

**FACTORS INFLUENCING THE CHOICE OF A  
BACKSTREET ABORTION BY YOUNG WOMEN FROM A  
TOWNSHIP IN DURBAN**

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## **DEDICATION**

This dissertation is dedicated to every individual who has supported me in putting this work together.

## DECLARATION OF ORIGINALITY

I, **Miss Nompumelelo Maureen Ndlovu** hereby declare that:

- The research reported in this thesis, except where otherwise indicated, is my own original work. This research work has not previously been submitted to any other University for any degree or examination purposes.
- This thesis does not contain other persons' data or other information, unless specifically acknowledged as being sourced from other persons.
- All citations, references and borrowed ideas have been duly acknowledged.

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**Mrs Sibonsile Mathe**

## ABSTRACT

Mortality rates among women of reproductive age have been the focus of attention in the past two decades. Sexual reproductive health issues have been identified as one of the major contributors to mortality among women of reproductive age (Lehohlo, 2013). In South Africa, the government's introduction of the Choice of Termination of Pregnancy (CTOP) Act of 1996 is a commendable effort to reduce maternal deaths among women. However, despite this progressive Act, women continue to risk their lives by undergoing backstreet abortion.

While illegal abortions are still prevalent in South Africa, there is little research on the factors that influence young women to choose this risky option over the legal, free and safe service provided by the state. This study aimed to fill this research gap. The study employed an explorative qualitative design. Using semi-structured interviews, data was collected from 15 purposively selected respondents between the ages of 18 and 24. Underpinned by an ecosystems approach the study explored the factors within the environment that push young women to opt for backstreet abortion.

The findings of this study show that socio-economic conditions continue to play a major role in young women's reproductive health decisions. Since the majority of the respondents were unemployed, the financial costs of raising a child were one of the major factors influencing young women to opt for backstreet abortion. Furthermore health practitioners' negative attitudes, a lack of privacy and the long waiting period for Termination of Pregnancy (TOP) services are some of the challenges experienced by abortion seekers at public health facilities. Based on the study's findings, recommendations include the need for TOP services to be made available at primary health care centers, such as clinics, in order to relieve the pressure on tertiary health care centers and to ensure easy access for women from all economic backgrounds. Health providers are key instruments in promoting safe TOP; therefore there is a need for healthcare workers to receive training in order to address negative attitudes towards TOP.

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## **Chapter one**

### **CONTEXTUAL AND THEORETICAL FRAMEWORK FOR THE STUDY**

#### **INTRODUCTION**

Women's reproductive health, especially the mortality rate among women of reproductive age, has received much attention in the past two decades (Lehohlo, 2013; Mbali & Mthembu, 2012; Corrêa, 2000). Pregnancy, particularly unplanned pregnancy has been identified as one of the major causes of mortality among women of reproductive age. According to WHO (2014), around 22 million unsafe abortions are estimated to take place worldwide each year, almost all in developing countries; and around 5 million women are admitted to hospital as a result of unsafe abortion every year. Deaths due to unsafe abortion account for 13% of all maternal deaths and Africa is disproportionately affected, with nearly two-thirds of all abortion-related deaths (ibid). Promoting maternal health is the fifth goal of the Millennium Development Goals (MDG); this means that women's health can no longer be ignored.

The South African government has invested much time and money in ensuring that women's health remains a top priority in the country. Particularly because WHO (2014) maintains that, almost every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe, legal induced abortion, and timely care for complications. In response, the South African Department of health have implemented different programs and policies to ensure that young women receive the best services to maintain good reproductive health.

One government intervention was the repeal of the Abortion and Sterilization Act (2 of 1975) and the promulgation of the Choice of Termination of Pregnancy (CTOP) Act (92 of 1996) (Guttmacher, Kapadia, Naude & De Penho, 1998). The 1975 Act (2) was regarded as a significant contributor to maternal deaths among women of reproductive age as it limited their reproductive choices and caused them to opt for backstreet abortion (Guttmacher et al., 1998). This Act only permitted abortion if the pregnancy put the mother's life at risk, if the child was likely to be born with severe mental or physical disabilities, or if the pregnancy was

the result of incest or rape. Women had to obtain approval for an abortion from a physician, psychiatrist or magistrate. Hospitals were the only facilities permitted to provide Termination of Pregnancy (TOP) services. These restrictions forced women living in previously disadvantaged communities to turn to backstreet abortion providers as they could not afford to travel to European countries where the abortion laws were more liberal (Guttmacher et al., 1998).

In contrast, the Choice of Termination of Pregnancy Act (92 of 1996) is commended for offering women more choice in dealing with unwanted pregnancies. The progressive provisions of this Act include the fact that it allows girls over the age of 12 to terminate their pregnancy during the first 12 weeks without their parents' consent and that counseling services are available to those who choose to access them. However, this does not mark the end of the challenges confronting women in dealing with unwanted pregnancies.

This chapter outlines the rationale for the study, the research questions, objectives and the significance of the study. It highlights the theoretical framework underpinning the study and the research paradigm and defines the concepts employed by the study. The chapter concludes by presenting the structure of the dissertation.

## **RATIONALE FOR THE STUDY**

Since the Choice of Termination of Pregnancy Act (92 of 1996) came into force, there has been increased interest in research on women's reproductive health, especially concerning policy, services and programs. Much of the focus has been on public perceptions of legal abortion, sexual and reproductive rights, barriers to the implementation of the Choice of Termination of Pregnancy Act (92 of 1996), the stigma that surrounds abortion, and health practitioners' attitudes in providing TOP services (Macleod, Sigcau & Luwaca, 2011; Kumar, Hessini & Mitchell, 2009; Harries, Stinson & Orner, 2009; Turner, Hyman & Gabriels, 2008; Harrison, Montgomery, Lurie & Wilkenson, 2000; Petchesky, 2000). However, there is a paucity of research that enables the voices of service users or potential service users to be heard. There is thus a need for research that investigates how and where women fulfill their reproductive health needs.

The main concern in South Africa, especially among previously disadvantaged communities is that despite the provision of safer TOP services, young women still risk their lives by seeking illegal TOP services. The researcher's sister who is a nurse at a public hospital in Durban has shared many stories of young women who are rushed to hospital in critical condition as a consequence of illegal TOP procedures or TOP attempts. These stories also motivated me to conduct this study.

Research shows that since the implementation of the Choice of Termination of Pregnancy Act (92 of 1996), the number of deaths due to maternal mortality has decreased and there has been an increase in legal abortions (Benson, Andersen & Samandari, 2011). The research problem was not therefore necessarily to determine whether there has been a reduction or increase in the use of illegal abortion services. Rather, the concern is that after 18 years of the legalization of TOP in South Africa women and girls still lack the freedom to choose how they want to deal with unwanted pregnancies. It is unfortunate that young women still risk their lives by using unsafe abortion methods while the state offers free and safe TOP services.

By exploring and understanding the factors influencing young women's choice of risky TOP services over the legal, free and safe service this study hopes to contribute to the promotion of maternal health, and the improvement of policies and programs that promote safe TOP. This study aimed to research the issue of illegal TOP from young women's point of view; they were treated as active agents negotiating their own social worlds.

## **MAIN AIM OF THE STUDY**

The main aim of the study was to explore the factors impacting the choices of young women who undergo backstreet abortion.

## **RESEARCH QUESTIONS**

This study aimed to answer the following questions:

- In what ways can other people's views of TOP influence a young woman's choice of abortion services?
- What role does support or lack of support from people considered important by a young woman play in her choice of abortion services?

- How accessible are TOP services to women from all socio-economic backgrounds and what are the eligibility criteria?
- What do young women know about the abortion services provided for under the Choice of Termination of Pregnancy Act (92 of 1996)?

## **RESEARCH OBJECTIVES**

The study's objectives were:

- To explore the influence of other people's views about TOP on a young woman's choice of termination services.
- To explore how the presence/lack of support by loved ones can influence a young women's abortion choice.
- To explore the accessibility of TOP services to women from all socio-economic backgrounds and the eligibility criteria.
- To explore young women's knowledge of the abortion services provided in terms of the Choice of Termination of Pregnancy Act (92 of 1996).

## **THE SIGNIFICANCE OF THE STUDY**

It is important to understand women's needs in relation to unwanted pregnancies in order to provide improved, safer TOP services. This study aimed to understand the meaning and significance that young women attach to the choices available to them in meeting their reproductive health needs, especially unwanted pregnancy. It therefore contributes to the available body of knowledge that can be used to improve policy on women's reproductive health.

As the study will be published as a report, it will inform different organizations and departments on the factors influencing women's choice of risky TOP services. Understanding the factors that push young women to seek backstreet abortions will assist in the adjustment of policies and programs that promote safe TOP. Furthermore, the study will hopefully also motivate other researchers to conduct further studies on abortion (both legal and illegal) and women's reproductive rights. Future research could evaluate progress in implementing the Choice of Termination of Pregnancy Act (92 of 1996) in order to propose amendments to further enhance TOPs services in South Africa.

## **THEORETICAL FRAMEWORK**

A theoretical framework is “a systematic ordering of ideas about a phenomenon being investigated, which includes the examination of disciplined based literature related to the phenomenon” (Potjo, 2012: 11). A framework allows a researcher to organize, make sense of and explain their observations, perceptions and thoughts when engaged in problem solving (Jorgensen, 2007).

Understanding young women’s reasons for choosing backstreet abortion requires that the researcher not only focuses on their behavior; the most important element is their interactions with their environment (MacLaren & Hawe, 2005). Life changing decisions such as abortion, including how and where to seek such assistance, are not be made in a vacuum. This study therefore employed an ecosystems approach in order to understand the factors within the environment that influence young women’s decisions in dealing with unwanted pregnancies.

Anderson, Carter, and Lowe (1999:4) define a system as “an organized whole made up of components that interact in a way distinct from their interaction with other entities and which endures over some period of time”. Wakefield (1996: 4) writes that from general systems theory, the ecosystems perspective borrows a variety of notions regarding systems: systems are sets of interacting elements, systems can be closed or open to interaction with the other world, systems are linked hierarchically, systems can possess state of equilibrium or can be in disequilibrium, systems are regulated through positive and negative feedback and casual influences are circular in that changes in one system have consequences for other linked systems that, in turn through feedback, have consequences for the first systems.

From an ecosystems perspective, a young woman who unexpectedly discovers that she is pregnant is in disequilibrium with her environment. At this point she has to consider how the consequences of an unintended pregnancy will affect not only herself, but other systems such as the family, school and the wider community. Young women have to consider if they can handle being condemned and criticized by their family and society for having an abortion (Shellenberga, Mooreb, Bankoleb, Juarezc, Omidayid, Palominoe, Satharf, Singhb & Tsuig, 2011). According to Meyer (2008), the ecosystems approach perceives an individual as a subsystem within other larger systems, such as the family, peer groups, schools, ethnic groups, churches and the broader society.

An ecosystems approach views systems as interdependent; therefore, when one system is disturbed the other systems are affected, impacting the individual's development (Krieger, 2001). In the South African context or culture, family and community systems or environments play an integral role in children's development, especially young women. In South African communities expressions such as: "It takes a village to raise a child" and "a person is a person because of other people", are used to convey that a human being cannot exist alone; in order to function properly they need to interact in one way or another. Gardner (1972) cited in Chetty (2012:5) makes the point that "the mother is not merely a physical reality, not even a psych-physical reality, but a social-psych-physical reality. She exists as a person in interaction with her community or society. The quality of her existence depends not simply on her physical or psycho-social wellbeing. She cannot in fact be isolated from her social wellbeing and our obligations to her are this socio-psycho-somatic entity".

In terms of the ecosystems approach, while the individual is a central part of the system, s/he needs other people and resources from the environment to survive. The environment and the individual influence each other as they co-exist (Du Bois & Miley, 2005). Studying backstreet abortion using an ecosystems framework gives meaning to the ideas that shape the knowledge and attitudes young women have adopted from their environment about abortion. When individuals make life-changing decisions it is common to involve their loved ones; they consult family members, peers and partners in order to receive support. In relation to this study, while a young woman makes the final decision on whether or not to continue with the pregnancy, she shares her abortion decision with a person she can trust in order to gain support (Mkhwanazi, 2010). The ecosystems framework therefore plays a significant role in understanding how various interconnected factors within the environment where a young woman is raised influence her perceptions of abortion.

While the ecosystems approach posits that an individual creates their own meaning and reality of the world, it also acknowledges that another person may create a different reality; therefore it is possible for people to compare their realities and reach consensus. In relation to this study, young women construct their own meaning of backstreet abortion and how it affects them. The ecosystems approach does not imply that all young women residing in the same community will create the same idea about backstreet abortion; it acknowledges that two people can attach different meaning to the same experience depending on their context. While women are not viewed as a homogenous group, the theory acknowledges that elements



of the ecosystem such as the family's economic status, culture or patriarchy could have similar effects on the lives of women in a particular context.

This study thus examines how different levels of the ecosystem interacted and played a part in the way young women regarded and carried out abortion. These levels of the ecosystem are:

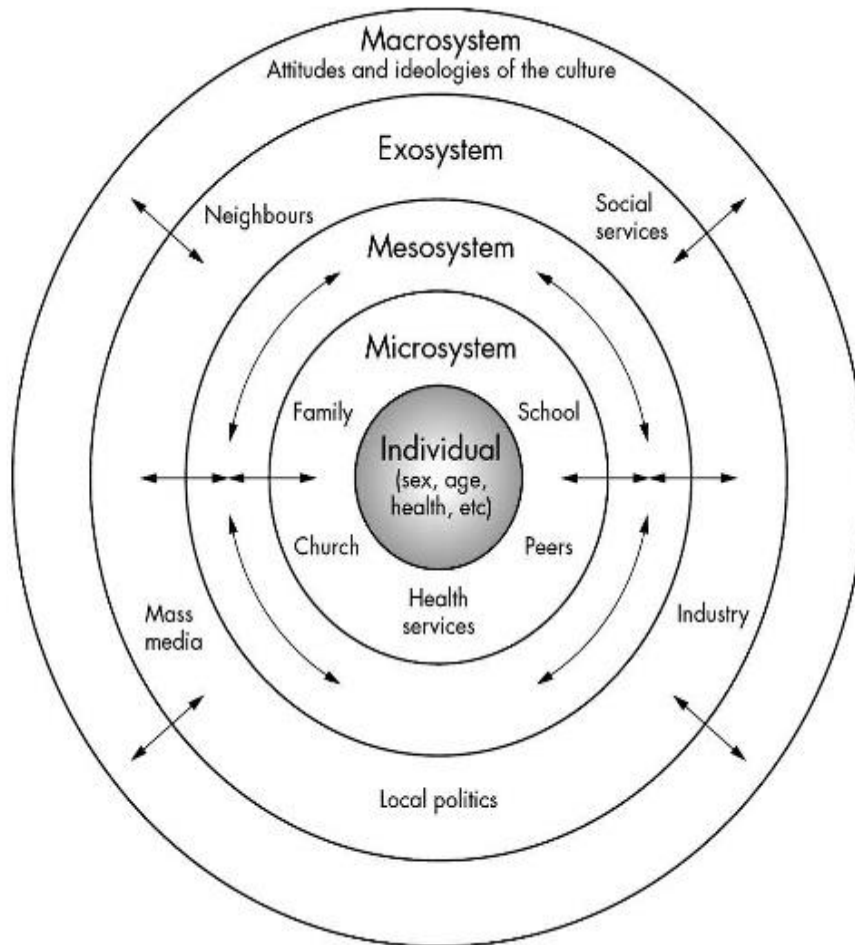


Figure 1: Bronfenbrenner's levels of the ecosystem

### **The micro system**

Paquette and Ryan (2001) cited in Potjo (2012: 12) make the point that “Relationships have bi-directional influences on the development of a young woman, both towards her and away from her”. In terms of the ecosystems perspective, the micro level is the first environment that young women are exposed to during their development. This level includes the people that she has close, regular contact with, such as her family and peers, interactions with these people (whether at home or outside the home), the nature of their relationship, and the significant role these people play in her life (McLaren, & Hawe, 2005). At this level, this study examines how young women’s friends and family’s views on abortion influenced their choice of abortion. It explores the closeness of their relationships with family members and friends in order to understand the nature of their interaction with those who were involved in their abortion decision and abortion choice.

### **The meso system**

According to Paquette and Ryan (2001) cited in Potjo (2012), the meso level seeks to examine the interplay among the individual’s micro system. The meso level refers to linkages or connections between systems which are part of the young woman’s life (for example, the family, school, and church). Interactions between these systems are as vital for the growth and development of young women as the interactions between individuals within the micro system (McLaren & Hawe, 2005). At this level the study explores the influence of social groups that young women are part of; these include the church and school. The focus is how the church and teachers’ opinions about abortion influenced young women’s perceptions of abortion.

### **The exo system**

The exo system refers to the connections between systems that are important in the young woman’s life as they affect her directly or indirectly (McLaren & Hawe, 2005). This includes her parents’ work environment, society at large and its values and moral standards. It is important to understand the effect that parents that have to live away from home because of better job opportunities can have on the development of a young girl. Darling (2007) is of the opinion that adolescents who are supervised by their parents are less likely to have behavioral

problems, such as early sexual activities resulting in unintended pregnancies. At this level the study explores how parental supervision or the lack thereof impacted young women's development. It also examines how the community's moral standards and opinions about abortion influenced young women's abortion decision, in terms of choosing to terminate at public health facilities or secretly at illegal facilities.

### **The macro system**

“The macro system refers to the overall patterns of ideology and organization that characterize a given society or social group, and may thus be used to describe the culture or social context of various societal groups such as social classes, ethnic groups, health, economic, and also political, religious and educational systems” (McLaren & Hawe, 2005: 11). Abortion is legal in the Republic of South Africa. At the macro level the study therefore explores the reasons why young women opted for illegal abortion services, which they paid for, when the Choice of Termination of Pregnancy Act (92 of 1996) gives women from all socio-economic backgrounds the right to free, safe abortions in state facilities.

## **DEFINITION OF CONCEPTS**

### **Youth**

According to the National Youth Policy youth are young people between the ages of fourteen (14) and thirty five (35) (National Youth Commission, 2002).

### **Young women**

For the purposes of this study, the term ‘young women’ refers to a female between the ages of eighteen (18) and twenty five (25).

### **An abortion**

An abortion is defined as the removal of the fetus or embryo from the womb/ uterus in order to end a pregnancy (Engelbrecht, 2005).

### **A miscarriage**

A miscarriage is an unintentional abortion which occurs naturally as a result of a problem with the pregnancy, while induced termination of pregnancy is performed intentionally as a result of an unwanted pregnancy for a variety of reasons (Gumede, 2004).

### **A safe or legally induced abortion**

In terms of the Choice of Termination of Pregnancy Act (92 of 1996) , a safe abortion is a TOP performed by trained providers, such as doctors and nurses, in hygienic, designated settings, such as clinics and hospitals, using medical procedures that carry fewer health risks. In terms of the Act women from the age of 12 have the right to access abortion services without their parent or partner's consent with counseling services available if needed (Macleod & Hansejee, 2013).

### **Backstreet or illegally induced abortion**

The World Health Organization (WHO) defines a backstreet abortion as “a procedure for terminating an unplanned/ unwanted pregnancy either by unskilled or unauthorized people in an environment lacking minimal medical standards” (Banerjee & Andersen, 2012: 882).

### **Post-traumatic stress (PTS)**

Post-traumatic stress is “a psychological dysfunction which results from a traumatic experience which overwhelms a person's normal defense mechanisms resulting in intense fear, feelings of helplessness or loss of control with a particular situation” (Major, Alpelbaum, Beckman, Dutton, Russo & West, 2009: 13). A number of studies have reported that many women suffer from PTS as a result of abortion related experiences (Mpshe, 2000; Adler, David, Major, Roth, Russo & Wyatt 1990).

### **Post Abortion Syndrome (PAS)**

Post Abortion Syndrome (PAS) are negative emotions associated post abortion depression with symptoms ranging from feelings of guilt, fear, regret, anger and grief (Major et al., 2009)

### **Medical abortion**

A medical abortion is an abortion procedure prescribed for women who are less than 12 weeks pregnant, which involves taking abortion pills (mifepristone and misoprostol) orally or vaginally (Cooper, Dickson, Blanchard, Cullingworth, Mavimbela, Mollendorf, van Bogaert & Winikoff, 2005).

### **Surgical abortion**

A surgical abortion is a mechanical uterine evacuation of the pregnancy using surgical TOP methods, which include Manual Vacuum Aspiration (MVA) and Dilation and Evacuation (D&E) (Cooper et al., 2005).

### **Incomplete abortion**

Goldman, Occhiuto, Peterson, Zapka & Palmer (2004: 1353) define an incomplete abortion as “an abortion in which tissue from the pregnancy remains in the uterus requiring a repeated abortion”.

### **Abortifacient**

“An abortifacient is an agent that induces an expulsion of a fetus; a drug, herb or any other chemicals that dilates of the cervix” (Gilbert, 2013: 13).

### **Misoprostol**

Misoprostol is an abortifacient used as a medical abortion method that is approved by the South African Medicines Control Council (SAMCC) and is prescribed for women seeking abortion up to 12 weeks (Cooper et al., 2005).

### **Manual Vacuum Aspiration (MVA)**

MVA is an abortion procedure which involves “a mechanical uterine evacuation of the pregnancy” (Mhlanga, 2003: 120).

### **Reproductive health**

Reproductive health can be defined as: a state of complete physical, social and mental well-being and not merely the absence of disease or infirmities, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying safe sex life and that they have the capacity to

reproduce and the freedom to decide, if, when and how often to do so. Implicit in this last condition are the rights of man and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility (Petchesky, 2000: 2).

## **STRUCTURE OF THE DISSERTATION**

This first chapter introduced and provided an overview of the study. The context, rationale, significance, aim and objectives, theoretical framework and research paradigm of the study were highlighted and the key concepts were defined. The remainder of this dissertation consists of the following four chapters:

**Chapter two** reviews the literature relevant to the study. This focuses on teenage pregnancy in South Africa, including trends, casual factors and the challenges this poses to the country. The global agenda on women's reproductive health is explored, as well as termination of pregnancy in South Africa. Thereafter the focus shifts to peoples' views on abortion, including the community, family and health professionals. The chapter concludes by examining gender relations and TOP.

**Chapter three** presents the research methodology employed for this study, including the research design, the sampling strategy, method of data collection and data analyses. It further discusses the validity, reliability and rigor of the data. The ethical concerns presented by the study, and its limitations and challenges are also discussed.

**Chapter four** presents the analysis, findings, interpretations and discussion of the collected data. Following a presentation of the participants' biographical information, the themes that emerged from the data are presented and explored in the context of the relevant literature.

**Chapter five** presents the main finding of the study and its major conclusions. Recommendations based on the findings and conclusions are also presented.

## **Chapter two**

### **LITERATURE REVIEW**

#### **INTRODUCTION**

A literature review on a particular research topic enables the researcher to learn more about the topic, to develop research questions and objectives, and to decide on a relevant research methodology. Researchers are therefore able to locate their subject in the framework of scientific knowledge related to the topic (Engelbrecht, 2005). This chapter examines the literature that informs this study and argues that any intervention that seeks to address women's reproductive health issues should invest in an analysis that is attentive to the complex nature and the multidimensionality of women's issues, status and experiences in a country like South Africa.

