

Whose bodies are they? Conceptualizing reproductive violence against adolescents in Ethiopia, Malawi and Zambia

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Abstract

We use a violence lens to visibilize how adolescents who sought abortion-related care in three African countries are coerced, controlled and punished with regards to their sexual and reproductive health. We suggest the use of the concept of reproductive violence to characterize these diverse experiences. Our data comes from a comparative study on adolescent contraceptive and abortion seeking behaviours in Ethiopia, Malawi and Zambia. We conducted 313 interviews that generated both quantitative and qualitative evidence in each country (2018 - 2019). Our analysis shows how adolescent bodies are subject to reproductive violence by parents, partners and healthcare workers, situated within a broader framework of structural violence. Reproductive violence manifests in multiple ways, often within a single abortion trajectory, including coercion to accept post-abortion contraception after receiving facility-based abortion services; having few to no choices of contraceptive methods prior to or after pregnancy; parents and relatives coercing adolescents to not/use abortion or contraception; lack of decision-making regarding sexuality or sexual identity; sex and contraceptive use in relationships rooted in gendered and power dynamics with partners; and - ultimately – adolescents' lack of control over their own bodies. We show how these experiences make adolescents vulnerable to the experience and perpetuation of reproductive violence.

Keywords

Reproductive violence, coercion, adolescents, reproduction

Introduction

Everyday gendered violence – reproductive, obstetric, sexual – is situated within systemic, structural violence. Focused on the experiences of adolescents who have sought abortion-related care, we use the lens of reproductive violence to make visible the multiple and cumulative violences that are individually experienced. Distinct from obstetric violence which happens at an intersection between institutional violence and violence against women during pregnancy, childbirth and the post-partum period (Chadwick 2016), reproductive violence draws attention to non-obstetric violence that is related to reproduction. In this paper we argue for the use of the concept of reproductive violence to make visible diverse experiences of violence prior to and post-abortion. We use data collected from a three country (Ethiopia, Malawi and Zambia) study that explores adolescent contraceptive and abortion-related care.

Before moving to conceptualizing reproductive violence, we briefly consider the context of our research and the critical need to focus on reproductive violence experienced by adolescents. A common framing – both within African countries and beyond from the Global North – is through demographic metrics; adolescents aged 10–19 years account for about one fifth of the population in our three study countries (UNDP 2019) and experience relatively high rates of “unwanted”¹ fertility (DHS Ethiopia 2016; DHS Malawi 2015-16; DHS Zambia 2018). Such metrics and aggregate framings “increasingly define what it means...for individuals to be healthy and happy” (Tichenor 2020) and serve to invisibilise the violences experienced by adolescents in their reproductive lives. Research in Africa consistently shows that adolescents are among the most vulnerable of groups due to a complex set of factors operating on various levels ranging from the individual (e.g.: age, class, dis/ability, gender, ethnicity, socio-economic status), to community (e.g.: gendered norms and power differentials about sexual decision-making and negotiations, provision of school-based

¹ We understand that the use of the term unwanted has been problematized for denoting a liberal subjectivity where a range of choices and desires are possible ignoring some of the reasons that make a pregnancy problematic (Chiweshe, Mavuso & Macleod 2017). We use it here as it is the term used when reporting fertility.

comprehensive sexuality education), to national (e.g.: laws on the age of consent and policies related to the provision of adolescent sexual and reproductive health services) (Kangaude, Coast & Fetters 2020).

Gendered and aged norms place restrictions on adolescent girls' reproductive autonomy and decision-making. Adolescent girls are constrained in their sexual interactions as dominant sexual scripts deny adolescent sexual agency and confirm adult control of adolescent sexuality (Mutema 2013). Power dynamics linked to patriarchal ideologies often construct adolescent girls in ways that include being asexual or passive, limiting their sexual agency (Chiweshe & Chiweshe 2017). African adolescent sexualities are rarely situated within scripts of pleasure or satisfaction; narratives of stigma, censure and punishment dominate (Kangaude 2017). Despite these contestations on adolescent sexuality, adolescents find ways to create spaces where they express and practice their sexuality (Chiweshe & Chiweshe 2017). With agency, adolescents are able to resist the constraints that society (parents, community members, healthcare professionals) place on their sexualities and make autonomous choices about their own pleasure and reproductive futures.

