An analysis of the Religio-Cultural Perception of Abortion of Marange People of Zimbabwe using a Feminist engagement.

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DECLARATION

I, Rubbie Rubete, hereby declare that this thesis is my original work, unless specified. I further declare that I have not submitted this thesis for any other purpose at any institution.

Signature Date 17/11/2024

Signature… ……………………………….. Date …21/11/2024.

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DEDICATION

This thesis is dedicated to my family, husband Godfrey, daughters Blessmore Anenyasha, Blessing Asaivaishe, and son Blessed Anotidaishe who remained patient and calm whenever I deprived them of their family time during this research writing.

ABSTRACT

This study uses a feminist approach to analyse Marange people's religio-cultural perceptions of abortion in Marange district of Manicaland province in Zimbabwe. The study was motivated by an increase in maternal mortality observed in Marange rural district. The study seeks to answer the key research question, which is: How can a feminist critical engagement with Marange people's perceptions of abortion contribute to life-affirmation of young women in Marange? Young and old women in Marange district expressed their views, attitudes and perceptions of abortion as one of women's sexual reproductive rights. This study excludes males and minors' participation. The theoretical frameworks used in this study are Feminist Cultural Hermeneutics and Reproductive Justice. Feminist Cultural Hermeneutics looks at how women's understanding of certain concepts is influenced by a given culture at a given time. Reproductive Justice advocates for freedom of choice by women in any given society. These clearly show that the social needs and individual bodily aspects of pregnant women cannot be separated. According to the interviewed Marange women, unwanted pregnancies are the major cause of backyard abortions, which are rampant in Marange. The study found that Marange women use a variety of abortifacients to terminate unwanted pregnancies. It is surprising to note that despite the designed strict abortion policies, men at times support, initiate and fund clandestine abortion acts, when they intend to cover up the shame and decline the responsibility begotten from unwanted pregnancies that occur outside of marriage

ABBREVIATIONS

ACHPR------- African Charter on Human and People’s Rights

AIDS---------- Acquired Immune Deficiency Syndrome

CEDAW—— Convention on the Elimination of All Forms of Discrimination Against Women

CDC----------- Centers for Disease Control and prevention

CTOP --------- Choice on Termination of Pregnancy Act

CRR----------- Centre for Reproductive Rights

FHRF --------- Fundamental Human Rights and Freedoms

GBV ---------- Gender Based Violence

GoZ ----------- Government of Zimbabwe

HIV ----------- Human Immuno-Deficiency Virus

HPA----------- Heartbeat Protection Act

ICDS ---------- Inter-censal Demographic Survey

JMC ----------- Johanne Marange Church

MDG---------- Millennium Development Goals

MoHCC ------ Ministry of Health and Child Care

NGO ---------- Non-Governmental Organization

RAHI --------- Research and Advocacy Health in India

SADC--------- Southern African Development Community

SRH ----------- Sexual and Reproductive Health

TOP ----------- Termination of Pregnancy Act

UNICEF------ United Nations International Children’s Emergency Fund

UNFPA------- United Nations Family Planning Agency

UNHCHR ---- United Nations High Commission on Human Rights

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CHAPTER ONE

General Introduction to the Study

1.1 Introduction

This research uses a feminist approach to analyze and explore Marange women's perspectives, views and attitudes on abortion, to see whether these are life-denying or life- giving. This chapter presents the background of the study, the statement of the problem, the research objectives, and the research questions. Key terms are defined, and a clear outline of the thesis is provided.

1.2 Background of the study

The issue of abortion is continuously debated globally. The World Health Organization (2008) sees abortion as the termination of pregnancy by removal or expulsion of an embryo or fetus. An abortion that occurs without intervention is known as a miscarriage or spontaneous abortion. Intentional termination of pregnancy followed by the death of the embryo or fetus is termed an induced abortion. Medical and surgical abortion services are considered safe when they are used within the health systems where follow-up on patients is guaranteed. The provision of post-abortion services is applauded, as long as they are a clear indication of women's life-affirming acts. Abortion is an ancient practice. As Klaaseen (2019) comments, until the late nineteenth century, Africans used a vast array of abortifacients to induce abortion, and eventually, settler women in Africa also used them to end pregnancies. This is a clear indication that the practice of abortion is as old as humanity.

The Guttmacher Institute's (2020) updated, and more recent quantitative study shows regional statistics on abortion from 2000–2019. The statistics reveal that sub-Saharan Africa is undergoing broad societal changes with improvements in standards of living, educational attainments and health as well. The Guttmacher Institute (2020) cites four African states with relatively liberal abortion laws namely, Zambia, South Africa, Cape Verde and Tunisia. Abortion is acceptable in some of these states for health and socioeconomic reasons but of course with gestational limits. As of now, safe abortion services can be provided using either medical or surgical means. Varying methods, from the use of herbs to antiseptic techniques and surgical abortion, are becoming common in some African countries. Despite these improvements, some states still criminalize abortion and have not granted this right to women as their sexual and reproductive health right. Williams (2020) concluded that countries with

restrictive abortion laws face high occurrences of unsafe abortions. This is very true of Zimbabwe, where induced abortion is legal when meant to save to women who have experienced sexual violence, as well as when the pregnancy poses health risks to the mother or the fetus, (according to the Termination of Pregnancy (TOP) Act of 1977, chapter 15: 10). Jewkes et al. (2005) agree that safe and legal abortion services reduce maternal mortality and morbidity. Despite all these positive insights, maternal mortality has been of great concern in the Marange district after a series of reported deaths due to pregnancy-related complications and childbirth (Girls not brides, 2021)

In a conservative culture of Marange, which cannot accept women who fall pregnant outside wedlock, single women and adolescent girls may find ways to protect their reputation and try all means and ways to avoid being exposed to shame and stigma from the society. The society labels such adolescents and single women as weak and loose. From both cultural and religious lenses, they can even be labelled as prostitutes who fail to have self-control over their sexual desires. As a quick relief, they secretly plan for the termination of such pregnancies before they can be revealed for public consumption. Nyagumbo (2023) laments women's risky sexual dilemma in Marange, considering the high rise of teenage pregnancies in Zimbabwean rural places. Kim et al. (2001) advise that socially constructed gender roles and norms socialize women into submissive roles.

Marange women try to free themselves from the pressures of unwanted pregnancies through unsafe abortions. Chikowore et al. (2004) observe that abortion acts are conducted secretly and in silence. Ongoing trends of traditional practices like child marriages, wife pledging and others that come with unequal power relations ignite unwanted pregnancies that send women to intentionally seek clandestine abortions to terminate pregnancies. This research uses feminist engagement with women of Marange, examining their religio-cultural perceptions on abortion to see if it is life-denying or life-affirming.

Adoption of abortion laws differ from country to and Zimbabwe has not liberalized these, according to the Zimbabwean TOP Act. Restrictive regulations, prevailing laws and the long procedure in attaining free safe abortion services seem to inconvenience women and instill fear of criminal punishments and overall stigmatization.

All this has resulted in women resorting to unsafe backyard abortions. These existing barriers send Marange women into attempting clandestine unsafe abortions despite the detrimental effects. Marc et al. (2012) concurs that abortion, when performed by persons with the necessary skills in a hygienic environment, can be very safe. Due to the geographical remoteness of their location, religious and cultural beliefs, Marange women adopt unsafe and unhygienic abortion acts since they cannot access

recommended health procedures. As a woman born and bred in Marange, I have heard a great deal about unwanted pregnancies, a major cause of abortion. Stories of clandestine abortions have been whispered into my ears, especially during my adolescence and at high school. The cultural frameworks, religious precepts and national policy are in parallel to the women's lived reality as far as abortion is concerned. What they have in common is that they do not accept abortion acts for socioeconomic reasons, they are all Pro-life centered. As a researcher, I am much concerned about women's sexual and reproductive rights and therefore I am using feminist critical engagement with Marange women on their perceptions of abortion. Examining Marange women's general perception on abortion is one of my objectives.

The Guttmacher Institute (2020) reported that sub-Saharan Africa has for many years faced the challenge of high levels of unsafe abortions. As a result, the prevalence of unsafe abortions has raised concerns around public health and women's sexual and reproductive health rights (Williams, 2020). In light of this background, this study therefore seeks to explore and understand women's sexual and reproductive health, particularly the trend of unsafe abortions in Marange, to see if it is life-denying or life-affirming. Henshaw (1995- 2015) revealed annual statistics showing that approximately 15 percent of pregnancies in Southern Africa end in unsafe abortions. According to Ganatra (2014), a reason for the rise of induced abortions is the growing unmet needs for contraception.

Zimbabwe has been singled out in sub-Saharan Africa, as 20 000 women die annually due to unsafe abortion complications (UNFPA, 2021). Moyo (2021) acknowledges that poverty, harsh abortion laws and religious and cultural perceptions compel many women in Zimbabwe to seek illegal means to terminate unwanted pregnancies. This is true with the Manyika women, who live under economic hardships and strict hegemonic precepts. Elderly girls in child-headed families become involved in intergenerational relationships with old men to make ends meet and reduce poverty, engaging in sexual activities with old rich men in exchange for resources to fend for their siblings. In attempting to fulfill their sexual desires, single women also find themselves with unwanted pregnancies. Married women may feel they are not ready to carry pregnancies if they are feeling unfit, are committed to education or a career, or when they are still breastfeeding. With the restrictive Zimbabwean TOP Act, women secretly plan for clandestine abortions.

The 2020 Voice and Choice, SADC, Gender and Protocol Barometer note that unsafe abortions mostly affect those who are poorer, unmarried women and adolescents. Chaminuka (2021) notes that these above-mentioned groups contribute to high mortality of the region and this makes it difficult to reach the goal of eliminating maternal mortality without addressing the need for safe abortions. Zimbabwe's Termination of Pregnancy Act of 1977 allows abortion only if the life of a woman is at risk or the pregnancy poses a serious threat of

permanent impairment to the woman's physical health, and in cases where the fetus had been conceived because of unlawful intercourse, including rape, incest or intercourse with a mentally handicapped woman. Zimbabwean constitution adopted in 2013 section 76 (1) emphasizes on human rights and right to life but mentions nothing about abortion.

In light of this background, this study seeks to explore and understand the perception of abortion among the Manyika people in Marange, towards women's sexual reproductive and health rights, particularly abortion.

1.3 Research problem

As girls grow into adulthood, great deal of changes take place in their bodies due to their biological make-up. Women's embodiment encompasses their right to express themselves, make choices and assert their identity. Women's sexual and reproductive health rights, including abortion, are essential for women's well-being. Women need empowerment and a great deal of support to sustain their sexual and reproductive health.

The support will instill in them confidence and higher self-esteem, such that they are able to make informed choices that will not hinder their lifestyle, career and education. Women engage in abortion practices that have detrimental effects. Mabanda (2024) declares that despite the fact that abortion is illegal in Zimbabwe, it is an open secret that a wide array of services is available, many offered by non-medical practitioners. Abortion policy is restrictive in Zimbabwe. There are national, cultural and religious policies that go against the practice of abortion but nevertheless it is still an ongoing practice. Zimbabwe's abortion policy is so restrictive that many women are resorting to backyard abortions from unprofessional practitioners. Such clandestine abortion acts are unsafe and unhygienic and, in most cases, pose harm to the pregnant women who seek such assistance. Despite the dangers surrounding clandestine abortions, Marange women are continually resorting to them, as evidenced by demonstrated side effects like heavy bleeding and even death. Abortion issues seem not to have prompted much academic interest among local scholars. Some scholars like Chiweshe (2022), Macleod (2006), Hwenjere (2016) and Chikovore (2004) have done justice in establishing some scholarship on different people's views and attitudes of abortion in Zimbabwe, but there is still limited literature on the subject. Due to stigmatization around this topic from religious and cultural circles, women have never been free to express themselves fully on abortion issues. Despite all the above-mentioned constraints, this study examines Marange women's views, attitudes and perceptions on abortion in Marange district,

Manicaland in Zimbabwe through feminist engagement with Manyika women's religio-cultural perceptions.

1.4 Research objectives

i. To examine Marange people's general perceptions on abortion.
ii. To scrutinize the religio-cultural factors that inform Marange women's current attitudes toward abortion.
iii. To evaluate how an African feminist theological examination of abortion in the Manyika context offers a life-affirming reality for women in Zimbabwe.

1.5 Key research question

How can a feminist critical engagement with Marange people's perception of abortion contribute to life affirmation of young women in Marange?

1.5.1 Research questions

i. What is the general perception of Marange people on abortion?
ii. What are the religious and cultural factors that inform Marange women towards abortion?
iii. What ways might an African feminist theological examination of abortion in the Marange context offer a life-affirming reality for women in Zimbabwe?

1.6 Significance of the study

As a psychosocial teacher in an elementary school, I, as the researcher, perceived the plight of young women in areas concerning their sexual and reproductive health rights (SRHR). I have seen young girls dropping out of school, committing suicide, becoming hospitalized and dying of failure to bear the burden of unwanted and unsupportable pregnancies. Some of these unwanted and unsupportable pregnancies are at times exacerbated by some of the religio-cultural practice, in particular sexual dalliance and child marriages. Most parents wishing to see their girls back in school would find means to end these pregnancies and this would be done through unsafe abortion acts. Indisputable evidence of this is found in reported cases of baby-dumping, heavy bleeding or damaged pelvis. Sexual experience and affection can be fulfilled, as well as conjugal rights, if exercised in mutual relationships with consent from both sides, and this may help to harmonize societies. In Marange, women's freedom and consent is a matter of concern due to the traditional and religious precepts that uphold men's perspectives

and desires while being inconsiderate of those of women.

Unsafe abortion-related injuries like heavy bleeding, vaginal infections and bladder injuries are spoken of about many young women in the area, who then hesitate to seek medical attention for fear of being questioned and reported. The rate of clandestine backyard abortions seems to be increasing amongst young women as traditionally parents do not accept pregnant girls into their homes. This becomes one of the reasons why teenage girls resort to unsafe, unhygienic means to terminate their pregnancies. Mandizha (2022) reported on infanticide cases hitting Mutare city, the capital of Manicaland in the local H. Metro Newspaper. She cited the outcry by Manicaland Provincial Police spokesperson Muzondo (2022) on the increasing rate of crimes of infanticide, baby-dumping and abortion.

The hegemony of patriarchal designs across the globe have created a war zone in individual women's lives especially where women's voices are inaudible. Patriarchy controls everything around the feminine, and in most cases, sexuality. Sherwin (1991: 345) laments the burdens of a pregnant woman who can no longer oversee her body, pursue her studies, continue with her career and make other personal choices. She argues that pregnancy may lead to serious health issues and can make women sick, such that they cannot continue with their everyday schooling or jobs.

Abortion has become an ongoing debate globally with various views emanating from different people. A feminist group, the pro-choice movements, asserts that a woman must be given a right to abortion and oversee her own sexuality and reputation. On the other side, the pro-life movement dismisses abortion and sees it as equally bad as infanticide.