Despite the legalization of abortion in many countries around the world, including SA, and improved policies and programs to ensure that women have access to safe TOP services, millions of women's lives are lost due to illegal TOP procedures. It is estimated that, each year, about 20 million women risk their lives by seeking unsafe abortion services. Twenty five per cent end up with permanent health complications and about 66, 500 die, half of whom are under the age of 25 (Kumar et al., 2009). When an unwanted pregnancy occurs, a woman may experience it as a very stressful event that will not only change her life forever, but those of her loved ones. A woman that experiences an unwanted or unplanned pregnancy has to decide whether or not to keep the child. Many issues surround a woman's abortion decision, including the broader society's views on abortion, her economic status, and the particular state's abortion laws (Whittaker, 2002).

Since sexual and reproductive health play a fundamental role in young women's development to womanhood, the main focus of goal five of the MDGs is the improvement of maternal health, especially in developing countries (Lehohlo, 2013; Ronsmans & Graham, 2006). Young people's sexual and reproductive health has been identified by the World Health Organization (WHO) as one of the primary contributors to morbidity and mortality among this section of the population (Alli, 2011). Worldwide, backstreet abortion is recognized as one of the major contributors to the high rate of maternal mortality among young women. In

developing countries such as South Africa (SA), backstreet or unsafe abortion not only causes millions of deaths, but many health complications for women (Haddad, Nawal & Nour, 2009; Grimes, Benson, Singh, Romero, Okunofua, Shah & Garatra, 2006; Campbell & Graham, 2006).

This chapter begins by examining the issue of teenage pregnancy in SA, in terms of trends, casual factors and the challenges it poses to the country. The global agenda on women's reproductive health is explored, as well as termination of pregnancy in SA. The focus then shifts to communities, the family and healthcare professionals' views on abortion. The chapter concludes by exploring gender relations and TOP.

## **TEENAGE PREGNANCY IN SOUTH AFRICA**

A number of studies in South Africa have indicated that girls are falling pregnant at a younger age than before (Nkani, 2012; Raniga & Mathe, 2011). Despite the efforts of development programs that aim to reduce the high rates of teenage pregnancy, it remains a major concern for both developed and developing countries. Worldwide it is estimated that 15 million pregnancies occur in girls between the ages of 14 and 19 each year (Potjo, 2012). The majority of teenage pregnancies reported occur in Sub-Saharan African. Global statistics reveal that there are twice as many teenage pregnancies in Sub-Saharan African countries than the world average of 65 births per 1,000 girls (WHO, 2004 cited in Govender, 2011).

Research conducted in South Africa indicates that approximately 80% of girls are sexually active before the age of 20, and 37% unintentionally fall pregnant (Makiwane, 2010; Panday, Makiwane, Ranchod & Letsoalo, 2009). Cooper et al. (2005) estimate that, 56% of pregnancies in SA are unplanned with 35% of these pregnancies occurring among women under the age of 20. Teenage pregnancy cannot simply be attributed to young women not taking responsibility for their sexual and reproductive health. A number of factors play a significant role in contributing to the high rate of unplanned teenage pregnancy.

According to the WHO (2003: 67), teenagers "often lack knowledge about sexuality, contraception, how pregnancy occurs, what the signs of pregnancy are and sexually transmitted infections. Young and unmarried adolescents may also have limited experience in talking to adults on such matters and in accessing and using health services to address their



sexual health and reproductive health needs”. Reasons for the high rates of teenage pregnancy identified by Willan (2013: 14) include: “gender inequality, gender expectations of how girls and boys should act, sexual taboos (for girls) and sexual permissiveness (for boys), poor access to contraceptives, high levels of gender based violence and poor sex education.” Furthermore teenage girls confronted with financial challenges are often forced to compromise their health. These young women get involved in relationships where they lack the power to make healthy sexual choices. Young women living in poverty may get involved with older man or have multiple sexual relationships where they are unable to exercise their right to make decisions with regard to sexual activities (Govender, 2011; Panday et al., 2009).

The escalating number of unplanned teenage pregnancies poses a threat to SA’s democracy as when teenagers fall pregnant many are forced to leave school without a senior certificate, which is regarded as a basic educational requirement to live a productive life. While the law allows pregnant girls to continue their studies during pregnancy, different social factors cause these girls to drop out of school. A study conducted in 2006 on teenage pregnancy among learners in KwaZulu-Natal (KZN) found that only 29% continued their studies after their pregnancy (Panday et al., 2009). Without a matric these women have few, if any job opportunities, directly contributing to poverty in the country.

The lack of platforms for young people, especially girls, to openly talk about sex deprives them of an opportunity to gain the knowledge they need in order to make informed decisions concerning their sexual health. According to Mkhwanazi (2010), young women regard sex as a way of demonstrating their love, trust and commitment in a relationship. Misconceptions among young women about sex include the fact that some young women think that if they do not engage in sexual activities or if they use protection during intercourse, this indicates that they do not trust their partner (Alli, 2011; Mkhwanazi, 2010). However, there are many competing views, perceptions and theories on the causes of the escalating number of teenage pregnancies in SA.

According to human development scholars, the high number of unplanned and unwanted pregnancies is the result of teens not being able to handle the physical changes and sexual desires they experience (Honig, 2012; Papalia, Olds & Feldman, 2009). On the other hand, teenage pregnancy is seen as the result of socio-structural problems in SA. Some view teenage pregnancy as resulting from a lack of adult supervision and sexual knowledge,

education and resources, as well as knowledge of contraceptives and their use (Honig, 2012; Smith & Pell, 2001). At the extreme end, it is viewed as resulting from a decline in society's morals (MacPhail, Pettifor, Pascoe & Rees, 2007).

Adopting a linear view on teenage pregnancy is dangerous. Studies conducted by Palomino Padilla, Telleo, Mazuelos, Carda and Bayer (2011) and Abma, Martinez, Mosher and Dawson (2004) show that although the majority of teenagers are sexually active, they find it challenging to communicate with adults about sex and contraceptive use in order to prevent unplanned pregnancies; this includes parents, teachers that provide sex education and health practitioners who offer contraceptive services. Adults, especially parents, would rather instruct their daughters not to engage in sex than teach them about contraceptives. Adults' attitudes towards contraceptives and teenagers' sexual behavior are some of the barriers that prevent teens from seeking contraceptive services.

There is a need to create a safe environment where young girls can share their sexual and reproductive needs without being threatened or judged by adults. Papalia et al. (2009) found that, while some teenage mothers and those that were expecting reported that they had some knowledge of the availability of contraceptives at clinics, they either decided not to use them or misused them, resulting in an unplanned/ unwanted pregnancy.

## **CONTRACEPTIVE USE AMONG YOUNG PEOPLE**

According to the Allan Guttmacher Institute (AGI) (1999) cited in Gumede (2004: 15), whether couples will be successful in preventing unplanned pregnancies is to a large extent determined by the effectiveness of their contraceptive use. The chance of an unexpected pregnancy is almost non-existent in couples that use sterilization and very low for users of injections or implants. It is moderate for pill and condom users, and very high in couples relying upon abstinence, withdrawal and spermicides. Since all methods may fail, many millions of couples around the world who are using contraceptives still face some risk of an unwanted pregnancy (ibid).

Many developing countries, especially African countries, are reported to have low usage of contraceptives. While a number of initiatives have been launched in the past 20 years to reduce the high rates of unintended pregnancies, it is estimated that, worldwide, 120 million

couples do not use any form of contraceptives although they are not planning to have a child and that of the 75 million unwanted pregnancies, close to 45 million are terminated; about 20 million of these terminations are done by backstreet providers (Gresh & Maharaj, 2014; Essig, 2010). Despite the fact that SA provides free, effective contraceptive methods, unplanned pregnancies are still prevalent among the youth. MacPhail et al.'s (2007) study found although two-thirds of young girls are sexually active before the age of 24, less than half use any form of contraceptive. The low use of contraceptives prevents young women from developing to their full capacity and being empowered to make sound decisions about their future.

Selebalo (2010) found that, "Among the sexually active teenagers there is evidence of an inconsistency and low contraceptives use, as low as 25% in some instances". This directly contributes to the high rate of unintended pregnancies, with the majority ending in abortion, in some instances illegally. A study conducted in Nigeria on unplanned pregnancies found that, of the 3,743 research participants, 91.3% knew about contraceptives, but only 36.6% were using some form of contraceptive (Ngene, 2011). A variety of factors contribute to young women's failure to use contraceptives effectively. These include gender inequality and power relations in heterosexual relationships. Interventions proposed by MacPhail et al. (2007) include educating male partners about the availability of male contraceptives, encouraging them to use contraceptives and equipping the youth with effective communication skills.

Other factors influencing the limited or inconsistent use of contraceptives among South African youth include lack of communication with their partner, fear of being ridiculed and mistreated by society and health care practitioners for being sexually active at a young age, and limited knowledge of and access to contraceptive services (Ngcobo, 2009). Mkhwanazi's (2010) study on teenage pregnancy in SA found that teenage mothers knew that contraceptives were available from state facilities, but chose not to use them or misused them, resulting in an unintended/unwanted pregnancy.

Ngene (2011) identified the reasons why women do not use contraceptives. These range from concerns about changes in their bodies such as gaining weight, to fears that using contraceptives will render them infertile or that their partners will leave them if they are forced to use protection. Young women experience pressure from their partners not to use

contraceptives because they do not enjoy sex with a condom, or because they feel that not using protection will prove that they trust their partners. The consequence of trying to make their partners happy and maintaining the relationship is an unwanted pregnancy.

While contraceptive methods are considered most effective in reducing the high rate of unplanned pregnancies, there are cases where they fail. Ngene's (2011) study also found that 75% of South African women living in the Durban area that requested TOP services at a hospital were using some form of contraception when they fell pregnant. While condoms are considered to be effective in preventing unplanned pregnancies, there are cases where they break. In this case, emergency contraceptives should be used. According to Gumede (2004: 15), "Emergency contraception is a method of preventing pregnancy that can be used immediately after unprotected sexual intercourse". The challenge with emergency contraceptives is that there is little knowledge of the service and it is not easily accessible to all women. Ngene (2011) reported that only 5% of women are aware of emergency contraceptives.

## **GLOBAL AGENDA ON WOMEN'S REPRODUCTIVE HEALTH**

Engelbrecht (2005: 27) states that, "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents."

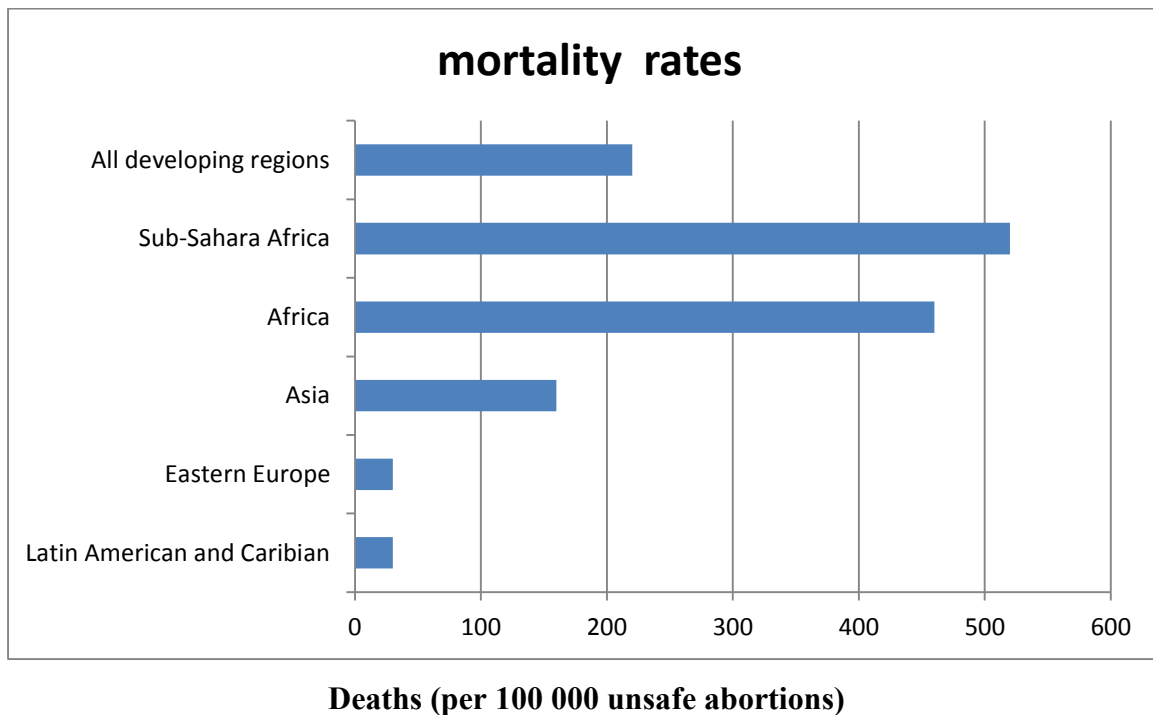
Worldwide, women's reproductive health is an area of concern. A holistic view of reproductive health and rights should not only include information and access to contraceptives as well as legal abortion, but sexually transmitted diseases (STD), cancer, prenatal care and mental health services (Petchesky, 2000). In light of the fact that maternal mortality has been identified as one of the largest contributors to the death of women around the world, 189 countries have committed to reducing the rate by 75% by 2015 (Ransmans & Graham, 2006). Sexual reproductive health requires that all women are able to access sexual healthcare services; this would result in fewer unplanned pregnancies, STD and deaths

caused by unsafe abortion (Gresh & Maharaj, 2014). In order to achieve the fifth MDG goal there needs to be a change in the way services are provided so that they fully meet every woman's sexual reproductive health needs (Alli, 2011; Ronsmans & Graham, 2006).

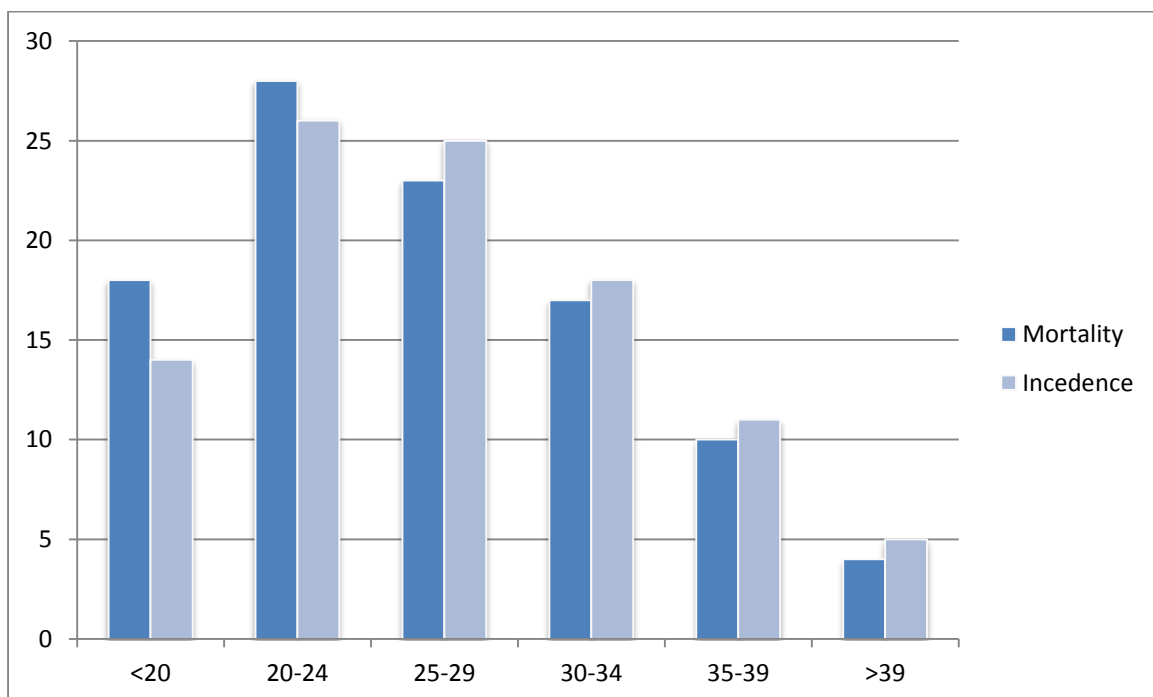
According to Alli (2011), issues relating to sexual reproductive health are the primary causes of mortality among women of reproductive age. According to WHO (2014); every day, approximately 800 women die from preventable causes related to pregnancy and childbirth and 99% of them occur in developing countries. WHO has alerted that maternal mortality is higher in women living in rural areas and among poorer communities and young adolescents face a higher risk of complications and death as a result of pregnancy than older women (ibid). Globally, backstreet abortion has been identified as one of the primary causes of maternal mortality among young women. Research reveals that unsafe abortion not only accounts for millions of deaths amongst women of reproductive age, but also contributes to health complications in many developing countries (Haddad et al., 2009; Grimes et al., 2006; Campbell & Graham, 2006).

In the past 20 years, countries around the world have made great strides in improving sexual and reproductive healthcare services. The purpose is to eliminate the obstacles faced by women in exercising their rights and meeting their sexual health care needs. It is important to recognize that women, especially young girls, have different reproductive health needs. Policies, laws and strategies are being put in place to provide women and girls with the best resources to improve their reproductive health. As unsafe abortion is one of the major causes of maternal mortality and a significant public health issue, many countries are making legislative adjustments to improve reproductive health services, and increase access to safe abortion services (Haddad et al., 2009).

**Figure 2:** A representation of the 2008 mortality rates per 100 000 unsafe TOPs (WHO, 2012: 21)



**Figure 3:** A 2003 percentage representation of unsafe abortion estimations and related death by age in developing countries (WHO, 2007)



In spite all these efforts made in ensuring that all women freely exercise their abortion rights. Many countries, especially African countries still have strict rules when it comes to the provision of abortion services. The restrictive nature of abortion laws in these countries leads to the loss of many women's lives.

Several studies conducted in some African countries as in other countries do not accurately state the extent of induced unsafe abortions. However, several authors confirm that the prevalence of unsafe abortion in African countries is very high (Alemu, 2010; Grimes et al., 2006; Raufu, 2002; Otoide, Oronsaye & Okonoua, 2001). In 2008 it is reported that approximately 460 deaths occurred for every 100 000 illegal TOPs performed in Africa (WHO, 2012).

At the Kenyatta National Hospital (KNH) in Nairobi, Kenya alone, it has been observed that more than 10,000 patients are treated for complications of unsafe abortions every year (Alemu, 2010). Another study conducted in Ethiopia indicates that about 32% of all maternal deaths are the result of complications related to unsafe abortion making abortion a second leading cause of death for women, after tuberculosis (Alemu, 2010). In Nigeria current deaths due to unsafe abortions account for 20, 000 of the estimated 50,000 maternal deaths are reported each year (Otoide et al., 2001).

Furthermore research indicates that the highest incidents of deaths due to illegal abortions in developing countries occur among young women (WHO, 2007; Engelbrecht, 2005). According to WHO (2007), in 2003 approximately 50% of deaths due to illegal TOPs occur to young women aged between 18-25 years in developing countries. It is estimated that the rate of mortality among young women is 440 for every 100 000 unsafe abortions performed (ibid). Hospital based studies conducted in Nigeria have indicated that 80 % of patients with abortion related complications are adolescents (Raufu, 2002). Statistics reveal that the majority of women of reproductive age in African countries are confronted with challenges in accessing safe abortions because the right to abortion is highly restricted by law (Gresh & Maharaj, 2014).

In countries such as Lesotho and Swaziland abortion still falls under Common Law. With this law abortion is prohibited or only permitted to save the live of the women. Likewise Mozambique permits abortion on the grounds of necessity to save the life of the pregnant woman and to preserve maternal health Girlbert (2013). Similarly the Zimbabwean 1977 Termination of Pregnancy Act allows an abortion if the pregnancy endangers the life of the

woman; in addition to this condition, if the child will suffer from a permanent physical or mental handicap or if the pregnancy was as a result of unlawfully intercourse including incest, rape and intercourse with a mentally handicapped woman (Engelbrecht, 2005).

In 1990 Namibia adopted South African's Abortion and Sterilization Act (2 of 1975). According to the Abortion and Sterilization Act (2 of 1975) in addition to abortion being permitted on the grounds of the woman and the unborn child's life being threatened or the pregnancy resulting from unlawfully intercourse, in addition it is required that other than the woman's doctor two doctors certify the existence of the grounds for abortion (Otoide et al., 2001). The abortion is strictly performed by a medical practitioner in a state hospital or and approved medical facility. In Namibia persons violating the law are subjected to five years imprisonment or required to pay a fine (Otoide et al., 2001).

Engelbrecht (2005) is of the view that South Africa's' Choice of Termination of Abortion Act (92 of 1996) could serve as a profitable example for many African countries in their effort to reduce the death of women of reproductive age, resulting from illegal TOPs.

## **TERMINATION OF PREGNANCY IN SOUTH AFRICA**

### **The Choice of Termination of Pregnancy Act, 92 of 1996**

While the law prevented South African women from having abortions in the past, this did not stop them from finding alternative ways to access abortion services. Gumede (2004: 8) observes that "abortion has been practiced since the earliest of times. No criminal sanction or constitutional provision has ever or will ever stop women from seeking abortion". Recognizing the negative consequences of restrictive abortion laws, the South African government introduced the Choice of Termination of Pregnancy (CTOP) Act (92) of 1996.

The CTOP Act 92 came into force in 1996 as part of the government's response to the struggle for women's rights and in order to protect women and girls from harmful acts. Different strategies and policy adjustments were put in place to ensure that girls and women have easy access to good services to maintain reproductive health. Choice of Termination of Pregnancy Act (92 of 1996), replaced the Abortion and Sterilization Act (2 of 1975) that caused many deaths of women of reproductive age, as it limited their reproductive choices



and they ended up seeking help from unsafe/ illegal abortion agencies (Guttmacher et al., 1998).

The Abortion and Sterilization Act (2 of 1975) only allowed women to have an abortion if a physician provided medical proof that continuing with the pregnancy posed a threat to the fetus or the mother’s life, or if the pregnancy was a result of incest or rape (Selebalo, 2010). In contrast, the CTOP Act (92 of 1996) states that every South African has the right to make safe reproductive choices; in order to do so, they require access to safe methods of fertility regulation, which include not only contraceptives and abortion services, but sexual education and counseling (Dickson-Tetteh & Billing, 2002).

**Table 1:** Grounds on which the CTOP Act (92 of 1996) permits abortion (South African Government Gazette, 2005).

<b>Gestation period in weeks</b>	<b>Ground</b>
<b>0-12 weeks</b>	Abortion available on request with no specific reason
<b>12- 20 weeks</b>	<ul style="list-style-type: none"> <li>▪ The pregnancy is a result of rape or incest</li> <li>▪ Socio-economic challenges</li> <li>▪ The pregnancy puts the women’s mental and physical life at risk</li> <li>▪ Fetus develops a mental or physical abnormality</li> </ul>
<b>Beyond 20 weeks</b>	<ul style="list-style-type: none"> <li>▪ Pregnancy endangers the women’s life</li> <li>▪ Pregnancy results in a deformation of the fetus</li> </ul>

Some of the progressive provisions of this Act are that from the age of 12, girls have a right to safe state abortion within a period of 12 weeks. The Act does not require that women give any reason for wanting to terminate a pregnancy. From 13 to 20 weeks, certain considerations are taken into account including if continuation of the pregnancy will endanger the woman’s life, negatively affect her socio-economic circumstances, or result in the deformation of the baby, and if the pregnancy is the result of rape or incest (Macleod & Hansjee, 2013; Mbali & Mthembu, 2012; Selebalo, 2010).