Because the broad category of adolescent (ages 10 -19 years) transects legal categories of child and adult, central to questions of autonomy about sexuality and reproduction are issues related to their capacity to make decisions and the legal frameworks by which they are framed. While this capacity to make decisions and act upon them is constrained by overlapping community and societal influences, this capacity evolves and is not linked directly to chronological age (Lansdown 2005). Competing arguments suggest that young people do not have the capacity to make decisions with regards to their sexual and reproductive health and parents need to be involved (Willan et al 2020).

Conceptualizing “reproductive violence”

We use the term reproductive violence to better capture the broader experiences of violence that might be missed by using single concepts of reproductive coercion, reproductive abuse, coerced reproduction, reproductive control, sexual coercion or pregnancy coercion. All these concepts involve perpetrator behaviours intended to maintain power and control. Reproductive coercion – and reproductive abuse and coerced reproduction - relate to behaviours that interfere with the autonomous decision-making of a person with regard to reproductive health (Silverman & Raj 2014). Reproductive control involves direct acts of ensuring that a person cannot use contraception (Miller et al 2007). Pregnancy coercion also includes direct interference with contraception and can also include interference with either keeping or terminating a pregnancy and forcing someone to become pregnant (Lang et al 2007). Sexual coercion involves behaviours that pressure or coerce a person to have sex without using physical force (Fernández-Fuertes 2018). Other closely related concepts include reproductive autonomy (Upadhyay et al 2014) and contraceptive autonomy (Senderowicz 2020).

We recognise each of these individual concepts as critical in unpacking the manifestations of power and its inequitable and unjust experiences and outcomes for individuals. We argue that in order to make visible – and intervene in - the experiences of adolescents, the concept of reproductive violence is analytically productive. We define reproductive violence as any acts that impact reproductive capacity or autonomy perpetrated by a third party (including, but not limited to, partner/s, parent/s, family/ies, and in/formal healthcare providers) that reduces an individual's reproductive autonomy. Unlike sexual violence – which is recognised as a distinct violence that carries sanctions – reproductive violence is under conceptualised and theorised. Whilst some reproductive violence can be linked to sexual violence, reproductive violence also occurs in the absence of sexual violence. We situate reproductive violence as a complementary lens to structural violence – violence that is “institutionalised and every day” and “the violence of injustice and inequity” (Nandagiri, Coast & Strong 2020). Combining institutional structural violence and individual reproductive violence demands an active and political framing of adolescent experiences; this choice is a deliberate one and distinct from a more passive social determinants framing.

Using a framing of reproductive violence centres adolescents' reduced autonomy and control over their own bodies, particularly (but not only) those below the age of legal majority. Reproductive violence incorporates the multiple ways in which coercion and violence happen across either the life course or a pregnancy (irrespective of how that pregnancy ends). Reproductive violence also affords the opportunity to expand understandings of the perpetrators of violence. Evidence relating to adolescents has tended to

focus on intimate partners (e.g.: the role of partners on coercing sex) or immediate family (e.g.: parents controlling contraception); the roles of others (e.g.: healthcare workers, employers) as perpetrators of reproductive violence are made less visible.

Methodology

Our data comes from a broader comparative study on adolescent contraceptive and abortion-seeking behaviours in Ethiopia, Malawi and Zambia (for more details see <https://abortionin africa.wordpress.com/> and Kangaude et al 2020). We conducted 313 interviews that collected both quantitative and qualitative evidence across the three countries between 2018 and 2019. Our participants were adolescents aged 10 – 19 years old who were interviewed by female research assistants who spoke their own local languages. Participants, who were either seeking a safe abortion or had come for postabortion care, were recruited at facilities by a senior study nurse who introduced the project. If the potential participant was interested, the nurse referred them to the research assistants who explained the project in detail and got informed consent. The interviews were done in a private room at the different sites. The interviews were recorded after consent was sought and transcribed and translated by the research assistants. The transcribed interviews were checked by Author 1 and Author 3. Data was analysed using Dedoose and thematic analysis was conducted by five members of the study team.²

