

Negotiating the Social and Medical Dangers of Abortion in Addis Ababa: An Exploration of
Young, Unmarried Women's Abortion-Seeking Journeys

Abstract

Unmarried, young women constitute a significant proportion of women who undergo unsafe abortion in Ethiopia. Based on material from an ethnographic study, the experiences of young, unmarried women who had been admitted to the hospital in the aftermath of an unsafe, clandestine abortion are explored in this article. The routes the young women followed in their search of abortion services and the concerns and realities they had to negotiate and navigate are at the fore. Despite their awareness of the dangers involved in clandestine and illegal abortion, the young women felt they had no choice but to use medically unsafe abortion services. Two reasons for this are highlighted: such services were affordable and, significantly, they were considered socially safe in that the abortion remained unknown to others and the stigma of abortion and its consequences could hence be avoided. In situations in which choices had to be made, social safety trumped medical safety. This indicates a need for abortion services that address both the medical and social safety concerns of young women in need of such services.

Keywords: Ethiopia, clandestine abortion, abortion safety, moral topography, negotiating danger, social safety.

Unsafe abortion and the complications associated with it remain significant reproductive health challenges in many countries worldwide and on the African subcontinent in particular (WHO, 2011). In Ethiopia, unsafe abortion ranks among the five predominant causes of maternal mortality (Abdella, 2010). In 2008, nationwide abortion complications accounted for almost half of all obstetric complication admissions (Abdella et al., 2013). Unsafe abortion procedures risk acute complications that may lead to maternal death within a short period, such as bleeding and infection. In addition, such procedures can expose women (including those who survive acute complications) to chronic health problems, such as infertility and HIV infection (Van Look, Heggenhougen & Quah, 2011). These conditions make clandestine abortion anything but danger-free.

Access to abortion in Ethiopia has widened in recent years (Abdella, 2010; Singh et al., 2010). A legal amendment that came into effect in 2006 included the following circumstances in which pregnancy termination is permitted: pregnancy resulting from rape or incest, instances in which continuation of the pregnancy endangers the health or life of the woman or foetus, cases of fatal impairment in the foetus, cases in which the woman is considered unfit to mother the child owing to her young age or a physical or mental deficiency, and cases of grave, imminent danger that can be averted only through immediate pregnancy termination (Federal Democratic Republic Ethiopia, 2005).¹ Following this legislative change, and along with the introduction of

¹ “Cases where Terminating Pregnancy is Allowed by Law.

(1) Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where:

a) the pregnancy is the result of rape or incest; or
b) the continuance of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or
c) where the child has an incurable and serious deformity; or
d) where the pregnant woman, owing to a physical or mental deficiency she suffers from or her status as a minor, is physically as well as mentally unfit to bring up the child.

national guidelines for safe abortion, the number of facilities providing abortion and abortion-related services has increased in both the public and private sectors (H. Gebreselassie et al., 2010). However, the number of women who are victims of unsafe abortion remains substantial. It is estimated that more than half of all abortions in 2008 resulted in complications requiring care (H. Gebreselassie et al., 2010). Among the 58,600 women treated for induced abortion complications in public hospitals and clinics throughout the country, 74% had undertaken their abortions outside of such health facilities, under conditions with questionable levels of safety and efficacy (Vlassoff, Fetters, Kumbi, & Singh, 2012). In Addis Ababa, the abortion rate is 49/1000 women, which is twice the national average (Singh et al., 2010). These figures indicate a significant discrepancy between the number of women who search for and/or undergo abortion and those for whom the amended law provides legal access to pregnancy termination.

The experiences of women in Ethiopia who have undergone unsafe abortion remain largely under-researched. This is particularly the case for *young, unmarried* women, who constitute a significant proportion of the women who undergo unsafe abortion (Bonnen, Tuijje, & Rasch, 2014; Geleto & Markos, 2015; Mulat, Bayu, Mellie, & Alemu, 2015) and whose experiences are at the centre of the present discussion. Considering the high number of unmarried, young women who undergo unsafe abortion procedures, and as argued by Coast and Murray, it is of vital importance to investigate women's routes to clandestine and medically unsafe abortion more closely (Coast & Murray, 2016). In our investigation, as we hope to demonstrate, it soon became apparent that an understanding of abortion safety in terms of medical safety alone will not suffice. Indeed, as Izugbara and colleagues write of the situation in

(2) In the case of grave and imminent danger which can be averted only by an immediate intervention, an act of terminating pregnancy in accordance with the provision of Article 75 of this Code is not punishable, (Article 551, Federal Democratic Republic of Ethiopia, 2005, author's translation).

Kenya (2015), courses of action that are medically unsafe are nevertheless often pursued in the interest of safety, albeit safety from a different yet vital set of dangers. An exclusive focus on medical safety, then, is likely inadequate for the work of meeting pregnant women's safe abortion service needs, in both Ethiopia and across many different socio-cultural contexts.

In the present article, we describe abortion-seeking safety considerations in social and cultural detail by exploring the routes to abortion undertaken by young, unmarried women in particular, whose social situation with regard to abortion differs significantly from that of married women with unwanted pregnancies. The exploration builds on a comprehensive ethnographic study that inquired into a broad range of phenomena related to unmarried, young women's sexual and reproductive health issues. An ethnographic approach was chosen in order to acquire an in-depth and socially and culturally contextualised understanding of induced abortion and its implications for young, unmarried women in Ethiopia (Kebede, Hilden, & Middelthon, 2012, 2014). We start by presenting our research methodology, followed by a consideration of the socio-cultural significance of premarital sex, premarital pregnancy, and induced abortion in contemporary Ethiopia. We then move on to the various providers of abortion (legal and illegal) in the country, and to an initial consideration of the abortion safety concerns associated with them. Following this, we examine the women's routes to the abortion service providers that eventually performed the procedures. At the fore in our discussion are the stakes and concerns the women themselves emphasize as decisive factors at important junctions in their paths towards resolving a socially as well as medically dangerous situation. Our ultimate interpretation of the material, as we will argue, is that the women's concern for managing the social dangers that arise from their situation invariably trumps concerns about the medical risks involved.