The CTOP Act (92 of 1996) was amended in 2004 and is now known as the Choice of Termination of Pregnancy Amendment (CTOPA) Act of 2004 (South African Government Gazette, 2005). The amended Act should remove any obstacles to women accessing free, safe state abortion services. Its main aim was to increase access and availability of TOP services across the country. The amended Act not only increased the number of designated facilities, but permitted an additional 14, 288 registered nurses who had received the prescribed TOP services training to offer abortion services up to a period of 12 weeks of gestation (Engelbrecht, 2005).

The objectives of the CTOP Amendment Act of 2004 (South African Government Gazette, 2005: 2) include:

- Not only allowing midwives to perform abortions, but all registered nurses who have received TOP training.
- Giving the Provincial Member of the Executive Council (MEC) the responsibility of prescribing and approving designated TOP facilities, instead of the Minister of Health.
- All public and private facilities with a 24 hour maternity service can perform TOP up to 12 weeks of gestation without asking for the MEC's approval.
- Instead of the Minister of Health regulating the requirements and conditions applicable to TOP facilities in each province, entrusting that responsibility to the MEC.
- The MEC is to submit an annual report on the number of approved facilities.
- The Head of the Provincial Department is to submit prescribed information to the Director-General of Health.
- To ensure that any individual performing an abortion illegally or in a facility not designated by the state faces the wrath of the law.

### **Designation of TOP facilities**

The amended Act aimed to provide women from all socio-economic backgrounds with easy access to TOP services, especially those that were disadvantaged during the apartheid era. In order to accomplish this, the government not only provided training to service providers, but increased the number of designated TOP facilities (Jewkes, Gumede, Margaret, Westaway, Dickson, Brown & Rees, 2005).

In order for a facility to be approved as a TOP services provider, it has to meet the following requirements outlined in section 3 of the CTOP Act of 2004 (South African Government Gazette, 2005: 4):

- Access to medical and nursing staff.
- Access to an operating theatre.
- Appropriate surgical equipment.
- Drugs for intravenous and intramuscular injection.
- Emergency resuscitation equipment and access to an emergency referral center or facility.
- Access to appropriate transport should the need for emergency transfer arise.
- Have facilities and equipment for clinical observation and access to in-patient facilities.
- Have appropriate infection control measures.
- Access to safe waste disposal infrastructure.
- Have telephonic means of communication.

In ensuring the availability and accessibility of TOP services the government designated 248 public health facilities across the country. This ensured that most community members in every province are 50-100 km from such facilities (Jewkes et al., 2005). However, despite all these efforts, women are still admitted to hospital in critical condition due to backstreet abortion (Benerjee & Andersen, 2012). Studies (Dickson-Telleh & Billing, 2002; Varkey, 2000; Harrison et al., 2000) reveal that not all facilities designated by the Department of Health (DOH) are providing TOP; only a third of these facilities provide the service (73 of the 248). Statistics indicate that since the abortion Act was enforced in 1996 abortions performed at designated facilities fell from 35% to 29% between the first and second year, by the third year they were down to 25% (Varkey, 2000; Harrison, 2000).

According to Varkey (2000), 99% of TOP services are performed in hospitals. Such procedures do not need to be performed in tertiary health institutions such as hospitals. Providing abortion services at clinics is vital, as it is much easier for communities across the country to get to clinics than hospitals. Furthermore there seems to be an unequal distribution of TOP services across the countries' nine provinces. In KZN only 10% of facilities are reported to be offering TOP services; this means that of the 40 facilities initially designated

only four are actually providing TOP. Yet, this is the province with the largest population in the country as well as one with the highest rates of poverty. On the other hand, 33% of the facilities are in Gauteng (18) and the Western Cape (15). These provinces have the highest levels of urbanization, the lowest levels of poverty and the best equipped health facilities (Gumede, 2004; Harrison et al., 2000). The researcher thus argue for the expansion and equitable TOP services across all South African provinces if the government is committed in ensuring equal access to services.

### **Training of TOP service providers**

The implementation of the CTOP Act (92 of 1996) meant that South African women from all communities were liberated to make sound reproductive health decisions. Unfortunately, the increased need for safe abortion services put a strain on public health resources. Designated facilities faced a number of challenges including staff shortages as doctors were the only permitted TOP providers (Mhlanga, 2003). With limited abortion providers at designated facilities, women experienced delays in accessing TOP, and turned to backstreet providers in frustration.

To overcome this challenge, different government stakeholders, including Maternal, Child and Women's Health (MCWH), the Department of Health (DOH) and the Reproductive Health Research Unit (RHRU), in collaboration with an international NGO specializing in TOP care training, International Projects Advisory Services (Ipas), introduced the National Abortion Care Program (NACP) in 1998 (Van de Westheizen, 2001). The main aim was to decentralize abortion services from tertiary care institutions to primary health care centers, including clinics (Gumede, 2004). The focus was on increasing the accessibility of TOP services by ensuring that health care providers across the nine provinces are fully equipped with TOP skills. The program trained midwives and registered nurses to provide care to abortion seekers up to 12 weeks of gestation (Harries et al., 2009; South African Government Gazette, 2005; Dickson-Teller & Billing, 2002). However, despite these positive efforts, the Act has been challenged by criticism and opposition.

Some healthcare managers who are not in favor of abortion refused to identify staff members for TOP training or to participate in value clarification workshops aimed at changing health practitioners' negative attitudes to the provision of TOP services (Rohrs, 2012). The lack of

willing TOP providers is a major factor preventing women from accessing safe services in SA. During the evaluation of the progress of the CTOP Act (92 of 1996) in 1999 it was found that only 69 of the 92 trained midwives were actually providing abortion services (Dickson-Teller & Billings, 2002). Health care practitioners' opposition to providing abortion services contributes directly to the continuous use of illegal services. In the face of insufficient TOP providers, facilities turn large numbers of abortion seekers away, leaving them with no choice but to seek help from illegal agencies (Engelbrecht, 2005).

### **Processes and procedures in performing abortion:**

#### **Legal and safe procedures**

Fertility regulating procedures that promote reproductive health by providing safe abortion care are continually improving in many countries that have legalized TOP. The choice of TOP method depends on the gestation stage as well as the condition of the pregnancy.

**Table 2:** Legal TOP procedures (Gilbert, 2013)

<b>Gestation periods in weeks</b>	<b>Procedure employed</b>
0-9	Misoprostol and mifepristone with Manual Vacuum Aspiration (MVA)
9-14	Dilation & Curettage (D &C)
14-20	Dilation & Evacuation (D& E)
Above 20	Dilation and Extraction

In trying to increase access to TOP services in South Africa, the government introduced misoprostol and mifepristone as an alternative to surgical methods. These drugs were approved by the South African Medicines Control Council (SAMCC) in 2001. The SAMCC prescribed that women seeking abortion up to nine weeks of gestation should be given an oral dose of 400g of misoprostol and 600g of mifepristone (Cooper et al., 2005). According to Encyclopedia Britannica (2009) cited in Gresh (2010: 11) "Mifepristone is an antiprogestin, its function is to block the progesterone hormone from nurturing the inner lining of the uterus, which supports the growth of the embryo. The drug is administered orally during the

first nine weeks of the pregnancy, and in less than two days the uterus deteriorate causing bleeding similar to that experienced during normal menstruation. On the other hand the misoprostol drug is taken orally or virginally and causes the uterus to contract much as it would at the beginning of labor or miscarriage. If this drug is administered alone, it is rarely sufficient to expel the fetus and the placenta from the uterus. But when misoprostol is used in combination with mifepristone it is considered to be the safest and most effective abortion procedure in early pregnancy” (ibid).

Benton and Robbins’s (1998) study cited in Harvey and Bechem (2002) revealed that this method was 92% safe and effective when used within the first eight weeks of pregnancy. Other benefits of using oral drugs are that they do not require complicated, expensive surgical instruments; the method does not require many staff; it is quicker than other methods; and it is easily accessible at primary health care institutions. Patients presenting with complications and those in the 12 week period are then admitted to the gynecological ward to be attended to by doctors (Ngene, 2011).

Worldwide, gynecological procedures were initially performed by doctors. In SA, the CTOP Act (92 of 1996) permits doctors and registered midwives to perform surgical TOP methods, including, Dilation and Curettage, Dilation and Evacuation, Dilation and Extraction, and Manual Vacuum Aspiration (MVA), (Benerjee & Andersen, 2012; Cooper et al., 2005; Mhlanga, 2003). Depending on the gestation period diverse surgical procedures are employed in termination a pregnancy. Gilbert (2013) mentions that an MVA procedure is usually prescribed for patients who have gone through medical abortion in order to evacuate any abortion substances left after a medical abortion procedure. This procedure is commonly employed during earlier stages of the pregnancy, as the pregnancy progresses it requires more intense time consuming methods (Grossman, Constant, Lince, Alblas, Blanchard & Harries, 2011).

While the TOP procedure is theoretically seems straightforward, many practical challenges are reported. Women who want to access safe TOP services often wait days, and even weeks before accessing the service. A study conducted in Cape Town found that after a woman’s first visit to the TOP facility, they waited a week to four weeks to receive assistance (Cooper et al., 2005). Engelbrecht (2005) found that women waited more than ten days after making an appointment with a TOP facility. TOP facilities have limited resources and large numbers

of women seek safe TOP; they are thus forced to turn women away because they can only assist a certain number of patients (Gresh, 2010). As a result, women have to choose wake up at about 3h00-4h00 in the morning or sleep on the hospital benches the night before in order to be first in the queue (Gresh, 2010; Mhlanga, 2003). Thus, while the law offers women safe abortion services, these services are still not available to many. Women then risk their lives by using unsafe abortion providers.

### **Illegal and unsafe procedures**

Eighteen years since the coming into force of the CTOP Act (92 of 1996), unsafe TOP methods are still being used extensively by South African women. While studies have shown that, since the passing of the Act, the number of women requiring post abortion treatment as well as the number of maternal deaths have decreased (Mhlanga, 2003; Guttermacher et al., 1998) hospitals still admit women with incomplete abortion as a result of using illegal services. Jewkes et al.'s (2005) study in Gauteng found that about 43% of women had undergone abortions outside designated facilities.

Furthermore, the decrease in maternal deaths and incomplete abortion complications may not necessary be the result of the accessibility of safe, state abortion services (Kumar et al., 2009). Some women successfully induce abortions without complications that may require them to go to hospital. There is a paucity of reliable statistics on the number of abortions taking place in SA. Kumar et al. (2009) is of the opinion that not all abortions are disclosed, as only about 35-60% of TOP procedures are reported by surveys. Over the years the misoprostol drug which was originally prescribed by a doctor has become increasingly accessible. Women can easily buy misoprostol pills from pharmacies, online and from backstreet abortion providers (Rowlands, 2012). The decrease in maternal deaths and incomplete abortions may be credited to women having easy access to this drug, which is a safe procedure that is used in hospitals.

The lack of access to safe abortion services could be one of the factors that drive young woman to risk their lives by seeking TOP from untrained and unauthorized providers. While some women terminate their pregnancies using misoprostol and other drugs, others are admitted to hospitals with incomplete abortions as a result of overdosing or incorrectly using this drug. Furthermore, some women go to much greater lengths to end unwanted

pregnancies by using extremely dangerous methods (Grimes et al., 2006; Goldman et al., 2004), including drinking poisonous substances such as cleaning detergents and herbs and inserting objects in the vagina. They are assisted by unqualified people, including friends, family members and traditional healers (Grimes et al., 2006).

Research indicates that the number of qualified, trained health practitioners providing legal TOP has increased (Gilbert, 2013; Haddad et al., 2009; Jewkes et al., 2005). Jewkes et al. (2005) found that doctors, pharmacist and nurses provided women with misoprostol drugs and warned them to immediately go to a health facility if they experienced complications. Although these people are qualified, they are not authorized to provide TOP services and they may be conducting these procedures in environments which expose abortion seekers to significant health risks.

The CTOPA Act strictly regulates that TOP may only be performed in facilities that meet all the requirements outlined in section 3 of the CTOP Act (92 of 1996) (South African Government Gazette, 2005:4). Any abortion performed by an unqualified or qualified person in a facility that does not meet these requirements is deemed to put women's lives in danger. Women who undergo these procedures either end up dead, or are unable to bear children because of major damage to the vagina, cervix and the womb (Goldman et al., 2004). According to section 10 of the CTOP Act (92 of 1996) any individual "who is not a medical practitioner, or registered midwife or registered nurse who has completed the prescribed training course and performs a termination of pregnancy; prevents the lawful termination of a pregnancy; terminates a pregnancy or allows the termination of a pregnancy at a facility not designated by the state, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period of 10 years" (South African Government Gazette, 2005:7).

The cost of treating post-abortion complications including incomplete abortion, negatively impacts the public health systems of many countries, including SA. Treatment of abortion complications involves the use of expensive instruments (surgical procedures), "blood transfusions, long hospital stays, staff time and medications; it is estimated that incomplete abortions take up to 50% of the money budgeted for gynecological treatment in developing countries" (Grimes et al., 2006: 1914). A study conducted in the United States of America estimated that about \$23 million was spent by the state on treating post-abortion



complications caused by backstreet abortion and about \$6 billion is spent to treat infertility complications.

It was also found that families and communities lost approximately \$930 million of their income to treat health problems arising from unsafe TOP procedures (WHO, 2012). In 1997, it was estimated that the South African government spent about R9, 74 million in treating post-abortion complications caused by unsafe abortion (Grimes et al., 2006). These are significant amounts that could rather be used to run pregnancy prevention programs and increasing the accessibility of TOP services.

## **PSYCHOLOGICAL CONSEQUENCES AFTER AN ABORTION EXPERIENCE**

### **Emotional experiences associated with abortion**

According to MacLaren and Have (2005) in an ecosystems approach an individual is considered to be a physical, psychological and social being. The approach argues that any disturbance occurring in the individual's physical well being, directly affects other aspects of the individual's life. Regardless of the reasons why women seek abortion, they respond differently to this life changing event. An abortion experience does not only affect women's physical well being, it also affects their psychological health (Alemu, 2010; Berger, McBreen & Rifkin, 1996). Despite studies indicating that not all women who undergo TOP experience negative feelings (Costa, 1991 cited in Govender, 2000; Alder et al., 1990), other researchers are of the view that after an abortion women experience deep seated traumatic stresses (Gilbert, 2013, Alemu, 2010; Grimes et al., 2006).

A post-traumatic stress is "a psychological dysfunction which results from a traumatic experience which overwhelms a person's normal defense mechanisms resulting in intense fear, feelings of helplessness or loss of control with a particular situation" (Papalia et al., 2009: 134). The notion that abortion is traumatic is rooted in that an abortion experience can result in a number of symptoms associated with Post Abortion Syndrome (PAS), these symptoms range from feelings of depression, guilt, fear, regret, anger and grief (Major et al., 2009). In the study conducted by Chetty (2012), some of her participants stated that, an abortion experience have made them to feel that they are not entitled to grieve as they were responsible for ending their unborn children's life. If prolonged negative emotions are not acknowledged and dealt with they can result in a number of maladjusted behaviors which

include, suicidal attempts, increased alcohol and drug consumption, eating disorders, sexual dysfunction and child neglect (Gilbert, 2013; Major et al., 2009).

### **Psychological Support and Coping Mechanism**

According to Alder et al. (1990) a woman who finds it hard to make an abortion decision experiences intense negative emotions after going through with the abortion. An abortion experience can be considered traumatic for a variety of reasons. One of the major factors pushing women to opt for an abortion is a lack of support for the pregnancy. Govender (2000) argues that negative feelings are not associated with the actual abortion experience; they are triggered and transpire when women do not receive support with the pregnancy and abortion choice or when an abortion has been postponed for too long. In support of this argument Lie, Robson and May (2008) is of the view that a woman's response to abortion is highly depended on her mental readiness and post abortion support.

In view of the sensitive nature of abortion and the emotional effect abortion has on women's lives there is a need to expand the scope of counselling services in South Africa. Abortion decisions are usually concealed. With so much humiliation and disgrace faced by young women when trying to attend to their reproductive health needs, especially when dealing with issues relating to teenage pregnancy and abortion, young women choose to rather hide their pregnancy and their abortion. A young woman who already fears being stigmatized for falling pregnant at a young age is more likely to consider hiding her abortion choice. According to a study conducted Adanlawo (1998) cited in Engelbrecht (2005) only 33% of abortion seekers discuss their pregnancy and their abortion intentions.

The South African CTOP Act (92 of 1996) regulates that counselling services be made easily available for patients if needed. This is a voluntary service. Considering the fact that abortion is personal, TOP Act additionally instructs that counselling be highly confidential and abortion procedure be conducted in such a way that women's dignity is respected (South African Government Gazette, 2005), which is normally interpreted to imply that counselling be provided in remote settings. This secrecy around TOP makes it isolated and not to be viewed like any other primary health care issue. This is concerning since pre and post abortion counselling services do not only provide women emotional support during the abortion process; but according to section 4 of the CTOP Act (92 of 1996), counselling

services should contain adequate information about different ways to deal with an unwanted pregnancy, which include foster care and adoption; abortion methods used and possible risks associated with those methods; and also provide information about contraceptive use in order to avoid future unplanned pregnancies (Engelbrecht, 2005; South African Government Gazette, 2005). Thus the researcher view counselling as an important element of TOP services which will promote a comprehensive women's reproductive health.

## **PUBLIC PERCEPTIONS OF ABORTION**

### **Perceptions of families and communities**

An abortion decision affects a woman's whole life. In making this decision, women not only have to consider the impact it will have on their physical or psychological wellbeing (Alder et al., 1990), but the impact on their relationships with other people. According to Palomino et al. (2011: 74), "decision making surrounding sexual reproductive issues such as contraception and abortion takes place in contexts of socially constructed norms on reproductive practices and childbearing". The chain of decisions, especially when the pregnancy is unplanned or unwanted, does not take place in a vacuum, but in the context of partner and family relationships and the broader social, political and cultural arenas.

An unwanted pregnancy affects a women's physical, social, financial and spiritual life (Alder et al., 1990). With so much stigma attached to abortion, women fear being mistreated and judged by their family and broader society and opt for backstreet providers in order to keep their abortion secret (Shellenberga et al., 2011; Kumar et al., 2009). The fact that termination of pregnancy has been legalized in many parts of the world, including SA, does not mean that everybody supports TOP. In many countries, especially Islamic ones, people are strongly against abortion. Some even go so far as killing women and those who help them obtain abortion, as well as attacking abortion clinics (Asman, 2004). It is clear that people have strong feelings about abortion, no matter how liberal a country might be. The media regularly reports on different groups protesting against abortion; this issue is debated across cultures. For example, the pro-life group believes that a child's life is very important and should be preserved before the mother's life (Khitamy, 2013).

Abortion is highly stigmatized within some communities, and this could be one of the reasons that a young person may try to hide her abortion intentions, and choose to get help secretly by going to illegal clinics. Shellenberg et al.'s (2011) study found that women who had an abortion feared that they may be rejected by their spouse, family members, and friends and also feared being rejected, mistreated and called names by the general public, if others were to learn about their abortion experience.

Religion and culture play a very important role in the lives of many South Africans (Macleod et al., 2011; Mhlanga, 2003; Harrison, et al., 2000). Traditional, cultural and religious views also play a prominent role in issues surrounding women's health, particularly their reproductive health. Belief systems, especially religious norms and values are the standards individuals refer to in judging whether or not TOP should be allowed. Worldwide, religion has been regarded as a major contributor to opposition to TOP (Selebalo, 2010). "The teachings of Islam, Judaism and Christianity affirm that what makes one a person with full moral rights is the possession of a soul, and they apply the moment of ensoulment which refers to the moment that a human being gains a soul during conception. Ensoulment should be the cut-off point in determining legislation on abortion" (Khitamy, 2013: 30).

Christian organizations have challenged the CTOP Act (92 of 1996) more than once in court. These include the Christian Lawyers Association, Christians for Truth and United Christian Action (Macleod & Feltham-King, 2012). The first challenge to the Act was that it was not in line with the Constitution. The Christian organization groups argued that there was a distortion between the CTOP Act and the constitutional right to life for all. The court ruled in favor of the Act, based on the fact that the law does not recognize an unborn baby as a South African citizen with rights until they are actually born and can breathe on their own. Another argument made by this Christian group was that the Act permits 12-year old girls that according to the Constitution are still considered minors, to make an abortion decision without an adult's consent. In this case, the state's response was that once a young girl fall pregnant she is mature enough to choose what she wants to do about her pregnancy (Macleod & Feltham-King, 2012; Mhlanga, 2003).

Islam also strongly opposes the legalization of TOP. The Roman Catholic Church's initial view was that legalizing abortion was interfering with God's creation. Muslims and Catholics share the view that abortion can only be allowed under certain circumstances such as in cases

of incest or rape, when there is a problem with the fetus and if the pregnancy poses a threat to the mother's life (Asman, 2004). This shows that no matter how much the government tries to make TOP services available and accessible to all, as long as society is against it, women will be afraid of having a safe abortion at a public facility.

### **Peer perceptions**

Peer pressure plays a very influential role in young people's decision making with regard to their sexual behaviour and reproductive health (Mkhwanazi, 2010). Young people find it difficult to source authentic information on the issues surrounding sexuality for young people and usually obtain it from their peers and the media (Honig, 2012). As such information is often limited or incorrect a young woman may end up having unprotected sex which results in an unplanned/ unwanted pregnancy and the dilemma of what to do about the pregnancy. Young women have different perceptions of abortion. Some regard it as wrong and feel that once a pregnancy occurs, it was meant to happen, while others regard termination as an immediate solution to their unwanted pregnancy (Mkhwanazi, 2010; Otoide, Oronsaye & Okonofua, 2001).

### **Healthcare professionals' perceptions**

Like all individuals, healthcare workers have their own value systems and principles that guide their lives. South Africa's Constitution takes this into account. All South Africans have the right to freely express their thoughts, opinions and beliefs; therefore healthcare practitioners have the right to refuse to perform TOP. However, they are still required to provide the patient with information about her reproductive rights, and to refer her to a willing practitioner (Harries et al., 2009; Mhlanga, 2003).

One of the obstacles women face in gaining access to safe abortion services is that some healthcare workers have been unable to draw the line between their personal views on abortion and their professional conduct (Varkey, 2000). While some nurses have no problem providing TOP, others disapprove of abortion, with some going so far as to verbally abuse women who come to the clinic seeking the service (Mbali & Mthembu, 2012; Harries et al., 2009). There are nurses who view abortion as murder; as healthcare providers they see

themselves called on to heal, save and preserve lives and not to end them (Harrison et al., 2000; Varkey, 2000).