Analysis

Our readings of interview transcripts across the three countries highlighted how adolescent bodies are contested by parents, relatives, strangers, partners and healthcare workers; adolescent reproductive preferences and desires are often minimized, ignored or overridden. In these contestations adolescent girls were exposed to reproductive violence, mitigating their autonomy, power and control over their reproductive lives and decisions. In every situation the adolescent girl's younger age in relation to her partner or family or acquaintance or healthcare worker is implicated – explicitly or implicitly - in her reduced control and autonomy. The analysis presented here focuses on the cases we identified where adolescents experienced reproductive violence; there were cases in which adolescents sought out or had the support of parents, strangers, partners and healthcare workers who acted as enablers to supporting adolescent reproductive autonomy. Reproductive desires, preferences and plans can be simultaneously complex, contradictory and ambivalent; they change within a short period of time, including over the course of a pregnancy. In our study, reflecting variations in legal and service provision for safe abortion, 98% of adolescents in Ethiopia had a safe abortion in a facility compared to 34% and 4% in Zambia and Malawi, respectively. The extracts presented in the analysis below exemplify patterns that emerged in the data; we have tried to do justice to the messy realities of adolescents' lives and relationships on the basis of interview-based accounts of sex, contraception, pregnancy and abortion. In our extracts R stands for respondent and Int1 for interviewer 1.

Sexual violence linked to reproductive violence

In all three countries sexual violence – by strangers, acquaintances, family members - was a common feature in adolescent narratives:

Extract 1

R: I was raped by my grandfather repeatedly and both times he did not use any protection. My aunt knew about this but kept quiet. My father did too, and he did not do anything about it, he was protecting my grandfather from going to jail and was also protecting the family reputation. My grandfather threatened that if I told anyone about what he did he will kill me.... – Malawi Age 15.

Extract 2

R: The place was close to bars.... there was a certain man that used to rent at a barber shop. So, that same man, when aunt was not around, he said come here your aunt has said I should send you [for an errand] When I went there, he locked me in the house with his friend, he locked the door and gave the keys to his friend. Then he played the stereo, removed my underwear and started raping me.... After he was done, he told me that you should never speak about it, if you speak and I hear it; wherever you are I will find you, I will beat you – Zambia Age 13.

² Ethical review was obtained in Ethiopia (Ethiopian Public Health Institute: 154-2018), Malawi (National Health Sciences Research Committee: 2003), Zambia (ERES- 2017-Nov-005) and the UK (London School of Economics: 000606).

Extract 3

R: We were coming from {town}. When we arrived at {town}, it was dark.... We were unable to travel. So, we spent the night in {town}. There were robbers. They started to follow us. When we got a hotel room, they broke the door to get in.....We were three women.....They were seven..... they raped all the three of us – Ethiopia Age 19.

These three extracts illustrate how sexual violence can be implicated in reproductive violence instigated by relatives, acquaintances or strangers, all punctuated by threats to avoid repercussions. In all three cases the sexual violence resulted in pregnancy and ended in abortion. In all three cases, involving different types of perpetrators, power and/ or fear were used to control participants' bodies, leading to three unsupportable pregnancies. In all three cases the participants sought abortion – of varying levels of safety - due to the circumstances of their pregnancies.

Sexual coercion linked to reproductive violence

Sexual coercion involves a wide range of practices (Moore et al 2007) and was a common feature of adolescents' narratives, linked to a wide range of reasons – in our study, these were primarily transactional, or for safety, security, and familial obligations:

Extract 4

R: I was looking for a job and I met a broker. He told me he would find me a job shortly and he was staying in a hotel...Then he told me he would find me a job and he would also arrange a place for me to spend the night. Then we went to a hotel room and he had sex with me – Ethiopia Age 18.