Method

The gathering of data took place in Addis Ababa during two periods; the first and most comprehensive phase lasted from December 2006 to November 2007, followed by a shorter follow-up visit from December 2009 to March 2010.

In order to enable an inquiry that situates the abortion experiences of the young, unmarried women in the socio-cultural contexts of their lives, an ‘interactive approach’ in design was adopted (Maxwell, 2013). This comprised a mutually informing set of complementary ethnographic methods: participant observation, individual interviews, focus group discussions, and identification and analysis of local discourses relevant to the research theme. While, in this piece, we engage most directly with the individual interview data, the material generated through the other data gathering means has been significant for our understanding of the social and cultural horizon against which we interpret the interview data. Hence a brief account of these methods is also provided below.

Individual, *repeat interviews* were conducted with 25 young women between 18 and 24 years of age who were residing in Addis Ababa, who had never been married, and who had undergone medically unsafe abortions that had led to serious complications (Table 1).

Table 1. Socio Demographic Characteristics of the 25 young, unmarried women interviewed

Three referral hospitals and five health centres in the catchment areas of these hospitals were approached, and the personnel at these institutions agreed to assist in the recruitment process.

The participating young women were all recruited by their attending nurse/physician while being treated for complications of induced abortion. In order to maximize variation, the first author emphasised the desire to recruit unmarried women of different educational backgrounds, economic statuses, religious affiliations and ages in her initial and follow-up dialogues with

recruitment personnel. Among the 25 women who participated in the study, 18 were under 20 years of age. Two were housemaids with elementary education, four were day labourers with 2-3 years of elementary education, three were students in tertiary institutes, six were high school students, two had completed junior high school and were waitresses working in cafeterias, three had acquired 4-5 years of schooling and were taking vocational training, one was an assistant cook without any formal elementary education, and four were high school graduates looking for a job. Regarding religion, three were Muslim, five were Protestant Christian, and 17 were Orthodox Christian. Furthermore, the recruited women had no history of contraceptive use, had never been pregnant before and, consequently, had no children or abortion experiences prior to the one for which they were hospitalised.

A repeat interview design was chosen for several reasons: to secure possibilities for further exploration of emerging themes, to revisit themes and issues pertaining to individual women so as to gain a fuller understanding of their stories, to ensure opportunities for clarification and double-checking and, lastly, to enable a temporal dimension to be included (Moen & Middelthon, 2015). On entry, all women were asked about and agreed to the repeat interview design, and all participants were interviewed at least twice. (Sixteen women were interviewed twice and nine women were interviewed four times.) The first interview took place after the women had been discharged from the hospital, in a location of their choosing. Altogether, 68 interviews were conducted with the 25 women. While the bulk of the interviews (59 encounters) were conducted during the first phase of the study, nine took place during the follow-up visit. The number of interviews conducted with each woman depended on the extent to which issues that we perceived as motivating further exploration were present. The interviews were conducted in a semi-structured style; i.e. interview guide(s) consisting of themes to be

covered together with open-ended questions were developed and used. While the same guide was used with all women in the first round of interviews, guides for subsequent interviews were planned individually. The guides for subsequent interviews comprised themes that had emerged during the first round, which were to be addressed with all women, *and* queries developed on an individual basis as they pertained to the individual participant and her story. Each first interview lasted 2-3 hours on average. The length of subsequent interviews varied according to the issues that needed further exploration. It is worth noting that none of the women dropped out of the study. While we are hesitant to suggest any simple explanation for this, we would nevertheless like to put forward the idea that their willingness and, indeed, enthusiasm for participation may reflect a general lack of non-judgmental environments for young women to safely reveal and reflect upon their abortion experiences.

In addition to the individual interviews with the young women described thus far, interviews were also conducted with 34 “*resource persons*”, which, in our methodology, are persons positioned so as to possess knowledge of particular relevance to the research themes. For this project, they included health workers, abortion service providers, community opinion leaders, religious leaders, abortion brokers (*delalas*), and other community members, all working or living among the six administrative wards in Addis Ababa where the participating women also lived (Table 2).

Table 2. Socio Demographic Characteristics of the 34 Resource Persons Interviewed

While health workers and abortion brokers were recruited directly by us (first author), the resource persons in the remaining categories were recruited with the help of the *kebele*², i.e. the

² *Kebele* is the lowest administrative government unit in Ethiopia.

administrative areas where the collaborating health centres were located. The resource person interviews lasted 1-2 hours.

Furthermore, 12 *focus group* discussions were conducted to complement the interview material. These involved 144 persons (other than those who took part in the individual interviews). Participants were recruited among the same groups as the resource persons mentioned above. As with the resource persons, participants in the focus groups all lived or worked in the catchment area of the selected health facilities.

For the *analysis of the cultural and social context*, public media (printed press, radio and television), including news, educational and entertainment program categories, were monitored closely. Special attention was paid to issues such as the public health consequences of abortion, ways of avoiding unwanted pregnancy, and moral and legal issues related to relationships, family, sexuality, and abortion. In addition, albeit more eclectically, we scrutinized religious teachings and folktales for topics relevant for the investigation: premarital sex, pregnancy, and abortion among unmarried young women and the moral evaluation of such actions.

The first author, who is a native Amharic speaker, conducted all data gathering; hence, interviews and focus group discussions were conducted in Amharic without interpretation, and all textual and audio-visual materials were accessed in their original language.