A woman that participated in Gresh and Maharaj's (2014) study recounted that one of the health practitioners wanted to call her pastor to talk to her when she came for an abortion. Other respondents stated that it was very hard for them to go to hospitals for TOP because the nurses were verbally abusive; as a result they consulted backstreet providers where they are not criticized or judged for their decision (Gresh & Maharaj, 2014). At the parliamentary committee hearing on the issue of providing TOP services held in the year 2000, some health practitioners who opposed abortion stated that they were being forced to abandon their belief systems and adopt those proposed by the government.

Health care providers argued that performing TOP presented them with contradiction between who they believe they are, as people who preserve life and what they are expected to do by the state, which is to end it. They reported that being forced to perform TOP had affected their personal lives and contributed to high stress levels to the point where some turned to drink (Gumede, 2004). Nurses stated that they would prefer to restrict their involvement in TOP to providing normal nursing assistance and helping with pre- and post-abortion counseling rather than providing the service itself (Harries et al., 2009).

## **GENDER RELATIONS AND TOP**

Gender inequalities are still prevalent, especially in developing countries like SA where maternal mortality is usually high (Haddad et al., 2009; Garba, 2006). According to Hardacre (1997) cited in Wittaker (2002: 14), "it is impossible to separate abortion from the relations of power that structure gender and sexuality". Society links ideas of manhood to control over women (Jewkes, 2002). In Africa and countries such as China and Pakistan, a girl's sexuality is usually strictly supervised because women are expected to preserve their virginity for marriage. Young women's sexual behavior is controlled by their father until they marry and after marriage their husbands take over that role (Garba, 2006; Ali, Rizwan & Ushijima; 2004; Wittaker, 2002).

Society condones certain behavior by men, but condemns the same behavior among women. When a man has more than one sexual partner, this is no big deal, but when a woman does so

she is stigmatized and verbally abused. Globally, women are the focus of reproductive health issues, including contraceptive use and pregnancy prevention programs, while little is done to encourage men to prevent unintended pregnancies. According to Palomino et al. (2011), numerous factors affect women as they make reproductive health decisions. Ignoring these factors and continuing to develop or improve pregnancy prevention programs and contraceptive methods focused on women does not instantly give women control over reproductive decisions.

While SA's Constitution guarantees women's reproductive health rights, translating these rights into practice is a huge challenge. Factors that play a significant role in young people's relationships include gender inequality, unequal decision making and lack of communication about sex, all of which influence their reproductive health decisions (Mkhwanazi, 2010; Corrêa, 2000). Men still dominate and control relationships, while women are accorded low social value and lack control. It is not uncommon in SA for the baby's father to decide to leave the girl when he learns that she is pregnant.

Paternity is defined by Kaufman (2000) cited in Selebalo (2010: 24) "as the father's public acceptance of the child". In African culture, paternity plays a significant role in defining an individual's identity. This is not just about knowing who one's biological father is, but is connected to who the individual is, where they come from and which direction they will take in life. When an unwanted pregnancy occurs and the baby's father refuses to acknowledge being the father, a young woman faces public ridicule and being dishonored by her family for shaming the family name. She also has to put her life on hold in order to raise her child without any emotional support and financial assistance from the father.

Mkhwanazi's (2010) study revealed that some men deny impregnating girls or question the paternity of a child; they make excuses like they only slept with the girl once or they were not the only ones sleeping with her. This leaves young women on their own in making the huge decision on their unplanned pregnancy. Some women decide to have an abortion without consulting anyone, especially when the woman experiences conflict with her partner (Wittaker, 2002).

Feeling abandoned or rejected by the partner they loved and trusted can influence their decision to continue without any support or to end the pregnancy. Humiliating experiences

such as these not only influence the young women's abortion decision, but how and where she gets help. She either attends a public abortion clinic where her personal information will be recorded and filed and where she could be seen by someone she knows, or aborts secretly where no one will ever find out about her being pregnant in the first place. The respondents in Orner, Bruyn & Cooper's (2011) study stated that the reason they did not inform their partners about their pregnancies and abortion decisions was that their partners refused to use protection during sexual intercourse and when an unplanned pregnancy occurred, were opposed to them getting an abortion despite the fact that they were unable to support the child.

## **CONCLUSION**

Worldwide, TOP has been performed for many years. No matter how restrictive or liberal abortion laws are in some countries women still find ways to deal with unwanted pregnancies. Unfortunately, despite the legalization of abortion in many countries, including SA and improved policies and programs to ensure that women from all economic backgrounds are provided with safe TOP services, women continue to die as a result of illegal TOP procedures or attempts. While there has been significant investment in policies and programs to provide safer TOP services, it is important to understand the factors that influence young women's abortion decision, whether legal or illegal.

This chapter reviewed the relevant literature in order to understand the factors that may play a part in a young woman's abortion decision. It examined the impact of teenage pregnancy in SA; the global agenda on women's reproductive health as a human rights issue; the progression and provisions of the CTOP Act (92 of 1996); the influence of peoples' perceptions of TOP, including family members, the community, peers, and TOP service providers; and the influence of gender relations. The following chapter presents the research methodology employed by this study.



## **Chapter three**

### **RESEARCH METHODOLOGY**

#### **INTRODUCTION**

Selebalo (2010: 31) defines a research methodology as “a way in which the researcher plans and structures the research process, as well as the manner in which the research will be carried out.” The research method provides a structure to successfully execute a study (Bereska, 2003). This chapter outlines the methodology employed by the study. It discusses the processes by which data was collected, organized and translated into findings. The chapter highlights the research design, and data collection and analysis procedures. It further discusses the validity, reliability and rigor of the data. Finally, it highlights the ethical concerns presented by the study, its limitations and challenges, and how these were addressed.

#### **RESEARCH METHODS**

Researching any element of sexuality, particularly women’s reproductive health issues, calls for an approach which renders visible the intersection of the psycho-socio-structural dimensions that influence and are influenced by the researched (adapted from Mathe, 2013). A phenomenological qualitative research approach was used to conduct this study. Mitchell, Kruger and Welman (2005: 188) define a qualitative research method “as a method that seeks to describe, decode, translate and otherwise come to terms with the meaning of naturally occurring phenomena in the social world”. Denzin and Lincoln (1994) cited in Chetty (2012: 24) state that a qualitative research is “a multi-perspective approach to social interactions, aimed at describing, making sense of, interpreting and reconstructing this interaction in terms of the meaning that the subjects attach to it”.

A qualitative approach offers the researcher an opportunity to understand phenomena as they occur daily in our social world. It promotes an understanding of peoples’ behavior patterns, how individuals structure their realities, how the environment they are exposed to influences the way they perceive and develop attitudes about the world, and how different group cultural

norms are formed (Hancock, 2002). Using a phenomenological approach, the researcher explored and gained an understanding of the way respondents' experienced illegal abortion and how their experiences impacted their lives. The focus was to explore abortion as a phenomenon that young women have experienced. The researcher explored the respondents' emotions and perceptions and the realities they attached to TOP. This approach challenged the researcher to set aside her own judgment, understanding or interpretations of the respondents' reality of backstreet abortion.

The characteristics of a qualitative research method identified by Creswell (2003) cited in Alpaslan, Du Plooy, Gelderblom, Van Eeden and Wigston, (2010) include the fact that the researcher personally conducts research in natural surroundings. Using the researcher as an instrument for data collection was of great benefit to this study. It enabled the researcher to interpret what the respondents shared about their experience of backstreet abortion, and to understand their thoughts and feelings based on what she observed. The researcher explored a variety of views about backstreet abortion from different respondents (Gilbert, 2013).

The researcher was interested in understanding what illegal TOP means for young women. The primary focus was to investigate the meanings and significance that young women attach to the choices available in dealing with an unwanted pregnancy. The inductive nature of the qualitative research method allowed the researcher to identify young women's shared themes and patterns of behavior as they attended to their unwanted pregnancies (Alpaslan et al., 2010). According to Babbie and Mouton (2011), a qualitative approach offers the innermost perceptions of the population under study.

The researcher employed a qualitative method to explore the issue of backstreet abortion from the perspective of young women who had actually experienced backstreet abortion; therefore backstreet abortion was deeply rooted within them. The fact that they had personally experienced this phenomenon meant that the respondents had sufficient knowledge of it that enabled them to share their perceptions and thoughts about what abortion means to them and how it affected their lives. Furthermore, this method was used because abortion is a very sensitive topic. The method allowed the researcher to structure questions in such a way as not to offend or threaten the respondents. In order to ensure that the interview process was less intense, the researcher responded empathetically and did not adopt a judgmental attitude (Ritch & Lewis, 2005 cited in Alpaslan et al., 2010).

The qualitative phenomenological research approach was well suitable for this study, as it enabled the researcher to explore the psycho-socio-structural issues that influence a woman's choice of an illegal abortion despite the legalization and service improvements in TOP. Young women's patterns of behavior and thoughts, such as deciding who to tell about the pregnancy, the intention to have an abortion and the place to go for assistance were explored, and inferences were made (Alpaslan et al., 2010).

## **RESEARCH DESIGN**

According to Mouton cited in De Vos, Strydom, Fouche and Delport (2011:132), a research design is "a plan or blueprint of how the researcher intends to conduct the research. It focuses on the end product, formulating a research problem as the point of departure and focuses on the logic of research." A research design includes elements such as sampling strategies, the data gathered, and methods of data collection and analysis. It therefore gives researchers specific guidelines on how the research questions can be answered based on the data collected (Bereska, 2003).

The study employed an explorative qualitative research design. This design was suitable to describe young women's backstreet abortion experiences and how they experienced, interpreted and structured these experiences. An exploratory design seeks "to explore and familiarise the researcher with basic facts, about people and problems that need to be addressed and also to determine what further research can be done about the topic" (Alpaslan et al., 2010: 93). The researcher acknowledges the fact that there have been a number of studies on abortion (Grimes et al., 2006; Jewkes et al., 2005; Gumede, 2004). However, those studies tend to be quantitative and focus on the factors that lead to abortion or on public perceptions of abortion.

The present study contributes to research that treats young women as active agents who negotiate their social worlds, by seeking to understand the topic from young women's point of view. The focus was to explore and understand the meanings and significance that young women attach to the choices available to them in attending to their reproductive health needs, especially unplanned pregnancies. The explorative design allowed the researcher to interact with participants in a non-threatening manner and at a level where participants felt and

experienced the research process as experts. It also enabled the research participants to talk about their views and experiences of backstreet abortion within their own frame of reference.

## **BRIEF DESCRIPTION OF THE RESEARCH SITE**

This study was conducted at a district hospital designated to provide TOP services in Durban, KwaZulu-Natal. The hospital is located in Umlazi Township which is about 15 km from the Durban city center. Umlazi is the second largest township in the country and is located in a province that has been identified as one of the regions confronting challenges in implementing the TOP Act (Gilbert, 2013; Harrison et al., 2000).

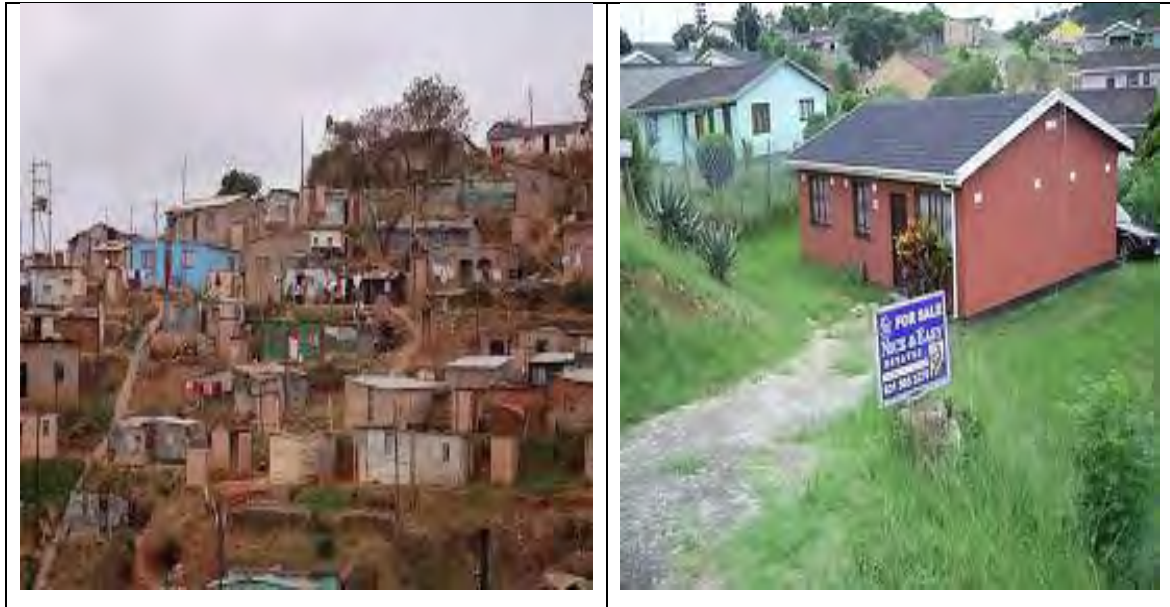
**Image 1:** Map of Umlazi



Umlazi has a population of approximately 300 000 predominantly African IsiZulu speaking residents (Zondo, 2011). The majority of the population is young, with 45% of residents between the ages of 15 and 35. The unemployment rate is estimated at 38%, with women constituting the majority of the unemployed (Zondo, 2011). In spite of twenty years of

democracy in South Africa, Umlazi is still one of the disadvantaged communities that resemble the scars of apartheid. See the images below of the housing conditions at Umlazi.

**Image 2 and 3:** Dominant housing at Umlazi



Fieldwork took place at the Gynecological Out-Patient Department (GOPD) ward. This ward admits patients that present to the hospital with post abortion complications. Approximately 80-105 patients are admitted per day with medical needs ranging from ectopic pregnancies, to spontaneous abortions, post abortion complications, habitual abortions, elective abortions, cervical cancer, genital warts, pelvic inflammatory disease, endometriosis and infertility problems. The hospital employs a multidisciplinary approach to provide comprehensive care. The multidisciplinary team offers treatment that not only focuses on patients' physical, but psychological needs. The team includes trained counselors, social workers, nurses, a gynecologist and psychologists. Given the sensitive nature of the issue of abortion, patients who show signs of being emotionally upset or anxious due to their abortion experience are referred to the hospital social work department. The social worker and the TOP and GOPD wards work together to meet the patient's needs.

## **SAMPLING STRATEGIES AND SAMPLING**

A sample is “a subset of the population that is used to study the population as whole” (Russell & Schutt, 2009:149). It is a group of individuals that have similar characteristics to the population. The sample group provides the researcher with relevant knowledge, facts and understanding about the population and thus enables the researcher to make inferences about the population, based on what has been learned from the sample group (Mitchel et al., 2005).

Purposive sampling was employed for this study. Purposive sampling can be defined as “a form of non-probability sampling where cases are selected based on the researchers’ judgment about information-rich respondents based on their first-hand knowledge and ability to describe the experiences, challenges and coping strategies of going through a particular situation” (Donalek and Soldwisch, 2004 cited in Apalsan et al., 2010:21). This type of sampling is not dependent on systematic experimental knowledge that focuses solely on statistics, the researcher’s intelligence or skills and existing findings, but considers the participants’ intimate experience of the topic at hand.

The researcher selected respondents that were willing to take part in the study, not simply because they were easily accessible. She explored the respondents’ backstreet abortion experiences with a view to understanding young women’s feelings about unplanned pregnancy and abortion, especially illegal abortion (Potjo, 2012). Mathe (2004) notes that one of the limitations of using a purposive sampling approach is that the results cannot be generalized; however the advantage was that it provided the researcher with information that was fitting and relevant to understand why the respondents opted for backstreet abortion.

Fifteen young women between the ages of eighteen (18) and twenty five (25) participated in the study. This age group was strategically selected because women in this category of are reproductive age and this is the age group with the highest level of pregnancy (Klein and American Academy of Pediatrics Committee on Adolescence, 2005). According to the literature, more than 40% of adolescent girls fall pregnant at least once before the age of 20. Fifty-one per cent of pregnant teens have their babies, 35% choose to abort, and 14% miscarry (ibid). This group has also been reported to have the highest number of unplanned and unwanted pregnancies; therefore they are commonly faced with an abortion decision dilemma (Chetty, 2012). Furthermore, the highest number of hospital admissions of women

reporting with post-abortion complications fall within this age group (Honig, 2012; Palomino et al., 2011; Mkhwanazi, 2010).

The researcher gained entry to the facility and access to the sample by obtaining written permission from hospital management and the Department of Health. The respondents were selected in cooperation with the nursing sister in charge of the Gynecology Out-Patient Department (GOPD) ward. To ensure that the researcher did not invade patients' privacy and violate doctor/nurse/patient confidentiality, the researcher firstly approached the nursing sister in charge, who had access to the register and files containing patients' details including their medical reports.

The researcher then took time to outline and discuss with the sister in charge the nature, purpose, procedures, anticipated value of the research, the fundamental role she was expected to assist with in conducting the study and the fact that respondents are to choose to participate voluntarily. When all procedures were sufficiently clarified and agreed upon, the sister in charge, identified and approached patients treated for post abortion complications individually. The nurse in-turn explained to the patients about the researcher, the nature, purpose, procedures, anticipated value of the research and the role of the researcher. Those who indicated to the sister that they were interested to participate in the study were referred to the researcher. Only willing respondents made contact with the researcher.

It was important that patients did not think that participating was part of the hospital's abortion procedure. They were informed that they were not obliged to participate and that choosing not to participate would not affect their right to assistance. The respondents were also informed that, should they agree to participate, they had the right to withdraw at any time. After making contact with willing potential respondents the researcher used an iterative process to negotiate respondents' informed consent. The researcher took time to once more clarify the nature, purpose, procedures, and anticipated value of the study to the respondents as well as their rights in order for them to make an informed decision. Willing respondents were asked to sign a consent form.

Only respondents who fulfilled the following criteria formed part of the study:

- Respondents who resided in the Durban region.
- Respondents who reported to the hospital with post-abortion complications.
- Respondents of the legal age of consent, between the ages of 18 and 25.
- Respondents who were willing and available to participate in the research, were fully aware of what the study entailed, and participated of their free will.

## **DATA COLLECTION**

Qualitative research values the importance of understanding the meaning and experiences attached to the topic under investigation (Mitchell et al., 2005). The data collection method employed by this study was semi-structured interviews with the aid of an interview guide. Semi-structured interviews include open-ended questions that offer the researcher and the respondents the freedom to explore the topic in depth. Semi-structured interviews enabled the researcher to engage in a conversation with the respondents. The researcher had an opportunity to ask questions and to ask the respondents to expand on their responses. This ensured thorough exploration of the respondents' experiences.

The researcher designed the interview guide and translated it into the respondents' home language (IsiZulu). The questions were clear and easily understood by the respondents. They were not formulated in a negative manner and related only to abortion and respondents who had had backstreet abortion (Nueman, 2011). There are a number of benefits of using face-to-face interviews rather than asking respondents to complete a questionnaire. Firstly, the interviews were flexible, iterative and continuous and enabled the researcher to clarify or rephrase questions. Interviews decreased the chances of respondents responding with "maybe" or "I don't know"; therefore the response rate was higher. Secondly, the researcher took note of the respondents' non-verbal communication. Thirdly, interviews were less expensive as the researcher was the main instrument for data collection. Finally, the interviews were conducted quickly (Letters, Wilkins, Law, Stewart, Bosch & Westmorland, 2007).

The researcher acknowledges that interviews as any data collection tools are not free from limitations. One of the disadvantages of interviews is that respondents may try to impress the



researcher by responding in a way they think will please him/her. In this study the researcher minimized this possibility by facilitating an environment where the respondents felt accepted and respected. She listened actively to their responses, and was sympathetic and non-judgmental. The interviews began with the least sensitive questions and the most sensitive, threatening ones were asked towards the end (Engelbrecht, 2005). The semi-structured nature of the questions ensured that the respondents were not restricted in providing answers; they were free to express their different perceptions, feelings and thoughts about abortion. The open-ended nature of the questions gave both the researcher and the respondents an opportunity to discuss backstreet abortion in more detail.

Engelbrecht (2005) is of the opinion that the success of a study depends heavily on the suitability of the interviewer; not having a suitable candidate to conduct interviews may cause a number of problems with regard to the data collected which will in turn affect the results of the study. Desirable qualities when choosing a person to conduct interviews (Engelbrecht, 2005) include someone who can speak the respondent's language, and who is possibly the same gender and from the same ethnic group. All the interviews for this study were conducted in IsiZulu and translated into English by the researcher who is bilingual. Each interview took approximately 60 minutes. The doctor's consulting room was used in order to ensure privacy and confidentiality. All the interviews were audio recorded after having gained permission from the respondents.

Apalsan et al. (2010) note that, data collection for qualitative research requires the researcher to be able to extract all kinds of information about the respondent's real world. In this study, the interviewer was the researcher who is a qualified social worker. The researcher used her social work experience, including paraphrasing, clarifying and probing in order to elicit rich information and address the sensitive subject of backstreet abortion. The researcher adhered to the South African Council for Social Services Profession (SACSSP) code of ethics throughout the study. Respondents were treated as individuals and were not judged, and their values and views on abortion were respected (Grobler & Schenck, 2009).

## DATA ANALYSIS

According to Mitchell et al. (2005:14), “qualitative data analysis transforms data into findings, this involves reducing the volume of raw information, sifting significant from trivia, identifying significant patterns and constructing patterns and constructing a framework for communicating the essence of what the data reveal”. Similarly, according to De Vos et al., (2011) data analysis is the process of bringing order, structure and meaning to a mass of collected data; it involves making sense of and interpreting and theorizing the data. During data analysis, the collected data is narrowed down and the researcher focuses on the findings that contain the most relevant information about the subject under study (Hancock, 2002).

In qualitative research, data analysis entails labeling pieces of information in order to identify commonalities or differences (Hancock, 2002). In this study the respondents’ perceptions, feelings and ideas about abortion were labeled, and commonalities and differences in their experiences of backstreet abortion were identified. This involved labeling or coding every item of information shared during the interview, which enabled the researcher to recognize differences and similarities between the respondents’ experiences and perceptions of backstreet abortion. It also involved picking up verbal and non-verbal items from each respondent’s interview transcripts, labeling them and identifying differences and similarities with other interview transcripts (Hancock, 2002).

The data was qualitatively analyzed using content analysis. Grey (2009: 35) states that content analysis “is a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns.” This method enabled the researcher to understand the reality that young women attached to abortion. “Qualitative content analysis is mainly inductive, grounded in the examination of topics and themes, as well as the inferences drawn from the data” (ibid).

In analyzing the collected data the researcher followed the following steps:

- According to Cresswell (2009), transcribing has to do with gaining some understanding of the data. The researcher first listened carefully to all the audio-recorded data collected during the interviews and wrote it down word for word, taking note of non-verbal communication in order to gain some understanding of young women’s thoughts, views and experiences about abortion and backstreet abortion.

