perform all the customary rights. Then whether she is alive or dead she is for you. If I married you and you are dead, I will get all your funeral ceremony expenses, so you are for me. Ideally, if I pay for you [then] you become my property. Traditionally too, although it is sad, our traditional rulings they also say that if you are a woman, you must follow the rules of your husband. But the husband is supposed to be fair to the woman.*

[2] See http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=190504
My emphasis.

These traditional notions of property also extend to sexual rights over a wife's body. The notion of 'wife as property' continues to be a feature in contemporary marriages in the village, albeit to the chagrin of the local women to whom I spoke. They describe their views of a customary marriage situation:

W: *So, even for example if a man marry you, and pay your bridewealth and all that...and for example you do something little like the man say 'cook this for me ' but you didn't cook it on the time he want...maybe he can insult you even beat you. He will say that he is the one who marry you, not you...he pay the bridewealth so he like what he want. Sex too.*

Me: *Oh it's like he owns you now because he paid the bridewealth?*

W: *Yeah. (Laughs) It's horrible...it's horrible. Like maybe 99% of the men do it. (Quietly) So it's horrible.*

Another participant states:

W: *The men never listen. All that they want is sex. Most men think [that] they have paid their bride price…they went to your parents and did everything, so your body belongs to them. They can do and undo anything. They want your body*

The popular interpretation of customary laws provides a discourse which facilitates a particular sexual ideology of female subordination and male entitlement. The female body is thus inscribed with a social sexual reality which may, or as demonstrated by the experiences of the participants of this study, may not correspond to a phenomenologically preferred sexuality of the individual body-self. The customary sexual reality as practiced by many currently, certainly does not correspond to MDG number 3 of gender equality and empowerment for women. Nor does it correspond to Ghana's Reproductive Health Strategic Plan 2007-2011. The plan was established by the Ghana Ministry of Health (MOH) and was written to provide a framework for a program of action and to reflect Ghana's commitment to reproductive health in accordance with global development goals.[3] The plan recognises that reproductive health is a human right. It cites the United Nations Family Planning Association (UNFPA) claiming that:

Reproductive rights encompass the right to reproductive and sexual health throughout the life cycle, reproductive self-determination, including voluntary choice of marriage and childbearing, and sexual and reproductive security, including freedom from sexual violence and coercion.

(UNFPA, 1997)

Indeed, the plan cites further the importance of human rights for women in relation to reproductive health by claiming in its objective 3 that:

Particular attention is paid to the issue of gender in sexual and reproductive health, respecting the inherent rights of women as equal partners in sexual and reproductive health decision-making.

Transformation of Sexual Social Relations

Despite these political commitments to international development goals for gender equality, the sexual and reproductive circumstances of women in the Tongu-Ewe village can be very difficult indeed. Moreover, the circumstances for unmarried women can be in many ways worse than for their married counterparts. More and more young people now forego the customary marriage rites and form culturally-illegitimate unions. Participants described the breakdown of the traditional bridewealth system as the principle factor for the abandonment of traditional marriage customs:

D: *Traditionally, in those days the [number of] males outweighs [sic] the females so it was illegal to date or be boyfriend/girlfriend before marriage because if I see you then the first day I must say to your parents that I want to marry you and assume the customary rights… a time came when they would judge the man according to the lady and ask for billions of Cedis and at times they can see the man is from a rich family and so they ask more….even billions of Cedis… So now most people will start with a relationship like boyfriend/girlfriend before marriage but it is illegal to the custom. …*

Me: *Do you think that that kind of greed is the breakdown of the system?*

D: *It was, it is and it is still breaking it down.*[4] *That is why…most boys don't have money to start so they just start with the relationship.*