Analysis and theoretical framework

Analysis, in the methodology of this study, is perceived as an on-going activity throughout the entire research process and is indeed conceived as a cyclical and ‘reflexive activity’ (Coffey & Atkinson, 1996, pp. 6). For us, this involves a continuous effort to let the diverse materials generated through the different methods enter into dialogue with each other, as well as with existing research in the field and potentially relevant social theory. Thus, emerging

themes, tentative analyses and theorizations were fed back into and explored through the remaining data gathering process. Upon completion of the fieldwork, the material was coded and thematized manually and the process of reflexive analysis continued in the research group until a plausible analysis was reached.

In this article, the following analytical movements may *exemplify* this process: *Firstly*, we pursued an expansion of the thematic purview. It became clear, in the early stages of fieldwork, that we needed to resist a narrow concept of safety when interpreting the material; we would, rather, (at least) have to relate to conditions of social danger in addition to medical hazard. Consequently, the young women's negotiation of social *as well as* medical dangers was incorporated as a research theme early in the process of data gathering. Thus, as we return to below, our analysis complements the recent call by Izugbara and colleagues to widen the meaning of abortion safety to include social, legal, and economic concerns (Izugbara, Egesa & Okelo, 2015). *Secondly*, analysis as a process of theorization is evinced by our development of a concept of 'moral topography'. In contrast to the adoption of the concept of 'social and medical safety', this analytical move took place at a later stage of the process. With 'moral topographies' we aimed to articulate, as precisely as possible, a set of phenomena that, in different ways, had been under scrutiny throughout the entire process, albeit without the assistance of such a concept. When we arrived at this conceptualization, it provided a useful means of not only articulation but also further theorizations of significant empirical data. *Thirdly*, we identified and engaged with social theory; this, admittedly, entailed choice, since material such as that presented here may be interpreted with respect to a number of theories. Here, since social identity and stigmatization quickly emerged as poignant themes, and since the social and cultural were at the fore of our inquiry into these themes, we chose to let the general theories of social identity and processes of

stigmatization of G.H. Mead and Erving Goffman inform our analysis (Goffman, 1963; Mead, 1962).

Ethical Considerations

Ethical clearance was obtained from the National Health Research Ethics Review Committee (Ethiopia) and the Regional Committee for Medical and Health Research Ethics (Norway) prior to data collection.

The study participants were informed that their names and any information that could be used to identify them would not be revealed, and written consent was obtained from all participants prior to the data collection process. In this article, names and other potentially identifying traits or markers have been altered to preserve the anonymity of the study participants.

The landscape of abortion service provision

Public Providers of Abortion Services

In Addis Ababa, as anywhere else in Ethiopia, government-owned hospitals and health centres³ are the main providers of reproductive health services, including abortion-related health services, and especially for the poor (Onarheim, Taddesse, Norheim, Abdullah, & Miljeteig, 2015). As in other areas of women's health, abortion services are more accessible in Addis Ababa than in rural areas (Abdella et al., 2013). While health stations/health posts are involved in abortion-related care⁴, public health centres and hospitals are the ones involved in the actual provision of abortion services (Federal Democratic Republic of Ethiopia Ministry of Health,

³ Health Centre is an establishment which provides both preventive and curative services. It comprises five satellite health posts and is expected to serve for 25,000 people (Federal Democratic Republic of Ethiopia Ministry of Health, 2011).

⁴ Health Post is one of the satellite facility in the Primary Health Care Unit which serves for 5,000 people (1 per Kebele) (Federal Democratic Republic of Ethiopia Ministry of Health, 2011).

2006). According to the Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia, health centres are allowed to provide first trimester and hospitals both first and second trimester abortions free of charge, provided that the legal conditions for permissible abortion are met (Federal Democratic Republic of Ethiopia Ministry of Health, 2006). Both health centres and hospitals provide post-abortion care, although there is great discrepancy regarding the severity of abortion complications that they are expected to manage and the resources allocated to them in order to do so. During the 2006-2007 fieldwork period, abortion services were available in only one public health centre. However, during the second fieldwork period, three years later, abortion services were provided in all public health centres in Addis Ababa, under the specific legal conditions described previously. In public health centres, the procedures are performed in Maternal and Child Health (MCH) service units, which typically also include family planning, delivery and/or PMTCT (prevention of mother to child transmission of HIV) services. In hospitals, abortion-related services are provided in gynaecology units.

Hospitals receive a significant proportion of the victims of unsafe abortion complications when other lower level facilities do not provide post-abortion services on a large scale (H. Gebreselassie et al., 2010; Abdella et al., 2013). During the main fieldwork period, the majority of the public hospitals provided post-abortion care, but not abortion services. At the three public hospitals selected for our study, post-abortion care was available, but abortion services were either absent or dependent upon the willingness of individual practitioners to perform the procedure. During the second fieldwork period, in 2009-2010, however, all public hospitals in Addis Ababa were providing abortion as well as post-abortion services.

Private Providers of Abortion Services

Among the private providers of abortion services, we find both licensed and unlicensed providers. We turn to the licensed ones first: In Addis Ababa, licensed, private facilities provide menstrual regulation and abortion services for clients who can afford to pay the service fees. The number of such private facilities has increased rapidly (H. Gebreselassie et al., 2010).⁵ Providers in this sector include for profit hospitals and clinics as well as clinics run by non-governmental organizations. Such licensed facilities have a qualified staff of professionals who provide menstrual regulation and abortion services on modern, well-equipped premises. Their service fees are, however, quite substantial (Shah, Wang, & Bishai, 2011). For example, in 2007, pregnancy termination at two months in a licensed, NGO clinic in Addis Ababa could cost up to 250 USD⁶. While some of these facilities exclusively provide abortion services, others offer a wider range of services, thereby rendering identification of abortion-seeking women less likely.