Extract 5

R: Most of the time, I had sex with him without my interest and my family supported his idea to marry me. Sometimes I had sex with him because of their pressure and without my plan – Ethiopia Age 17.

Extract 6

R: He was just a destroyer..... He just forced me; I didn't know anything.....When I went there, that's how he caught me. I told him to at least use a condom he said, no, you think I have diseases. I tried here and there but it didn't work. After making me pregnant then he told me here drink this and that you will not get pregnant... – Zambia Age 17.

These extracts illustrate the diverse forms and sources of sexual coercion that led to unsupportable pregnancies that ended in abortion. Extract 4 focuses on coercion from a labour broker who required sex in return for getting the respondent a job, a common theme in our research. In extract 5 the coercion is rooted in familial pressure to marry, irrespective of the adolescent's wishes. Extract 6 shows multiple forms of reproductive violence enacted in a relationship with a boyfriend, including forced sex, condom refusal and coercive control over potential pregnancy. Sexual coercion, as described here, does not involve interpersonal violence but demonstrates how adolescents' sexual autonomy is constrained and compromised by structural and gendered factors, such as negotiating with a sexual partner or a lack of livelihood options for girls, that combine to lead to reproductive violence.

Control in the use of contraceptives

Contraceptive control by male partners was most commonly framed in terms of male condom use, reflecting limited information and availability and understanding of other forms of contraception available to most of the adolescents we interviewed. Narratives referred to scripts of love, male sexual pleasure and economic power that led to condom non-use or stealthing. Our analyses are necessarily limited to adolescent girls' interpretations and presentations of contraceptive control or coercion; we present one side of the complex realities that underpin and influence contraception decision-making and non/use in heterosexual relationships (Garcia-Iglesias & Strong 2021):

Extract 7

R: So, I told him that, if you have Maximum (brand of condom), I can sleep with you, so that this ends [arguing]. He said, when I was giving you my money, were you eating it in a wrapper? – Zambia Age 17.

Extract 8

R: He was refusing that if he used something then how was he going to feel the actual taste of a woman? But I told him that we needed to use them to prevent diseases, but he insisted and told me to leave if I did not want. So, I told him that I was going to leave but then he started begging me not to go – Ethiopia Age 16.

Extract 9

R: My boyfriend told me he has used a condom when we had sex, but he did not use it then the pregnancy happened – Ethiopia Age 17.

In extracts 7 and 8 both partners refuse the use of condoms linked to male sexual pleasure, reflecting findings from other studies in Africa (De Villiers, Mash & Mash, 2010). In extract 7, the partner exerts pressure by reminding the respondent of the money he had spent on her. This type of coercion – which some authors construct as a form of transactional sex – reflects the relatively lower economic power of adolescent girls, especially (but not only) in relationships with older men. Gifts or money that are an integral part of the relationship exacerbate the power and often the age differentials and can be used to demand complacency, monogamy, or unprotected sex (Austrian et al 2019). In extract 9, the boyfriend lied about his use of a condom, resulting in an unsupportable pregnancy. Work elsewhere identifies non-consensual condom removal as a form of reproductive coercion (Grace & Fleming 2016), underpinned by gendered power asymmetries in heterosexual relationships that are amplified by age asymmetries.

Coercion around male condom non/use was also framed in terms of gendered scripts about proving trust and / or love in a relationship:

Extract 10

R: For me I thought... I was thinking that we were using a condom but him he was like, because when I started working, we started having problems in the relationship.... We started having quarrels, so he was like, "No, you are going to leave me then, no wonder you are doing this." That's how he did that – Zambia Age 19.

Extract 11

R: He was refusing to use any method. We argued about it and he said that means I did not love him, then I just gave up – Malawi Age 18.

In both extracts above male coercion to not use contraception uses trust issues, either regarding fidelity or true "love". In Extract 10, because the respondent had recently started a job, her partner constructed her requests for having protected sex as a sign that she does not trust him. Her agreement to not use condoms was a way for her to express her trust in him. In Extract 11, having sex without any contraception was presented by the boyfriend as a sign of love; to prove her love and maintain the relationship, the adolescent girl "gave up" trying to negotiate contraceptive use.