- The researcher went through all the transcripts, carefully reading them over and over again. She compiled summary notes of the ideas, thoughts and meaning attached to the transcripts.
- Coding is defined as “the process of organising the material into segments of text before bringing meaning to information” (Creswell, 2009: 186). The researcher summarized portions of the data and assigned codes to them. She then underlined key words, phrases and sentences, and compiled topics with them. The researcher looked at recurring thoughts, experiences, ideas and feelings that were shared by the young women during the interviews. Topics that contained similar ideas were grouped together and assigned suitable abbreviations or codes. The relationships between codes were identified and themes were developed (Miles & Huberman, 1994 cited in Potjo, 2012).
- “This step involves defining and refining themes that have emerged, identifying their meaning and lastly defining the main idea that each theme deals with” (Potjo 2012: 46). At this stage, the researcher defined and organised all the themes developed in the previous step. These themes were then grouped together to develop the main themes.
- In reporting the findings, the researcher recorded what she had discovered about abortion and discussed the approach used in order to ensure the trustworthiness of this study (Grey, 2009). The researcher further provided descriptions of the respondents, backstreet abortion and the setting of the study in order for the reader to understand what was investigated (ibid). Finally, the literature review was used to substantiate the data in order to ensure that the data was adequate in terms of informational value, credibility and neutrality as outlined in the following chapter.
- The researcher developed an understanding of the emerging themes relating to respondents’ backstreet abortion experiences (Grey, 2009). The patterns of the respondents’ perceptions and behaviours relevant to the factors that drove them to seek backstreet abortion were identified and explored. Finally conclusions were drawn as outlined in the final chapter.

## LIMITATIONS AND STEPS TAKEN TO MINIMIZE LIMITATIONS

- This study was conducted in one township located in Durban. The sample did not represent all socio-economic backgrounds. However, since the researcher was not planning to generalize her findings, this limitation did not impact the value of the study. The study reports on the findings in a specific context.
- Abortion is a very sensitive topic and illegal abortion is even more sensitive. This negatively affected participation in the study. It took the researcher some time to find willing respondents. This limitation was minimized by working closely with the nursing sister in charge of the GOPD ward. To ensure that the researcher did not violate the privacy and doctor/nurse confidentiality of all patients admitted for abortion, prospective respondents were first approached by the nursing sister. The researcher explained the nature, purpose, procedures and anticipated value of the study to the nursing sister and the respondents.
- The researcher's personal limitation was that she struggled with her own values and views on abortion. To overcome this, she adhered to the South African Council for Social Services Profession (SACSSP) code of ethics throughout the study. These included respecting respondents' values, the importance of self-determination and individualization, being non-judgmental, and sticking to the respondents' perceptions of abortion.

## VALIDITY, RELIABILITY AND RIGOR

According to Neuman (2011: 208) "Validity, reliability and rigour are ideas that help to establish the truthfulness, credibility or believability of the findings. Trustworthiness refers to the extent to which the findings of a study can be viewed as worthy of confidence. To assess the trustworthiness of this study the researcher employed the following criteria: credibility, transferability, dependability, and conformability (Lincon & Guba cited in Krefting, 1991).

**Credibility:** According to Lincon and Guba cited in Krefting (1991: 217) "credibility can be ensured by using a formal member check, which involves obtaining the original informants' viewpoints about the accuracy of results". The researcher used semi-structured interviews to

ensure credibility. The interviews were conversational in nature and the participants were free to express their views. To enhance credibility, the researcher also refrained from using double barrel questions, expressed statements clearly, refrained from framing the questions in a negative manner, reframed and repeated questions, and asked questions related to the study and the participants, in order to ensure that the participants clearly understood the questions (Nueman, 2011). Credibility was further enhanced by minimizing sources of measurement of error. The researcher demonstrated acceptance and respect by listening actively to the participants' responses, and being sympathetic and non-judgmental.

**Transferability:** Transferability refers to the extent to which the findings of a study can be applied in another situation or context (Krefting, 1991). Transferability was ensured by compiling detailed descriptive information about the young women who participated in the study and the setting where the study was conducted. Sufficient literature relating to unplanned pregnancy and abortion (both legal and illegal) was also reviewed in order to enable future researchers to refer to other studies related to abortion (Shenton, 2004).

**Conformability:** Conformability refers to the degree to which the results can be confirmed or corroborated by others (Sinkovis, Penz, & Ghauri, 2008). The researcher was aware of her own perceptions and beliefs about abortion. To prevent these from interfering with the gathered data, she set aside her own realities and focused on the experiences, feelings and meaning that the respondents attached to abortion (Shenton, 2004; Streubert-Speziale & Carpenter, 2003). Furthermore, conformability was ensured through a partial audit of audio-taped interviews and transcripts relating to the identified thematic categories and the interpretations and inferences that were made (Krefting; 1991).

**Dependability:** Dependability refers to a criterion that is considered equivalent to reliability and is similarly concerned with the stability of the results over time (Sinkovics et al., 2008). Dependability was ensured by working with the researcher's supervisor to ensure consistence in the research plan and its implementation (Krefting, 1991). The researcher further enhanced dependability by providing sufficient information about the qualitative research approach employed by this study, which will make it possible for a different researcher to repeat the study and possibly achieve similar results (Shenton, 2004).

## **ETHICAL CONSIDERATIONS**

De Vos et al. (2011:114) define ethics “as set of moral principles which are suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioral expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students.” Conducting a study in an environment with set moral standards and laws requires that certain ethical procedures be followed. Given the sensitivity of abortion and the fact that backstreet abortion is an even more sensitive subject, the researcher adhered to the following ethical principles:

**Permission to conduct the study:** In order to gain access and receive permission to conduct this research study at the hospital, a site permission letter was acquired from the hospital and an approval letter was received from the Department of Health.

**Confidentiality:** According to Babbie cited in De Vos et al. (2011), confidentiality means that the information shared between the respondents and the researcher remains confidential and that if there is ever a need for someone else to gain access to that information, the respondent should be made aware of this request. To ensure that the researcher did not invade the privacy and violate the doctor/nurse confidentiality of all patients admitted for abortion, respondents were initially approached by the nursing sister in charge of the ward. Only willing respondents made contact with the researcher. To ensure privacy, all interviews were conducted in the doctors’ consulting room. The tape recordings, notes and transcripts are locked in a cabinet to which only the researcher has access. These will be destroyed within the period agreed upon with the respondents (five years).

**Informed consent:** According to Ryse cited in De Vos et al. (2011), informed consent ensures that respondents are properly informed about the purpose, methods, and risks and benefits of participating in a proposed study. The goal of the research, the questions to be asked, the duration of interviews and the interview procedures were properly explained to the respondents. The researcher provided accessible information to respondents in the form of a letter in their home language (IsiZulu) and she also explained the information. In order to ensure that respondents made an informed decision the researcher used an iterative process of informed consent to bring to their attention the fact that they were not compelled to participate and that participation was not part of the hospital’s abortion procedure.

The respondents were also informed that they were free to withdraw from the study at any time. Sufficient time was taken to explain the nature, purpose, procedures and anticipated value to the nursing sister and potential respondents. Therefore, the respondents had all the information they needed to make an informed voluntary decision. Finally, only willing respondents of legal age of consent signed a consent form.

**Anonymity:** Anonymity entails that respondents' identities are protected in such a way that they cannot be connected to information (Russell & Schutt, 2009). The researcher changed minor details so that the respondents could not be recognized. Codes were used instead of respondents' names. The researcher is the only person that can link these codes to the respondents' names and identities. The researcher made sure that as much as other colleagues (such as the supervisor) gained access to the information, respondents' identities were disguised. In addition, the researcher was governed by the SACSSP code of ethics which includes individuality, a non-judgmental attitude, respecting respondents' values and the importance of self-determination.

## **CONCLUSION**

This chapter discussed the methodology employed by this study. It described the processes by which data was collected, organized and translated into findings. The research design, sampling strategies, and data collection and analysis procedures were discussed. The chapter also briefly described the research site and discussed the validity, reliability and rigor of the data. The limitations and challenges of the study and how these were minimized were discussed. Finally, the chapter outlined the ethical principles that the study adhered to. The following chapter presents the findings and discussion on the data gathered.

## **Chapter four**

### **ANALYSIS AND DISCUSSION OF RESULTS**

#### **INTRODUCTION**

This chapter presents the analysis, findings, interpretations and discussion on the collected data. It begins by presenting the respondents' biographical information, including their age, marital status, previous TOP, educational level, number of children and employment details. This enabled the researcher to understand the respondents' backgrounds and build rapport with them. The following section presents the themes that emerged from the interviews conducted with 15 women who had undergone backstreet abortion. Their responses were analysed using thematic content analysis which involved transcribing the interviews, reading and rereading the transcripts carefully and taking notes, in order to be familiar with their content and meaning. The data was then organized and categorized into themes.

The themes include: Contraceptive use; Attitudes to TOP; Decision making with regards to TOP, with a focus on the reasons for abortion, discussing the decision with family and friends and support from loved ones; The CTOP Act (92 of 1996), focusing on the respondents' knowledge of legal TOP services and designated facilities and reasons for not using legal TOP services; and Illegal TOP services, including the reasons for resorting to such services, illegal TOP procedures used and persons assisting with the TOP. The themes and quotations from the transcript are subjected to control by the reviewed literature.

#### **BIOGRAPHICAL PROFILE OF RESPONDENTS**

##### **Race**

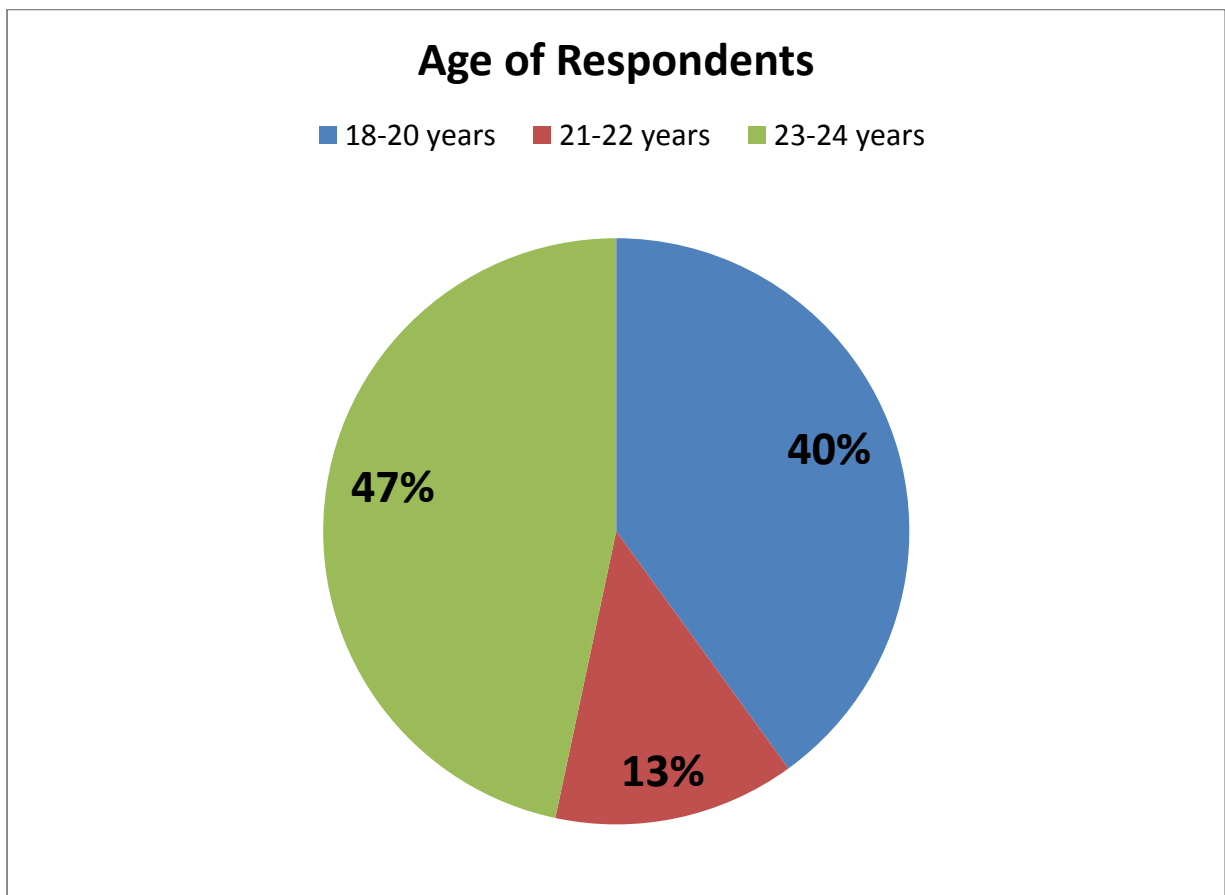
All the respondents in this study were isiZulu speaking Africans from Umlazi and surrounding areas. As noted in the methodology chapter, the study sample was not representative of all races and socio-economic groups in Durban. Despite the abolition of the group areas Act in South Africa, residential areas are still racially inclined. In South Africa (SA), an individual's financial status and colour of the skin still plays a major role in



determining where they live. This study was conducted in a government hospital located in a township which is located 15 km from the Durban city center. According to Rees (1991) cited in Gumede (2004), the majority of people who seek help from state hospitals and clinics come from previously disadvantaged communities. The majority of people attending this hospital are Africans who were disadvantaged during the apartheid era, and still have very low income.

## Age

**Chart1:** Ages of Respondents



All the respondents in this study were of reproductive age. The researcher targeted women aged 18-25 but the respondents were between the ages of 18 and 24. In the current study the majority of respondents were between the ages of 23-24 (47%), followed by 40% of the respondents falling between the ages of 21-23 and only 13% of respondents were between 18-20 years. Different studies conducted in SA reveal that the majority of women reporting to

hospitals with post-abortion complications are between the ages of 15 and 35 (Palomino et al., 2011; Papalia et al., 2009). This age group is reported to have the highest number of unplanned and unwanted pregnancies and is therefore commonly faced with an abortion decision dilemma (Chetty, 2012). Ankomah, Aloo-Obunga, Chu and Manlagnit's (1997) study in Nairobi found that 91% of women who reported to the hospital with complications resulting from induced abortion were under the age of 25. According to Klein and American Academy of Pediatrics Committee on Adolescence (2005), more than 40% of adolescent girls have been pregnant at least once before the age of 20. Fifty-one per cent of pregnant teens have their babies, while 35% choose to abort, and 14% miscarry.

### **Marital status**

In this study all 15 respondents were single. This concurs with Gumede's (2004) study on backstreet abortion that found that 59% of the respondents who had undergone backstreet abortion were single. Ankomah et al.'s (1997) study found that the majority of women who presented with post-abortion complications were single. Approximately 81% of patients admitted with symptoms of induced abortion were unmarried. According to Chetty (2012), high abortion rates are common among single women; she adds that gender inequality is one of the factors that contribute to high rates of unintended pregnancies which end in abortion among young women.

### **Religious affiliation**

**Table 3:** Respondent's religious affiliation

<b>Religious group</b>	<b>Number</b>	<b>Percentage</b>
Christianity	10	67%
Nazareth Baptism Church	2	13.3%
Zion Christian Church	2	13.3%
<b>Total</b>	<b>14</b>	<b>93.3%</b>

Fourteen (93.3%) of the 15 respondents associated themselves with a religious belief system and only one did not claim religious affiliation. Three main types of Christianity were identified, namely, Christianity (67%), Nazareth Baptist Church (13.3%) and Zion Christian Church (ZCC) (13.3%). Petchesky (1990) cited in Whittaker (2002: 8) is of the view that when a woman decides to have an abortion she not only considers her own intentions, “but she also has to look at ideologies and social realities. Religion and culture play a very important role in the lives of many South Africans (Macleod et al., 2011; Mhlanga, 2003; Harrison et al., 2000).

Traditional, cultural and religious views play a prominent role in issues surrounding women’s health, especially their reproductive health. Belief systems, especially religious norms and values are standards that individuals refer to in judging the conditions under which TOP may be permitted. Negotiations between these concepts result in an unarticulated morality of the situation, of praxis which incorporates social and individual need into the shifting ground of moral values.” All the respondents that identified themselves with a religious denomination viewed abortion as wrong and as a sin. These young women associated having an abortion with killing an innocent soul which is a gift from God.

This study revealed that even though young women choose to have an abortion, their religious norms and values play a prominent role in how they perceive abortion. The following excerpts from the transcripts attest to this:

*“I don’t have peace because I am a Christian... At church they tell us that if it happens that we fall pregnant we must keep the child because every child is a gift from God.”*

*“Sometimes I think about it, what if I get married and I can’t have another child, maybe God gave me just this one child and I killed it, it is really painful when I think about it sometimes.”*

*“I always thought abortion was not a right thing. Because when you do it you are killing an innocent soul. But because I was in a bad space....I was left with no choice but to do it.”*

*“Even in my church they really don’t want abortion, they say we must keep the child if we fall pregnant....if my mother knew about this she would say I’m doing something very bad because I know the truth...”*

*“After I have done it I just feel guilty. Sometimes I feel that I did not do the right thing. I’ve sinned and that’s it...”*

The utterances illustrate the findings of the study conducted by Selebelo (2009) where respondents referred to abortion as murder. South Africa is not the only country where religion has been identified as one of the main forces opposing the provision of TOP. Whittaker’s (2002) study in Thailand revealed that Buddhist respondents felt that abortion is a serious sin, even if it is one that is necessary.

#### **Number of children and previous abortions**

**Table 4:** Number of children respondents had and previous abortions

	<b>Number</b>	<b>Percentage</b>
<b>With children</b>	9	60%
<b>Without</b>	6	40%
<b>One child</b>	4	27%
<b>Two children</b>	5	33.3%
<b>Previous abortions</b>	2	13.3%

Only two respondents reported having had a previous abortion, of which one respondent never had a child before and the other already had two children. Six did not have children, while nine had children. Five respondents had two children and four had one. Therefore, the majority of the young women who had undergone backstreet abortion already had living children.

The respondents who already had children shared their reasons for having an abortion:

*“I was very sad because I have another child at home and I’m not working. They are taking care of my child, and they also pay for my college fees.”*

*“I was shocked because this was the second child.... I can say that my heart was in pain that I was doing this again....So I had to do it.”*

*“After I had my first child my father gave me a second opportunity to finish my studies....I saw that if I have this child he would be very disappointed.”*

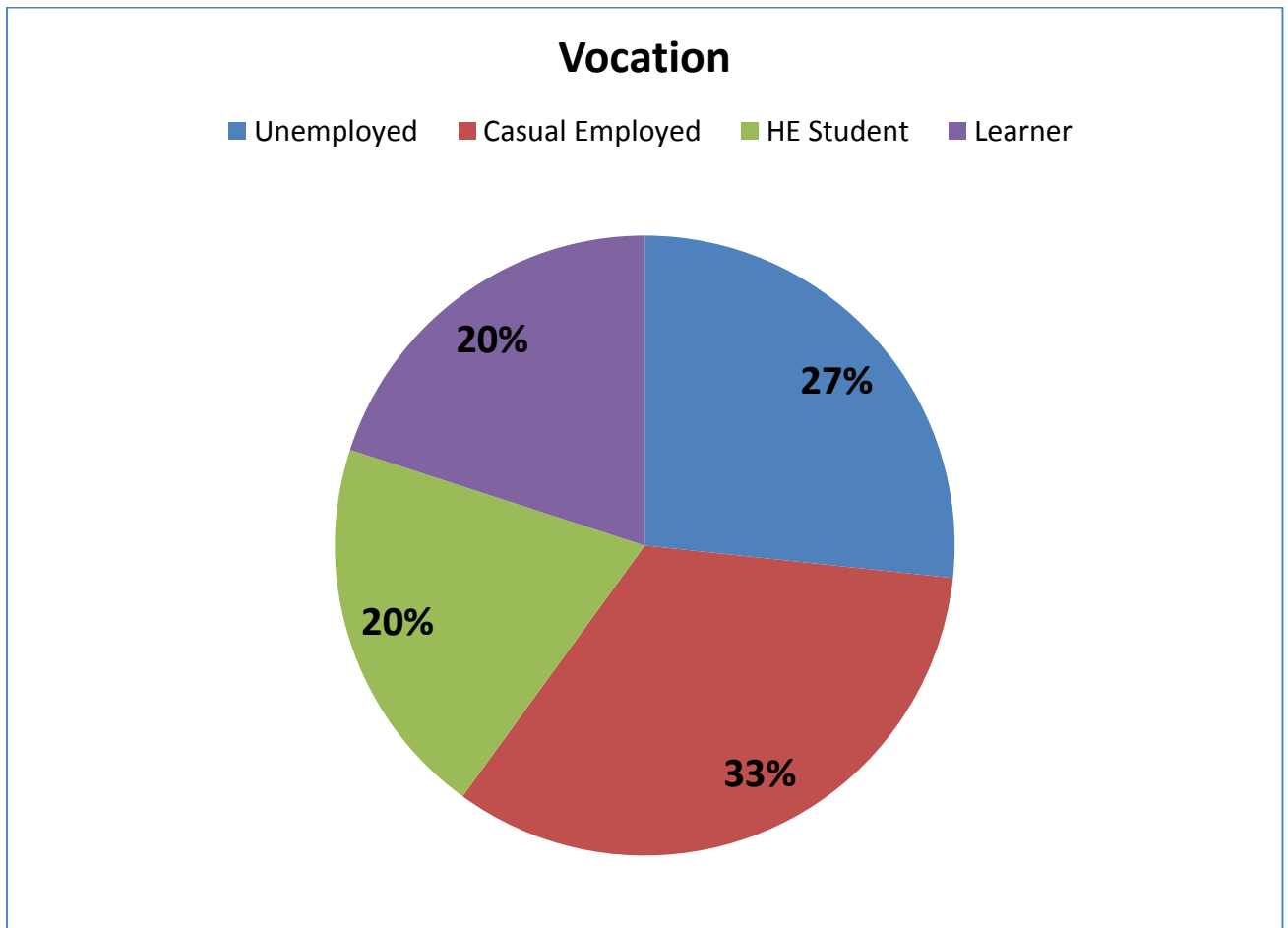
*“I already have two children, I don’t want another child... there are still things that I need to do.”*

These statements concur with the finding of Benerjee and Andersen’s (2012:887) study that “the majority of women (92%) with post abortion complications had at least one living child.” This suggests that when young women make an abortion decision they take into account the number of children they already have and their financial situation. The South African situation is made worse by high population rates which complicates the socio-economic status of women and keep them in the vicious cycle of poverty.

## **Vocation**

One of the important factors that play a part in young women’s abortion decision is their employment status. Ten of the respondents were unemployed and the five that were employed described their jobs as unstable. One worked three days per week as a domestic worker while the remainder were employed at factories and restaurants as casual employees. See the pie chart 1 below that illustrate the vocational divisions of respondents:

**Chart 2: Respondents' Vocation**



All 15 respondents had reached secondary level education. Two respondents left school in the eleventh grade, three (20%) of the respondents were currently doing grade 12, the other 20% were still pursuing tertiary education and the remaining seven held a senior certificate. These results indicate that the young women's desire to pursue a better life through education influenced their abortion decision. This is confirmed by the following statements:

*"I'm not working. They are taking care of my child, and they also pay for my college fees."*

*"I panicked and thought about how am I going to write my matric exams with a big belly... then I started about way to get out of this problem."*

*“.....I am not completely at peace with it, but I’m happy that I can continue with my studies.”*

*“I feel relieved because I can continue with my studies and there is no baby...”*

The statements are confirmed by a study conducted at a South African university by Gresh and Maharaj (2014). Young female university students stated that the main reason why they would choose to have an abortion if they unexpectedly fell pregnant is that before they commence child bearing, they want to ensure that they have a stable career in order to provide properly for the child. For these students, continuing with a pregnancy would hinder them from accomplishing their educational goals (ibid).