Unlicensed, private abortion providers, on the other hand, are characterized by clandestine operation, inadequate medical skills and/or procedure environments that fail to fulfil even minimal medical standards (Lukman & Ramadan, 2003; Tadesse et al., 2001). Several methods are used to induce or initiate abortion, including herbal drinks and the insertion of foreign materials, such as herbs, plastic tubes, and surgical instruments, into the uterus (Senbeto, Alene, Abseno, & Yeneneh, 2005). The procedures are performed in the providers' private clinics, in private homes or even at the backdoors of local *tej beats* (mead houses). Compared to licensed providers, they charge relatively low fees, which are also often negotiable. For example,

⁵ However, although limited in number, there were such private facilities providing menstrual regulation and abortion services for paying clients even before the legal reform (see S. Gebreselassie, 1999; Yoseph & Mulleta, 1996).

⁶ In 2007 1 Ethiopian Birr (ETB) was equivalent to 0.11115 United States Dollar (USD).

during the first phase of the study period, the minimum price charged by the non-licensed providers was around 15 USD.

The women participants of this study attributed great importance to how the various abortion service providers differ in terms of anonymity and discretion. As described above, while abortion services in public facilities are considered medically safe and are accessible free of charge, the facility arrangements make it difficult to protect the identity of those who seek these services. For unmarried women, keeping their pregnancy and abortion hidden is of utmost concern. Indeed, in the accounts of the participating women, this issue is formulated in terms of danger and risk. From this description of the landscape of abortion service provision, then, we turn now to how women navigate in this landscape of medical as well as social safety; that is, we explore the meaning and significance they attach to risks and dangers of different kinds.

Findings

Five traits can be identified as common to all of the young women's journeys to the providers that eventually carried out their abortions. We present these first, before we proceed to an in-depth presentation of the trajectories of three women in particular, carefully chosen to eke out in more detail how these concerns and conditions that are common to all play out in diverse ways in specific cases. We hope by this to both convey the general picture and at the same time highlight the nuances and variations that necessarily characterize the trajectories of individual women. First, all described complex processes of consideration in which medical, social, and economic concerns were weighed against each other. Second, the legal status of abortion did not feature prominently in these processes of consideration, even for the research participant whose situation made abortion permissible by law (a victim of rape whose case will be presented shortly). Third, none managed to meet their needs via the first service provider they approached.

Fourth, all struggled to access information about abortion possibilities and attributed this difficulty to the morally charged silence surrounding abortion and premarital sexual activity.

Fifth, while all shared the experience of being hospitalized in a public facility with post-abortion complications, this did not reflect a lack of awareness of or concern with the medical dangers associated with clandestine abortion. On the contrary, all were well aware of such dangers.

First Attempts to Access Abortion

Misrak was a 19 year-old college student who was living with her widowed mother when we first met her. She first approached an NGO clinic to terminate her pregnancy. Talking about why she had initially chosen this particular facility and how she had carefully tried to address her safety concerns, she said:

... I checked if the abortion service is licensed and if it is clean. I had prior information [to the effect] that the abortion service in this hospital is done by specialists. I also heard that even those who came in to get abortion service and those who have gotten the service do not meet. You go in through the front door and out through the back door. Besides, the clinic provides only abortion services. So, if I meet women who know me in a place that provides only abortion services, it means we are in the same situation. They wouldn't dare to talk about me. I decided to do it there after considering all these issues. It is important for me to keep my abortion secret, for me and my mother's sake.

Misrak carefully assessed the medical and social safety of the abortion services at the clinic she first approached. In deciding to approach this particular facility, she considered a set of concerns, including location and distance, the exclusive nature of the service and the discrete service

arrangements within the facility. She learnt that she would not even share a space with other women receiving the same service. In addition, she presents the abortion seekers' shared bond of social norm transgression as a safeguard against the possibility that one woman would expose the other. Hence, this facility offered relative medical as well as social safety. But, as it turned out, this was available only for those who could pay the service fee:

When I went to the private hospital that I opted for, the nurse told me that the service fee was 240 USD. This is the same as my mom's six-month salary. I felt hopeless and left the clinic crying. I was desperate because there was no way that I could get hold of that much money and also because I couldn't hide my pregnancy for long [...] I was more than ten weeks pregnant. If the abortion was not done quickly, everyone can see the change in my body and know that I am pregnant. After that, even if I have the abortion, it is of no use. The damage is already done.

As for all the women, Misrak's trajectory took form with time as an absolute condition; it took form under the pressure of the gradual progression of her pregnancy, which, of course, made her status increasingly visible. Misrak had to search for another solution.

Rahma was an 18- year-old high school student living with her parents and two brothers. She started her search for abortion services by approaching a public clinic for adolescents.

I thought about using the health centre in my neighbourhood, but what if my mother, father or neighbours who use the same health centre see me entering there? It is dangerous. I decided to go to a public health centre located close to my high school that provides adolescent health services. I could access the service using my student ID for free. Since this health centre is used by people from my

neighbourhood, I did not worry about being seen in the abortion clinic. I knew that the service in public facilities is clean so I didn't worry about infection. I have to have an abortion in secret. Exposure of my pregnancy will cost me not only my name but also my life. If my dad finds out he will kill me. [...] [But] When I went to the health centre located near my high school, I was told that the adolescent clinic doesn't provide such a service and the health centre was providing care only for women who come to the clinic after having abortion.

Rahma sought to accommodate her social safety needs not only by choosing a geographically distant location, but also by choosing a provider located in an adolescent clinic. This would mask, as it were, the true reason for her visit should she be seen there. But, as it turned out, this socially safe provider did not offer the service she so desperately needed.