There are common religious and cultural practices that coerce Manyika women into sexual indulgence. Pregnancies may come through such practices or acts like child marriages, rape, incest, wife-pledging and sexual dalliance. Such practices are rampant in Marange and they affect the health and welfare of women who must then automatically resort to unsafe abortion whenever unwanted or unsupportable pregnancies occur.

1.7 Theoretical framework

This research uses two frameworks. The reproductive justice framework and feminist cultural hermeneutics are the main pillars of this research study. These theories are both significant and play a pivotal role in centering this research on finding out the views and attitudes of Marange women on abortion. Feminist cultural hermeneutics looks closely at how some cultures

condition women's understanding of reality in any context at any given time. People's understanding of different aspects of life are at times conditioned by their own culture in certain eras of life. The reproductive justice framework upholds women's value and their right to sexual reproductive health including abortion. The right to have children or not. The right to carry pregnancy to full term and the right to parent those children. Women must be able to freely exercise these rights without coercion. The Reproductive justice framework and the Feminist cultural hermeneutics center my study and go well with issues of sexuality and reproduction. They pay adequate attention to the physical, social, economic, and emotional realities of vulnerable women. The researcher noticed in them common core features. These include having a social justice orientation, social analysis and centering marginalized groups.
Morrison (2018), Herbert (2018) and Bailey (2011) concur that the Reproductive justice framework critiques gender inequalities rooted in social positioning, which is relevant for this study that analyses gendered power relations and reproductive issues among the Marange people. Reproductive justice allows for an analysis that goes beyond legal access (the concept of rights) and enables a focus on the context of social, economic, gender, and colonial inequalities (Ross, 2006; Roth, 2012). This research explores how women in Marange view abortion and their decision-making process, in ways which may be either life-giving or life-denying.

This research mainly focuses on Marange women's sexual and reproductive health rights, particularly abortion. Women are burdened with (un)supportable or unwanted pregnancies due to personal, structural, socio-political and economic conditions of their lives as well as the gendered power relations that shape them (Macleod, 2015). Thus, in line with this point, Marange women are under patriarchal religio-cultural practices that make them vulnerable to unwanted pregnancies.

1.7.1 Pregnancies

According to Sister Song, Loretta and Ross (2006), reproductive justice addresses reproductive oppression by simultaneously applying three main frameworks at local, state, national and international levels.

These frameworks include reproductive health (service delivery), reproductive rights (legal issues) and reproductive justice (social justice). The reproductive justice framework fits well in the research because of its inclusive approach to systems as it moves the debate away from individual woman's sexual reproductive health rights to an inclusive vision of better lives for

women. Women differ in class, age and economic status and so do their needs. I value its inclusivity as it allows me, as the researcher, to investigate issues of Marange women's sexual reproductive issues from a pro-choice feminist angle. As a woman, it is of paramount importance to know how much attention is given to women's sexuality in terms of contraceptives, prenatal and postnatal care. This is an important aspect of every woman's life as it influences the issues of unwanted pregnancies that automatically send most women to seek unsafe abortion services in Marange. Women of Color Activists of the The Asian community for Reproductive Justice (2010) has defined reproductive justice as: The complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about their bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives. This movement, created and led by women, has emerged to broaden the scope of reproductive rights. This coalition of women activists and their allies are using a human and women's rights and social justice framework to redefine choice. The above calls for justice, welfare reform, housing, prisoners' rights, environmental justice, immigration policy, drug policies, and women's sexual and reproductive health and well-being, including abortion.

1.8 Definition of key terms

1.9 Abortion

The Centers for Disease Control and Prevention (CDC), and the World Health Organization (2020) define abortion as the termination of pregnancy by removal or expulsion of an embryo or fetus prior to 20 weeks of gestation. An abortion that occurs without intervention is known as miscarriage or spontaneous abortion. Intentional termination of pregnancy followed by the death of the embryo or fetus is termed as abortion, according to the Oxford English Dictionary (2010).

Abortifacient

These are substances that induce abortion. These may range from herbs to prescribed medication (Oxford English Dictionary, 2010).

Unsafe abortion

Unsafe abortion is defined by the World Health Organization (2008) as a procedure for terminating an unintended pregnancy, carried out by persons without the necessary skills or in

an unsafe environment not conforming to medical standards. This is usually performed secretly, and it is often called backyard clandestine abortion.

Pro-choice

People who advocate for abortion rights identify themselves as pro-choice. The movement believes that women have the basic right to access abortion legally when needed, and whether to have children.

Pro-choice advocates affirm abortion as an important option for all women. They believe women must have control over their reproductive lives and have the right to choose to terminate pregnancy as an option for an unintended pregnancy (Gale Encyclopedia of Medicine 2014).

Pro-life

This is an anti-abortion movement which believes that the unborn are the weakest of the weak, and the right to life is the most fundamental of human rights, so it is appropriate and necessary in a democracy to have legal protection for the right to life of the unborn (McCarroll, 1997: 6).

Reparation

This is social repair and transformation as a response to unequal social conditions. Hegemonic patriarchy suppresses women's decision making. Loretta Ross (2017) observes and laments about the hell-like lives of women whose sexual health rights are violated, for they cannot choose whether to have a child or not. Social reparation and transformation therefore address various physical, mental, social and economic harms that are life-denying to women's sexual reproductive health lives in favour of life-affirming practices, particularly on abortion, as addressed in this research.

1.10 Outline of chapters

1.10.1 Chapter one

This is a general introductory chapter of the study. This chapter describes the motivation and the background to the research problem. Research questions and objectives are identified, key terms in use are defined, and an outline of the whole thesis is provided.

1.10.2 Chapter two

This chapter presents the literature consulted on abortion regionally, nationally and in the

locally targeted area. It highlights current abortion issues and how they link with women's sexual and reproductive health rights.

1.10.3 Chapter three

This chapter provides the theory and method in this section. The reproductive justice framework and feminist cultural hermeneutics form the basis of the theoretical framework. It explains the justice women need in the provision of their sexual and reproductive health rights, and how femininity is viewed by different cultural backgrounds. A step-by-step methodology outline is presented.

1.10.4 Chapter four

This chapter presents and analyses data collected from the field. It discusses the perceptions, experiences, attitudes and knowledge on the phenomenon of safe and unsafe abortions of young women in Marange district, Manicaland in Zimbabwe. The chapter also investigates the challenges and obstacles faced by the researcher in accessing (translating) true information about the actual reality in the Marange context.

1.10.5 Chapter five

This chapter summarizes the entire study. It draws together the arguments made in the thesis, makes recommendations and concludes the whole dissertation.

1.11 Conclusion

The chapter presented the background and significance of the study, the research objectives, question and problem. It defined the key terms and provided an outline of the structure of dissertation. The next chapter explores the history of abortion in Africa. It discusses how abortion is perceived in Africa, south of the Sahara, in Zimbabwe, as well as in Marange, the targeted study area. The influence of the Johanne Marange Church (JMC) (a dominant church in Marange) and its impact on women's sexual health rights is highlighted.

CHAPTER TWO

Responses of Sub-Saharan Countries to Human Rights Instruments that Speak on Abortion

2.1 Introduction

This section presents an overview of scholarly articles. It highlights some human rights instruments and how they link with women's sexual and reproductive health rights, including abortion. It also looks at the response of some of the Sub-Saharan countries that are Zimbabwe's neighbors to abortion issues. It gives an overview of international and regional instruments that support women's access to sexual and reproductive health rights and services in relation to safe abortion. It reviews Zimbabwe's domestic legislation pertaining to abortion. The section also explores the Manyika people's religio-cultural understanding of abortion, which can contribute either negatively or positively to Manyika women's sexual and reproductive well-being.

The section also looks at the sexuality of women in the Johanne Marange Apostolic Church (a church that predominates the district).

2.2 Women's sexual and reproductive health rights including abortion

Laws relating to access to healthcare and contraceptives are of paramount importance to every nation, for the benefit of every woman. Laws regulating women's access to healthcare affect their reproductive health in every society. Women's access to healthcare affects not only herself but also her entire family, her job, her financial situation, population control and the welfare and development of the country in which she lives. Unwanted pregnancies are a major cause of abortion, which affects women's psychological, spiritual, social, economic and physical health status. Katswe Sistahood (2018) emphasized on the importance of finding means and ways of supporting women to prevent unwanted pregnancies. Katswe Sistahood (2018) proposed and gave two ways of ensuring adequate support, which are: covering unmet contraceptive needs; and addressing women's social and economic rights. There are a series of negative repercussions stemming from unmet contraceptive needs. Adde (2021) laments the burdens brought about because of unmet needs for contraceptives, especially among young women. With unintended and unsupportable pregnancies, more than half of these end up as induced abortions that are clandestine and potentially unsafe. Guttmacher (2022) reveals that 92% of women live in countries with highly or moderately restrictive laws, and in these

countries, unsafe abortion incidences increase statistically as policies are tightened.

The Zimbabwean government recognizes sexual and reproductive health rights through its accession to numerous international and regional conventions and statutes such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the African Charter on Human and Peoples Rights (ACHPR) and the Maputo Protocol. The Maputo Protocol is an instrument that was put in place to guide African states in safeguarding women's rights. Article 14 of the Maputo Protocol is specifically on the sexual and reproductive rights of women and is the only instrument that speaks about abortion.

A general comment 2 on article 14 of the Maputo Protocol is focused on a woman's right to control her fertility, contraception, family planning, information and abortion. The Zimbabwean Constitution in section 76 (1) says that the citizens and permanent residents of Zimbabwe have the right to basic healthcare services, including reproductive health services. Despite such advocacy on abortion in these instruments, the government of Zimbabwe remains silent on the subject.

The UN Office of the High Commission on Human Rights (2018), instead of creating new human rights standards, rather draws explicitly and implicitly from existing UN human rights law and authoritative guidance that give precedence to *health, choice, and rights*. International and regional obligations on sexual and reproductive health rights concur in support of this long-standing recognition in international law. They put emphasis on how sexual and reproductive rights are not just an essential part of the overall right to health, they are rather fundamentally connected to the full enjoyment of many other rights such as the right to work, education, equality, life and privacy. These interpretations are what must guide states in providing for the protection of the rights of women. When empowered to make their own decisions on their sexual reproductive health, including abortion, they can enjoy good health in a holistic manner.

A right to reproductive health rights means little, should a woman with an unwanted pregnancy be compelled to either become a mother, or to alternatively seek out an unsafe abortion due to the criminalization of abortion or the inaccessibility of safe abortion services. Legislation and policy within Zimbabwe criminalize abortion and allow it only if pregnancy occurs due to rape or incest or when it threatens the physical health of the mother or the fetus. According to UNFPA statistics (2020), around 80 000 illegal abortions take place in Zimbabwe annually and this automatically presents risks to maternal mortality and morbidity. UNICEF (2020) records 20 000 maternal deaths following unsafe abortions every year, and half of these are adolescents.

UNICEF (2020) reports that further investigations revealed that most female adolescents demonstrated poor attitudes toward sexual and reproductive health services especially the use of contraceptives. Approximately 77% of female adolescents agreed that they face criticism around contraceptives use.

Tamale (2008) laments how taboos around women's sexuality, in most African cultures, mostly affect single parents like widows and divorcees, as well as adolescents in many African cultures. Many women and girls in rural parts of Zimbabwe, particularly Marange, fall pregnant due to poor sex education, taboos surrounding sex and limited access to contraceptives. UNFPA (2015) reports that female adolescents who use contraceptives face the risk of being labelled as promiscuous. The Zimbabwean government, to an extent, restricts and treats sex education with suspicion. In Marange rural community, this has an influence on attitudes, with the result that many young women fall pregnant with unwanted and unsupported pregnancies. Backyard abortions then become rampant, resulting in untold detrimental consequences.

World Vision (2020) reports that more illegal abortions are performed in rural areas than urban areas and Marange rural district is no exception. Pregnant women and girls in Marange seek abortions from untrained female practitioners whom they nickname *Vanambuya Godobori. Godobori* in Shona literally describes experts in the use of traditional medicine. These perform unsafe abortions in unhygienic surroundings using desperate methods. Some women are said to perform self-induction by drinking bleach, or inserting glass, plant stalks or bicycle spokes into the vagina to get rid of the embryo. The poor illiterate rural women of Marange are afflicted with the complications of unsafe terminations of pregnancy, such as heavy bleeding, cervix cancer, damage to the uterus, and death.

As much as women resort to homemade mixtures to induce an abortion, there are other methods some choose to employ to get rid of an unwanted baby. The issue of baby dumping is also prevalent within Marange as there are often reports of newborn babies dumped alive or dead in pit latrines, shallow graves, by the roadside or in forests. The local newspaper, the Sunday Mail (2021) commented on the high and rising cases of baby-dumping. The Police Commissioner of Zimbabwe confirms many reported cases of baby-dumping and others that go unreported.

The Ministry of Public Service, Labour and Social Welfare (2022) cites depression, psychosis, poverty, incest and rejection as major causes of baby dumping. Resorting to baby dumping is often a woman's response to continued strains placed on her due to deprivations,

vulnerabilities, and often a desire for differing forms of survival. Restrictive abortions laws in Zimbabwe do not stop women from accessing them; instead, the rate of unsafe abortion acts impacts negatively on women's health and proves costly to the nation. The Ministry of Health and Child Welfare reports that in the year 2018, over 2000 young women aged 17 to 25 sought post-abortion care at Harare hospital. Musinguzi (2021) laments the pressure that unsafe abortions put on already fragile health services and systems.

Mavodza et al. (2022) noted that the sudden disruption of health systems due to the national lockdown during the Covid-19 pandemic also impeded youth's access to SRH services. This impacted on women's health since they would not easily reach their local health facilities in Zimbabwe, risking their health due to their bodily life cycle. Mavodza (2022) encouraged African members of Parliament to push for legal reforms on sexual and reproductive issues in the region, including the ratification of international and regional human rights instruments. On the same matter, Singh (2021) encouraged the sub-Saharan Africa states to expand access to modern contraception since this might help prevent unwanted and unintended pregnancies associated with unsafe abortions.

2.3 Abortion in Africa, south of the Sahara

African countries have adopted different abortion laws. In Africa, only four countries have liberal abortion laws (Guttmacher Institute, 2018). In sub-Saharan Africa, these include South Africa and the Seychelles. The Choice of Termination of Pregnancy Act no 92 of 1996 of South Africa is the most liberal piece of abortion legislation in sub-Saharan Africa. The act legalizes abortion on request until 13 weeks of gestation and thereafter under specified conditions like when life is at risk or there is risk to physical health of the mother or the fetus. As of 2019, 92% of women of reproductive age live in countries with highly or moderately restrictive laws.