About 33% of respondents in this study were casually employed. These respondents described their jobs as unstable and not guaranteed. Two of the employed respondents described their situation:

*“I work then I stop. They call me if they need me... I’m on and off work.”*

*“I work, but its part time...”*

The total number of unemployed women in this study including those that were pursuing their education was ten (66.7%). Some of the reasons pushing young women to opt for an abortion were raised by the 27% of respondents who were neither employed or studying are as follows:

*“I stay at home...and no one is working at home so I thought I will be increasing costs or expenses.”*

*“It is very hard to be in my position... with no job and still relying on my mother, how can I bring another child....”*

*“I worked so hard last year hoping to go to the university, but look at me I am stark at home with nothing. Sometimes I feel like there is nothing for me here... Bringing a child on top of all this would have been a disaster.”*

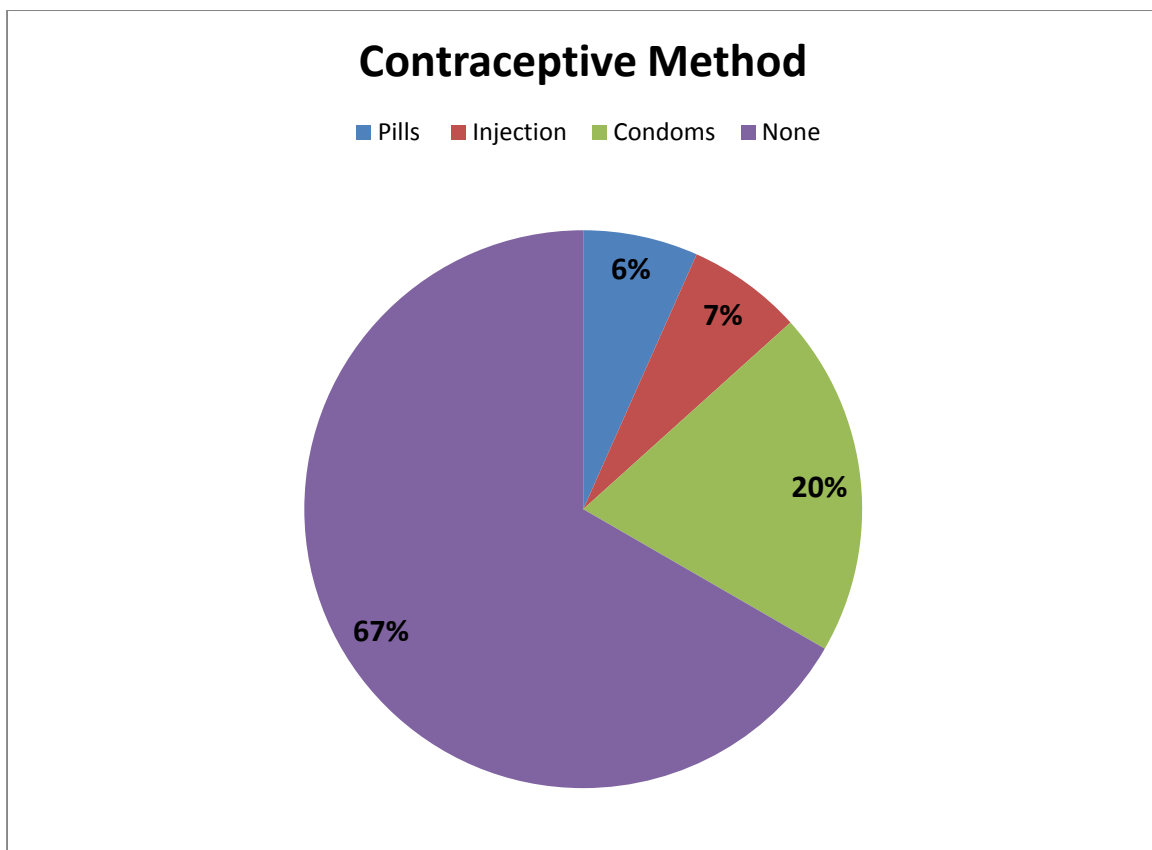
*“Raising a child is not a joke, it’s even worse when you still depend on other people, I just did not want to cause more trouble....”*

These statements are supported by the results of a study conducted by Orner et al. (2011) that found that financial challenges were a common reason for opting for TOP. Without financial security women feel under pressure to end their pregnancy. They are concerned about having another child in a household that is already overburdened (ibid).

### CONTRACEPTIVE USE

Various studies have identified the lack of or low contraceptive use as one of the root causes of unwanted pregnancies which end in abortion (Ngcobo, 2009; MacPhail et al., 2007; Deschner & Cohen, 2003). According to Deschner and Cohen, (2003: 7) “women who are determined to limit their family size and time their child bearing will use all available means to do so; if contraception is not a viable option, women will turn to abortion even if it is illegal”.

**Chart 3:** Contraceptive methods employed





This study established that contraceptive use among the respondents was either very low or that those who were using some form of contraceptive were inconsistent, leading to an unintended pregnancy. Even though all the young women said that they were not intending to have children, about 67% of respondents reported that they were not using any form of contraceptive. MacPhail et al.'s (2007) study revealed that even though two-thirds of young girls are sexually active before the age of 24, less than half use some form of contraception to prevent an unwanted pregnancy.

Only five (33.3%) of young women in this study were using contraceptives, one respondent was using the pill:

*“Yes I was taking pills... but it happened...”*

Another respondent was using the injection:

*“Yes I was using an injection...”*

The remaining three (20%) were using condoms; one reported that it burst and the other two were not consistent in their use of condoms.

*“I used a condom ...but it burst.”*

*“Yes I do use a condom...but that day we just didn't.”*

*“I was using some contraceptives, condoms... but sometimes I would not use.”*

These responses are supported by a study conducted by Salebalo (2010: 2) which found that “Among the sexually active teenagers there was evidence of an inconsistency and low contraceptives use, as low as 25% in some instances”. Limited or inconsistent use of contraceptives is a direct contributor to the high rate of unintended pregnancies with many ending in abortion, in some instances illegally.

Other research findings indicate that while contraceptive methods are effective, there are incidents where they fail to prevent unintended pregnancies. Ngene's (2011) study revealed

that 75% of South African women living in the Durban area requesting TOP services at hospital were using some form of contraceptive method when they fell pregnant. While condoms are considered to be effective in preventing unplanned pregnancies, there are instances where they break and a pregnancy occurs. In this case, the most effective method would be the use of emergency contraceptives. The challenge with emergency contraceptives is that there is little knowledge of the service and that it is not easily accessible to all women.

Ngene (2011) reports that, only 5% of her female study respondents knew about emergency contraceptives. In the current study two young women knew about the morning after pill, but did not know where to access it. Similar results were obtained by a study conducted by Engelbrecht (2005) who found that only 15, 9% of women surveyed knew about emergency contraceptives. However, even those who were aware of them did not know what they looked like.

## REASONS FOR SEEKING AN ABORTION

**Table 5:** Respondents’ reasons for seeking TOP

Reason	Number	Percentage
<b>Wanting to finish school/ studies</b>	6	40%
<b>Conflict with partner</b>	4	27%
<b>Lack of financial means to support a child/ second child</b>	4	27%
<b>Fear of parents’ disappointment</b>	1	6%

A TOP decision impacts an individual’s entire life. When women make decisions concerning their reproductive health, especially pregnancy and termination of pregnancy they consider a number of issues, including their physical, social, financial and spiritual life. According to Palomino et al. (2011: 74) “The chain of decisions, especially when the pregnancy is unplanned or unwanted, does not take place in a vacuum, but in the context of partner and family relationship and the broader social, political and cultural arenas”. The reasons cited by

the respondents for seeking an abortion were those commonly given in various studies (Chetty, 2012; Orner et al., 2011; Harries, Orner, Gabriel & Mitchell, 2007). They included not being able to provide for a child, in some cases a second child; wanting to complete their studies and conflict with the baby's father. Some reasons cited by the respondents have been discussed under previous sub headings of this section.

Four respondents in this study shared that their abortion decision was due to their partner's lack of interest in them once they told them they were pregnant. These findings are in line with other studies which show that an unplanned/unwanted pregnancy can cause conflict between a woman and her partner and when that happens, some women find it hard to continue with the pregnancy without their partner's support. Gresh and Maharaj's (2014) study revealed that women decided to end the pregnancy if they did not receive support from their partners. There are instances where women separate from their partners because they refuse to take responsibility for the child or deny paternity. This is confirmed by the following statements by respondents:

*"I told the person that I was with (partner), but he did not want to accept the situation. He moved to Johannesburg and left me alone. I'm four months now, I was delaying having an abortion thinking that he will come to his senses but he is not, so I had to...."*

*"The baby's father was just a boy I met when I came here to the university...I was taken by his charm... he did not even care about me, he just used me ..."*

*"I was warned not to fall pregnant again. So I told my boyfriend about the problem, but he refused to accept the fact that I was pregnant... he left me."*

*"He said I should go to the baby's father, I know who he is...."*

Mkhwanazi (2010) found that some men question the paternity of a child or make excuses that they only slept with the girl once. Conflict with their partners often means that young women have to make the huge decision about their unplanned pregnancy on their own. The fact that all the young women in this study are single and that some were deserted or rejected by their baby's father could have played a significant role in their abortion choice.

## DISCUSSION OF THE TOP DECISION

**Table 6:** Personnel whom the TOP was discussed with

	Number	Percentage
<b>Sister</b>	2	13.3%
<b>Close friend</b>	7	47%
<b>Father of the child</b>	1	7%
<b>None</b>	5	33.3%

In order to establish whether or not the young women received any support during their abortion decision process, the respondents were asked who they discussed their decision with. When people make life changing decisions it is common to involve their loved ones; this could include family members, peers and partners (Constance & De Tolly, 2012). Studies have revealed that abortion decisions are intimate and highly confidential. Adanlawo (1998) cited in Engelbrecht (2005) found that 33% of the women seeking TOP services in a KZN hospital did not discuss their pregnancy and their desire to have an abortion with family members and friends. The current study revealed that five (33.3%) respondents did not tell anybody about their decision. The majority (9) discussed their decision with a significant other. Out of the nine respondents, seven (47%) spoke to their friends, two (13.3%) spoke to their sisters and one told a partner. These findings suggest that young women feel more comfortable confiding in their peers than family members.

*“It was my friend.... She was the one who told me about the person I can go to for help...”*

*“I spoke to my friend... I told her that my boyfriend does not want to take responsibility that the child is his so I am going to have an abortion.”*

*“I spoke to my friend, she was the only person that was easy to talk to...she is the closest to me. It was not easy for me to speak to my family.”*

It is difficult for South African youth to access sufficient information on issues surrounding their sexuality and they often obtain such information from their peers and the media (Honig, 2012). As this information is sometimes limited or totally incorrect, a young woman can end up having unprotected sex which result in an unplanned/ unwanted pregnancy, and the dilemma of what to do about the pregnancy.

The findings of this study suggest that young women's peers played a major role in influencing young women to seek illegal abortion services. The following statements confirm this:

*“My friend has done it before, she told me where to go...she said no one will know and my parents will never find out.”*

*“I spoke to my friend....she told me where I should go for this, so I went to him (traditional healer) ”*

When a young woman discovers that she is pregnant her biggest concern is how her parents will react. This is also the most difficult moment for the young woman's mother. A pregnant daughter reflects her failure as a parent. She is viewed as someone who was not able to teach her child good moral values and standards, which include maintaining her virginity until she is married. On hearing of their child's pregnancy, some parents administer corporal punishment, scream at her and in extreme instances banish her from the home (Mkhwanazi, 2010). One respondent shared her fears of her father's reaction if he found out about her pregnancy; as a result she did not tell her parents:

*“My father is a pastor, he has a bad temper (unolake), if he find out that I was pregnant again I would be in trouble...because he warned me that if I ever do it again, I will be on my own...”*

Another said that she couldn't tell her mother about her abortion decision:

*“Even at home as I was telling you that I did not even tell my parents about the pregnancy. They say it is better to allow the child to grow. My mother hates abortion, she does not believe in it. They always say that a person who does an abortion is a bad person and a murder.”*

It is evident that young people find it difficult to talk to their parents about their reproductive needs. It would seem that some adults, especially parents, make it difficult for young women to approach them with their sexual and reproductive problems. In Engelbrecht's (2005) study, respondents who did not confide in their parents about their abortion decision said that they feared that they would be disappointed in them and that they would not accept their decision; those whose parents discovered that they were planning to abort responded with rage and sadness. Fear of their parents and the lack of parental support therefore seem to have played a significant part in the young women's decision to seek an abortion secretly from illegal providers. Furthermore, they received support from their peers who might not have had knowledge of legal TOP services and therefore influenced them to use illegal providers.

### **ABORTION AS UNACCEPTABLE YET NECESSARY**

One of the objectives of this study was to explore the influence of other people's views of TOP on the choice of termination options. All 15 respondents noted that society disapproves of abortion. This is in line with a number of studies which reveal that the fact that abortion has been legalized in South Africa does not necessarily translate into it being socially accepted (Gresh & Maharaj, 2014; Shellenberga et al., 2011; Palomino et al., 2011; Kurmar et al., 2009). The findings of this study show that even though the respondents had an abortion, they still viewed it negatively; it was something they did as a last resort.

The following statements attest to this:

*“...I always thought that a person who does abortion was a killer. But when I was faced by this situation, I thought it was something that can help me with the problem*

*that I had. Mainly because I do not have money, and I don't think the baby's father will take care of this child even if I tell him."*

*"Abortion is not a good thing when you look at it, but sometimes a situation compels you to make bad decisions."*

*"I don't see abortion as a nice thing. If it was so, I could have been easy for me to involve other people, like my friends and parents tell them that I was going to have an abortion. But I can see that it is something that is not acceptable, even myself I'm scared of it. It is not something that is part of our culture. Our culture does not allow us to do something like this, but under some circumstances and the problems I perceived will happen or were starting to happen forced me to end up doing an abortion."*

The respondents stated that, society views TOP in a negative light and that those who opt for abortion are treated harshly:

*"Most people see abortion as something that is not right, because they say that if you give birth to the first child like me, you should learn a lesson that if you do not control yourself that's what happens to you. It's how you should see that you were wrong. So now if you have an abortion you are worse, you are viewed as an immoral person in the place where you live."*

*"In my community they see it as something that is not right..... Also at church they do not approve of it, they say that it when you have a child you should allow him/her to live. They say people may laugh at you for some time but the child will live. People do not really like abortion."*

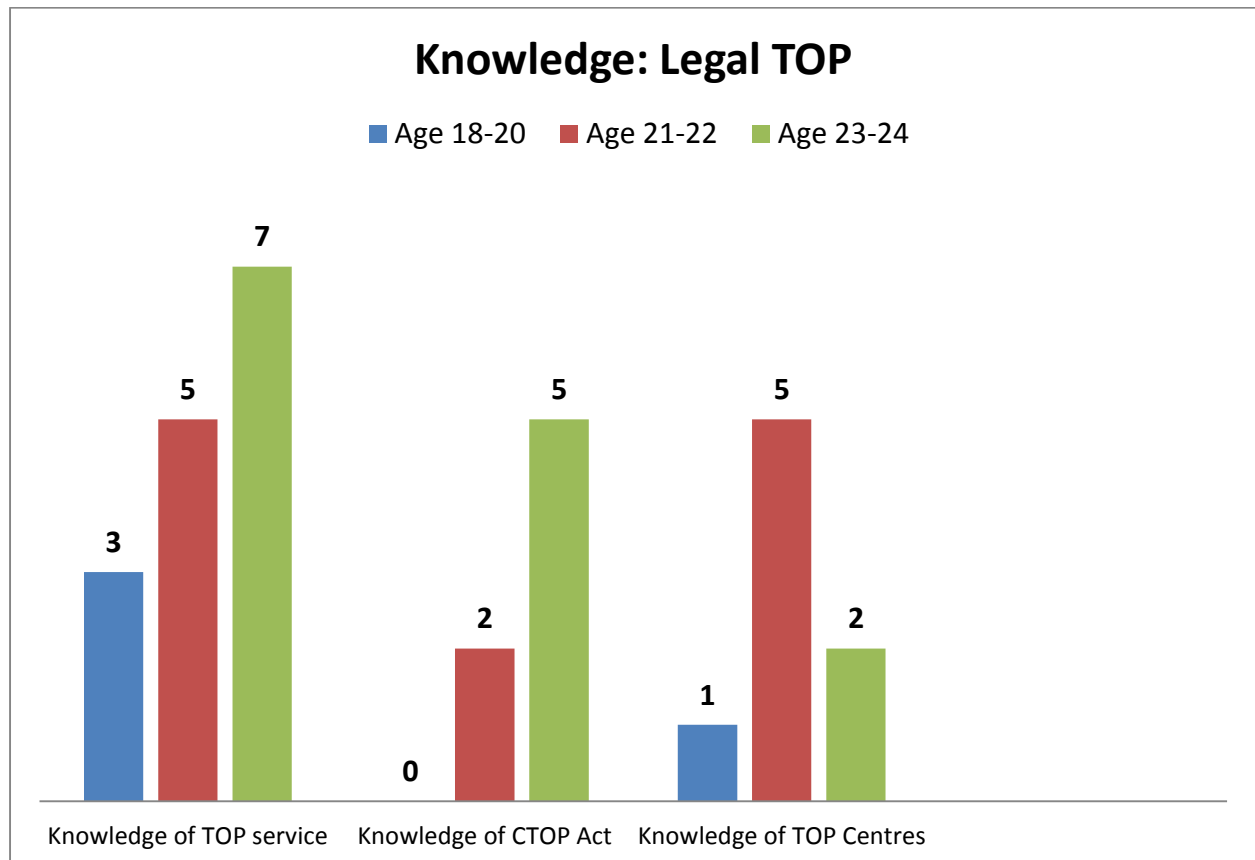
These statements suggest that the stigma surrounding abortion does not give young women the freedom to choose how they meet their reproductive needs. Abortion is highly stigmatized in South African communities; as a result women often try to hide their intention to abort, and choose to get help secretly by going to illegal clinics so that no one will know what they have done. A study conducted by Shellenberga et al. (2011) revealed that, women who had had an abortion feared that they may be rejected by their spouse, family members and friends

and also feared being rejected, mistreated and called names by the general public, if others were to learn about their abortion experience. Similarly, in Gresh and Maharaj’s (2014: 685) study, when women spoke about why they would not want people to know about their abortion, “they mentioned the social consequences that women face for having an abortion in their communities, which included being an outcast. As a result of that women do not discuss abortion and seek alternative methods, which perpetuate a cycle of unsafe and illegal methods.”

### THE LEGAL STATUS OF TOP SERVICES IN SOUTH AFRICA

This part of the study explores and discusses the findings related to young women’s understanding of the provision of legal abortion services in South Africa. It explores young women’s knowledge of legal services and of designated facilities within their community as well as the reasons why they chose not to use legal abortion services.

**Figure 4:** Respondents’ knowledge of legal TOP





## **Knowledge of legal TOP services**

In this study thirteen (13) of the 15 respondents stated that they knew that TOP was legal in South Africa. These high levels of awareness of the legal status of abortion among women of reproductive age are also reported by a number of studies conducted in SA (Kumar et al., 2009; Harries et al., 2007; Jewkes et al., 2005). In their study that explored the reasons why women still abort outside designated facilities in SA, Jewkes et al. (2005) found that 81% of the respondents were aware that TOP services were provided at state health facilities. Harries et al.'s (2007) respondents indicated awareness of their right to receive TOP services at a state hospital. Even though young women in this study indicated that they know about the legal status of abortion however, the statements below show, they added that they had limited knowledge of the provisions of the CTOP Act (92 of 1996):

*“Yes I did know, but I did not know that much because I’ve never asked anyone about it...I’ve just heard some women talking about it.”*

*“I did have knowledge, but not much. Even if you want to know these things, it’s not easy to approach a person about it. You can’t go to a person and ask them how the abortion process works.”*

*“I’ve heard before that if you want to have an abortion you can go to the clinic and they arrange for you to have an abortion.”*

## **Knowledge of the CTOP Act (92 of 1996)**

Out of the fifteen respondents, thirteen had knowledge of the existence of the CTOP Act (92 of 1996). None of the respondents between ages 18 and 20 possessed any knowledge of the CTOP Act (92 of 1996). This reflects the gaps in knowledge distribution on issues relating to women’s reproductive health. A lot has been done at a policy level, but there are so many gaps at an implementation level. For young women to be able to make informed reproductive health decisions, especially in dealing with unwanted pregnancies, they need to be fully aware of the provisions of the CTOP Act (92 of 1996). When women are aware of their reproductive rights they have the confidence to make sound reproductive health choices. Knudsen (2006) cited in Gresh (2010: 23) points out that “in South Africa an average woman

still has no clue of the CTOP Act and how liberal it is.” The findings of the current study confirm that due to a lack of sufficient knowledge of the provisions of the CTOP Act (92 of 1996), young women seek help from backstreet abortion providers. This is supported by a study conducted by Jewkes et al. (2005), where one of the reasons mentioned by the 15% of the respondents who consulted backstreet TOP providers for assistance was their lack of knowledge of where legal services could be accessed.

### **Knowledge of designated facilities**

Eight (8) of the respondents knew where they could access free, safe, legal abortion services in their area.

Two of the respondents said:

*“Yes at polyclinic they do it...in other places they write you a letter to the hospital.”*

*“Yes I do know them. It was the clinic I went to for my pregnancy test....So I know that it was available there. But who in her right mind can ask a nurse about TOP facilities?”*

Another respondent mentioned hospital referrals:

*“At the clinic I know that they write you a letter to the hospital.”*

According to Engelbrecht (2005), 76, 7% of adult women and 50% of adolescents who initially approached a clinic for abortion services were referred to a hospital without being provided with patient transport. Clinics are the most accessible health institutions for the majority of South Africans, especially the previously disadvantaged who live in townships and rural areas, yet hospitals seem to be the main legal abortion providers. Eighteen years have passed since the CTOP Act (92 of 1996) came into force; however there seems to be no change in the distribution of services.

Benson et al. (2011) notes that, while 31,312 legal abortions were reported in 1997, the majority were performed at hospitals rather than primary healthcare facilities such as clinics. While the province of KZN has the largest population in South Africa, Varkey (2000) found that only 10% of healthcare facilities are reported to be offering TOP services; this means that of the 40 facilities initially designated only four are providing TOP. Varkey (2000) adds that 99% of TOP services are offered at tertiary health institutions. It is thus a challenge for the majority of women to access safe services as they live far from tertiary health institutions.

Seven (7) respondents were not aware of where they could access legal TOP services:

*“No, not really I just know that hospital do it, but I don’t know which one around here....”*

*“No, I’m not sure where.”*

The findings above indicate that overall younger women 18-20 in South Africa still have limited knowledge or lack sufficient correct information about how they can attend to their reproductive health needs. According to Pojto (2012: 21) “Adolescents consider their peers and friends to be the most accurate and reliable source of information when it comes to sexuality issues”. The respondents said that they heard about legal abortion from other women and friends. Two (2) said that they read about it on posters while visiting a clinic for other services. However, they stated that they never paid much attention to this issue as it never crossed their minds that they might require such services. These findings point out a prevailing need for the improvement of programmes aimed at educating young girls about issues surrounding sexual and reproductive health rights.