Adanu was 19 years old during our first encounter. Since she was 13, she had worked as a house maid, following her father's accident, which left him unable to work and support his family. She became pregnant after being raped by her employer's son. Talking about her path to abortion, Adanu explained:

I decided to go to a public referral hospital located far away from my home. Since the hospital is not located in my neighbourhood and doesn't serve people from my neighbourhood, people can't see me while getting the service there. [...] –I know that the service in public facilities is clean, so I didn't worry about getting sick after I had the abortion there. Public facility staff income is not dependent on the profit the hospital makes. So, if they have clean equipment they help you, if they don't they will just tell you to come back next day.

Adanu knew that, as a victim of rape, she was legally entitled to abortion. Her account reveals two concerns that nevertheless complicated her access to the service. First, as we return to below, she did not expect her account that the pregnancy was a result of rape to be believed. Second, she feared that her pregnancy would bring shame to herself and her family. Hence, by initially resolving to approach a public referral hospital at a geographical distance, she hoped to avoid social as well as medical danger. But, nothing turned out as she had hoped:

I went to [name of hospital] public hospital. From the hospital's registration room, I was sent to a clinic for rape victims located in the hospital compound. There I was told that the clinic's services don't include providing abortion services.

We would like to note here that, when we met to make arrangements for our interview, Adanu was hospitalized due to post-abortion complications at the very same public hospital that had refused to provide her with the abortion in the first instance.

Moral Legitimacy and Entitlement to Service

Before we proceed, we wish to note that some of the women did not only navigate closeness and distance with regard to geographies and localities, but also evaluated their options according to a scheme of where, in the terrain of possible providers, they could *morally envisage themselves* as clients – the scheme that we propose to call a moral topography.

Rahma said:

If the service was in the Maternal and Child Health unit, I couldn't use it. A mother's service is for mothers but not for people who are trying to get rid of babies like me.

But the service I chose was located in the adolescent clinic.

And in Misrak's words:

I have been to the health centre with my aunt when she had a miscarriage. The service is located in the Maternal and Child Health unit. I could have used services there if I were married and was in the same situation, but I am not. A mother's service is for mothers, not for people like me.

For both Misrak and Rahma, the service arrangements in the public health centres made abortion-seeking clients easy to detect, since Maternal and Child Health units otherwise only provide reproductive health, family planning and pregnancy- and delivery-related services. In addition to the danger of being detected, their decisions to look for alternative services were also influenced and indeed reinforced by the moral meanings they attached to the particular health services given in the Maternal and Child Health units. Misrak and Rahma both described the maternal and child health units as places for proper mothers and women, that is, pregnant *and* married women *with intentions to carry out their pregnancies*. Thus, Misrak and Rahma felt that the abortion services located there were not for women like them – pregnant, unmarried women seeking abortion for other than medical reasons. Hence, they operate with a distinction between morally legitimate and illegitimate mothers and women. Seeking and acquiring abortion services in such places, then, would actually reinforce their moral transgressions, as their actions would imply that they claim to be something they are not, in their own eyes as well as in the eyes of others.

When First Attempts Fail: Encounters with Intermediaries

When, as described above, the young women could not obtain abortions from the providers they first approached, they had to look for alternative abortion providers. However, being a stigmatized and silenced topic, to ask, talk and know about such matters would itself constitute a moral transgression, thereby involving social dangers. Hence, they had to search for unconventional sources of information. The sources our study participants ended up using fall into two main categories: women who had themselves transgressed societal moral norms, for example prostitutes (or “bar ladies”), and intermediaries who recruit clients to unlicensed abortion providers (so-called *delalas*, to whom we will return in some detail.)

Describing what happened and how she went about her search for an alternative abortion service, Rahma explained:

When the health centre nurse told me that there is no such service in the health centre, I didn't know what to do. But afterwards I thought a lot about it and decided to ask a bar lady who used to live in our neighbourhood for possible help. I thought that it is impossible for her to be in this job for years and have no experience of abortion. [...] I begged her to help me find a provider who is willing to do it for the small amount of money that I can afford to pay. She did help me to get such a provider. Talking to anyone about abortion is not easy but I thought that it would be easier to ask this lady [...] because at least she won't judge me.

While Rahma started her journey in search of an alternative service by selecting her informant (a bar lady), Misrak and Adanu were approached by intermediaries working for private abortion

providers, referred to as *delalas* in Amharic.⁷ Describing how she met a *delala* and how this facilitated her onward path to abortion, Misrak explained:

After learning the amount of money that I am expected to pay to get the service, I decided to look for other affordable clinics. I wanted to get such information from people who have no connection with me or my family but I didn't know where to find such help. While sitting outside the hospital compound not knowing what I should do next, the *delala* approached me and asked me if I needed help to get an abortion service. I said yes. Then he gave me all the information I needed. All I had to do was to listen to him and ask the questions I had. He made it so easy. There was no judgment. It was just a business deal.

Adanu gave the following description:

I knew that I couldn't ask for information about abortion services from people who I am close to and yet keep my pregnancy secret. [...] I did not know even how to raise the issue. But the *delala* was there. He approached me while sitting outside the hospital compound. He himself brought up the issue and gave me the information about abortion service providers. Back then I didn't know that he was a *delala*. He was nice. He promised to find me a provider who gives clean services for a fair price.

Our observations indicate that intermediaries are commonplace in the pursuit and provision of abortion services in contemporary Addis Ababa. Among the 25 women interviewed, 15 had made use of *delalas*, and we were able to interview several such brokers and observe their

⁷ *Delala* is a generic term that denotes transactional intermediaries, regardless of field of operation.

activity during fieldwork. *Delalas* who mediate abortion in Addis Ababa usually hang out around health institutions known for providing exclusive reproductive health and/or abortion services, especially private hospitals and clinics. Some *dalalas* are full-time brokers dealing in a variety of goods or services; others double as operators of small kiosks or shoe shine services along the nearby streets. They approach potential clients and offer information about abortion service providers, carefully presenting their services so as to instil confidence and avoid causing offense. Indeed, throughout the observation period, we never heard the *dalalas* use the term ‘abortion’ (referring to the procedure, instead, as “it” or in other ways that avoided explicit mention). As far as we were able to assess, it is the service providers, not the women, who pay the *delalas* for their service. (To our knowledge, licensed abortion providers do not use *delalas* to recruit clients.)⁸ In the recruitment process, according to many of the young women, *delalas* may intentionally exaggerate the standard and quality of the services they promote, as was indeed experienced by several participants.