These laws either prohibit abortion altogether or restrict it to cases where a woman's life or health are threatened. Most sub-Saharan African countries have restrictive policies on abortion. For the past decade, the occurrences of unsafe abortions in sub-Saharan Africa have raised alarm and concern around public health, human and women's rights. The Guttmacher Institute (2020) reports that, as of December 2019, sub-Saharan Africa has the highest abortion case-fatality rate of any world region, at roughly 185 deaths per 100 000 abortions. Ongoing efforts to both improve the safety of abortion and expand access to quality post- abortion care have likely contributed to a two-fifths decline in this rate since 2000, when an estimated 315 women died per every 100 000 abortions. Many countries in this region are reported to have broadened

the legal grounds for abortion, improved the safety of abortions and increased the quality and reach of post-abortion care. Sub-Saharan Africa bears the highest burden of global reproductive ill-health, with unsafe abortion being one of the most neglected aspects. In this regard, there is still much progress to be made pertaining to the avoidance of women's unintended pregnancies and unsafe abortions. Adde (2021) acknowledges that unintended pregnancies occur mostly because of unmet needs for sexual health services like contraceptives, sex education, as well as the provision of safe abortion. Dickson (2021) argues that most maternal deaths in this region are attributed to unsafe abortions.

Singh (2021) highlighted the reduced costs and increased benefits of fully investing in sexual and reproductive health services. Musinguzi (2021) advised policymakers to address the issue of women's sexual reproductive health including abortion seriously. Weighing up the consequences of unsafe abortions, Musinguzi (2021) emphasizes the pressure that unsafe abortions put on already fragile health services in the sub-Saharan Africa region. Guttmacher (2020) sees the legality of abortion in sub-Saharan Africa as falling along a continuum, from prohibited to allowed with restrictions. Musinguzi (2021) encourages African Members of Parliament to push for legal reforms on sexual and reproductive health issues in the region, including the ratification of international and regional human rights instruments that support women's sexual and reproductive health rights. Below are international and regional instruments that speak to human and women's sexual and reproductive health rights in sub-Saharan Africa.

2.3.1 African Charter on Human and the Rights of Women in Africa (Maputo Protocol, 2003)

The Maputo Protocol obliges state parties to authorize medical abortion in protecting the reproductive rights of women, based on several grounds and circumstances. The protocol states for instance, that it is allowed in incidents of sexual assault or where the pregnancy endangers the life either of the mother or fetus. The African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol, 2003), Article 26 explicitly connects state obligations to individual rights, and directs state parties to adopt all necessary measures, including all budgetary measures, to fulfill the rights guaranteed by the protocol. Thus, state obligations arising from Article 14(2) require implementation from the state, not just in terms of recognizing the grounds for abortion, but also providing the requisite infrastructure, including health information and health care services for the fulfillment of the

guaranteed abortion rights. Adopted by African states on the 11th of July 2003, it extensively guarantees the reproductive health rights of women in African states. Zimbabwe is bound by this protocol as it also ratified it in 2008. Under Article 14(1), state parties are obliged to respect and promote women's reproductive health rights (Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, 2003).

The protocol further accords women rights over the control of their fertility in Section 14.1(a). The right of women to make their own decisions on whether to have children or not, spacing, as well as the number of children, is also provided for. Zimbabwe's Termination of Pregnancy Act adopts Article 14(2) of the protocol which recognizes a right to abortion in cases where pregnancy poses a risk to the life of the fetus or where pregnancy results from rape or incest (Sully et al., 2018).

Castuera (2017) recalls an earlier period when the American Medical Association advocated for the criminalization of abortion at any point during pregnancy, and the Catholic Church spoke out and became radically anti-abortion. As a Christian nation, Zimbabwe has failed to accept and utilise the instrument that speaks of women's sexual health rights as well as abortion. Basing on the Christian Holy Scriptures, one of the biblical verses used to support this view is Exodus 20 verse 13, "You shall not kill". However, this has never stopped the occurrence of abortion, even among church goers. Illegal abortions are performed outside the health sector by unskilled persons under unhygienic conditions. The WHO has reported that 47 000 women globally, with 27 000 of these being from African states in sub-Saharan Africa, account for deaths related from unsafe abortions. Regionally, unsafe abortion estimates associated with death in the period 2008–2012 were 62% (WHO, 2012).

2.3.2 International Covenant on Economic, Social and Cultural Rights (ICESCR)

Although not wholly focusing on reproductive health rights, the ICESCR provides for the right to health. In short, the ICESCR instructs state parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (van Banning et al., 2004). This instrument considers the state of being healthy through a holistic lens. It focuses not only on the physical but is also concerned about the state of the mind. This is one of the main concerns of this research, to examine if women are carrying pregnancies to full term with or without coercion. As long as there is no free-will, then the state of the mind is stuck, risking mental instability. However, in realizing women's right to health, issues of women's right to safe abortion also come into account. In light of this, the ICESCR is normally referred to when

referring to reproductive health rights (Ngwena, 2014). The Committee on Economic, Social and Cultural Rights (ICESCR) general comments have continuously linked high maternal mortality with illegal unsafe abortions (Zampas and Gher, 2008). It is important to note that the review of global and regional human rights instruments includes the extent to which the sub-Saharan countries respond to them.

In addition, the Act also puts in place several burdensome certification procedures (Chipato et al., 2018) which compel the woman to be certified as eligible for safe legal abortion by three medical personnel. Further, the woman seeking abortion should also apply to the magistrate in seeking a certificate to abort (see Termination of Pregnancy Act, 1977). It is argued that such restrictive legislation violates the rights of Zimbabwean women to exercise their reproductive health choices and freedoms in terminating pregnancy (Phiri, 2018). Having said the above, the section that follows explores how reproductive health rights are guaranteed under the Zimbabwean Constitution. Instruments on reproductive health rights are not exhaustive. The sub-Saharan countries signed these important international and regional instruments and others not included here, like the SADC Declaration on Gender and Development, the Millennium Development Goals, the African Charter and CEDAW, which speak on human and women's rights that they are nonetheless not fully implementing. In contrast, women in Africa are continually being socialized into subservience and passivity in sexual decision-making, and made vulnerable in some African societies, like Marange in Zimbabwe.

Acknowledging there are a range of other global human rights instruments that speak to issues of reproductive health rights, this study focuses only on a few, due to their specific applicability to abortion as a woman’s sexual reproductive health right in the Zimbabwean context. The Center for Reproductive Rights (2014) has classified abortion laws, ranging from the liberal, the most restrictive and the least restrictive. There are laws that completely prohibit abortion, and other laws permit abortion to save a woman’s life. Some laws allow abortion without restriction or reason. Despite these insights, Zimbabwe adopted its 1977 Termination of Pregnancy Act with restrictions that clearly show that it is difficult to seek safe legal abortions in Zimbabwe for any women whose situation does not fall within its outlined categories. Human rights scholars have criticized the Act for its restrictions on women who either decide or are compelled by circumstances to terminate pregnancy.

Nearly all sub-Saharan countries link specific legal grounds to gestational limits. For example, one such country in SSA is Mozambique. The Assembleia da Republica de Mozambique, Lei Da Revisao do Codigo PNAL, Lei no (2014) guarantees that in Mozambique, abortions that

are needed to ensure a woman's survival or health are allowed through 12 weeks of pregnancy; the limit then extends to 16 weeks for pregnancies resulting from rape or incest and 24 weeks for severe fetal anomalies.

Like its other counterparts in sub-Saharan Africa in the southern region, Zimbabwe is characterized by restrictive abortion laws and unsafe abortions. The UNFPA (2017) discovered that poorer women and those living in rural areas are more likely to experience complications compared to urban-based, non-poor women. Young age is a determinant of vulnerability to unsafe abortion and the associated access to care. Unsafe abortion mostly occurs amongst women aged 15-24. Sedgh (2018) compared older women to adolescents and concluded that youth generally have less knowledge of health services, and this will affect their healthcare-seeking behavior. In Marange, young girls who are still in school, who feel they are not yet prepared to have a child, and fear parents' reaction, resort to unsafe clandestine abortions.

2.4 Abortion law in Zimbabwe

African countries adopted the above instruments differently. Some laws are liberal; they allow abortion within a specified gestation time. Zimbabwe's abortion law is restrictive. Abortion is permissible only under certain circumstances as laid out in the Zimbabwean Termination of Pregnancy Act (1977). Zimbabwean policy only legally permits abortion in the country under limited circumstances, including if the pregnant woman's life is in danger or in cases where the pregnancy results from rape or incest, or when there is fetal impairment.

2.4.1 Zimbabwe's Termination of Pregnancy Act of 1977

According to the TOP act of Zimbabwe, safe abortion services are offered when: (i) continuation of the pregnancy endangers or poses a serious threat of physical health to the pregnant woman; (ii) when the fetus is impaired in any way that threatens his/her life permanently, or; (iii) when the pregnancy results from unlawful intercourse like rape or incest (Termination of Pregnancy Act of 1977, chapter 15:10). The Act clearly lays out several conditions or procedures to be followed before women may attain safe abortion services. The process itself is immensely dehumanizing and embarrassing as it invites so many people to become involved in the matter. In his comprehensive study on reproductive health rights and abortion law reforms in Africa, Ngwena (2014) observes that it is difficult to carry out safe legal abortion in Zimbabwe; one has to prove beyond any reasonable doubt that there is a serious risk that the child to be carried to full term will have mental or physical defects. In

addition, the Act also puts in place numerous burdensome certification procedures, according to Ngwena (2014), which compel the woman to be certified as eligible for safe legal abortion by three medical personnel. If its rape or incest, there is the need for a police report, and the magistrate also needs to give authentic permission through a signature (see Termination of Pregnancy Act 1977). With such delays, time ticks on before the final decision is made and this often makes the women feel more and more distressed. On the other, side the fetus is growing to a level where abortion will not be acceptable due to gestational limit.

Such restrictive procedures are tiresome and strenuous to such an extent that women turn to illegal abortion as an immediate relief. It is argued that such restrictive legislation violates the rights of Zimbabwean women to exercise their reproductive health choices, freedoms and right to privacy in terminating pregnancy (Chin'ombe, 2014:23; Ngwena, 2010, 2014). Chin'ombe (2014) argues that such restrictions violate Zimbabwean women's sexual and reproductive health rights. After such a tiresome procedure, women are left without confidence, privacy, choice or freedom at all. There are so many frustrations women may meet in the process of obtaining the service, even for those who qualify. As Hwenjere (2016) discovered, it is difficult to obtain abortion services in Zimbabwe; many health providers are reluctant to perform abortion services even when a woman meets the legal requirements.

The new Zimbabwean constitution adopted in 2013 guarantees the right to life under Fundamental Human Rights and Freedoms Section 48(3) (Constitution of Zimbabwe, 2013). As argued by Chin'ombe (2014), this clause places a legal duty on the state to protect and guarantee the right to life to the unborn child (fetus), against termination. Section 48(3) guarantees protection of the right to life of the unborn child. Pregnancy may be terminated only in accordance with that law (Constitution of Zimbabwe, 2013).

The above shows that although the Zimbabwean supreme law regulates termination of pregnancy, the Constitution does not make a clear legal position on the right to abortion in Zimbabwe. As seen from the discussion above, the supreme law leaves this right open to wide interpretation subject to an Act of Parliament. However, this brings contradictions in terms of the expression and exercise of the right to abortion, as Ngwena (2010) argues, between respecting fetal rights (right to life of the fetus) whilst at the same time considering a mother's right to abort creates a maternal and fetal conflict. This seems to be the case as we can see from the Zimbabwean Constitution. It is submitted therefore that although the law recognizes the legal rights of a fetus, this should not be grounds for infringing upon the rights attached to the pregnant woman (Chin'ombe, 2014: 24). Another point to note is that although the Zimbabwean

constitution does not explicitly guarantee the right to abortion, it provides for the right to health, which in any case broadly guarantees sexual and reproductive health rights under Section 76. The supreme law states that: Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services including reproductive health-care services (Constitution of Zimbabwe, 2013).

The right to abortion is again restricted under the Criminal Law (Codification and Reform) Act [chapter 9:23] in section 60 that regulates Unlawful Termination of Pregnancy. Under this specific section, it is stated that, any person who intentionally terminates a pregnancy; or terminates a pregnancy by conduct which he or she realizes involves a real risk or possibility of terminating the pregnancy; shall be guilty of unlawful termination of pregnancy and liable to a fine or imprisonment for a period not exceeding five years or both (Criminal Law Codification and Reform Act, chapter 9:23).

It is extremely difficult to obtain a legal abortion. Katswe Sistahood (2018) clearly expresses that the Act criminalizes abortion except in cases where it has been proven beyond doubt that the pregnancy will endanger a woman's life; as a result, most abortions are clandestine and potentially unsafe. UNFPA (2018) reported that Zimbabwe is a country experiencing an increase in its maternal mortality, with unsafe abortions being one of the contributing causes (Magwali, 2007).

Benson, et al. (2006) have expressed concern over the deadly effects of unsafe abortion, like cervical infections, permanent damage, and death. Africa News (2018) decries Zimbabwe's controversial abortion issues.

2.5 Religio-cultural understanding of abortion

Different religions have different views and attitudes regarding abortion. There are legal and recognized ethical debates which are interlinked. In the ethical debate, the focus is largely turned into a discussion on the question of when the fetus is considered a living human being with rights, specifically the right of life as any other recognized human beings. Many Christian denominations see and condemn abortion as morally wrong. The Catholic Church is the most ardent supporter of anti-abortion states. Roman Catholic leader Pope John Paul II (1995) expressed deep feelings of the alienable right to life of the fetus as he condemned abortion and saw it as the direct killing of an innocent human being, and as such, immoral. The Manyika people affiliate to both Christianity and traditional beliefs. Patriarchal designs play a major and

pivotal role in forming societal values. Machingura (2012) comments on the dominant male orders and hegemonic religious practices therein. To fulfil the Great Commission, some Apostolic sects in Marange base one of their doctrines on Genesis 1, verse 28, which says "be fruitful and multiply". They indulge in polygyny, early child marriage and wife pledging, which burden many women and girls with unwanted and unsupportable pregnancies.

Chiwara (2015: 17) documented the above-mentioned practices where daughters are sold out to men without their consent. This is a clear indicator of the violation of women's rights in Marange, and has been going on for ages. Machingura (2011: 197) despises another prevalent trend where young women are married off to older men within this dominant church. Makombe (2015: 193) bemoans the Shona norms and values that see Marange women's prospect of negotiating sex becoming difficult; they endure silently with their voices shut down and give no input on it rather than being subordinates. This means that sex is something that men can do to women without women's negotiations.

Such a Shona taboo has since corrupted the mindsets of men among most African cultures. Taboos, according to Chigidi (2009: 177), are instruments of socialization and social control in indigenous social systems that educate the society and impart knowledge on the order of the society. These avoidance rules are restrictive for they tell the individual what not to do. Such patriarchal precepts are common in the Shona culture and Marange society. These expectations govern women's sexuality for the benefit of men since they are the designers of these precepts. Taboos, precepts and mythology in Manyika cultures protect males and make women and girls vulnerable.