In some instances, refusal to use [or allow the use of] contraception was framed explicitly by a male desire to produce a pregnancy:

Extract 12

R: He was just refusing that I should not use these things [contraception].

Int1: Why do you think he was refusing?

R: He was saying that he wanted me to bear him a child – Zambia Age 15.

In Extract 12, the adolescent girl had introduced the idea of using contraception, but her boyfriend wanted her to become pregnant. It is unclear whether the adolescent was ambivalent about pregnancy, or thought her chances of becoming pregnant were low, or thought that a pregnancy might lead to marriage. Irrespective, the result was an unsupportable pregnancy as a result of contraceptive refusal by her boyfriend. The assumptions of a pregnancy leading to marriage or a marriage proposal and the unsupportability of a pregnancy outside marriage can be linked to social norms where marriage is seen as the appropriate place for reproduction (Chiweshe et al 2017).

Coercive care frequently extended to post abortion family planning, and was perpetrated by healthcare workers:

Extract 13

Int1: Were you offered a family planning method today?

R: Yes.

Int1: Which type of method?

R: They told me as it works for three years.

Int1: Did they tell you about another option?

R: No, they did not tell me.

Int1: Was it your choice?

R: No, it was not my choice. I thought that they would not provide me the service, or the pregnancy would not terminate if I did not use family planning, then I accepted it – Ethiopia Age 18.

Extract 14

Int1: Were you interested in the method [implant]?

R: I was not interested, since they said it is the requirement to get the service of termination, I agreed – Ethiopia Age 18.

In extract 13, the respondent is not given a choice on what contraceptive she would like, in both extracts the providers propose the longest acting and most effective methods available to them. The respondent is also made to think that if she does not take postabortion contraception then she will not be offered abortion services. In extract 14 the respondent does not want contraception, but she is told that postabortion contraception is required to access the service. Postabortion contraception is supposed to be voluntary, but this is not reflected in these extracts. The evidence we identified relating to coercive post-abortion family planning is all drawn from Ethiopia where more girls were “offered” contraception than in Malawi or Zambia.

Control and coercion around terminating a pregnancy

Adolescents we interviewed experienced control and coercion about abortion, either to have or prevent an abortion, enacted by multiple actors:

Extract 15

R: ... he [boyfriend] told me to take medication and clean my womb so that I should start menstruating. I refused.... and he said that if I do not want to do it then it is none of his business. I said that whatever happens to me I am ready.... That is when his sister told me to escort her somewhere, and I told her that I cannot escort her because my mum was not at home.... but she still insisted that I should go with her.... we stopped somewhere, and I asked her why we stopped there, and she told me that she wanted them to give me medication to help me develop the baby. That's when they inserted some medicine in my vagina and told me that my pregnancy has been terminated; then I told them that it was not good they should have asked me if I wanted the abortion or not – Malawi Age 17.

Extract 16

R: My period got delayed for two months. I, my boyfriend and his friend were sitting together the other day drinking a soda and he [friend of her boyfriend] put medicine in the Miranda [soda] I was drinking..... The next day, I started bleeding. That time I thought it was my period.... But I didn't think that it might be a pregnancy.... Why would I want to abort my pregnancy?... So, because of what he did to me my pregnancy got removed but I wouldn't do that on myself – Ethiopia Age 19.

Extract 15 and 16 illustrate how some adolescents had pregnancies terminated against their will or without their knowledge. In extract 15, the participant is pressured by her partner to have an abortion that she refuses; subsequently, her partner's sister tricks her into taking abortion medication against her will. In Extract 16 the partner and a friend conspire to put pills in the participant's drink, leading to an abortion. In these two extracts reproductive violence is enacted on adolescents who had not wanted to have an abortion – involving partners and their partners' networks – demonstrating coercive actors extend beyond sexual partners, although the gendered response was most often initiated by male partners. There is a dearth in literature that looks at this form of reproductive violence in African settings (Freeman, Coast & Murray 2017). Most research has explored women's networks (partner, partners' family, friends, colleagues and other societal members) as enablers or barriers when women want to have an abortion (Kumi-Kyereme, Gbagbo & Amo-Adjei 2014). One response of male partners to disclosure of a pregnancy – both in our study and in studies elsewhere in Africa – is of absenting themselves from the relationship, either by direct denial of paternity or disappearing from the relationship. It could be argued that this behaviour reflects another dimension of reproductive violence – violence by deprivation of support (emotional, economic) to continue with or terminate a pregnancy (Schwandt 2013).