Facing Medical Danger in Socially Safe Places

In different ways, the young women in our study explained that they experienced the abortion services they eventually used as socially safe. However, in their encounters with the socially safe places where the abortions were eventually undertaken, and despite the assurances of the *delalas*, all but one came to feel insecure or even scared with regard to medical safety. Misrak described the place as dirty and worried about being exposed to the surgical equipment:

When I went to the clinic, the quality of the clinic was much less than what I expected. When I saw the equipment and the small room stuffed with surgical

⁸ Depending on their prior agreement, the amount they get paid varies from as little as 10 Birr to 10% of the money that an individual woman pays to the abortion service provider. The estimated maximum amount is 100 Birr. In most brokerage business, *delalas* are paid by both parties to the transaction. In the case of abortion brokerage, however, they are paid only by the providers. *Delalas* interviewed explained that this protects them from liability should a conflict arise between an illegal abortion provider and a client.

equipment, I got scared. The abortion provider tried to reassure me by pointing to the women sitting in the waiting room waiting for his service. He said, "If I wasn't good, why do you think all these women come to me?" His reassurance didn't take away my fear. But I told myself that I have to decide what to do next. My belly is getting bigger. Soon, hiding my pregnancy is going to be impossible.

Unlike Misrak, Adanu saw no surgical instruments the first time she met her abortion provider in his clinic. The provider told her that he would induce the abortion with a very effective herbal drink. When she heard this, she said she was relieved because she was worried about the possibility of contamination while undergoing surgery. However, his herbal drink failed to trigger the abortion. Describing what happened thereafter, Adanu said:

After I took the herbal drink he gave me for one week, all I saw was slight bleeding. I went back to tell him. He told me that, if the herbs didn't work, then he has to do it surgically. When he mentioned surgery, I got scared and thought about declining the surgery because I knew the danger involved. But I also reminded myself that I don't have time and that I have to think about what I should do and decide quickly before it is too late.

It bears emphasis that, as Misrak's and Adanu's statements illustrate, they acted under the extreme time pressure dictated by the progress of their pregnancy. To frame what happened at this junction as a choice would belie the pressured course of action they then describe. Without options that are both medically and socially safe, their accounts go on to describe how they

simply had to go through with it, as well as the thoughts and considerations that accompanied the course taken.

Rahma said:

I know that I could get sick or die while having abortion in a clinic which I have no information about, other than the provider's own words. But exposure of my pregnancy will also cost me not only my name and my family's name but also my life. I said to myself that, surely, if everyone having abortion was dying or getting really sick, then these clinics wouldn't be still open and there wouldn't be many women coming here. I thought I could be lucky and things could go smoothly. But I couldn't imagine or say the same thing when it comes to what follows exposure of my pregnancy, especially my father's reaction. The thought was so scary! So I decided to have the abortion in that clinic and try my luck.

Despite the time pressure involved, and despite the very limited options available, the weighing of different categories of danger, social and medical, dominate the women's accounts. Moreover, it becomes clear that what we group as social dangers outweigh medical safety concerns, pointing to the gravity and reality of the threat posed by the social dangers. Indeed, social dangers in the women's accounts are also threats to health and well-being and, as Rahma and Adanu elaborate, not only threats to themselves but also threats to the wellbeing of their families.

Unlike Rahma, Adanu's worry was not about her family's reaction to *her* but, rather, the possible repercussions to her family likely to follow should her pregnancy be exposed. As described above, Adanu was denied an abortion at the hospital despite being a rape victim.⁹

⁹ We would like to point out here that, although the young women focused on the social safety challenges they could face if they utilized abortion services in the public health centres, assuming that they could access such service,

Describing her powerlessness to control her situation and how she went through with the abortion at the unsafe clinic despite her worry, Adanu explained:

Nobody except for my family will believe me even if I tell them that the pregnancy resulted from rape. I can't afford to take care of a baby. [...] But, more than that, for a poor family like mine, getting poorer and poorer day by day, enjoying the respect of their neighbours and their *senbete mahiber*¹⁰ members is the only thing that helps them to keep their heads up and I didn't want to jeopardize that. I have to have an abortion. I have exhausted my options and the only service that I could afford to access to without exposing my pregnancy was the service in the [unlicensed clandestine] clinic. So, I just convinced myself that God who knows how I got pregnant and what I am going through will protect me and nothing will go wrong.

When we explore the underlying logic in Adanu's discourse, the threat posed by the exposure of her premarital pregnancy was the loss of what mattered most in her parents' day-to-day life in their community. This was the danger her medical safety was up against. As the excerpt makes clear, Adanu did not doubt which dimension of safety was more important, and she was just as certain about which scenario carried the worst odds. While she saw a chance of escaping the medical dangers unharmed, the social implications of exposure were a certainty to her – a given that even God could not help avert.

Misrak emphasised how her situation would implicate her mother, explaining that it would be interpreted as an indication of her mother's failure to raise a well-behaved child. She

except for the one young woman who was a rape victim, none of the young women were legally eligible for abortion service since they were neither under age nor physically or mentally deficient.