Shona cultural norms and values see a married woman as someone who does not negotiate sex as a dignified wife. Divorced and widowed women are expected to remain chaste. On the other hand, cultural norms like the delay of sexual debut, virginity testing and a call for abstinence (among adolescent girls only) are still influential in Marange. These have caused women to suffer silently, while men perform all forms of gender-based violence against women, mostly sexual, in the form of rape and illegal forms of marriages without women's consent. Women are left with the burden of unwanted and unsupportable pregnancies. At the end, some of these women secretly terminate these pregnancies in unhygienic and unsafe surroundings. Despite all the barriers to abortion, unsafe abortion is common among the Manyika people. Mabanda (2022) comments that abortion is illegal in Zimbabwe, but it is an *'open secret'* that some non-medical people in Zimbabwean communities are offering these services. Secret abortion is practiced to free pregnant girls and get them back to school as well to avoid pregnancy's interference with career and housework. In some cases, abortion serves to avoid shame for the entire family, church or tribe; that is, when pregnancy occurs outside of marriage or wedlock. For single parents and divorcees, abortion is used to cover shame as well, for they are expected to remain chaste and to maintain their celibacy as the expected cultural norm.

Chikovore et al. (2004) concur that men view abortion as a way for women to hide their

unfaithfulness. Christian women are expected to display biblical attributes like humbleness, submissiveness and faithfulness as well. While these are good for harmony and peace within families, in hegemonic systems these are taken advantage of, to instill patriarchal practices that oppress women and their freedom of choice.

To counter this, men and women play unending hide and seek games. Chikovore et al. (2014) admit how powerless they feel to control abortion as this practice is conducted in silence and secrecy. However, restrictions on abortion do not stop women from terminating their pregnancies. The church, ethicists' positions and legislation in place do little to curb occurrences of abortion.

2.6 Women in the Johanne Marange Church

The Johanne Marange Apostolic church is an African initiated church started in the early 1930s (Musevenzi, 2017). This dominant church in Marange mixes both traditional and Christian practices in its church doctrines. The church has several practices that expose women and make them subservient beings. The promotion of virginity testing, and polygamous marriages entangled with pedophilic acts that go unnoticed have negative impacts on the full realization of sound womanhood. Child marriage, wife pledging, and sexual dalliance are the topmost accelerators of unwanted and unsupportable pregnancies.

Biblical examples of polygamists are regarded as models, like Abraham, Jacob, David and Solomon who are regarded as forbearers of faith in God. Dillion-Mallone (1978) sees polygamy as doubling women's numbers as wives by one man. Women constitute most of the membership in the church. Juules-Rosette (1987) sees women as bearers of the church's belief system, though they are not allowed to be church leaders. This clearly shows that women are excluded from designing the church's programs. The exclusion of women from church leadership, positions, management and administration has greatly affected women and young girls. The greatest area of concern in this regard is that the sexual and reproductive health concerns of women are overlooked. Phiri (2008) rightfully noted the anti- modern health practices in this church that place women in the position of victims through polygamy and forced marriage. These have further adverse effects as they become vulnerable to contracting HIV and AIDS as well. Mavunganidze (2008) asserts that women in the Apostolic church do not express their agency in choosing the number of children they want to have. Further, Sibanda (2011) found that members of the JMC are not allowed to use bio- medical family planning methods.

However, studies show that some women in the JMC resist these teachings and secretly use

contraceptives. Mashonganyika (2017) asserts that after being discovered by prophecy, they just confess, and their sins are forgiven. As a woman born and bred in Marange, I observed most of these women manifesting symptoms and signs of STIs (sexually transmitted infections) and carrying the burden of providing care for many with ill-health, and needy children. Once every year in July, members of the Johanne Marange Apostolic church meet for the annual Passover at a shrine in Marange. This has impacted negatively on young girls' education as they drop out of school in massive numbers every season at the same time every year. Bishau (2010) has found a high illiteracy rate among the married women belonging to this church. The health status and wellbeing of Marange women have been greatly affected by the hegemonic church doctrine. Any form of family planning has been prohibited by the church and labelled as devilish. Any form of biomedical service is disqualified. Mashonganyika (2017) says that some women in the JMC express tacit agency as they manage to solve their immediate problems or prevent problems; however, all is done with the fear of being revealed and discovered by prophets. Yet this provides clear evidence that women at times defy church teachings and make decisions to seek to free themselves secretly. This exposure of women to STIs and unwanted pregnancies at times leads women to secretly seek unsafe abortions.

Members are required to ensure strict adherence to and compliance with religious teachings, practices and all normative values of the group. Imposition of penalties on those who violate church regulations and beliefs is a common practice. Spiritualization of illness and disease instills resistance to modern health facilities among the members of the Johanne Marange church. Chakawa (2010) pointed out that the church believes that its spiritual interventions have a spiritual competitive edge over secular, modern healthcare services. Thus, there is a strong emphasis on adherence to church beliefs, teachings and doctrine on matters pertaining to religion and health.

Chitando (2007) bemoans the philosophy of faith healing and reveals its disastrous consequences for women and children needing biomedical assistance. Detrimental effects of such practices are a reality. Newsday, in July 2021, reported the sad death of a fourteen-year-old girl who died while giving birth at a shrine during the Passover meeting in July 2021. The minor was denied prenatal care services, and she succumbed to labor complications.

In the subsequent year, another victim was recorded and went viral on Facebook. On the 5th of October 2022, Tete Urban Zuva posted a petition to the President of the Republic of Zimbabwe over the unsanctioned increase in disastrous pedophilic relationships involving the Johanne Marange followers. She laments the death of a 15-year-old who also died at the shrine after

being denied maternal health care.

During the Passover feast of 2022 July, a vast number of children succumbed to measles at the same shrine, giving clear and undisputable evidence that many people are denied access to medical services and are suffering and dying within this church. Phiri (2008) rightfully noted that anti-modern health methods put women at risk, as victims of polygamy, forced marriage, HIV and AIDS, and recently, Covid-19. Phiri's analysis shows that women have the highest infection rate and they carry the burden of providing care for the ill and the needy.

Studies reveal dual doctrine and belief systems where some of the members of the Johanne Marange church adopt the modern health system as well as belief and doctrinal systems of the church. Some church members continue to secretly seek knowledge and biomedical services that is against their church doctrine. Just like any other medical services they may need, Marange Apostolic sect members also secretly seek sexual and reproductive health services like contraceptives and seek clandestine abortions as well.

2.7 Conclusion

This chapter began by looking at the link between abortion and women's sexual and reproductive health rights. It highlighted instruments that speak of human and women's sexual and reproductive health rights, including abortion. It also discussed regional adaptation to these instruments that guarantee these rights. It further explained how Zimbabwe as a nation translates these human and women's rights into its abortion policy. The chapter further discussed the life of women in the JMC their sexuality. The next chapter presents work on the theoretical frameworks that centre this research and highlights method used in capturing data.

CHAPTER THREE

Feminists Lens on Abortion in African Contexts using a Religio-Cultural Perspective

3.1 Introduction

This chapter provides an analysis on how certain cultural practices impact on women's abortion decision-making using the feminist cultural hermeneutics perspective. The chapter also highlights how abortion is viewed from different feminist angles. The research engages a feminist approach in understanding abortion decision-making by Marange women, particularly whether it is life-giving or life-denying. Reproductive Justice framework is another critical feminist theory centering this research. Luna and Luke (2013) concur that reproductive justice focuses on women's choices on whether to have a child or not. The issue of women's sexual and reproductive health rights, including abortion, that have stirred debates and placed women in different camps, are analyzed in this chapter. The chapter also presents detail on the methodology used to find out the attitudes, views and perceptions of Marange women on abortion.

3.2 Viewing abortion from a cultural perspective

According to Ahikire (2014), feminists in Africa are a group of people who politicize the struggle for women's rights, question the legitimacy of the structures that keep women subjugated, and develop tools for transformational development. Kanyoro (2002) defines feminist cultural hermeneutics as a method of analysis and interpretation of how culture conditions people's understanding of reality in a particular time and location. Abortion issues have affected women globally in their diverse dwelling places, throughout history. Today, substantial evidence, as shown by Marange women, clearly shows abortion as a women's reproductive health issue that is affecting them. The landscape of Marange cultural practices is embedded in prescribed myths and taboos around women's sexuality, despite their bodily autonomy.

Women in Marange suffer the adverse results of unsupportable and unwanted pregnancies they get willingly or unwillingly in their everyday dwelling places. Men design the political, religious and cultural frameworks. At the end, Manyika women become vulnerable as their religious life, social life, sexuality and embodiment are fully controlled by and for the benefit of patriarchy.

Kanyoro (2002) explains how gender analysis considers ways in which roles,

attitudes, values and relationships regarding women and men are constructed by all societies all over the world. The concepts and practices of equality and discrimination determined by social, economic, religious and cultural factors lie at the heart of gender sensitive perspectives. Theological engagement with gender issues seeks to expose harm and injustices that are in society and are extended to Scripture and practices of the Church through culture. The fact that gender roles differ significantly from one society to another and from one historical period to another, is an indication that they are socially and culturally constructed. It is a true fact that these cultural behaviors brace some sexual behavior, especially from the time adolescents are initiated into adulthood (at 9-12 years' onset of puberty), up to the time youth leave home for high school, college and university. Boy and girl children are treated differently and expected to perform differently. Shikukutu et al. (2022) speak about one African cultural phenomenon, *you are not a man until you prove it by your first sexual intercourse.* Shikukutu (2022) comments on how the first adolescent sexual encounter is viewed as a landmark towards manhood and positive expression of masculinity. Engaging in risky sexual activities might serve as a gateway for adolescent boys to prove that they are real men. Ironically a girl child is expected to remain chaste, to keep her virginity for her future husband. If the young man is supposed to prove his manhood by having sexual intercourse, this in contradiction to the young woman who is expected to keep their virginity. This contradiction raises a lot of suspicion – will this not be the source of incest and rape? Generally, socialization is reliant on institutions like family, community and churches. These norms and behaviors are upheld as people are exposed to liberal cultural practices which exist in higher educational and tertiary institutions. Here sexual-risk behaviors like premarital sex and intergenerational relationships begin to surface with peer approval. Gendered dominant discourses of masculinity strongly influence the occurrence of teenage pregnancy. All these risk unwanted pregnancies that end in unsafe abortions due to fear of censure that affects only the female counterpart from churches, and punishments and shame from families and communities.

3.3 Way of life for Marange women

There is a high rate of impoverishment experienced in Zimbabwean rural communities due to unemployment, hyper-inflation and unsustainable livelihoods. Poverty has become both rampant and a catalyst of women's vulnerability in Marange.

Older girls who lead child-headed families, young female college and university students, single mothers by death or divorce, and young women under forced betrothal are the most vulnerable and are among those whose sexuality is exploited. The vending business has seen many women endings up

exchanging their bodies for goods and money, thereby leaving them with unplanned, unsupportable and unwanted pregnancies. Marange women are the type that affiliate earnestly to their cultural and religious precepts. Child marriage is one such trend where very young women are married off to very old rich men. Women who fall prey to this remain subservient with no confidence to negotiate, choose or use contraceptives. In this community, prevalent patriarchal systems of operation fuel the phenomenon of the occurrence of unwanted pregnancies, pregnancies that are secretly aborted.

3.3.1 Religious life for Marange women

Christianity is a dominant religion in Zimbabwe in the chosen geographical area under study. Gandhi (2018) asserts that religion can never be separated from politics. On the same note, political views impact greatly on social issues like gender and abortion in Zimbabwe. Religion, politics and social issues that affect women's sexual and reproductive health, like abortion, interlink and cannot possibly be divorced from each other. Policy makers are the same religious men who come from the constituencies where women dwell.

The Inter-Censual Demographic Survey (ICDS, 2017) reports that 84% of Zimbabweans are Christians. Among the most found denominations in Manicaland are the Seventh Day Adventists, Methodists, Catholics and the African Initiated Churches. The Catholics are known for their opposition to the use of contraceptives. The church at one point had associated birth-control with promiscuity and adultery (Pope Paul, 1968). Pope Benedict XV talked about the necessity of making everyone aware of the intrinsic evil of abortion because it is akin to attacking human life in its very first stages. Gregory XIV (2010) asserted that the Catholic Church has condemned abortion and teaches that human life is sacred from conception to natural death. Most of the denominations use the Bible as a reference on life matters.

Generally, all Christian churches follow the same thinking that abortion is wrong and is a sin because it is killing and killing is against biblical principles. Christians base their abortion principles on the Bible which is their holy book. It prohibits killing and views abortion as unethical. This principle governs almost all Christian churches that see human life beginning at conception and is sanctified. Churches in Marange have a high turnover of women and children as compared to men. The RAHI (2018) asserts that the Johanne Marange Apostolic church predominates in the Marange rural community with 42% of the population belonging to this sect in Manicaland only. Members of the Apostolic church are predominantly in rural parts of Manicaland and greater numbers are in Marange where it originates. This insight shows how influential this denomination is to the women of Marange.

According to RAHI (2018), members of the Apostolic churches have stronger political affiliates than other churches. Women in Marange practice a blend of both Christianity and

traditional spiritual beliefs. Traditional healers take a major role in healing the sick though some patients may be referred to nearby local clinics and Marange hospital. Some pregnant women, due to their doctrine, seek prenatal non-scientific services from faith healers, herbalists and prophets.

3.3.2 Economic life of Marange women

For survival, Marange women rely on agriculture, small businesses and mining. A few of these women are government workers in clinics, schools and Agritex offices. The majority of women are peasant farmers who grow maize, sweet potatoes, and vegetables for their families' consumption. The surplus is sold on local markets to raise a little money for children's fees, food items and clothes. With climate change, women toil in the fields for the whole season and yield nothing from their daily struggles. Women do not own the land. Men own and control women's labor and make agricultural decisions supported by patriarchal social views. Lack of land and climate change threaten women's security and leaves them vulnerable to poverty.

Mgugu (2008) expresses concern over the vulnerability of poor and illiterate rural women who rely on men economically. Local Marange men earn a living through thriving industries of construction and transport. Mpahlo (2003) comments on the plight of these rural women who are continually marginalized by being reliant on their husbands and male relatives for survival. The discovery of large diamond fields in Marange in 2006 gave them hope and this changed their socio-economic lives. At first people mined informally and they built houses and acquired assets like livestock. Some women in Marange participated in mining activities just like their male counterparts. Male miners were named the *Gwejas*, a Shona name which denotes the manual action of digging underneath the soil, usually should be done by drilling machines, to extract any valuable resource. Brave Marange women who joined these activities were nicknamed *vana* (*Gwejelyn*). Such women left families and sacrificed to live in the bush in order to support their children. Some cooked and sold food items to the miners, while some sold clothing and even drugs.

Towriss (2013) observed that the regulation of diamond mining fields and their becoming state-owned left Marange women power-stripped and defenseless, dancing in poverty again. Some women resorted to anti-social behavior, abusing drugs and being sex workers, exchanging their bodies for goods. In Marange, diamond mining activities have far-reaching political, economic and cultural implications for women, as observed by Mkwambo (2012). All these socio-economic activities impact greatly on women's sexual health and life, including abortion. Anti-

social behaviour like drug and substance abuse and unacceptable sexual debut impact greatly on unwanted pregnancies that automatically lead to unsafe abortion acts. Vulnerability and misogyny increase as women depend on men for survival and all decisions are centered on their male counterparts, even decisions that pertain to their own bodies and reproductive health.