Many young men in and around the village find their human physiology frustrated by the seeming impossibility of the financial demands of the contemporary bridewealth payment. Thus, they simply bypass the customary social regulations. While the personal motivations for this are obvious, the unintended consequence has been the transformation of the traditional social structure as a whole and the emergence of new forms of social relations which create challenges for women. While the customary law sees a wife as a man's property, it also ensured her material provision at least to some degree, and in particular, her moral standing in the community. For the local women who form sexual unions without the social legitimacy of customary rites, life can be even harder than it is for their married counterparts. Rose, an unmarried participant has five children and farms cassava alone to support herself and her family. Despite fearing another pregnancy, she describes her inability to refuse a boyfriend's sexual requests:

R: *[laughs embarrassed] Sometimes we women can't say no to men.*

[4] Zeitzen (2008) confirms a drastic inflation in the amount of bridewealth demanded in west Africa (p.150).

Me: *Other women said they found it difficult to say no as well. What situations do you feel you can't say no?*

R: *Sometimes the man will force you and impregnate you and not even take of you…*

Many local women fear that they may be forced into sexual intercourse without their consent and, unfortunately, this is frequently the case. There exists a potentiality within patriarchal Tongu-Ewe cultural ideology for a fine and ambiguous ideological transformation between customary concepts of female obedience to male *will* in the sense of just leadership, to a concept of female obedience to male *desire*. This has become very much more than an issue of semantics as this ambiguity is reflected in patterns of sexual social relations which significantly disempower women. Within these transforming patterns of sexual social relations many local men still exercise the older customary belief of male entitlement to sexual relations regardless of the fact that they are not married and therefore have no customary rights over the woman's body.

High levels of impoverishment also contribute to circumstances where women have less control over sexual encounters. Rose states also that:

In some situations you have a new boyfriend who comes and you can't refuse him sex so…[voice trails off]

Me: *Why not?*

R: *Because you… you can't refuse him sex…you have to. He has been coming to you all the time…you can't refuse it. It might mean you are very ungrateful.*

There is a sign on the wall inside the community clinic which reads 'if your gift is for sex, then keep it'. The sign has a picture of a local man soliciting a young woman. She has her back turned away from him. Unfortunately for many young local women it is not so easy to turn their back from the man and his 'gift'. This is probably particularly so if women fear that they may be forced into sexual intercourse anyway. When local men court a woman, they bring gifts of food, clothing or money. The high levels of poverty in the village make it very difficult to refuse such gifts. Rose's fears of accusations of ingratitude refer to the social expectation that sexual relations will be provided in return for these 'gifts'. Zeitzen (2008) describes these patterns of exchange claiming that 'the system allows women to maintain the traditional pattern of men assuming responsibility for their financial outlays in return for sexual relations (p.164). Zeitzen (2008) mainly discusses this phenomenon with regard to urban Ghana, particularly in the cities such as Accra but such relationships occur in the villages also. For most women such arrangements are in the long-term unsatisfactory because the relationships are usually very insecure and if the boyfriends lose interest in them, the women are without support (Zeitzen 2008, p.164). Hence Rose's explanation that she cannot refuse to have sex with a

boyfriend. Without partner co-operation or financial resources for contraception, another pregnancy for Rose is the likely outcome of her social circumstances. Previously, she has dealt with unwanted pregnancies three times by self-induced abortion.

The application of medical and technical policies and programmes to reduce incidences of unsafe abortion is not addressing the root of the problem in this Tongu-Ewe village. Local men do not usually co-operate with contraceptive use. Some women told me they would be beaten if their husband found contraception at their home. Furthermore, these women cannot afford the fees charged at the hospitals for a legal abortion. Almost all of them are farmers. The compromised policy trajectory of the MDGs, means that attention will not yet be given to addressing the social issues which largely determine the need for these women to perform self-induced abortions. Therefore the women will continue to exercise agency over their body and personal circumstances by using a highly toxic local plant to remedy the toxic social circumstances of gender inequality which lead to their unwanted pregnancies.