¹⁰ Mahber/Senbete is a voluntary community religious association unique to the Orthodox Christian Church followers.

explained how she compared the different dangers involved and made the decision that the social dangers trumped the quite apparent medical risks, and also how she made herself able to undergo the surgery:

When I went to the clinic, I was not sure whether the clinic was as clean as the one I chose first. I thought about the backbiting that follows exposure of my abortion to me and to my mom – who’s alone and who sacrificed her life for me – if I use the health centre close to my home. *Yeseat lij lasegnat alfelekum*.¹¹ I compared this with the possible problems I could face while having the abortion in the clinic the *delala* found me. I knew the danger, but I had to have an abortion. To make such a decision, I had to block such fearful thoughts and that was what I did. I said I could be lucky and everything will be completed without any problem. Just prayed to God to forgive me for what I was about to do and at the same time to protect me from all possible danger.

The young women’s overriding concern with social safety was echoed by staff from the community health centres. Among the five health centres selected for our study, only one provided abortion services. However, according to an interviewed midwife, only one young woman had utilized this service during the six months prior to our study and throughout the main fieldwork period. Talking of the health centre where he worked and where the abortion services share space with the family planning clinic, the midwife explained this seemingly paradoxical situation in this way:

They don't come here because they are afraid of being seen in this place.

¹¹ While the term literally means “a child of a woman”, it is a term used to insult a child who is not following societal norms or behaving well. The term indicates the widely held belief in Ethiopia that single women are not capable of bringing up well-mannered and disciplined children on their own.

Afraid of whom?

Afraid of people who know them, seeing them arrive here. They are also afraid of us [the staff]. We live in the same community. They know us and we know them and their families.

Another nurse midwife echoed his account:

We used to have a clinic ready to provide such services seven months ago for the conditions provided by the law but no young woman came here asking for such a service. If young girls come to our facility, they come either when they are in severe and unbearable pain or if they are bleeding after the abortion was induced somewhere else. Even for that they wait until it gets dark so that no one will see them. We used to see such young women coming with a lot of pain when we were on night duty but never in broad daylight.

Discussion

When young, unmarried women describe how they come to find themselves at the mercy of clandestine abortion providers, they describe compelling social and moral concerns with the power to subordinate grave medical dangers. We are assisted in understanding the operation and power of these concerns by some of the significant insights of Erving Goffman, as presented in his seminal work on social stigma (Goffman, 1963; see also Link & Phelan, 2001). This choice emerged from the consistency of this analytical framework with our empirical material (and one that indeed is internal to it in many ways). The framework enables committed attention to the repercussions of social visibility and concealment, the social effects of apparent moral identity

marks and the interrelationship between such ‘outer’ qualities of moral standing and their repercussions for family relationships, as well as for self-identity and self-understanding – all of which were dimensions that loomed large in the accounts and reflections of the young women who trusted us with their stories.

Induced abortion is, in general, morally condemned in Ethiopia. This condemnation is aggravated in cases in which the pregnancy results from a premarital sexual relationship, which is also widely seen as immoral and a breach with traditional codes, even if there are reports of changes, (Lucas, 2001; Mulumbet, 2006; Taffa, Sundby, Holm-Hansen, & Bjune, 2002). If a young, unmarried woman becomes pregnant, the pregnancy threatens to make her moral transgression public, as a visible testimony to her violation of the norm of premarital abstinence. In the absence of possible marriage prospects that may avert the negative social repercussions of premarital pregnancy, to complete the pregnancy and have a child out of wedlock will make this state of affairs permanent, thus compromising her future marriage prospects.

Several points can be made here: Firstly, it is clear from these accounts that what the women fear is an irreversible and highly discrediting status shift, one that arises in the expected moral assessment made by social others with whom they interact and from which the women see little room for escape. In line with Goffman’s argument, they see themselves as subjected to interactions where *other* traits defining them socially and to themselves are rendered marginal or socially void, subordinated to *the one discrediting* mark that, in this way, spoils their identity.

Secondly, while the stigma is socially produced, an anticipated product of the women’s social existence, it is clear that the women’s perception of themselves and their situation is similarly overshadowed by the morality of transgression; they have, to a degree, internalized the anticipated stigma and evaluate their options in terms that are also moral, in the sense that the

options are assessed in relation to the moral status of their condition. Thus, when the women discuss the different institutional arenas to consider on the path to abortion, they employ a logic that excludes certain arenas on the grounds of moral dimensions inherent, as it were, in the arenas themselves. Or, rather, they exclude themselves from certain arenas on the grounds that the arena in question was not, in a moral sense, “for them”. We think here, for instance, of the rejection of maternity and child health clinics as an option, exemplified in the reflections of both Rahma and Misrak, since these are clinics for “real mothers”. Under the ordering, albeit oppressive, operation of the moral codes that engender the women’s anticipated stigma, we propose, the women review their options as if distributed in a terrain that is morally charged in this fashion; that is, they negotiate and manage what we propose to call *a moral topography* of institutions, arenas and personnel. In fact, self-stigma may here be too strong a term, at least to the extent that self-stigma or internalized stigma is seen by necessity to find expression in self-contempt or self-condemnation. Perhaps the phenomenon is more adequately illuminated by applying G.H. Mead’s description of how the generalized other is internalized (Mead, 1962) in applying the moral scheme to the institutional landscape (rendering it a moral topography), the women themselves exercise a version of the very scheme to which their stigmatization is attributed, in a way that indeed discredits themselves. As far as self-judgement is concerned, however, other moral imperatives originating in the same codification of family relations and propriety serve also to buttress their choices as moral choices, cf. Adanu’s commitment to sparing her widowed mother from a moral downfall she could not and should not be made to bear. (Morality and decision-making is considered more fully in Kebede, et al., 2012).

Thirdly, the physical materiality of their growing belly threatens to become the socially irrevocable manifestation that represents metonymically the moral state of affairs, combining the

physical and moral stigma in Goffman's typology. As such, it threatens to enter, in poorly manageable ways, into the interchange through which signs become socially operational and acquire social significance as marks of identity, through processes of concealment, management, and interpretation.