3.3.3 Socio-cultural life of Marange people

Marange rural community is under the leadership of Chief Marange. Under him are headmen and village heads who lead communities organized into different villages.

Traditionally, women are responsible for farming, maintaining the house, cooking and taking care of both the children and their husbands, while men lead the community and families, and provide for the families. Some families are polygamous while others are large and extended. We can find nuclear, single parent and child-headed families due to family dynamics. Livestock like cattle, goats and sheep are regarded as forms of wealth which can be used to pay bride price or lobola. Women are expected be submissive to their husbands. Patriarchal systems are noticeable in families, churches and in the community. To sustain their families, women engage themselves in small-scale farming, pottery and weaving. At puberty boys and girls are taught life skills to prepare them for adulthood. One of the Shona teachings during puberty initiation ceremonies is abstinence on the girls' side. Girls are taught to abstain from sex until they get married; *the best gift you can give to your husband on your wedding eve is your virginity,* as the elderly women's saying goes. This sees young women struggling to meet the societal expectations against their own bodily sexual desires. On the other hand, single mothers who are divorcees or widows are expected to remain chaste and maintain celibacy until they decide to officially remarry. Traditionally, these groups cannot easily and comfortably seek contraceptives for fear of being labelled as promiscuous. When they get pregnant, their only option is to secretly abort using unsafe methods.

In contrast to women's orientation on sexuality, men are praised for sexual prowess and prevailing beliefs are that men's sexual desires are uncontrollable. This societal appraisal alone sends men to roam about while displaying hegemonic masculinity, sleeping around with women, and increasing unwanted and unsupportable pregnancies. The '*Bull' is* a nickname often given to the most adventurous, brave and noticed man. In married situations, women are encouraged to be humble and submissive to the extent of remaining silent even when the situation costs their lives. In many instances, some sexual abuse that happens within families and churches goes unreported to protect the family and church reputation. Socialization, gender,

age and context form the basis for the undeniable need for abortion as a woman's sexual and reproductive health right. It is common in Marange to learn that women are continually socialized into becoming subservient beings whose voices remain shut even unto death.

In a safe space like a church, women suffer to death as they are denied access to medical services, prenatal care and the ability to make their own choices about the pregnancies they carry due to some prescribed church policies. Girls not Brides (2021) bemoans a number of girls who have succumbed to pregnancy complications in safe spaces like churches in Marange.

3.4 Feminist cultural perspective

A hermeneutics of suspicion was used to analyze and question some of the practices that are oppressive to women in Marange. In employing a hermeneutics of suspicion, Kanyoro (2002) encouraged the questioning of such questionable practices to be approached cautiously. Phiri and Nadar (2006) critiqued religion and culture's oppressive practices that negatively affect women's health. In Marange there is much evidence of the continuation of such questionable practices in both religious and cultural set-ups. Virginity testing, wife-pledging, polygamous set-ups, and sexual initiation are examples of such practices in question. These practices in Marange speak volumes on how culture and religion is biased to patriarchy. Religio-cultural frameworks suppress women while favouring masculinity. Schussler (1984) raised alarm on what is said and the silence on certain issues. Child marriage and pedophilic acts that impregnate minors need to be critiqued from a hermeneutics of suspicion lens. The non-governmental organization Girls Not Brides, during the Covid-19 era (2019-2022), lamented the high rise in maternal deaths following reports of minors dying at a shrine in Marange while giving birth in July and October 2021. A hermeneutics of suspicion encourages questioning and critiquing of some religious practices that are patriarchal and have detrimental effects on maternal health.

Women are not given adequate attention, their voices and views are not listened to, and their participation is not allowed and ensured. Prescribed myths and societal taboos around sex marginalize Marange women and deny them the right to sexual and reproductive health services and choices. These taboos around women's sexuality vividly portray women's vulnerability. Men's interests are upheld while women's decision-making rights are suppressed.

Kanyoro (2012: 17) writes:

> *If today's African women are able to name the oppressive aspects of African cultures,*

telling these stories of dehumanizing cultural practices is still rare and a struggle… The question confronting women theologians in Africa is how can discussions on culture be incorporated in our communities so that women find it safe to speak about issues that harm their well-being?... African women theologians who have encountered feminist analysis do not quickly jump to condemn women for being custodians of dehumanizing cultural practices. It is realized that even women's actions are too deeply rooted in patriarchal socialization and therefore the analysis of women's oppression has to be done in the context of gender analysis. We need to look and see how our societies are organized and how power is used by different groups, men and women, young and old, people of varying economic means, and so on. Who benefits from a particular interpretation of culture and how is the system kept in place?

Following Kanyoro's words as explained above, this research adopts a gender analysis, applying a hermeneutics of suspicion and feminist cultural interpretation to some of the religio-cultural beliefs on Manyika women's sexual and reproductive rights, including abortion issues. The rampant occurrence of clandestine abortion acts within Marange emphasizes the need for dialogue on whether their beliefs are life-affirming or life-denying.

It is against such a background that this study examines women's sexual and reproductive health rights in line with their gender and bodily make-up, cycles, needs and challenges. The research taps into reproductive justice and feminist cultural hermeneutics frameworks to interrogate gender attitudes, sexual beliefs, norms, mythology and perceptions amongst the Manyika women of Marange to find out if they are life-giving or life- denying to women. As Siwila (2011) says, "The hermeneutics of suspicion must go hand in hand with a hermeneutics of commitment". With this view, African women must take up the responsibility to change and transform those oppressive customs to bring about the fullness of life. This study critically analyzes cultural and religious practices that make women recipients of policies, and cultural and religious precepts. Some of these lead to unplanned and unsupportable pregnancies that send women to seek freedom through backyard abortion acts.

These women are dying in silence. Thus, this study also uses the reproductive justice theory that seeks to free to women tied-up in religious, cultural and national policies.

3.5 Reproductive justice framework

This research uses the reproductive justice framework as indicated in chapter one. Reproductive justice is centered on giving support and enabling social repair for women on

issues that affect their sexual reproductive health, including abortion. Roth (2012) advocates for the analysis of social, economic and gender inequalities that affect women's sexual reproductive health. Macleod (2011) laments how some socio-political, economic and religious aspects shape women's sexual and reproductive health by impacting on their decision-making. As highlighted above, Marange women's lives operate under patriarchal systems in religious, cultural and family circles. Botha (2016) notes that men are the ones who design policies and laws that directly affect women. She notes that the same men are at the fore-front of opposing the reformation of laws concerning the health rights of women. Many African societies are patriarchal in the way they operate. Marange men are not exceptional in this practice of designing traditional and religious precepts that benefit them at the expense of women and children. Women do not operate in isolation in their everyday routines. In families, communities, churches and workplaces they interact with men, following the same codes of conduct that are inconsiderate of their bodily autonomy.

In this regard, Botha (2016) commented that the decision to continue or end unwanted pregnancy should be left in the hands of the one carrying it. Men should not make laws for women on issues that they do not experience and understand.

3.5.1 Pro-choice attitudes

Pro-choice feminists advocate and affirm abortion as an important option for all women, though not all women may need it. When a woman feels that she cannot bear the burden of a pregnancy to full term, it shows she cannot bear full responsibility of the newborn baby. This therefore means that forcing her to do so will exacerbate the social and economic forces that would already be pressing down on her. In Marange, where some parents are poverty stricken and resources limited, care for an unwanted baby may be a burden. Adding a child through unwanted and unsupportable pregnancy simply adds oppression and is like adding salt to a painful wound. Edgington (2002) emphasizes the need for women to have full freedom to pursue their education and career, and to have control their own lives by being in full control of their sexuality and reproductive health. Pro-choice feminism highlights issues affecting women in Marange like issues of gender-based violence, patriarchal dominance and their impact on women's sexual health. This is greatly valued in this research, particularly to the target population, as they speak out for women on issues that have been hidden and suppressed in their life history. Pro-choice advocates make sure women's voices are heard on issues that affect them in homes, workplaces, and wherever a woman is. When focusing on women's sexual and reproductive health rights and abortion, they ensure the liberation of women from social, religious, economic and cultural bondage that ties them and impedes their decision-making processes. Women are tied to their designed feminine gender roles that come with their biological make-up, and these guarantee them the right to have special attention.

Marquis (2013) argues that a woman has the right to control her body and this perhaps means the right for abortion. Where cultural precepts and national policies are patriarchal, it is common for women to be denied their sexual and reproductive independence (Cherry, 1995).

Marange women are under such patriarchal practices embedded in religious and cultural policies with the agenda of seeing women as mothers regardless of the circumstances. Pro-choice proponents argue against valuing an unborn fetus over the living woman (Siegel, 2014). Pro-choice take into consideration that a woman might be in an unstable or unloving relationship and may not want to risk carrying an unwanted pregnancy to full term. In some cases, pregnant women might be experiencing financial hardships and maybe in need of basic freedom to determine whether to carry the pregnancy to full term or not. Young women at times maybe having life plans that may be disrupted by carrying pregnancies to full term like education, work or travelling afar. In such instances women regard restrictive abortion laws that criminalize abortion as denying women's dignity and depriving them of full control over their sexual and bodily lives (Siegel, 2014). Despite being illegal, abortion is thriving in Marange, an indicator of gender discrimination in law and policy. Kumar et al. (2009) acknowledge that lawmakers dominate debates and decision-making on women's reproductive health and thus influence patriarchal practices that reinforce gender discrimination. The pro-choice movement believes that the woman has the prerogative to make an informed decision either to abort or not. Sherwin (1991: 345) explains how women may feel too young, too old or too weak and unable to carry the pregnancy. They argue that women have a right to safe abortion and it shows compassion if the law allows them freedom to decide whether to carry the pregnancy to full term or terminate it. The study respects women's physical, emotional, social and mental wellbeing, and is committed to respecting women's sexual and reproductive health rights that include abortion (pro-choice).

3.5.2 Anti-abortion, pro-life movement

Barkan (2014) observes that religious and conservative people are usually more willing to declare themselves as pro-life. Feminists also have an organization or group known as pro- life that condemns abortion. They believe in the sanctity of life even from conception. Bube (2008) reveals this common assumption among anti-abortion ethicists. The fetus is regarded as a human with a right to life, thus the legal system must respect that right by restricting abortion. Mbiti (1969) and Sindina (1995) state that African traditionalists see life in its totality. They believe that life begins right from conception. The Roman Catholic Church is one denomination in Christianity that is anti-abortion and the followers are usually pro-life (Jonason et al., 2022). Morality is the greatest concern for pro-life proponents and all abortion seekers are labelled as murderers. Kumar et al. (2009) argues that the embryo has the right to life right from conception, even in its smallest form like an egg, sperm or embryo. Alcorn (2012) declares

abortion as the deliberate killing of a human and should be a punishable offense. A Bible verse used to justify criminalization of abortion is Exodus 20, verse 13, which says, ‘Do not kill, thou shall not murder’.

Besides morality, there is an underlying gendered agenda among the anti-abortion precepts controlling women in Marange. Malka et al. (2012) acknowledge the connection between religion, politics and abortion. This is so in the Zimbabwean context where the same politicians are the policy makers and church leaders as well.

In designing these laws, religious leaders employ a patriarchal approach. This can be seen in precepts that have no consideration of girls’ and women’s unique biological considerations. Women who adhere to the Apostolic faith (a dominant religious sect in Marange) are the most at risk, as they are exposed to religious practices like child marriage and wife pledging. All these expose them to risk, to the extent of leaving them with unintended and unsupportable pregnancies. Mpofu et al. (2016) observe that Apostolic churches in Marange have a recognized sector of the Zimbabwean population, and to their advantage, the Zimbabwean politicians have targeted this religious sect, using its pulpit to garner electoral support. Very old men, under the pretext of the church, declare they have been directed by the Holy Spirit to marry minors. The girls will only adhere to these prophecies after being threatened with curses if they ever attempt to deny them.

The ties between the Government of Zimbabwe and the Apostolic Faith groups have endured for a lifetime. These have made policymakers overlook the oppressive issues that affect Marange women, for fear of losing a significant proportion of the electorate (Makururu et al., 2019). This alone clearly shows the kind of struggle that women in Marange are dealing with. Later in their lifetime, the indoctrinated young girls and women may become enlightened as they socialize with the outside world, and with this they may try to free themselves from such oppressive and exploitative ways by secretly indulging in punishable crimes like unsafe abortions.

3.5.3 Absolute-moral and relative-moral

Another group that seems so rigid is known as the ‘absolute-moral’. They hold a strong argument that abortion is wrong in any circumstances. Marquis (2017) justified why abortion is immoral and gives five rational arguments against abortion. Firstly, an embryo or fetus is regarded as a person, a person who has the right to life. This means that an embryo or fetus has

a right to life. It is absolutely wrong to kill a being with a right to life. Therefore, this means an embryo is a being with a right to life. Abortion here is wrong because it violates moral standards.

The relative-moral holds the notion that abortion is permissible in certain circumstances. This is like the Zimbabwean legal and legislative context that allows abortion in only three circumstances. It is only allowed when the pregnancy comes through rape or incest, or when it poses a danger to the physical health of the mother or the child. In a similar vein, Billings (2023) highlights the Heartbeat Protection Act that promotes fetal personhood and legal protection. Legislators in the United States proposed a Bill that criminalized abortion after 6 weeks of gestation. This was done through the Heartbeat Protection Act 2021. This became an abortion prohibition – no abortion is allowed without a fetal heartbeat check in America and any physician who performs an abortion without checking for a heartbeat would be subject to criminal penalties.

3.6 Method

Following Creswell's (2014) guidelines on interviewing participants, the research made use of in-depth interviews as the data collection method. The effectiveness of this method allowed me as the researcher to discover intangible religious and cultural constructions of the perceptions of abortion among Manyika people of Marange. Interviews were conducted with women within the age range of 18 to 60 so as to gather information on their knowledge, experiences, attitudes and perceptions on abortion. Creswell (2012) sees interviews as an effective means of exploring and understanding the meaning individuals or groups ascribe to certain social human problems, in this case, abortion issues. The chosen age ranges comprised women of all social classes, including adolescents, those of child-bearing age, the aged, the youth, housewives, single, married women, the literate, illiterate and very elderly women. Close interaction between the researcher and the respondents enriched this paper by furnishing it with rich and useful information. Simple random sampling was used for its advantage of allowing equal representation of each group. With simple random sampling, there is high probability of each of the subset members to be interviewed. Boyle (2023) asserts that this is the best method to have unbiased representation of the targeted population.

This study was inclusive in that it incorporated all groups of women who dwell in Marange community, in additional to the elderly, and experienced and long-standing members in religious and traditional circles who furnished investigation on this abortion issue with useful

data.