Reflecting the young age of our interviewees – many of whom were in school and lived at home with their parents – coercion to have an abortion came from family members:

Extract 17

R: So, my mother said to me “you can't be pregnant, it's got to be a lie. All your elder sisters have completed school without getting pregnant....” She said in this case she was going to have it terminated. So, I asked her what if the guy finds out? And she said, “That has no use to me whether he finds out or not, I am having this pregnancy terminated” I told him I was pregnant, and he was

happy about it, he even told his family about it, the mother and everyone.... So, they tried to talk to my mother about it.... But she just refused that she cannot be a grandmother at her age. ... I wanted to keep it.... There was nothing I could do; she is my mother. So, that is how we came here, and the doctor asked me if I wanted to keep it or have a termination. Then my mother said if I kept it, she would kill herself – Zambia Age 17.

In Extract 17, the participant does not want to have an abortion but is coerced by her mother, who uses threats of killing herself if the pregnancy is not aborted. The participant is taken to the healthcare centre and the decision to terminate is made for her, despite her wishes and the wishes of the partner and his family to continue the pregnancy. The abortion still occurred despite the doctor ostensibly asking the adolescent if she wanted it, showing the intensity of the familial pressure as noticeable even for healthcare providers who would usually defer to parents' directives. The mother in this extract uses her power and position to make the decision to have an abortion because the pregnancy threatens her own standing. The role of mothers in abortion decision-making processes is minimally documented with literature.

Coercive abortion-related care

Our framing of reproductive violence includes the violence that adolescents experienced within institutions (eg. health facilities) or agents of those institutions (eg. healthcare workers). Despite clear policies and protocols for the provision of abortion-related care in each of the study countries (Kangaude et al 2020), adolescents reported treatment that would constitute reproductive violence:

Extract 18

R: Yes, I then went to a health centre to get checked and after confirming that I was pregnant I wanted to terminate the pregnancy. But they asked me to bring my partner's consent or I have to come with my parents to have the procedure. I don't know the man and I can't tell my parents... – Ethiopia Age 18.

Extract 19

R: Then she [the pharmacist] took me to that clinic and they asked me why I wanted to terminate my pregnancy if I was married, and I told to them all about my husband. And after I took a medication card for 150 birr, they made an appointment for me to come back by the next day with my husband. But my husband refused to go with me, and this made me get referred to a nearby facility. However, they said that they never do this unless they discuss with him. – Ethiopia Age 18.

Both these extracts are from Ethiopia, the country in our study with the most widely available abortion services in public health facilities and with established protocols not requiring third party consent from parents or partners. In both cases the result was that the respondent had to seek abortion care elsewhere, delaying her care. In extract 18 the respondent was asked to bring parents or a partner before abortion care would be provided. In extract 19, the married respondent was instructed to bring her husband, who refused to accompany her. Such denial of care is an institutionalised form of reproductive violence, preventing an adolescent from exercising her agency to achieve reproductive autonomy. In these cases, the adolescents were able to obtain care, many others are turned away and may seek unsafe procedures.

In other cases, respondents were coerced to disclose unsafe abortion attempts in order to receive post-abortion care:

Extract 20

R: They asked me if I had aborted and I refused. There was evidence of pills in my vomit, they threatened to withhold treatment if I didn't tell the truth. I was in pain and I finally gave in and told them – Malawi Age 19.

In extract 20, the respondent did not want to disclose to healthcare workers that she had induced an abortion, but she was given a choice of either disclosing or care was going to be withheld. The role of healthcare providers has been interrogated with research reporting how their care can become a barrier when they act in a judgmental or ageist manner (Gelaye, Taye & Mekoonen 2014).