'Babati Te' to Facilitate Abortion

The abortifacient plant is called babati te in the local language. Women who wish to use it to abort a pregnancy break off the stem of the plant and tie a string around it. They then tie the other end of the string to their waist or upper thigh. The stem is then inserted inside the woman. The string will prevent the stem going into the cervix, which would kill her. The plant is highly poisonous and will induce profuse bleeding within hours. Very frequently the women haemorrhage. During the fieldwork for this research, a number of women who had used babati te ran to the community clinic late at night for an oxytocin injection which would stop the bleeding and save their lives. However, participants explained that before the establishment of the clinic many women died from attempting an unsafe abortion. Abortion is against local customary laws and many local women bled to death because they had to maintain secrecy about the abortion attempt and had no access to medical assistance.

Social Issues at the Root of Ill-Health

The importance of analysis of social factors relating to problems defined as 'health' issues is made clear by Avotri & Walters (2001) study of the health of Ghanaian women, which was also undertaken in the Volta Region. According to the article, the women understood health in social terms. In particular, the women were concerned about the way in which their health was shaped by gender and their relationships with men (Avotri & Walters 2001, p.199). The women in the study describe their ill-health as being caused by insecurity and a lack of control over their lives. Similarly, the Tongu-Ewe women described women's health problems as 'abdominal pain', 'bleeding' or 'problems with relationships with men'. The perception of women's health problems was clearly linked with patterns of social relations. This leads me to question the appropriateness of simply providing oxytocin injections or medical and technical solutions for women, without addressing the social issues which create the

need for those injections in the first instance. To continue to do so is to medicalise a social problem.

The number of women presenting gynaecological problems at the clinic was extensive. However the case of Lucia is demonstrative of the issue of medicalisation in the Tongu-Ewe community. Lucia came to the clinic for constant bleeding since performing a self-induced abortion one year ago. Every month she bleeds until she goes to the clinic for an injection of oxytocin. Recently she went to a hospital in Accra and the doctor told her she had a fibroid, then gave her an injection of oxytocin and sent her home with no further treatment or advice. Lucia is just 21 years old. She has been married for a little under two years. She had explained how she was unable to refuse her husband's sexual demands and had experienced sexual intercourse by force numerous times. Her husband did not permit her to use contraception so she had performed self-induced abortions with the babati te plant three times because of these life circumstances. She was 'saving up' for contraceptive implants because these could be 'kept a secret' but she became pregnant before she could afford them.

Medicalisation

The fact that Lucia had been to the hospital and was diagnosed with a fibroid but had not been given any real treatment or advice is concerning to say the least. Scheper-Hughes (1992) describes the way in which a social problem is 'appropriated and transformed into something else: a biomedical disease that conceals the social relations of sickness' (p.169). Currently, the social sexual inequalities experienced by many village women are being appropriated and transformed into purely personal 'medical problems' to be mitigated by bio-medical treatment regimes. Medical anthropologists argue that sickness can be a passive resistance to the social and moral order of the community and as such, sickness becomes a way of expressing the real state of things which cannot be spoken. I do not believe that it is coincidental that in a community where women experience frequent sexual coercion or violence, the health issues cited as most problematic and common are all gynaecological. Of course, even from a conservative perspective, it is difficult to deny that repeated internal use of toxic plant substances is a possible cause of the gynaecological problems which are so common among these women. In these circumstances, the notion of 'bad faith' can be applied to state health services who merely offer injections and a variety of family planning methods and, worse still, scold women for a lack of bio-medical compliance or label them ignorant. Scheper-Hughes (1992) argues that 'the opportunity for transformation may be lost' if social actors do not recognise the medicalisation of their needs. However, these women do recognise that their health problems are at least as much social as biological in origin.

Conclusion

In accordance with the global political climate and subsequent policy output, political discourses and programmes of action which focus on family planning and health are promoted in Ghana at the expense of addressing a more effective discourse on gender relations which would encompass the social origins of Ghana's

persistently high levels of unsafe abortion. The predominance of technical and medical perspectives towards unsafe abortion in rural Ghana simply medicalises social sexual inequalities and is unlikely to achieve significant change.

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