Of the twenty women, some were still in high school, college or university, some were housewives, civil servants, businesspersons, while some of them were from the local prominent faith community and some were deeply rooted in Manyika cultural practices. Marshall and Rossman (1999) note that "an interview is a conversation with a purpose and is a useful way of getting large amounts of data quickly". Within the in-depth interviews, the focus is not on the number of participants but rather on the quality of the data gathered, hence the time was spent interviewing each of these twenty participants. All the in-depth interviews were done face-to-face in both Shona and English. This alone enriched the paper with varying perceptions and views obtained from different living experiences, portraying individual differences and lifestyles of women of Marange. These interviews allowed me as the researcher to read further beyond verbal expressions by interpreting facial expressions and displayed behavior and conduct. It was interesting to note that women poured their hearts out while sharing their opinions on issues that affect their sexual and reproductive health. One-on-one, face-to-face interactions with certain individuals under a conducive atmosphere created such close relationships and mutual trust that women already interviewed re-invited the interviewer back to share their missing ideas, as they named it.

Plooy (2010) sees an interview as a data-collection method with personal contact and interaction between an interviewer and an interviewee (Du Plooy, 2010: 179). He states that the main aim for in-depth interviews is to obtain detailed information (Du Plooy, 2010: 179). This was evident as some women would make follow up phone calls saying, "*pane zvandasiya*", meaning that they would have missed some points. Berg (2004) describes interviews as a "conversation with a meaning". In this research, dialogues between the participants and the researcher became meaningful and were created in conducive and friendly environments. Guest et al. (2005) indicate that interviews are best for collecting data on individuals" perspectives and experiences when sensitive issues are being discussed. Richer information from diverse groups of elderly and young people, literate and illiterate, married and single women, those of child-bearing age and those who reached menopause was gathered. Abortion, despite being a very sensitive issue, was presented and tackled in a friendly and reluctant but very focused and analytic manner that created lasting bonds between the interviewer and the interviewees.

Marange women could freely pour out their hearts on women's sexual and reproductive health issues that interlink with abortion without any hesitation. As a researcher, I started to question

if this is why Mabanda (2024) referred to abortion as an open secret. I realized that the use of interviews enabled the collection of deeper information from Marange women on abortion. The use of these interviews successfully facilitated the achievement of the objectives of this research.

3.7 Research process

Firstly, permission was sought from the gatekeepers who were informed of the aim of the study and that it was being conducted for academic purposes. The objectives of the study were also outlined and clarified to the two selected community leaders of Marange district. Chipfatsura and Chegore village leaders provided ten women each to represent the targeted population. The two community leaders who granted permission to do the research assisted in gathering women from their villages. After clarifying that all will be done for academic purposes, they gave their permission for the interviews to be carried out freely. All this transparency helped to avoid any form of suspicion and victimization toward the participants.

As the researcher, I made sure to keep my approaches in check to ensure the respondents' dignity and confidentiality remained protected. I tried to use good choice of words to avoid hurting anyone socially, mentally and emotionally. Consent was sought from the women and it was made clear that the whole process was to be carried out on a voluntary basis. Proposed dates, times and places of interviews were discussed and these were done according to the agreed schedule. There was much flexibility to allow absent participants to give their input whenever they would be present within the stipulated period of the data collection period. Volunteer leaders from each group were chosen by the researcher, who assisted in the identification process to allow representation of each subgroup. Minors and male participants were excluded in this study analyzing abortion as a woman's sexual health right. The selected twenty participants were interviewed successfully.

The simple random sampling used was very effective in choosing the group that fairly represented the targeted population of Marange women.

3.7.1 Sampling procedure

Rensburg (2010) sees a sample as a part of a whole or a subset of measurements drawn from the population. A sample then is a selected group of elements from a defined population. Thus, in this research, whatever ideas came from the chosen groups represent the ideas of the entire targeted population of Marange women. As Rensburg (2010: 151) indicates, we study the

sample in an effort to understand the population in which we are interested. The simple random sampling procedure was used as it allowed equal representation of the targeted population of Marange women. Boyle (2023) asserts that this is the best method for unbiased representation of the targeted population.

3.7.2 Simple random sampling

Thomas (2020) argues that simple random sampling is a randomly selected subset of a population. In this sampling method, each member of the population has an exactly equal chance of being selected. Single and married women of child-bearing age, the youth and elderly as well as the adolescents aired out their views and attitudes on abortion as a woman's sexual and reproductive health right. Kanyoro (2002:27) argues that "one of the greatest benefits of women's scholarship has been to hear stories of women by women and to become aware that the subordination of women as a gender is a world phenomenon defying the confines of race, class, creed and nationality." Hearing abortion stories from Marange women of different backgrounds helped me as the researcher to understand and assess their perceptions and experiences from their different contexts. Goodman's (2011) snowballing method was effectively used for the best outcome of a random referral process. This allowed participants to recruit each other for the reason that they know each other, therefore allowing full representation of each subset. Close examination of the views from the interviewees in Marange allowed further exploration on how these contribute to life-affirmation or life- denial.

As the researcher, I took into account the sensitivity of the topic and made wise choices of words to avoid resuscitation of bad memories or any form of harm to the respondents, keeping in mind that there might be those with previous abortion experiences. As a researcher, I put much effort into upholding the expected ethics and practices of the college, including seeking informed and voluntary consent of the respondents to participate.

3.7.3 Confidentiality

The names of participants and those interviewed are withheld for confidentiality and ethical considerations. Participant's names have been replaced by letter codes. For an example, p1, p2 and p3 are codes used to replace the original names. P represents participant and they are numbered up to twenty. This study took into account the ethical considerations surrounding research of this nature. Participation was voluntary and no one was forced to participate without being willing. Participants were given freedom of choice, including whether to continue or

withdraw from the exercise at any moment. Participation was free and voluntary; no-one was coerced into the exercise but joined out of free will. Names of respondents are withheld for confidentiality and ethical reasons.

Collected literature review themes and the themes that emerged are put together to answer the key research questions of this research. No harm would befall the studied population before, during and after the interviews.

3.8 Conclusion

This chapter has discussed the two theoretical frames that anchor this research. It also outlined the method and research process. The next chapter presents and analyzes the collected data from the villages in Marange district in Manicaland.

CHAPTER FOUR

Data Presentation and Analysis of Marange Women's Perceptions on Abortion

4.1 Introduction

The chapter presents the collected data and analyzes the trend of unsafe abortions among women in Marange district in Zimbabwe. It also covers an array of themes and an overview of the phenomenon. The chapter examines the varied experiences, perceptions, attitudes about abortion among the young women of Marange. It gives a glimpse of concerns, obstacles and challenges met by Marange women as they seek to realize their sexual and reproductive health rights, including safe abortions.

4.2 Research Process and Data Analysis

The randomly selected twenty women represented the targeted population of Marange women. The 20 women were interviewed successfully as was scheduled. Of the 20 respondents, nine (9) were young adults within the age range of 18-24. These included students from high school, tertiary colleges and some school leavers. Eight (8) participants were middle-aged women, including single parents and married women of ages 25-45. This group comprised women of child-bearing age, divorcees, widows and some who never married but they have children. The remaining three (3) were elderly women of ages 46-60 who proclaimed that "*Taguma ura isu, kana kugeza hatichagezi*" (meaning that we have reached menopause; we can no longer bear children)(P19). These three elderly women brought the group to a total of 20 respondents. The whole group consisted of housewives, health personnel, business women, students, midwives, peasant farmers, and vendors, self- employed and un-employed women of Marange. Some of them indicated that they are aware of Zimbabwe's Termination of Pregnancy Act's contents in general but not in detail. All of the interviewed women indicated that they know about abortion and at one time they once heard stories about abortion from newspapers, from peers, from social media, as well as rumors around their immediate communities. All interviewed women from these sub-groups provided comprehensive information depending on their context.

A schedule was made for interviews. The interviews were carried out following the agreed dates, time and meeting places. These varied from individual to individual. Interviewees were allowed to choose the appropriate time and convenient meeting places where they would feel free to engage in the process. Having the interests of the interviewees up-front ensured great success of the interviews. The respondents were very cooperative to an extent that some of

them went as far as sharing their sexual and reproductive lived realities without reservation. This made it easy for me as the researcher to analyze Marange women's views, attitudes and perceptions about abortion.

Most of these participants expressed their thoughts freely, saying their views out with no hesitation, while a few were uncomfortable at first and gained composure in the long run. Responses varied from individual to individual. Interviewed women of Marange shared their views and perceptions as well as the challenges they once met as they seek to translate their sexual and reproductive health rights into lived reality. Despite the fact that opinions and perceptions differed due to noticeable individual differences of age, social class, education level and marital status, the participants highlighted common ideas and views that could be identified and classified into major themes.

As Braun and Clarke (2006) state, a theme captures something important about the data in relation to the research question. Interviewees gave varying but common reasons for the causes of unsafe abortion amongst Marange women. The reasons given as major causes of abortion are unintended and unsupportable pregnancies, gender inequality, the strict policy of Zimbabwe's Termination of Pregnancy Act, and cultural taboos surrounding accessibility to sexual reproductive and health services, including abortion, with these mostly affecting young adults and single parents. Marange women admitted to procuring abortion with the assistance of experienced elderly women and traditional healers. Gumede (2014) pointed out the use of herbal infusion as a method of pregnancy termination in most African contexts. In the same manner, this practice is also common in Zimbabwean communities like Marange, as acknowledged by a number of respondents. Herein are the themes that emerged during the data collection process.

4.3 Unintended and unsupportable pregnancies, a major cause of abortion

Unintended pregnancies were cited as the major cause of abortion by young and old interviewed respondents in Marange. Sedgh (2010) describes unintended pregnancies as pregnancies that are unwanted or unplanned at the time of conception. For this reason, unsafe abortions are practiced by women of all ages and social classes to eradicate such pregnancies. Single mothers and young adults testified that family, culture, religion and the national policy impacted greatly on their sexual and reproductive health rights, including abortion.

Intolerance to abortion decisions within these institutions robs women of their life opportunities. Schuster (2005), in a study in one sub-Saharan African country, found that young women

terminated pregnancies because of a variety of considerations, including fear of losing educational opportunities. "*Have you ever imagined the plight of a mid-twenty female college student who has to complete a four-year course, remain chaste, please parents and fight the natural sexual drives within her*?" This was a question posed by P1, a college student.). P3 expressed how sexual desires cannot be suppressed, as single and unmarried mothers are expected to do in most cultures. Their morality is questioned as they try to access contraceptives. When nature calls for sexual gratification, engaged in without contraceptives, the pregnancy is one termed unwanted and its fate is unsafe abortion. This study has proved that unintended pregnancies are no longer bound to teenagers only. Married and unmarried women as well as adolescent girls are all at risk of unintended and unsupportable pregnancies, according to the findings. Their dilemma is how to evade the burden and consequences of the unplanned, unintended and unwanted pregnancies. As a result, girls and women find themselves caught and trapped between two hard rocks. One respondent explained the difficulty of shouldering the burden of nursing a baby born out of an unintended pregnancy, and secretly procuring unsafe abortion despite its life-taking risks or facing the verdict of the law. These haunt women's lives and induce pressures which jeopardize their psychological, economic, social and physical health, according to P2, a technical college student on apprenticeship.

4.3.1 Abortion and married women

Salama (2015) laments the impact of unplanned pregnancies on women's health. In Marange, the illiterate married women living in poor households are the ones mostly affected. Young married women who are sexually active have the tendency of discontinuing and improperly using contraceptives, thereby risking unwanted pregnancies. Some married women receive criticism from their partners over the use of contraceptives. P8 (a married young woman) testified how her husband would not tolerate seeing the birth control tablets in their bedroom. She explained that she would at times keep them at her friend's house.

"I usually forget taking them with me at times when I would be travelling," shared P9 (a young married woman). This discontinuation and improper use of contraceptives always risks married women's health by unplanned pregnancies. The lack of support from partners, poverty and religious beliefs suppress some Marange women, such that they would not realize their sexual and reproductive health rights. Henshaw (2016) commented on the vulnerability of economically disadvantaged women and their risk of unprotected sex. In most African societies, just like in Marange, the cultural need and preference for male children also pressurizes women into unplanned pregnancies as they continually fall pregnant in anticipation of a boy child (Singh, 2010). A subconscious desire to

have a baby boy may remain and lead women to fall pregnant within short spaces of time; this has a great impact on the occurrence of unwanted pregnancies if the sex of the baby does not turn out as desired. All of this results from gender inequality that makes women vulnerable, and lack knowledge and confidence to make informed choices. They are incapacitated to access contraceptives of their choice.

These factors were on the list of the top drivers of unintended pregnancies among Marange married women. P10, a married middle-aged woman, jokingly revealed a common trend among many women, who, when realizing they have an unplanned pregnancy, intentionally delay registering with any health facility for the reason of paving a way to secretly eradicating the pregnancy, by no other means but through unsafe clandestine abortion. The educated, literate and well-off women of Marange are less likely to suffer the risk of unplanned pregnancies due to their capacity to access contraceptives of their choice and their ability to have their voices heard.

4.3.2 Teenagers and unwanted pregnancies

In Marange, adolescents have the highest risk of unintended pregnancies due to peer pressure, drug and substance abuse, inaccessibility of contraceptives, limited contraceptive knowledge, and incorrect and inconsistent use of contraceptives when available. There are also perceptions embedded in religio-cultural frameworks that young women in Marange are tied to.

Traditionally, most parents value their daughters' virginity status while the girl child may be under peer pressure of risking pregnancy. Also, poverty in child-headed families who lack parental support goes a long way toward causing unwanted pregnancies. Young girls who lack communication with parents about sex education before or during puberty also are at risk for the occurrence of unintended and unsupportable pregnancies. One respondent cited a friend whom she suspected of having an unintended pregnancy who finally resorted to an unsafe backyard abortion.

The behavior of our classmate Nee (not her real name), a fourth form student in high school started to change, she became passive, withdrawn and inactive in most school activities. Nee has been an all-rounder, very active in class, athletics and ball games. She was even an extrovert. Her breasts grew bigger and I personally observed many physical changes that everyone suspected she was pregnant. She was absent from school for about a week. By the time she came to school, she had many complaints about stomach pains, chills and heavy bleeding. We all suspected and proved beyond doubt that she had an abortion.

This was shared by P4, a high school student in Marange. Most high school, college and university girls would not stand the shame of disappointing their families, communities and churches by evidence of promiscuity, so they would risk by doing away with the unwanted pregnancies that come out of wedlock using any possible way, be it unhealthy and unsafe.

Another participant (P6) testified,

> *A day before we left home for college in our last semester, my college roommate started bleeding. I was with her at her aunt's home, I asked her elderly aunt to organize transport so that I would escort her to a local clinic but they insisted that all will be well. After two days we were together at college. I personally concluded that she had aborted. She bled heavily for about two weeks. Awkward clots of blood came out of her.*

Fearing to embarrass parents, to drop out of college or to be labelled a failure may drive young school, college or university students to find ways to secretly terminate pregnancies. Women cannot easily seek post-abortion medical care for fear of the full wrath of the law. After undergoing an unsafe abortion, women pretend as if all is well. They pretend to be well and endure conditions that risk their lives.

The fear of being castigated by family or communities has made women keep abortion issues to themselves. In cases of miscarriage, health personnel at the clinic can only attend to them after they produce documentation that prove that they registered their pregnancies with the local clinic. Failure to do so may raise alarm or suspicion is raised they may be arrested. P11, a middle-aged woman, testified.