Conclusions

Adolescents experience reproductive violence perpetrated by institutional and individual actors, violence that can be concurrent and cumulative. The ways in which adolescents experience reproductive violence are likely to be different to that experienced by older women; age is just one factor – but a profoundly important one. We argue that adopting a reproductive violence framing helps to make visible the multiple

forms of violence that adolescents may experience in their trajectories of abortion-related care, in ways that are not possible if we only focus on single concepts, such as reproductive coercion, for example. Our evidence shows how reproductive violence manifests in different ways including: coercion to accept postabortion contraception before or following obtaining facility-based safe abortion services; lack of autonomy regarding sexuality or sexual decision-making, sex and contraceptive use in relationships; ultimately, reduced control over their own bodies. Reproductive violence is distinct from sexual violence; whilst sexual violence was implicated in many adolescents' experiences, reproductive violence also occurred in the absence of sexual violence. Reproductive violence acknowledges the wide range of perpetrators – individual and institutional; it is broader than obstetric violence which focuses on institutional perpetrators and excludes violence wrought by informal providers of less and least safe abortions outside of facilities. Our choice of reproductive violence as a lens to understand the experiences of adolescents who have sought abortion-related care forces us to link sometimes multiple and cumulative instances of violence within a single abortion trajectory in an effort to more clearly articulate this treatment and to propose potential solutions to mitigate it. Each abortion trajectory is situated within the structural violence enacted by – for example – legal and healthcare institutions and histories that affect abortion access and the reproductive autonomy of adolescents.

References

- Austrian, K, Soler-Hampejsek, E, Duby, Z & Hewett, PC 2019, "When He Asks for Sex, You Will Never Refuse": Transactional Sex and Adolescent Pregnancy in Zambia. *Studies in Family Planning*, vol. 50, no.3, pp.243-256.
- Central Statistical Agency (CSA) [Ethiopia] and ICF 2016, Ethiopia Demographic and Health Survey 2016, Addis Ababa, Ethiopia, and Rockville, Maryland, USA.
- Chadwick, RJ, 2016, 'Obstetric violence in South Africa', *South African Medical Journal*, vol. 106, no. 5, pp.423-424.
- Chiweshe, M & Chiweshe, M 2017, 'Not My Child': Parents' Denial About Adolescent Sexuality in Harare, Zimbabwe, *Journal of Family & Reproductive Health*, vol. 11, no. 3, pp.119–127.
- Chiweshe, M, Mavuso, J & Macleod, C, 2017, 'Reproductive justice in context: South African and Zimbabwean women's narratives of their abortion decision', *Feminism & Psychology*, vol. 27 no. 2, pp.203-224.
- De Villiers, P, Mash, B & Mash, R 2010, 'Why don't you just use a condom?': understanding the motivational tensions in the minds of South African women'. *African Journal of Primary Health Care and Family Medicine*, vol. 2, no.1, pp.1-4.
- Fernández-Fuertes, AA, Carcedo, RJ, Orgaz B & Fuertes, A 2018, 'Sexual coercion perpetration and victimization: Gender similarities and differences in adolescence'. *Journal of interpersonal violence*, vol. 33, no.16, pp.2467-2485.
- Freeman, E, Coast, E & Murray, SF 2017, Men's roles in abortion trajectories in urban Zambia, *International Perspectives on Sexual and Reproductive Health*, vol. 43 no. 2, pp. 89-98.
- García-Iglesias, J & Strong, J 2021, 'From contradictory to complementary: Acknowledging the complex everyday choices of men's sexualities', <https://blogs.bmj.com/medical-humanities/2021/02/03/>
- Gelaye, AA, Taye, KN & Mekonen, T, 2014, 'Magnitude and risk factors of abortion among regular female students in Wolaita Sodo University, Ethiopia', *BMC women's health*, vol. 14, no. 1, pp.1-9
- Grace, KT & Fleming, C 2016, 'A systematic review of reproductive coercion in international settings', *World medical & health policy*, vol. 8 no.4, pp.382-408.
- Kangaude, G 2017, Adolescent sex and 'defilement' in Malawi law and society. *African human rights law journal*, vol. 17 no. 2, pp. 527-549.
- Kangaude, G, Coast, E & Fetters, T 2020, 'Adolescent sexual and reproductive health and universal health coverage: a comparative policy and legal analysis of Ethiopia, Malawi and Zambia', *Sexual and Reproductive Health Matters*, vol. 28 no. 2.
- Kumi-Kyereme, A, Gbagbo, FY & Amo-Adjei, J 2014, 'Role-players in abortion decision-making in the Accra Metropolis, Ghana', *Reproductive Health*, vol. 11 no. 1, pp.1-9.
- Lang, DL, Salazar, LF, Wingood, GM, DiClemente, RJ & Mikhail, I 2007, 'Associations between recent gender-based violence and pregnancy, sexually transmitted infections, condom use practices, and negotiation of sexual practices among HIV-positive women', *Journal of Acquired Immune Deficiency Syndromes*, vol. 46, no.2, pp.216-221.
- Lansdown, G, 2005, *The evolving capacities of the child*, No. innins05/18.