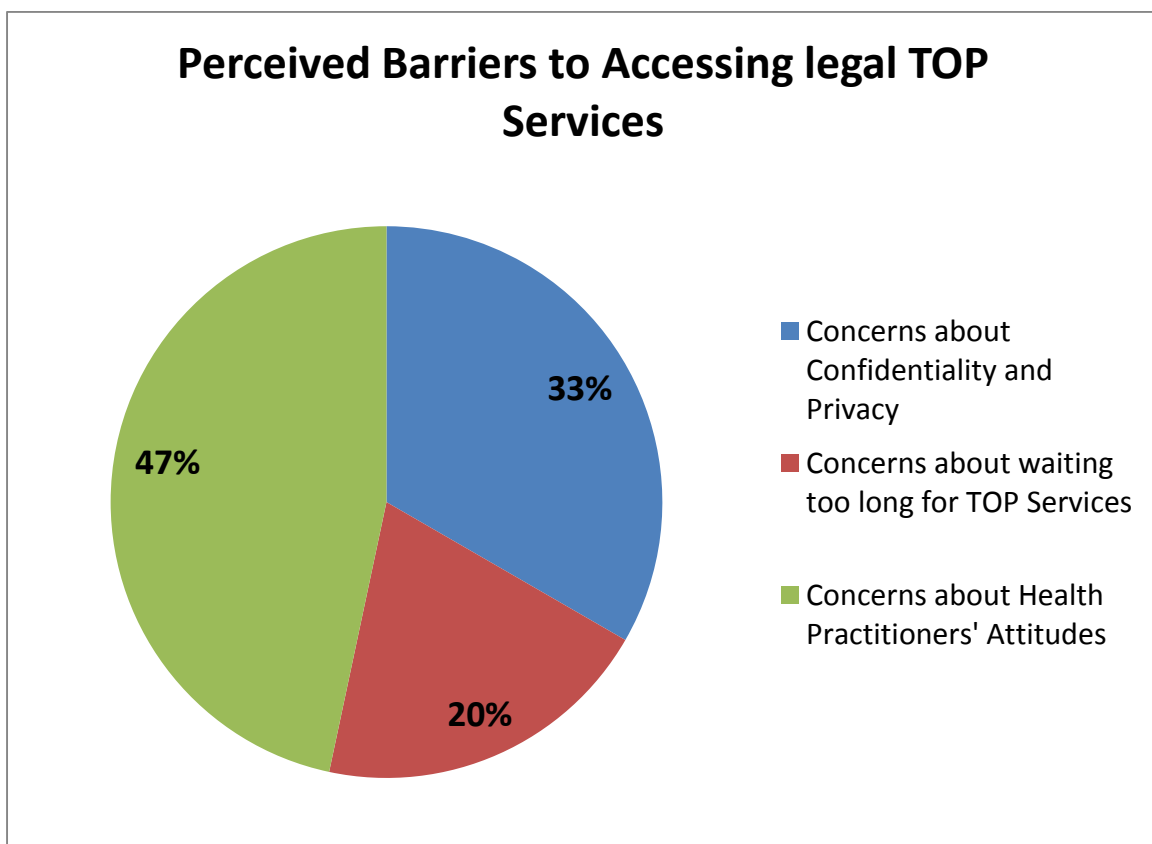
## **THE CHOICE OF ILLEGAL TOP SERVICES IN SOUTH AFRICA**

Since the passing of the CTOP Act (92 of 1996), there has been a growth in the use of legal TOP services and a decrease in both maternal deaths and the number of women hospitalized with complications from incomplete abortion (Mhlanga, 2003; Guttmacher et al., 1998). However, illegal TOP providers have also taken advantage of the Act’s liberal provisions. Barot (2011) cited in Gilbert (2013) states that in the past five years, illegal TOPs increased by 1, 9 million. This means that despite the provision of free, safer services for TOP, many

women, especially those from previously disadvantaged communities, still risk their lives by seeking illegal TOP services. This section examines the reasons why young women turn to backstreet providers, those offering the services, the methods used and finally, the costs involved.

### Reasons for not using legal abortion services

**Chart 4:** Perceived barriers to accessing legal TOP services



The respondents gave the following reasons for not using legal services:

#### *Concerns about waiting too long for TOP service*

The CTOP Act (92 of 1996) was adopted in order to ensure that women’s reproductive health needs are met. It is commended for offering women the freedom to choose how to deal with unwanted pregnancies. With the passing of the Act, there was increased demand for free TOP services and designated facilities were overcrowded with long waiting lists. This means that,

while legal abortion services are available in terms of the law, in practical terms, women are still unable to access them, and as a result some turn to backstreet providers (Mhlanga, 2003). This is supported by data collected in this study. About 20% of respondent shared that their concern was delays commonly faced by women who want to access safe abortion services from designated public health facilities of this.

This was illustrated by the following excerpts:

*“I heard that you can get help from the clinic. But I knew that there is a number of people they take per day, so I thought that I was running out of time...”*

*“As you know that in this public places you have to wait for a long time in queues, by the time you get help you are already frustrated and tired, so I did not want to go through that.”*

*“The first time I found out that I was pregnant, the first place I consulted was this clinic. I arrived at 7am, I was told that I was too late. I must come back the next day. When I asked the nurse what time, she never bothered to answer. The girls that were waiting told me that they came at 4am. So, how was I supposed to reach the hospital at 4am?”*

These statements are confirmed by a study conducted by Cooper et al. (2005) in Cape Town which revealed that after women made an appointment with a TOP clinic they waited one to four weeks to have their pregnancy terminated. Engelbrecht (2005) found that women waited ten (10) or more days to have their pregnancy terminated. The respondents stated that when they went to the hospital with a gestation period of below seven weeks they were told to come back when they had reached seven or eight weeks. Due to the lack of qualified providers and resources, facilities can only assist a few abortion seekers and turn away a large number of women each day. One of Gresh's (2010) respondents stated that she was turned away by nurses at the hospital because they already had ten patients that day. Because of the limited number of patients accepted per day women often have to wake up very early or travel to the hospital the night before in order to be the first in line.

These findings reveal that although women try to access safe abortion, they often have to wait a long time. While in some cases women approach facilities very early in their pregnancy, they may end up not obtaining the service as in some cases the pregnancy advances beyond the permitted period (12 weeks) (Engelbrecht, 2005). This is the moment where some women consider backstreet abortion providers who do not always ask how far their pregnancy has progressed.

### ***Concerns about confidentiality and privacy***

Many women view reproductive health issues as a private matter which should be treated with sensitivity. As a result, there is a lot of secrecy around sexual and reproductive matters. Termination of pregnancy is one of the highly ranked secrets. Many women who have experienced tend to pretend that it never happened or struggle to accept that it happened (Chetty, 2012).

One of the concerns expressed by the 33.3% of young women in this study was the lack of privacy at public health facilities. The respondents felt that confidentiality is compromised by the fact that their abortion history is kept in their general medical files which are handled by many departments and a number of hospital officials. They were unsettled at the thought that a file would be kept on something so sensitive and personal and would be a constant reminder of what they did. The following statements represent some of the concerns expressed by women in regards to confidentiality of their information:

*“At the clinic they record information about you; who you are, where you’re from. You have to explain everything about yourself. There has to be a file that is detailed about you, so that was one of the things I did not like”.*

*“Let’s say it happens that someday I get sick or have some problem and have to go to the clinic. Let’s say that someone in my family accompanies me to the clinic and see my file and find out what I did...no I can’t take that risk”*

*“The reason why I didn’t come to this clinic is that I did not want them to have information about this, so that’s why I did my own thing.”*

*“My friend who came to this clinic for TOP told me that while waiting, everyone can see what you are here for. Your card is written TOP in big letters. There is no privacy in hospitals. I did not want anybody to know I came to the clinic to have an abortion”.*

*“I did know that abortion is available at clinics, but my problem was that in these public clinics it is easy to bump to someone you know or people who know your family. People start talking about your private matters and tell your parents that you were at the clinic. And parents start asking questions that you cannot answer. Coming here is asking for trouble.”*

Most of what the respondents expressed as concerns above was also observed by the researcher during her visits at the TOP clinic. Women were waiting in a communal waiting room. Each person was holding a medical card that is written TOP in bold and big letters. They were not only identifiable through the medical cards, the nursing staff made random, public announcements which identified the reasons for their hospital visits. For example, directing the TOP patients to sit at designated places. What was happening at this hospital was not an isolated experience.

In a study focusing on young people’s experiences in trying to access reproductive health services at public clinics and hospitals conducted by Maharaj cited in Mbali and Mthembu (2012), young people said that one of their concerns was the lack of privacy during consultations. Women who seek abortion services at public health facilities often have to wait in long queues that go directly to a door with a big ‘TOP clinic’ sign. Young women also feared being seen by community or family members while visiting the TOP clinic. This is indicated by the following statement:

*“My problem was that at the closest clinic sometimes you bump into people you know even people who know your family, you see that they may tell someone that they saw you at the clinic...”*

*“My aunt works at this hospital. What if I bump into her?”*

This shows that the stigma that surrounds abortion frequently discourages young women from seeking safe legal TOP at public health institutions. They fear being condemned and criticized by their family and society at large. Their main purpose is to keep the abortion secret in order to protect themselves from the “social consequences” of having an abortion (Shellenberga et al., 2011:120; Kumar et al., 2009).

Respondents of this study felt that illegal abortion clinics enabled them to control the situation in terms of privacy and confidentiality; they felt that they could choose how much information to provide. They repeatedly mentioned that this was the main reason they chose to use illegal providers:

*“....so when I went to backstreet providers I wanted to make sure that no one has my personal details, nobody knows me, and they only want money, not personal information about me...”*

*“...That is why I was doing things on my own privately. I did not want anyone to know what was going on with my life. It’s just easy because no one sees you... so no one will ever find out.”*

*“They were okay. They did not judge me... They do not ask a lot of question... And you do not bump into someone you know....They do not ask about your age or if you are a scholar.”*

For some young women, illegal TOP services provided an immediate solution to their problem (unwanted pregnancy). They described the service as quickly and easily accessible:

*“You do not have to wait, they do it quickly.... Same time.”*

*“They only asked if you are really sure that you want to have an abortion, and then they help you...You can go there anytime, late in the evening or early, they do not have a problem.”*



Three (3) respondents referred to adverts for abortions on walls, traffic lights, bridges etc., as the reason they entered the doors of illegal providers:

*“I saw this piece of paper on the street that said it is quick, so I thought that I should go there because I wanted something quick.”*

*“I was walking around Durban and I saw this advertisement saying same day abortion and there was a number so I thought I should call them.”*

*“I attend my classes in town I saw abortion service post on a wall. So I just went there to ask about the service. Then I told myself that I’m just going to do this.”*

*“The backstreet providers are much nicer than the nurses at our clinics. They understand your pain.”*

According to Chetty (2012), a young woman who suddenly learns about her unplanned pregnancy often experiences anxiety, fear and confusion. Any level of intimidation or questioning might be perceived as a threat to her privacy and her future. The numerous adverts posted by illegal TOP providers that promise women quick, pain free and cheap abortion in the Durban city centre, including the surrounding townships target vulnerable young woman and they seem to be meeting their needs by providing non-threatening environment.

### ***Concerns about health practitioners’ attitudes***

According to Rohrs (2012), a major barrier in successfully implementing the CTOP Act (92 of 1996) is health practitioners’ opposition to abortion. Women face a number of obstacles in gaining access to safe abortion services at state facilities. One of the challenges some healthcare workers face is being able to draw a line between their personal views on abortion and their professional conduct. In some cases, they express their disapproval of abortion by calling women derogatory names, like ‘loose woman’ and ‘baby killer’. The majority of young women (47%) in the current study expected nurses to condemn and judge them if they visited public health facilities:

*“...I was also afraid of the nurse, because if you are a child who comes to the clinic to abort, you are viewed as someone who is immoral and also that black people we believe that it is sin to do that even if the law allow you to. I had that feeling of fear....I feared that they were going to judge me.”*

*“I’ve been to the clinic before I know how they are like. Going there was not even an option for me”*

*“I can’t lie to you I was really afraid of nurses, this is not an easy thing even though I knew that it was just their job, but you think about how they will look at you or maybe judge you.”*

*“You know those nurses do not treat us like humans....To them you are just a nobody, they talk to people as if they are nothing...I just did not want to put myself through that.”*

The findings of this study show that the young women’s negative perceptions of public healthcare facilities compelled them to look for alternative providers. These findings are confirmed by a study conducted by Gresh and Maharaj (2014) that found that it was very hard for women to approach hospitals for TOP because nurses were verbally abusive even when they asked for contraceptives; as a result, they turned to backstreet providers where they were not criticized or judged. Jewkes et al. (2005) also found that women who attended illegal abortion clinics stated that one of the reasons they did not go to state facilities was fear of being mistreated and ridiculed by nursing sisters. Harrison et al.’s (2000: 427) study on barriers to implementing the CTOP Act in KZN found that nurses felt that the CTOP Act (92 of 1996) encouraged women to be immoral. As one nurse put it, “women just want to enjoy sex and do not care if the sex will lead to an unintended pregnancy.”

Culture plays an important role in raising children in South African communities. Children are taught to respect and honour older people. In the absence of their parents, other adults in the community take responsibility for disciplining children. As the young women in this study could not discuss their pregnancy and intention to have an abortion with their own parents, approaching nurses, who are often their mother’s age, was unthinkable:

*“I was scared that the nurses will shout at me and say I am too young for this...”*

Mkhwanazi (2010) notes that adolescent mothers who attended clinics for reproductive health services reported that health workers shouted them and said they are young to engage in sexual activities. In South Africa, young people and adults’ fear of discussing issues relating to sexuality and the authority that adults have over the youth are some of the reasons why young women are reluctant to seek abortion services from public health facilities.

### **Illegal TOP service providers**

This study sought to establish how and where young women attend to their reproductive health needs, specifically abortion. Its results show that young women risk their lives in dealing with unwanted pregnancies. Unsafe abortions are commonly performed by unqualified helpers, such as a woman’s friends, family members, traditional healers and the women herself (Grimes et al., 2006). Two (2) of the respondents personally induced their pregnancy, six (6) turned to traditional healers and the remaining seven (7) were assisted by nurses, doctors and those they referred to as ‘foreigner doctors’ on the street.

One of the six young women who consulted a traditional healer shared her experience:

*“I went to this one room shack it was scary there were snake skins and other dead animals and it was really dark... it was a man I’m not sure if he was a sangoma or imnyanga ....it was dirt, but because I wanted to do this so I just told myself that I’m just going to put everything aside and get it done quickly.”*

Research has shown that not all backstreet abortion providers are unqualified or untrained; some are qualified health practitioners including doctors, nurses, doctor’s assistants and pharmacists. In Jewkes et al.’s (2005) study, 46 women reported that they were given misoprostol by health practitioners, including doctors, nurses and pharmacists to terminate their pregnancies, and were advised to go to the hospital if the bleeding did not stop within three days.

The two respondents who induced their own abortion reported that they went to a surgery and were given pills by the person working at the doctor’s office. One said:

*“I brought pills from someone who works at the Doctors office and I did on my own.”*

Medical doctors and nurses’ involvement was also mentioned:

*“He was like a doctor he appeared to know what he was doing...”*

*“It was a lady (umama nje). She seemed to have some knowledge about medical things or so...”*

Some studies have associated the increase in incomplete abortion complications (20 per 100 births each year) with health personnel unlawfully providing abortion seekers with medical abortion outside the designated centres (Gilbert, 2013; Haddad et al., 2009). It is evident from the above statements that, while they are aware of the legal status of abortion services in South Africa and the dangers associated with unsafe abortion, some health practitioners choose to promote illegal abortion services. Gumede’s (2004) study on backstreet abortion revealed that health care practitioners, including nurses and doctors, played a major role in providing TOP outside state facilities (Gumede, 2004). The fact that these people are trained and qualified does not mean that they are authorized to provide TOP services and they may be conducting these procedures in environments that do not meet the standards set by the CTOP Act (92 of 1996), exposing abortion seekers to significant health risks.

### **Illegal TOP procedures employed**

**Table 7:** Procedures used to induce respondent’s abortion

	<b>Number</b>	<b>Percentage</b>
Pills	7	46.6%
Traditional medicine	4	26%
Home remedies	3	20%
Cleaning substances	1	7%

In the past decade there has been a huge increase in the use of medical abortion, both legal and illegal. One of the most easily accessible forms of medical abortifacient is the misoprostol drug. The decrease in maternal deaths and incomplete abortion complications may not necessary be due to the accessibility of safe abortion provided by the state, but to increased access to this drug.

The most used abortion method in this study was abortion pills. Seven (47%) young women in this study reported that they were given pills to take vaginally and orally by their helpers:

*“There were two pills...they inserted one in my vagina and the second one they told me to drink.”*

*“I brought pills from the doctor’s offices, but I did not get them from the doctor, it was the lady working there, and she gave me five. Then I drank pills at home and then started bleeding....”*

These findings are in line with a study conducted by Mitchell, Heumann, Araujo, Adesse and Halpern (2014) which found that 41% of women who experienced post-abortion complications indicated that they had taken misoprostol pills. On the other hand, Kumar et al. (2009) acknowledge that not all women who induce abortions have complications that require them to go to hospital. According to Kumar et al. (2009) only 35%-60% of TOP are reported. Misoprostol was initially prescribed by doctors at designated facilities, but can now be bought from pharmacies, online and from backstreet abortion providers (Rowlands, 2012). It is therefore safe to assume that the decrease in maternal deaths and incomplete abortions may be attributed to women’s easy access to this drug.

While the majority of respondents turned to current abortion techniques, traditional procedures have not lost their value in society. About 26% of respondents who visited traditional healers for their abortion mentioned the use of bitter *muthi* (a mixture of different tree barks, roots and leaves).

*“No I don’t really know what it was. To be honest they don’t even explain to you what they are pouring for you or what they have mixed....but I could see that there were leaves...”*

*It was mixed and you could see some dirty particles like trees and leaves. He poured that in a mug and told me to drink... .. I just took it and drank because I wanted this to be over.”*

*“She gave me muthi..... It was a bit bitter like Zulu muthi”*

*“I drank muthi form a small black bottle and after that I was given another bottle of muthi to administer as enema .....*”

Finally the least employed procedures included home remedies (20%), soap, laxatives, soft drinks and pain killers. The respondents described their abortion process:

*“It was soap (brick of sunlight) she mixed it with castor oil. She cooked it until it was liquid and mixed it with castor oil. She made me drink some of the castor oil and the mixture of castor oil and soap, administering it as enema....My stomach was painful as if I was having birth pains and it was runny... I got really weak.”*

*“He sent someone to buy a litre of coke and disprin tablets. He mixed coke with the tablets and told me to drink the whole bottle.”*

*“She gave me a bottle of stametta she said I must drink half of the bottle, after some time I had pains it was unbearable ...”*

One of the respondents who induced her own pregnancy shared her experience:

*“One friend of mine told me that I can go somewhere and it was R400 and I did not have that kind of money...so my other friend advised me that Epsom salt (commonly used as a laxative) works if you are not far along with the pregnancy, since I was only one month it will work ... I then went to the tuck shop and brought four packets, and then I was on my periods for three days, after that something a bit heavy came out when I went to the toilet...”*

These statements show that the lack of access to safe abortion services drives young women to risk their lives by seeking TOP from untrained and unauthorized providers, who employ dangerous methods, including drinking poisonous substances, herbs and laxatives (Grimes et al., 2006). For those given some form of medical abortifacients it is possible that the complications are due to overdosing or incorrectly using the drugs. The SAMCC prescribes that women seeking abortion up to eight weeks of gestation are to be given 400g (two tablets) of misoprostol and 600g (three tablets) of mifepristone orally (Cooper et al., 2005). With the gestation period not considered by backstreet providers, the chances are that mistakes are made in prescriptions. As a result, young women end up in hospital with incomplete abortion complications that will impact their entire lives.

### **Cost of illegal TOP services**

Private healthcare facilities play a very important role in relieving some of the burden carried by public healthcare centres. However not all South Africans seeking abortion are able to afford the high cost of the services provided by the private sector. Women pay about R1 900-R3 200 for an abortion at a private facility, depending on how far along they are with the pregnancy (Gilbert, 2013). This limits many young women's options in dealing with their unplanned pregnancy, often leaving them with no choice but to seek help from backstreet TOP providers who promise quick, pain free, affordable TOP services (Gresh, 2010; Engelbrecht, 2005; Guttmacher et al., 1998). In the current study respondents who visited illegal abortion providers spent between R200 and R400. The least amount paid for an illegal abortion was R12, 00. This was the cost of four packets of Epsom salts that were used by one respondent who induced the abortion at home. Below are some of the advertisement of illegal abortion displayed around the Durban and the surrounding areas.

**Image 4 and 5:** Illegal abortion posters



“The indirect cost of unsafe abortions is more difficult to put in numbers. The loss of the productivity of women and their house hold can cause far-reaching effects for the community” (Singh, 2006 cited in Gresh, 2010: 19). According to Benerjee and Andersen (2012), incomplete abortions not only impact woman’s financial state, but that of her family and society. As noted in the literature review, the costs of treating post-abortion complications negatively impact the public health system.

Treating abortion complications involves the use of expensive instruments (surgical procedures), blood transfusions, long hospital stays, staff time and medication. It is estimated that incomplete abortions take up to 50% of the money budgeted for gynaecological treatment in developing countries (Grimes et al., 2006). In 1997 the South African Government spent approximately R9, 74 million in treating post-abortion complications caused by unsafe abortion (Grimes et al., 2006). Furthermore, families and communities lose \$930 million of their income in dealing with chronic illnesses and death as a result of unsafe TOP (WHO, 2012). These are huge amounts which could rather be used to effectively meet women’s reproductive health needs.



## PSYCHOSOCIAL SUPPORT AND COPING MECHANISM

The secretive nature of TOP causes many women to suffer in silence as a result of unacknowledged post abortion feelings. According to Gilbert (2013) unacknowledged painful emotions after an abortion can lead to psychological trauma as women try to recover from this experience alone. Irrespective of the reason why a woman chooses to have an abortion, this choice has emotional impact on her whole life. Within an ecosystems point of view an abortion experience can disturb a woman's physical, social and psychological well being (Alemu, 2010; MacLaren & Hawe, 2005).