> *When I got married in a scarcely settled area, I heard stories in that village of a secluded hut where a very old woman stayed, who was regarded as a midwife, raditional healer and was nicknamed Mbuya Godobori. This woman would assist pregnant women when giving birth as they said. It surprised me a lot to see people of all walks of life visiting her. Some young, some old, some would come as couples. It was only after she was arrested that I learned that she was in the habit of facilitating unsafe termination of pregnancies. She would stay with some women, nursing them after inducing abortion for some time, this was according to rumors. People who passed by this house testified hearing groaning and wailing voices of young women in pain. A certain young lady almost died in her custody and was ferried to a nearby hospital unconsciously after heavy bleeding. It was then that the cat was let out of the bag.*

For clandestine abortions, post-abortion care is not something to consider as long as the fetus or embryo has been successfully removed. The pregnancy termination facilitators would receive payments in the form of groceries or money. Lives of women get sacrificed for exchanged goods and abortion services.

Poverty in most parts of Marange promotes such behavior and it increases the occurrence of unwanted pregnancies as well. Many times, men lure disadvantaged women into sexual relationships by pampering them with gifts; in return, they are left with unintended and unsupportable pregnancies, ending in backyard abortions which the responsible men opt to pay for.

Another major cause of unintended pregnancies, as highlighted by the women of Marange, is sexual violence. Sexual violence occurs in safe spaces like homes and churches. Women and girls are raped and they at times fail to report incidences of sexual violence in order to protect kinship relations. At other times, they feel they need to protect the reputation of the church.

In some cases, women's sexual rights are violated by cultural norms like sexual dalliance, wife pledging, early marriage and some practices in puberty initiation. Christofides et al. (2014) connect early marriages with early childbearing and increased vulnerability for poor reproductive health outcomes. One of the elderly women (P17) narrated the story of two minors who were in a showdown with their grandmother after she forbade, declined and resisted reporting their maternal uncle (late mother's brother), this grandmother's own son, after he impregnated their young sister. This and other stories about women came in different versions from different respondents. They speak volumes about Marange women, culture and religion.

4.3.4. Inaccessibility to sexual and reproductive health services

> *You just take an overdose of the natural birth control and that's enough to delete any developing embryo. As long as it is in the first trimester. You don't feel any pain, no clots, no bleeding, with these roots, you are assured its deleted. Ha ha ha, I have no husband who will support a newborn baby, how will I survive the shame bearing a child whom I cannot even take care of?*

These are the words of P13, a young widow who carried on in a joking manner, *"…and remember these are still eggs, not a human being. If it's killing, who has been murdered? Isn't prevention better than cure?"* She explained further as she sought to justify the act of abortion. Inadequate provision of women's sexual and reproductive health services, particularly

contraceptives, has led women to try other means. In some cases, they feel they have breached the cultural taboos which demand widows to be remarried to their late husband's brothers, or choose to remain single and practice chastity without fail. It is clear that in Marange, according to the findings, married, single, young and old women resort to abortion as their first immediate resolution to free themselves from unwanted pregnancies. Sometimes pregnancy is unintended even within married circles, and the Termination of Pregnancy Act does not allow abortion to be performed. Further, if you lie that you were raped, police need to investigate and demand evidence. First the police need to investigate the issue to see if it results from rape or incest. The case needs to be taken to court and the magistrate has to certify if it is a crime before clearing the woman for post-abortion service. Women and girls argued that this difficult, long procedure to abortion services lead many to try backyard clandestine abortions.

A local newspaper, The Chronicle, recently published (06/2023) the story of a high school student from a local high school who gave birth and dumped the baby in a blair toilet, that is, a pit latrine. Such cases of baby-dumping are rampant in Manicaland schools among young girls. This and other cases reveal that if a woman is forced to carry on with a pregnancy, to full term, they will find ways and means to disown it.

According to the respondents, issues of baby-dumping and abortion follow after inconsistent laws and policies relating to the age at which girls are able to access sexual and reproductive health services without parental consent in Zimbabwe. National policies, religious and cultural beliefs still regard them as not sexually active, while they secretly are sexually active. When they get pregnant, they try to conceal it and to pretend they are not engaged in sexualbehavior. Abortion and baby-dumping manifest women's untold inner feelings about the pregnancies. In addition to this, lack of comprehensive sex education has led to many youth falling pregnant unintentionally. There is too much stigma and mythology around women's sexuality. One of the Zimbabwean women parliamentarians, Misihairabwi (2023), toured the country and collected information on people's views on abortion. She testified that she had a lot of conversations with these teenagers and most of them are not yet ready to be mothers. She reported that their first option when they fall pregnant is to go for an illegal abortion.

Another female Zimbabwean parliamentarian, Majome (2023), expressed great concern over the practical difficulty in obtaining abortion on legal grounds, especially for low-income victims. One college student, P5 concurred with her and showed great concern over the delay of the procedure in obtaining a legal abortion. She witnessed this when a well-known, mentally

challenged woman in their community fell pregnant. There was a tug of war between the woman, her family and the village health workers who had earlier on facilitated the rehabilitation of her child to a safe shelter by a certain non-governmental organization. It took ages before she was cleared for abortion and this intensified the war zone between herself, the family and the responsible mediators. Time ticked off beyond the accepted gestational limit thereby creating another major issue with the responsible medical practitioners.

4.3.3 Abortion and women with disabilities

P14 concurred with P5 on the plight of women with disabilities in relation to the provision of sexual reproductive health services including abortion. Chikumba (2014) observed that women with disabilities are still perceived as non-sexual or as not having the capacity to engage in sexual activities. In most cases, it is their immediate family members who decide for them on whether to carry pregnancies to full term or not. They are more prone to sexual abuse and victimization as they are considered to be weak easy targets. Very sober-minded men have the habit of luring mentally challenged women into sexual acts, while their immediate family members have to rush for abortion as soon as they discover this. Blackburn (2002) argues that communities do not have enough knowledge and information about disability issues. Hunt (2006) observed that many communities in developing countries view women with disabilities as being too unwell to engage in sexual activities, and more so, not being strong enough to carry pregnancies. P14, a middle aged single woman, in sync with P5, also testified to the tug of war she witnessed between her physically disabled sister and the members of her entire family. For a long time, she quietly observed that when people were gathering and discussing family issues, they sidelined her. When they gathered to discuss family developments or joyous ceremonies, they would not involve her. Worse still, when families discussed family matters, they seemed not to realize her presence or dream that any sensible idea could come from her. It was after they realized she was pregnant and they tried to reason with her on their abortion procedure decision. She rebelled and rebuked them violently and openly on how they were lost in thinking that *disability is inability* in everything. She declared she was capable of working, thinking, making her own decisions, love and perform sexual activities. She showed dissatisfaction in how they treated her and looked down upon her like she was an empty vessel. She professed she could do things better than what people thought. She resisted the idea of terminating her pregnancy for she felt she had the capability to carry the pregnancy to full term and care for the child on her own.

Immediate family members decide on what to do with the pregnancy of a disabled women. Choruma (2014) argues that women with disabilities are viewed as broken objects and their plight remains on the periphery of policy makers as well as their own immediate family members. It is assumed that the pregnant woman with a disability will transfer the disability to the unborn child, hence they are discouraged from giving birth. Many times, it is assumed that they have no capacity to take good care of the unborn child and the immediate family members advocate for abortion. When a disabled woman is impregnated, immediately, family members rush to seek lawful procedures for safe abortion. With the policy so strict and tiresome, clandestine abortion becomes the first preference.

Chadha et al. (2011) concluded that women with mental disabilities are more prone to forced sterilization and abortion. In most documentation, relatives decided for women with disabilities without their consent. P5 testified of a mentally challenged woman who threw stones at all who would pass by her shack, protesting that they once stole her two other daughters, and now they want to poison her so that she would not give birth. By so doing, she was protesting against a rumor of the family's attempt to terminate her pregnancy

4.4 Abortifacients

One participant, P20, an elderly woman, said *"traditionally, women used herbs for birth control. We would drink the roots, leaves and barks of known trees and they provided perfect birth control."* WHO defines traditional medicine as the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures used in the maintenance or treatment of physical or mental illnesses. Traditional medicines had been used for thousands of years before the introduction of scientific medicines. Giday et al. (2003) discovered that knowledge about medicinal plants is usually communicated orally from generation to generation. Nowadays, in social gatherings, women discuss and share ideas about means and methods of doing away with unwanted pregnancies, twisting the normal use and function of the herbs, by taking an overdose of these natural birth control herbs. "*This has never been so"*, bemoaned P20, an elderly woman. P20 bemoaned the abuse of birth control herbs, converted to abortifacients. Socialization of women takes place in social gatherings like baby showers or kitchen parties and other social gatherings where they meet.

In such gatherings, women discuss ways and means to free themselves from the bondage of patriarchy and all its forms that deny them freedom in terms of their sexual and reproductive health rights, as these are entangled in sexual taboos in religious and cultural practices. Pregnant women and girls in Marange seek abortion from untrained practitioners in unhygienic surroundings. In some cases, they self-induce themselves using desperate methods ranging

from drinking bleach to inserting glass, plant stalks or sharp objects like bicycle spokes into the vagina in order to terminate the pregnancy.

One of the interviewees, P7, expressed great concern that women's sexual and reproductive health issues are taken for granted by both religious and traditional leaders. This has become an endemic problem in Zimbabwe and particularly in Marange rural district, where a dominant African Initiated Church commonly oppresses women through practices like polygamy and child marriage, and at the same time, women are denied bio-medicine. Demographic Survey (2012) indicated that pregnant women of the Apostolic Church have poor outcomes due to their refusal to utilize modern bio-medicines. Members are discouraged from using modern hospital medicine and instead use sacred objects, spiritual symbols and prayer. This becomes a complex issue when it comes to pregnancy complications. Instead of decreasing maternal mortality due to awareness of women's rights, the incidences are actually increasing and there have been a number of deaths during and after the pandemic.

WHO (2013) argues that maternal mortality can be reduced by health-care interventions such as the provision of family planning and maternity care and access to safe abortion practices. Poorer and less educated women are the most disadvantaged, as most of them live in rural areas and are more likely to give birth in the presence of unskilled health workers than better educated women who live in wealthier households or urban areas.

In Marange, whenever there is an emergency, people travel for up to 15 km in ox-drawn carts or in wheelbarrows to Marange hospital, which is situated at the center of the rural district. There is a high burden of ill-health, lack of prenatal care and health interventions, and death from unsafe abortions among women of child-bearing age in Marange. Margaret Chan, General Director of WHO (2014), called for an urgent need to free women by ensuring access to healthcare facilities, including sexual and reproductive health services. She stated that almost 80% of the world's healthcare services are provided by women in their homes, and mostly in the form of traditional remedies.

4.5 Christianity and abortion

Christianity has an impact on abortion discourses, practices and constraints that affect young women's access to safe abortion, beyond the law (Chidavaenzi 2013). This finding is in line with the fact that Zimbabwe is a country that adheres strictly to Christian religious values, doctrines and teachings. Strict and conservative religious values and teachings adhered to by many some of the Christians in Marange are at odds with the advocacy of human and women's

sexual reproductive rights, including abortion, in the Maputo Protocol (1994). Msasa Project also advocated for the reform of the abortion laws during the 2012 Constitution review process (New Zimbabwe 2012). Many young women face challenges when they raise the issue of safe abortion within Zimbabwe Christian circles and in society due to such strong influence. In the case of Marange, the respondents clearly acknowledged that the strong presence of Christian denominations like Catholics, Methodists, Adventists, Pentecostals, as well as African Initiated Churches like Johanne Marange, take it as an abomination to speak about abortion as a woman's sexual health right.

There are many Catholics within the parliament and they are the law makers. As such, it is unrealistic to expect liberal laws on abortion. Nonetheless, is important to recognize that besides the law being restrictive, people still obtain abortions by other ways, and the measures that they put in place suit the conservative nature of the government officials. The government is run by religious and conservative people, especially Catholics, and so it is hard to realize certain rights under such situation. This was the view of respondent P8, a civil servant.

Some of the interviewed respondents seemed to concur on the role of Christianity in stalling policy and legislation reform on the right to abortion (as elaborated above). One can contest the notion that the mere presence of Catholics and believers of Catholicism among government ministers within government structures substantially influences policy decisions on the law and practice of abortion. The Christian religion in the abortion discourses is contested in Zimbabwe and elsewhere in Africa, as seen in emerging literature, though not centering on Zimbabwe (De Zordo and Mishtal, 2011).

These studies cite religious beliefs (mainly Catholicism) embedded within the government system as an obstacle to the recognition and realization of safe abortion (a reproductive health right). In their comparative study on Brazil and Poland, De Zordo and Mishtal's (2011) study established that pushing for abortion rights within countries with strong influence from the Catholic Church was indeed a challenge. Other scholars also alluded to how the presence and influence of the Catholic Church in many parts of sub-Saharan Africa influenced people's attitude and perceptions on abortion (Brookman-Amissah and Moyo, 2004; Braam and Dangor, 2002).

Among the participants, varied perspectives surfaced in relation to the role of Catholicism in mitigating the practices of unsafe abortions in Zimbabwe. For instance, even though some respondents professed to being Christians (Catholics), they still viewed abortion as a positive

move to free themselves from the bondage of unwanted and unsupportable pregnancies among Marange women. Following pregnancy complications and the death of minors during childbirth in Marange within a short space of time, many women now are very particular about the dangers around pregnancies, though they are not fully in control. As gathered throughout the interviews, this indeed was a contradiction to the very teachings, doctrines and values of Christianity, specifically Catholicism and AICs, which are dominant in Marange. The dominant AIC in Marange (Johanne Marange church) does not allow the use of any scientific medicine; neither do its adherents use any contraceptives. This therefore suggests a high probability of unwanted pregnancies. P17, an elderly woman aged 49, narrated how some of the elderly well-known church leaders go around spoiling young women's lives by impregnating them in exchange of material things, for ritual purposes and mostly as mere abuse of power. Then they later encourage the young women to engage in unsafe, clandestine abortions, which they take responsibility to pay for.

This fully illustrates the contradiction among elderly church leaders who purport to adhere to Christian values whilst stiffening regulations relating to women's sexual and reproductive health rights, including abortion.

As P8 testified, her two close church mates were encouraged to abort by church leaders who had impregnated them. One of them was a married college lecturer who is also a Christian, while the other one was their church choir leader. P8 further commented on how some of the Christian men practice double standards.

4.6 Conclusion

The chapter highlights, scrutinizes and analyses the collected data. Interviewed Marange women gave comprehensive data without hesitation. Marange women's stories varied with experiences, age, placement and economic status. Collected data was arranged into common emerging themes. Most respondents spoke of the use of abortion to disown any unintended pregnancy. Participants displayed a great deal of knowledge of Zimbabwean policy on abortion. The only reason they seek backyard abortions is to find quick and readily available services. They indicated knowledge of some of the detrimental effects of clandestine abortions, which they overlook and outweigh to obtain their freedom from intended pregnancies.