- Miller, E, Decker, MR, Reed, E, Raj, A, Hathaway, JE & Silverman, JG, 2007, 'Male partner pregnancy-promoting behaviors and adolescent partner violence: findings from a qualitative study with adolescent females', *Ambulatory Pediatrics*, vol. 7, no .5, pp.360-366.
- Moore, AM, Awusabo-Asare, K, Madise, N, John-Langba, J & Kumi-Kyereme, A 2007, 'Coerced first sex among adolescent girls in sub-Saharan Africa: prevalence and context. *African Journal of Reproductive Health*, vol. 11 no.3, pp. 62.
- Mutema, F 2013, 'Breaking the silence: Communication between parents and secondary school adolescents in the context of HIV/AIDs in Zimbabwe: A Case of Mkoba high density suburb, Gweru', *Journal of Emerging Trends in Educational Research*, vol. 4 no. 4, pp.604.
- Nandagiri, R., Coast, E. and Strong, J., 2020, COVID-19 and abortion: making structural violence visible, *International Perspectives on Sexual and Reproductive Health*, vol. 46 no. 1, pp. 83 - 89.
- National Statistical Office [Malawi] and ICF 2017, Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA.
- Schwandt, HM, Creanga, AA, Richard, MK, Adanu, K, Danso, A, Tsiri, A & Hind, MJ 2013, 'Pathways to unsafe abortion in Ghana: the role of male partners, women and health care providers', *Contraception*, vol. 88 no. 4, pp. 509-517.
- Senderowicz, L 2020, 'Contraceptive autonomy: conceptions and measurement of a novel family planning indicator', *Studies in family planning*, vol. 51 no. 2, pp. 161-176.
- Silverman, J.G. and Raj, A., 2014. Intimate partner violence and reproductive coercion: global barriers to women's reproductive control. *PLoS Med*, Vol. 11 no. 9, p.e1001723.
- Tichenor, M 2020, Metrics. In the Cambridge Encyclopedia of Anthropology (eds) F. Stein, S. Lazar, M. Candea, H. Diemberger, J. Robbins, A. Sanchez & R. Stasch.
- United Nations Population Division 2019, World Population Prospects: 2019 Revision, <https://population.un.org/wpp2019/>
- Upadhyay, UD, Dworkin, SL, Weitz, TA & Foster, DG 2014, 'Development and validation of a reproductive autonomy scale' *Studies in Family Planning*, vol. 45, no.1, pp.19-41.
- Willan, S, Gibbs, A, Petersen, I & Jewkes, R, 2020, 'Exploring young women's reproductive decision-making, agency and social norms in South African informal settlements' *PloS one*, vol. 15, no.4, p.e0231181.
- Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF 2019, Zambia Demographic and Health Survey 2018. Lusaka, Zambia, and Rockville, Maryland, USA.