Lastly, the stigma described in the women's accounts is *shared*; that is, it is a moral downfall that reflects negatively the moral fabric of the young woman's family, which will thus become an object of shame and disgrace as well. We would like to emphasise here that, given the marginal economic situations in which the women live their lives, the risked loss of familial support that some of them fear in the wake of their shared stigmatization is very grave indeed. For the young women in this study who were either poor, economically dependent on their families or, indeed, both, to choose a solution that might result in social exposure would risk not only stigmatization but, with it, also the loss of familial support, hence potentially jeopardizing their means of survival.

In focusing specifically on paths to abortion, we have argued that individual women's decisions are not made by considering matters of legality, medical safety, and/or geographic and economic accessibility alone. Socio-cultural concerns and meanings, as well as gendered power relations, are equally influential in the shaping and structuring of these women's priorities and considerations. Indeed, the social repercussions of the stigma associated with both premarital sexual activity and abortion emerges as the most powerful concern of these young women while navigating the terrain of abortion possibilities and limitations. All of the women who participated in this study were well aware of – and feared – the possible medical complications of using unlicensed abortion services. However, social safety concerns trumped whatever medical safety concerns they might have had as they traversed the restricted path of possibilities available to

them whilst their pregnancies progressed. They sought services that they believed could be accessed without social exposure and within the limits of their financial reach, whilst, as their accounts have illustrated, attempting to reconcile medical safety concerns with the overriding force that results from the social significance of their situation.

In the last couple of years, the availability of public abortion services in Addis Ababa has improved. During the follow-up visit, we observed that all health centres and hospitals provide abortion services for the conditions legally provided for, as described in the introduction. Regrettably, however, the arrangement, including the locations of these services, remains the same.

As we have noted, the women participating in this study view MCH units to be beyond their moral remit, since such locales are also subject to the logics of the moral topography, leading some spaces to be deemed accessible and others taboo for them to enter. Even being seen in that environment may raise suspicion, and sharing such a space with married women makes utilizing MCH services very difficult, if not impossible. Therefore, the assumption that the same service arrangements in public health centres will meet the needs of all abortion-seeking women needs to be reconsidered. In our judgement, abortion service provision needs to be organized in a fashion that allows young, unmarried women to utilize services without jeopardizing the social fundament that sustains their day-to-day lives, economically as well as socially and morally.

It bears emphasis that, as we have shown elsewhere, the severity of the social stigma surrounding premarital sexual activity and pregnancy in Ethiopia means that young, unmarried women lack choices with regard to both carrying out and terminating pregnancies (Kebede et al., 2012). The revised criminal code widened the circumstances in which abortion is allowed, but it does not recognize the predicaments of young and unmarried pregnant women (Wade, 2008).

Consequently, many unmarried, young women who want to terminate their premarital pregnancies are left with few options apart from clandestine abortion providers.

The need to improve abortion services with respect to the experiences and perspectives of young, unmarried, and poor women is evident. It is, however, equally required from a public health perspective in a setting of limited resources. As reflected in the narratives of the young women presented here, although all abortions were undertaken in unlicensed, private facilities, the complications were managed by public hospitals. This back and forth criss-crossing between public sector health care providers and private operators – first in search of abortion services and later for treatment following abortion complications – causes an unnecessary burden, not only on the already deprived women, but also on the limited public health resources. Ensuring services that operate within a broader understanding of abortion safety, including social safety, might permit one to direct medical costs and human resources to the provision of services that ensure abortion safety and prevent unwanted pregnancy instead.

In sum, our study indicates that, in order to develop abortion services that are sensitive to social as well as medical abortion safety needs, what we have called the moral topography of abortion needs to be taken into account. Based on the lived realities of unmarried women like those who shared their stories with us, there is no way ‘abortion safety’ can be reduced to a question of protection from medical dangers. Therefore, any effort to improve abortion safety must pair attention to medical safety with an appreciation of the contexts and needs of young, unmarried women in Ethiopia to navigate also threats to their social safety.

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Table 1

Socio Demographic Characteristics of the 25 young unmarried women interviewed

| Characteristics | | Number of persons | % |
|-----------------|-----------------------|-------------------|----|
| Age | 18-19 | 18 | 72 |
| | 20-24 | 7 | 28 |
| Education | Can read & write | 1 | 4 |
| | Primary | 9 | 36 |
| | Junior Secondary | 2 | 8 |
| | Secondary | 10 | 40 |
| | Tertiary | 3 | 12 |
| Religion | Orthodox- Christian | 17 | 68 |
| | Muslim | 3 | 12 |
| | Protestant- Christian | 5 | 20 |
| Occupation | House maid | 2 | 8 |
| | Day labourer | 4 | 16 |
| | Student | 12 | 48 |
| | Cook | 1 | 4 |
| | Waitress | 2 | 8 |
| | Unemployed | 4 | 16 |

Note. The category 'student' includes students in formal educational institutions as well as those taking vocational training outside formal schools.

Table 2

Socio Demographic Characteristics of the 34 Resource Persons Interviewed

| Characteristics | | Number of persons | % |
|-----------------|-----------------------|-------------------|----|
| Age | 18-45 | 13 | 38 |
| | 46-60 | 16 | 47 |
| | >60 | 5 | 15 |
| Sex | Male | 20 | 59 |
| | Female | 14 | 41 |
| Education | Cannot read & write | 2 | 6 |
| | Primary | 10 | 29 |
| | Secondary | 9 | 27 |
| | Tertiary | 13 | 38 |
| Religion | Orthodox- Christian | 26 | 76 |
| | Muslim | 5 | 15 |
| | Protestant- Christian | 3 | 9 |
| Marital status | Married | 17 | 50 |
| | Single | 8 | 23 |
| | Divorced | 5 | 15 |
| | Widowed | 4 | 12 |