Religious and cultural precepts are most acceptable when they impart Ubuntu or good morals. They, however, become threats when they become oppressive, especially to the most disadvantaged gender (females). Shelfer (2016) concludes that sexual danger has become a

normative construction of African male sexuality. A scholarly and strategic focus on young, poor women in global contexts does not necessarily imply a promotion of their health and well-being, nor discursive or material agency or freedom. Rather, the focus is on the machinery of policy and other responses generated by such and serve to reinstate a range of problematic and discourses on gender, class or citizenship. In this instance, the poor women from Marange rural settings are continually oppressed by gender inequality and their impoverished lifestyle, leaving them vulnerable and obsequious. Women reveal their unwillingness to be denied their freedom by performing secret acts like induced clandestine abortion. It is surprising to note that despite the designed strict abortion policies, men at times support, initiate and fund clandestine abortions whenever they intend to cover up the shame and decline the responsibility of unintended pregnancies that occur outside wedlock.

The next chapter provides a summary and feminist reflection before concluding the research paper. Recommendations of this study are also given at the end of the chapter.

CHAPTER FIVE

Summary, Feminist Reflections and Conclusions

5.1 Introduction

The previous chapter presents the views, attitudes and perceptions of Marange women on abortion. It also reveals the major causes and the impact of unsafe abortions on Marange women and the whole nation of Zimbabwe. This chapter presents a summary, feminist reflections, recommendations and conclusions of the study. The study revealed that contributions relating to abortion can be both life-affirming and life-denying so it is necessary to continuously engage and critique some policies, and religio-cultural views pertaining to abortion that continuously oppress and violate women's sexual and reproductive health rights, including abortion. This chapter now outlines and summarizes the study and findings.

5.2 Summary

This study makes the conclusion that women in Zimbabwe, particularly in Marange, practice unsafe abortion as way to free themselves from the bondage of unwanted and unintended pregnancies. Women are denied full access to their sexual health rights due to the designed national policy, as well as religious and cultural frameworks. In Zimbabwe, abortion is legally permissible in limited circumstances; in fact, abortion should be performed in accordance with the provisions of the 1977 Termination of Pregnancy Act. Interviewed women testified how difficult it is to receive legal abortion services in accredited health facilities. Imagining the long and embarrassing procedure, and fear of the full wrath of the law sends them to seek backyard abortion services. Stories from the respondents clearly indicate that abortion is an ancient activity practiced throughout time. Women sacrifice their lives as they seek unsafe abortion procedures to free themselves from unintended pregnancies.

In reality, facing the dangers and risks of clandestine abortions far outweighed the risks of carrying an unintended pregnancy to full term. Both men and women of Marange advocate for unsafe abortions under certain circumstances. Men or women may plan for self- inducement or any abortifacient in order to do away with an unintended pregnancy. According to the respondents, some herbs used in certain proportions as birth control methods are abused as means and ways to terminate pregnancies. The practice of unsafe abortions put the Ministry of Health and Child Care and the whole nation at risk due to post-abortion costs. Unsafe abortions may result in heavy bleeding, damage to the uterus or loss of life. Despite having previously

witnessed unsafe abortions, adverse effects and the endangered life of post-abortion victims, women of Marange continuously undergo clandestine abortions. One respondent claimed that undergoing unsafe abortion procedures is a win-or-lose or do-or-die situation. It is only women who understand the burden and cannot bear the implications of carrying an unwanted pregnancy. The anticipation of an unwanted baby may affect them intellectually, socially, emotionally and physically. In their lived reality, facing the dangers and risks of clandestine abortions is far preferable to carrying an unintended pregnancy to full term. Therefore, the Termination of Pregnancy Act of Zimbabwe, and religious and cultural views on abortion need to be critically analyzed using a feminist lens, assessing whether they are life-denying or life-giving.

5.3 Feminist engagement on Marange women's perceptions on abortion

Pro-choice feminists have focused on abortion in the quest to further the liberation of women. Sherwin (1991) emphasizes how a pregnancy may interfere with the life plans of the mother. These feminists view abortion as a positive move when it is needed. Some women do not have resources available to care for the child. To have the child would simply add to the oppressed state that she already finds herself in, therefore to force her to bear this responsibility will exacerbate the social and economic forces already stacked against her by virtue of her sex (Sherwin 1991: 395).

Anand (2011) wrote that laws that restrict access to reproductive health services interfere with human dignity, which requires that individuals are free to make personal decisions without interference from the state, especially in an area as important and intimate as sexual and reproductive health. Undesired child-bearing exposes women to job loss, family rejection, economic hardships, and foreclosed educational and career opportunities. Bruyn and Uberoi (2013) concur on the impact of reproductive choices on their being central in empowering women because of their being first order strategic life choices which are critical for people to live the lives they want. This means that women's self-determination is impacted by their own choices and ability to access sexual and reproductive health services.

The WHO's constitution, under guiding principles, lists and defines health as a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity.

Based on this definition of health, wellness includes social well-being and access to sexual and reproductive health services, including abortion. Looking closely at this definition of complete

health, a holistic approach to health denotes freedom from any illness or physical ailments as well as freedom from any mental torture or coercion of any form. Women who carry unintended pregnancies will suffer physically, mentally and emotionally. This already brings their lives to a standstill as this mental torture only yields stress and depression. In Zimbabwe, where abortion policy is restricted, women who carry undesired pregnancies have no option besides continuing with the pregnancy to full term. This disempowers women and hinders their educational and career opportunities. Many young women have their education, career and future disrupted at such a critical juncture of their reproductive lives.

Murray (2012) observed that the Maputo Protocol, which came in force in 2005, was widely welcomed as an historic event and a huge step forward in the promotion of women's equality rights in the African region. It became the first international treaty to recognize abortion as a human right with corresponding duties of the state. It situates abortion as a human right within a broader scope of rights to respect.

Dickens (2012) observed that a number of African states, including Zimbabwe, have failed to domesticate the instrument that speaks about women's sexual reproductive rights including abortion and have not served to clarify the law or create new rights and services that empower women, particularly poor women and those who live in rural areas. This is the true experience of Marange women in the eastern parts of Zimbabwe in relation to their sexual and reproductive lives.

Lack of abortion services has dire consequences on women's lives, as highlighted in the findings above. Women bleed to death, have their uterus damaged and they are dying in the attempt to save themselves from patriarchal forces and designs. In Zimbabwe, Manicaland Province, Marange District, there are reports of minors dying during childbirth. This leaves a lot to be desired and food for thought on how maternal deaths and morbidity from childbirth complications can be reduced. Banda et al. (2012) laments on the region's abiding patriarchal legal cultures, customs and traditions in many spheres of life, including the reproductive sphere, which have served to subordinate, impoverish and diminish the personhood of women. The approach and the theories used in this research work are all for women's freedom in their bodily decision making.

Women capable of making decisions enjoy health physically as well as spiritually, emotionally, intellectually, economically and socially. This therefore means that a feminist critical engagement with Marange women's perceptions of abortion contributes to their life- affirmation

and thus answers the key research question of this research.

5.4 Recommendations

The findings reveal that despite the dangers of unsafe abortions, Marange women continue to seek and undergo the procedures. Therefore, national awareness campaigns are essential. Women need to be alert to the life-threatening after-effects of unsafe abortion like hemorrhage, pelvic damage, cervix cancer and death itself. On the other hand, it is wise for women to claim, exercise and realize their sexual and reproductive rights within their communities, in safer ways.

The provision of the Termination of Pregnancy Act and the Criminal Law Codification Act clearly set limited conditions under which abortion can be conducted, and any abortion done outside of these is punishable by law. The shortcomings and strictness of the Termination of Pregnancy Act of Zimbabwe needs to be revisited so that it matches and meets the needs of women's sexuality and reproductive health rights in this twenty-first century. There is a need for reformation to meet the WHO guidelines. The Act recommends abortion services if the pregnancy hinders the physical health of the mother, whereas intellectual, social, emotional, economic and spiritual aspects are overlooked. Mental torture and depression that come with unintended pregnancies will only be solved by a holistic approach to a whole well-being of a pregnant woman.

Some religio-cultural aspects that uphold patriarchal practices and oppress women and girls on issues that affect their biological make-up need close analysis. There is also a great need for closer scrutiny on common cultural practices in Marange, like polygamy, wife pledging and sexual dalliance that leave women with unintended and unsupportable pregnancies and consequently lead to unsafe abortions. Women and girls have to speak up on things that concern them, like their bodies. Women are continually victimized in safe spaces like homes, communities and churches. If the government would work hand in hand with the AICs, communities and NGOs, it would improve women's sexual health services and reduce maternal mortality in Marange particularly. There is a need for pregnant women to seek prenatal and antenatal services from clinics and hospitals rather than getting help from unskilled midwives and prophets in unhygienic surroundings. It is encouraging to see women and girls being empowered, as this will benefit them, their families, communities and the nation at large. Empowered women can make their own decisions, especially on choices concerning their own body.

5.5 Conclusion

Having examined Marange people's religio-cultural perceptions of abortion, the research comes to the conclusion that it is important to understand abortion using a feminist lens. Women need to be empowered to make bodily choices with friendly cultural, religious or political support. Sufficient provision of sexual and reproductive health services, including abortion, can be life-affirming. However, religious and cultural positions on abortions in Marange ought to be critiqued accordingly to detect whether they are life-affirming or life-denying. Considering the context of this study, feminist engagement on the issues has proven to be vital.

It is of great importance to seek to empower women and have their voices heard, especially on issues of their sexual and reproductive health. Pro-choice and pro-life movements need to be clarified so that the debates around abortion are understood, giving more weight to women who carry the pregnancies. The Zimbabwean Termination of Pregnancy Act needs to be revisited so as to assess the restrictions on abortion. A holistic approach to health means considering not only the physical state but the social, intellectual and emotional well-being of a pregnant woman. Such considerations will be life-giving to the women of Marange and the nation at large. The study highlights the difficulty in accessing safe abortion, the reality and occurrence of unsafe abortions, and the relationship to maternal mortality in Marange rural district, Manicaland, in Zimbabwe. The findings presented in this research paper add to an understanding of how global and regional human rights instruments and frameworks can be adapted in local contexts in seeking to protect, promote and fulfil women's sexual and reproductive health rights, in particular, the right to access contraceptives without interference and to attain safe abortion in Zimbabwe. This implies that there is need for cultural, religious and political reformation.

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APPENDICES

Appendix 1: Map of Zimbabwe showing location of Marange rural district in

Manicaland

Marange area is located in the mountainous border town of Mutare under Manicaland Province in Zimbabwe. It is located about 100km South-west of Mutare city. The area is predominantly home to Manyika speaking Marange people and is traditionally administered by the Marange Chieftaincy.

Appendix 2: Interview guide

Research Topic: An analysis of the religio-cultural perception of abortion of Marange people of Zimbabwe using a feminist engagement

Aim: To determine the perception of the Marange women of Zimbabwe on the issue of abortion and how they situate themselves.

Facilitator: Rubbie Rubete

Date: _______________

Would you prefer to remain anonymous Yes No

Age: ________________

1. Have you heard about abortion?
2. What do you think abortion is?
3. Does abortion happen in your community?
4. How do these procedures occur? Is it through certified medical practitioners or illegal practitioners?
5. What do you think are the contributing factors that influence the occurrence of abortion in your community?
6. What is the position of your church and culture on women's sexual reproductive rights including abortion?
7. If a friend successfully induces abortion, would you continue to befriend her?
8. As a woman of Marange, what is your opinion or views on the occurrence abortion in your community?
9. Do you think abortion can be life-affirming or life-denying to a woman?
10. Do you think abortion should be legal or illegal? Give reasons.

Thank you for your participation.

Appendix 3: Consent form

Consent form

My name is Rubbie Rubete, a Master's Degree in Religion and Gender student with the University of KwaZulu-Natal. My research topic is: An analysis of the perception of abortion of Marange people of Zimbabwe using a feminist engagement. This study is under the supervision of Professor L. Siwila.

Your participation is greatly appreciated, please note the following:

(i) participation is entirely voluntary

(ii) you are free to withdraw anytime you may wish to do so

(iii) you are free to answer questions without coercion or threat.

This study is not focusing on women who aborted but is for those who know or once heard abortion issues to share their views and perception. Shared experience will enable the researcher to analyze the attitudes and perceptions of Marange women towards abortion, whether it is life-denying or life-giving. Great appreciation is given for the time spent, however this is of personal benefit since the topic enables women to speak out on issues that affect their sexual and reproductive health. Much effort is put to ensure that all responses are treated with confidentiality. Use of code names is put in place to ensure anonymity of all respondents. As a researcher I will ensure no harm to all individual participants. For any further information please contact; RUBETE RUBBIE CELL;

I have read and understand this, I agree to participate freely

Sign……………………………………………

Date…………………………………………….

Appendix 4: Primary sources

Marange women from Chegore and Chipfatsura villages.

Code name	Gender	Date
P1	female	25/09/2023
P2	female	25/09/2023
P3	female	25/09/2023
P4	female	26/09/2023
P5	female	27/09/2023
P6	female	27/09/2023
P7	female	28/09/2023
P8	female	28/09/2023
P9	female	28/09/2023
P10	female	29/09/2023
P11	female	29/09/2023
P12	female	02/10/2023
P13	female	02/10/2023
P14	female	02/10/2023
P15	female	04/10/2023
P16	female	04/10/2023
P17	female	05/10/2023
P18	female	05/10/2023
P19	female	06/10/2023
P20	female	06/10/2023

CHIPFATSURA
PRIMARY COURT
P.O BOX 7075
MUTARE
DATE 10/10/2022

TO: WHOM IT MAY CONCERN

SIR/MADAM

RE: PERMISSION FOR MRS RUBBY RUBETE I.D. [redacted] TO UNDERTAKE HER ACADEM RESEARCH IN MY VILLAGE

This letter confirms that MRS RUBBY RUBETE is a bonafide resident of MARANGE COMMUNAL AREA.

She is currently stationed at NZAZUKA area where she is teaching. She is persuing her masters degree with KWAZULU NATAL. I give my consent that she is free to interview and discuss with anyone in my village. However any deviation from the purpose of the research shall attract stiffer penalties. All discussions should not meddle with political issues.

Thanking you in advance.

Faithfully yours

Headman Chipfatsura Solomon T.

CHIPFATSURA
PRIMARY COURT
P.O BOX 7075
MUTARE
DATE

CHEGORE VILLAGE
Dumbaushe (Marange)
P O BOX 123
Odzi

10. 10. 2022

TO: WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: PERMISSION FOR MRS RUBBY RUBETE
[redacted] TO UNDERTAKE HER AC
RESEARCH IN MY VILLAGE

This letter certifies that Mrs RUBBY R
is a bonafied resident of MARANGE C
area.
Currently she is stationed at Nyazura
and she is persuing her Masters de
with KwaZulu Natal. I give my con
that she is free to interview and di
with anyone in my village.
However any deviation from the purpo
the research shall attract stiffer pe
All discussions shouldnot meddle with p
issues,

Thanking you in advance.

Yours faithfully

MACHIRI M — Village Head.