The findings of this study indicate that each young woman responded differently to their abortion. Some of the emotions experienced by respondents were similar to those associated with symptoms of Post Abortion Syndrome (PAS). Post Abortion Syndrome signs include feelings of depression, guilt, fear, regret, anger and grief (Major et al., 2009). The following represent some of the respondent's emotional responses after the abortion:

### **Guilt:**

Guilt was the predominant feeling among the respondents. The majority (5) of respondents felt guilty for terminating the pregnancy. These are some of the utterances they made:

*“After doing it I just felt guilty. Sometimes I feel that I did not do the right thing. ..”*

*“....those are the thoughts that I have, feelings of guilt, that it what I have to live with because I cannot change the fact that I aborted.”*

*“I feel so sorry. To me it's like I deprived someone an opportunity to live and become something big...”*

**Sadness:**

*“My heart is still in pain because this is a child. It’s painful, but I did not have a choice.”*

*“I can’t lie to you, it is very painful. It is painful when I am alone thinking.”*

*“I don’t think any normal person can do this and live a normal life...sorrow and pain will always be there. I have to accept that my life will never be the same.”*

**Fear:**

*“It was scary, and I’m still scared..... But there was no turning back.... As bad as it was I knew I had to do it.”*

*“I’m feeling bad ....I am afraid, worried of what my family will think of me.....”*

*“When I see some one who is pregnant fear attacks me... I think of my own child growing... its not easy to move past this”*

**Regret:**

*“Sometimes you think about what if you get married and you are no longer able to have children, maybe this was the only child that God had given me and I killed him/her...sometimes I just wonder....”*

**Grief:**

*“I cry a lot when I’m alone. Although I never had a child, and I don’t know how it feels to be a mother it’s like some part of me is missing”*

*“I did not think it was going to be this hard, I think about the baby and it is so sad because I have lost him/her and there is nothing I can do about it....”*

**Anxiety:**

*“I feel that at sometime my baby is crying and my heart start to beat really fast”*

*“I don't have peace... sometimes I feel that someone can see what I have done I can't even sleep sometimes”*

**Mixed feelings:**

*“I do feel a little bit better. But my conscious eats me.”*

*“I'm a little bit relieved, my nightmares are over.....I can't say okay because I'm also a Bit scared.....”*

*“This is good for me...I am glad that I can now get on with my life and finish my studies...but there is just that thing you know....It comes back and disturbs me when I'm alone ..... To tell you the truth I haven't stopped thinking about what I have done”*

Findings of this study show that TOP experiences brought feelings of distress, suffering and pain for respondents. Unfortunately none of the respondents received some form of counselling after the abortion to assist them in dealing with their unresolved post abortion feelings. Lie et al. (2008) argues that even though policy makers have recognised that legalising TOP played a significant role in promoting reproductive health care, there is a gap on developments aimed at empowering women to deal with the psychological impact of an abortion experience (Lie et al., 2008).

Lack of counselling services for these women after abortion was not only isolated to them because their abortion was illegal. Engelbrecht (2005) reported that approximately 48% of women in her study reported that they did not receive counselling after terminating their pregnancies at the registered state facilities. Regardless of the abortion Act of 1996 instructing that counselling be made available for abortion patients if needed this service is still scarce (South African Government Gazette, 2005; Mhlanga, 2003). As a result of the shortage of resources (staff, time and private rooms) counselling services are rarely

accessible at public health care facilities. There is still a need for platforms where women can address their emotions in order to deal with their unresolved feeling.

### **Relief:**

Data gathered in the current study also revealed that discussing an abortion with someone provided women with support. As uneasy abortion was for all respondents; those who discussed their intention to abort with someone felt relieved and were less likely to blame themselves. The following are some of the statement made by the respondents which indicated some sense of relief provided by any form of discussion about their intentions to terminate their pregnancies:

*“talking to my friend was hard. But she did not judge me and gave me strength to deal with this thing”.*

*“...yooo, my boyfriend was furious but talking about it together made things better for me. I had to tell someone and he needed to know as the father of the baby”*

*“it is better now... At least we are talking about this...now I feel alright.....I can go back to school feeling better”*

The statements above are in line with the view shared by Lie et al. (2008) on the significance of talking and receiving support from someone when undergoing TOP. According to them, a woman's response to abortion is highly depended on her mental readiness and post abortion support. Women who discussed their TOP decisions with significant others appeared more accepting of their present circumstances than those who suffered in isolation.

## **CONCLUSION**

This chapter presented the findings and analysis of the data. It provided a holistic understanding of the meanings and significance that young women attach to the choices available to them in attending to their reproductive health needs, especially unplanned pregnancies. It examined the issue of illegal TOP from the young women's point of view; they were treated as active agents negotiating their own social worlds. Biographical information on the young women who participated in this study was outlined. Themes relating to the factors influencing the choice of a backstreet abortion by young women were identified, discussed and subjected to literature control.

The following chapter presents the conclusions and the recommendations arising from the study's findings.

## **Chapter five**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **INTRODUCTION**

The study explored the factors influencing young women's choice of risky, illegal TOP services instead of the legal, free and safe service provided by public health institutions. It was underpinned by the ecosystems theoretical framework, which was of great assistance in understanding the role played by various systems in influencing young woman's views on abortion. An explorative qualitative research design was employed that took into account the sensitive nature of backstreet abortion and enabled the researcher to be empathetic and non-judgmental in interviewing the respondents.

Using a purposive sampling technique, a sample of 15 young women between the ages of 18 and 25 was acquired from the Gynecology Out-Patient Department (GOPD) ward in a governmental hospital in the Durban region. Data was collected by means of semi-structured interviews with the aid of an interview guide. The interviews were tape-recorded with the respondents' permission and transcribed word for word. The data was qualitatively analyzed using thematic content analysis and themes were identified, discussed, translated into findings and subjected to literature control. The study also adhered to the ethical principles outlined in chapter 3.

A TOP decision impacts an individual's entire life. When women make decisions concerning their reproductive health, especially pregnancy and termination of pregnancy they consider a number of issues, including their physical, social, financial and spiritual life. Fear of parents and their lack of support seem to have played a significant role in the young women's decision to secretly seek abortion from illegal providers. Furthermore, the young women received support from their peers who might not have had knowledge of legal TOP services, therefore influencing them to use illegal providers. Incomplete abortions are a major consequence of illegal abortions and they not only negatively impact the illegal abortion seeker's life, but her family and society. South Africa's public health system loses millions of

rand in treating women presenting to health facilities with post-abortion complications (Benerjee and Andersen, 2012; Singh, 2006 cited in Gresh, 2010).

This chapter presents the study's main findings and its major conclusions. Finally recommendations are offered based on the findings and conclusions.

## **MAJOR CONCLUSIONS**

Based on the findings of this study, its major conclusions are synthesized and presented under the following headings:

### **Conclusions regarding contraceptive use**

In terms of contraceptive use among the youth, this study produced similar findings to other studies on teenage pregnancy and abortion. MacPhail et al., (2007) found that while two-thirds of young girls are sexually active before the age of 24, less than half use any form of contraception to prevent an unwanted pregnancy. The findings of the current study clearly demonstrate that even though the majority of young women are financially, psychologically, emotionally and socially not ready to have children, their contraceptive use is limited or inconsistent which directly contributes to the escalating number of unplanned teenage pregnancies. In this study only five (5) of the respondents were using contraceptives.

Contraceptive methods included pills, an injection every three months and condoms. While condoms are thought to be effective in preventing sexually transmitted infections and unplanned pregnancies one woman reported that it burst during intercourse, resulting in an unintended pregnancy. In such a situation, the most effective method would be the use of emergency contraceptives. The challenge is that there is little knowledge of this service and it is not easily accessible. In Ngene's study (2011) only 5% of the women were aware of the existence of emergency contraceptives. In this current study two (2) young women knew about the morning after pill, but did not know where to access it.

In some cases, contraceptive methods fail to prevent unintended pregnancies, contributing to high rates of unwanted pregnancies among young women, with many ending in abortion, in some instances illegally. According to Deschner and Cohen (2003: 7), "women who are

determined to limit their family size and time their child bearing will use all available means to do so; if contraception is not a viable option, women will turn to abortion even if it is illegal". These findings show that there is a pressing need to not only make information on contraception accessible to the youth, but to improve contraceptive methods so that they are effective in preventing unintended pregnancies.

### **Conclusions regarding knowledge of the CTOP Act (92 of 1996)**

An important finding of this study is that young women were aware that abortion is legal and free at government healthcare facilities. However their knowledge of the provisions of the CTOP Act (92 of 1996) and the designated facilities where abortion is available was quite limited. High levels of awareness of the legal status of abortion among women of all reproductive age groups have been noted by various studies conducted in South Africa (SA) (Kumar et al., 2009; Harries et al., 2007; Jewkes et al., 2005). In the current study, the young women attributed their knowledge of the legal status of abortion to hearing other women talking and friends, and posters at clinics when visiting the clinic for another service. However, some did not pay much attention as they never thought they would need this type of service.

South African youth lack information on issues surrounding sexuality and commonly consult their friends who also have little knowledge. For women to be able to make informed reproductive health decisions, especially when dealing with unwanted pregnancies they need to be fully aware of the CTOP Act (92 of 1996) . When women know their reproductive rights they will have the confidence to make sound reproductive health choices and where they can attend to them. Knudsen (2006) cited in Gresh (2010: 23) points out that "in South Africa an average woman still has no clue of the CTOP Act (92 of 1996) and how liberal it is."

Women who attended clinics for a pregnancy test made reference to abortion seekers being referred to hospitals. This is of concern since clinics are the most accessible health institutions for the majority of South Africans, especially in previously disadvantaged communities in the townships and rural areas. Eighteen years have passed since the CTOP Act (92 of 1996) came into force; however, there seems to be no change in the distribution of the services. Statistics indicate that 31,312 legal abortions were provided by the state a year



after the Act was implemented, the majority of which were performed in hospitals rather than primary healthcare facilities, such as clinics (Benerjee & Andersen, 2012).

Since young women lack sufficient knowledge of the provisions of the CTOP Act (92 of 1996) and of designated facilities, they are unable to make a sound decision on how to deal with their unwanted pregnancy which can drive them to seek help from backstreet abortion providers. This is supported by a study conducted by Jewkes et al., (2005). Fifteen per cent of their respondents who consulted backstreet TOP providers did not know where to access legal services.

### **Conclusions regarding making an abortion decision**

An abortion decision is often made in fear and confusion. When young women make a life changing decision like abortion, a strong support structure could be of great value in helping them make informed decisions. Unfortunately the stigma surrounding abortion forces women to go through this life changing experience alone because of fear of being mistreated and judged by the community and those close to them. Similar to the study conducted by Engelbrecht (2005), this study concludes that young people in general find it difficult to talk to their parents about their reproductive needs; on the other hand it can be assumed that parents make it difficult for the youth to approach them with their sexual and reproductive problems.

Young women felt more comfortable confiding in their peers than in family members, especially parents. One of the most important concerns emanating from this study is the communication barrier between parents and young people. The fact that none of the young women considered speaking with their parents about the pregnancy shows that there is a problem with child-parent communication. Every young woman wants to make her parents' proud. When she unintentionally falls pregnant, this is a great disappointment to her parents. In trying to maintain a good daughter identity and avoid disappointing a parent, the majority of young women secretly turn to abortion.

According to Mkhwanazi (2010), on learning of their child's pregnancy, some parents administer corporal punishment, scream at her and in extreme instances banish her from the home. Therefore, when a young woman discovers that she is pregnant her biggest concern is

often her parents' reaction. Fear of parents and their lack of support seem to have played a significant part in the young women's decision to secretly seek abortion from illegal providers. Furthermore, young women received support from their peers who might not have had knowledge of legal TOP services and therefore influenced them to go to illegal providers.

### **Conclusions regarding challenges in accessing legal TOP services**

Another major concern is the public health system's reaction to young women's needs. The findings of this study suggest that, while in theory, the CTOP Act (92 of 1996) offers women a choice in attending to their unwanted pregnancies this does not exist in practice. Women attending clinics for their reproductive health needs are not offered a choice but have to settle for whatever is offered even if it will cost them their respect and dignity. As noted above the respondents were aware of the legal TOP services available to them. However they did not seek the service from the right place. The major reason was the lack of respect for their human dignity.

Some health providers feel that the legalization of TOP promotes immoral behavior among women; they therefore subject abortion seekers to shame and harsh criticism (Harrison et al., 2000). Women seeking TOP services at public healthcare facilities are forced to endure verbal abuse from healthcare workers and disapproval and judgment of their abortion choice. Their lack of freedom to choose within the public healthcare system leads women and young girls to opt for alternative providers. Consistent with the findings of the current study, in Jewkes et al.'s (2005) study, women who attended illegal abortion clinics reported that one of the reasons they did not go to state facilities for abortion was fear of being mistreated and ridiculed by nursing sisters.

An abortion is something that women want to pretend never happened in their lives. One of the concerns expressed by young women in this study was the lack of privacy at public healthcare facilities. The respondents felt that confidentiality may be compromised by the fact that their abortion experience would be kept on file; they also feared being seen by family or community members while visiting a TOP clinic at a public hospital.

This study concurs with a number of studies (Gresh; 2010; Cooper et al., 2005; Engelbrecht; 2005) that after the Act provided for TOP services, demand for the service increased putting

strain on designated facilities. Facilities with limited resources are forced to turn away a large number of abortion seekers. The respondents indicated that they wanted to get rid of their problem as quickly as possible before anybody found out that they were pregnant. Going to a hospital meant waiting for a long time which would increase the risk of someone, especially parents, learning about the pregnancy.

It is therefore concluded that, despite the liberal provisions of the CTOP Act (92 of 1996), women do not seek help from public healthcare facilities as they are unable to access them; as a result some seek the service from backstreet agencies where they are promised quick, effective service. Another important issue is that “social consequences” (being condemned and criticized by their family, healthcare providers and society at large) discourage young women from seeking safe legal TOP at public healthcare institutions (Shellenberga et al., 2011: 120).

### **Conclusions regarding the choice of a backstreet abortion**

Despite the state’s efforts to address the deaths and complications related to unsafe TOP procedures, research shows that women and young girls continue to risk their lives by seeking illegal TOP services (Grimes et al., 2006; Jewkes et al., 2005; Gumede, 2004). The passing of the CTOP Act (92 of 1996) not only increased the number of legal abortions performed, but the number of backstreet abortions. These findings indicate that there is a need to understand backstreet abortion services. Until the state can establish why women go to the extreme of having an abortion outside the provided facilities, the incidence of unsafe TOP will continue to rise. Perhaps the most important question to consider is what is it that backstreet providers offer that the state is not able to give young women.

The respondents felt that illegal abortion clinics offered them control in terms of privacy and confidentiality. Attending an illegal TOP facility ensured that the abortion remained secret. They added that backstreet providers offer them an immediate solution to a major problem. With so many advertisements promising quick; pain free abortion services, out of desperation and fear of being judged by society, young women fall victim to unsafe abortion procedures. Unsafe abortions are commonly performed by unqualified helpers. The study respondents either induced the abortion themselves or were assisted by traditional healers or people from

other countries referred to as 'foreign doctors'. These people used procedures that include traditional herbs, soap, laxatives, soft drinks and pain killers.

Healthcare providers' promotion of illegal TOP services is grave cause for concern. Gumede (2004) notes that healthcare practitioners are fully aware of the legal status of abortion services in SA and the dangers associated with unsafe abortion, yet they still choose to promote the use of illegal services. Seven of the respondents were assisted by nurses, doctors and pharmacists. Like others, this study found that professional health practitioners' involvement in illegal abortions has led to increased access to misoprostol drugs.

Health practitioners are people that are expected to be the front runners in promoting safe TOP services, yet they endanger many women's lives by conducting TOP in environments that do not meet the standards set by the CTOP Act (92 of 1996) and therefore expose abortion seekers to significant health risks. This finding is supported by a number of studies, including Haddad et al. (2009) which associate the drastic rise in hospital admissions due to abortion complications with health personnel illegally supplying TOP seekers with medical abortion and instructing them to rush to a health facility if they experience complications.

It is therefore concluded that young women's lack of knowledge of their reproductive rights, especially the provisions of the CTOP Act (92 of 1996), challenges in accessing safe abortion services and the stigma attached to abortion are the major factors that drive young woman to risk their lives by seeking TOP from untrained and unauthorized providers, who employ dangerous methods. As a result, young women end up in hospitals with incomplete abortion complications that will impact their entire lives.

### **Conclusions regarding psychosocial support**

Irrespective of the where and why women seek abortion; going through this life changing event is not an easy journey. Influenced by the multidimensional factors, women respond differently to termination of pregnancy. This study shows that without proper support abortion could be the most traumatic event in a woman's life. Depending on whether a woman's abortion decision received support or not determines how she copes with the consequences of abortion. The study shows that respondents who had an opportunity to talk about their intention to abort were not as emotionally affected by the abortion as those who

didn't. There was also less self-blaming for those who received support pre and post abortion. According to Lie et al. (2008) when a woman has post abortion support and is mentally aware of the all the consequences of having an abortion, which includes its social, physical, and psychological aspect she is able move. Data gathered in the current study also revealed that discussing an abortion with someone provided women with support. In the study respondents who did not have someone to discuss the abortion had feelings of guilt, sadness, fear, grief and they blamed themselves and felt a sense of responsibility for the death of the child. While abortion was an uneasy experience for all respondents; those who discussed their intention to abort with someone felt relieved and were less likely to blame themselves. After the abortion they were able to separate who they are and what they have gone through and that assisted them to cope better.

An additional concern is the lack of access to counselling services for young women in the public health system. The findings of this study suggest that, as much as the abortion was a painful experience and depressing for young women; counseling was not offered to them. Regardless of the fact that respondents of this study attended to their abortion needs outside the appropriate health care institutions there is evidence that post and pre counselling services are rarely available at TOP facilities (Englbrecht, 2005). Women attending legal TOP facilities still do not have access to counselling services because of a number of factors including, a lack of trained counselor and private counselling rooms. Even though the government, policy makers and related stake holders have made great efforts to attend to the physical aspects of the abortion process, there is still a limited focus on developing strategies to deal with the psychosocial effects of abortion (Lie et al. 2008).

## **RECOMMENDATIONS**

### **Recommendations pertaining to the findings of the study**

Based on the research findings, the following recommendations are made:

#### ***Making information on sexual reproductive health easily accessible***

This study found that young women lack knowledge of the provisions of the CTOP Act (92 of 1996) and their sexual reproductive rights. It is recommended that radio discussions, community public meetings and reproductive health campaigns be used as platforms to educate young women and the community at large about the provisions of the CTOP Act (92 of 1996) as well as where TOP services are available. Furthermore, young women need to be informed of high risk TOP methods and their consequences. Involving the whole community could also help to reduce negative attitudes to abortion.

#### ***Making TOP services accessible in primary healthcare facilities (clinics)***

It is evident that there is a need for more even distribution of TOP services in order to make them easily accessible to all communities. The findings show that such services are predominantly offered at hospitals. TOP services should also be rolled out at clinics, as it is easier for the majority of South Africans to visit clinics than hospitals. This means increasing clinics' resources, including qualified, trained staff and equipment.

#### ***Need for value clarification workshops in order to transform health workers' attitudes***

Health workers are in the front line in the provision of TOP services. While their right to refuse to perform an abortion must be upheld there is a need to clarify exactly what their rights entail and what their responsibilities are as healthcare personnel. Value clarification workshops would not only provide clarity on the role they need to play in providing TOP services, but offer a platform for healthcare practitioners to share their perceptions, feelings and concerns about providing the service. This could change attitudes to abortion.

### ***Need for the improvement of counselling services***

Abortion is extremely personal; this issue needs to be attended with care and respect. A young woman who lacks social support before, during and after the abortion needs a platform where she can find resources that will help her cope. Nurses are already overwhelmed with providing physical care for patients. There is therefore a need to train more professional counsellors in order to expand counselling services. Improving both pre and post abortion care for women can help women acknowledge and deal with pre and post abortion feeling. More than that counselling will also provide young women with useful information in order to make better choices in terms of preventing future pregnancies.

### **Recommendations pertaining to future research**

In view of the fact that this research study was not representative of all the population groups in the Durban area, it is recommended that a follow-up study be conducted using a sample of women who have undergone backstreet abortion from the black, white, Indian and Coloured communities residing in the Durban area. The research study focused on the factors influencing the choice of a backstreet abortion by young women. In view of the finding that healthcare practitioners are increasingly involved in providing illegal TOP and the fact that some are reported to have negative attitudes to providing the service at healthcare facilities, it is recommended that further research be conducted to explore the factors that influence healthcare practitioners to provide illegal TOP services while they are fully aware of the CTOP Act (92 of 1996) and the dangers associated with unsafe abortions.

The study also found that abortion pills are easily available from pharmacists and backstreet providers. This suggests the need to understand the laws and policies on the legalization of abortion pills. It is therefore recommended that research be conducted on the legal status of abortion pills and the laws governing their distribution.

## CONCLUSION

This research study aimed to understand the factors influencing young women's choice of risky TOP services instead of the legal, free and safe service. It is hoped that the findings will contribute to the promotion of maternal health, and improvements in policies and programs aimed at safe TOP. The study investigated the issue of illegal TOP from the young women's point of view. It sought to determine the meanings and significance that young women attach to the choices available to them in attending to their reproductive health needs, especially unplanned pregnancies.

The CTOP Act (92 of 1996) was promulgated to ensure that all women's reproductive health needs are met. It is commended for offering women freedom of choice in deciding how they want to deal with unwanted pregnancies. It is unfortunate that some still risk their lives by using unsafe abortion methods. The findings of this study show that even though 18 years have passed since the CTOP Act (92 of 1996) came into force, women still face challenges in accessing services at designated facilities and as a result, they opt for backstreet providers.

The findings of this study show that the major factors that influence young women's choice of a backstreet abortion include their lack of knowledge of the provisions of the CTOP Act (92 of 1996) and designated facilities, challenges in accessing safe abortion services at public healthcare institutions and the stigma surrounding abortion.

When young women lack knowledge of their reproductive health rights in terms of the provisions of the CTOP Act (92 of 1996), it is not possible for them to make informed decisions in dealing with unwanted pregnancies. The fact that abortion is still highly stigmatized in South African communities is one of the reasons why women and girls hide their intention to abort, and choose to get help secretly from private, illegal providers. As a consequence of dangerous TOP methods, they end up dead or hospitalized with incomplete abortion complications. Furthermore, the challenges faced by women in public healthcare institutions, including having to wait too long for the TOP service, and verbal abuse, disapproval and judgment of their abortion choice by healthcare workers, as well as the lack of privacy, drive them to seek illegal services.



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# APPENDICES

## Appendix A: Interview Guide

### TOPIC: TO EXPLORE THE FACTORS INFLUENCING THE CHOICE OF A BACKSTREET ABORTION BY YOUNG WOMEN

#### Section A: Demographic Information:

- Gender
- How old are you?
- What is your home language?
- What religious group do you associate yourself with?
- Which cultural group do you associate with yourself with?
- What is your marital status?
- Have you had a TOP before?
- Do you have children? If yes how many are they?
- Are you working?
- Are you attending school? If you are what grade are you doing?

#### Section B: Topic guide

- When did you learn that you were pregnant?
- How did you come to know that you were pregnant?
- Were you planning to get pregnant?
- What feeling did you experience initially when you found out about your pregnancy and how did you react to it?
- Did you have someone to talk to about your pregnancy?
- What are your thoughts about abortion?
- From your own perception, what are people's views about abortion (family, friends etc.)?
- When you were considering having an abortion did you have someone to discuss your decision with?
- Can you share with me how you came to a decision to have an abortion backstreet?
- How did you experience the abortion service that you receive backstreet?

- How far were you with the pregnancy?
- Who assisted you with TOP?
- Do you know what was used to terminate the pregnancy?
- Did you have to pay for the service, if so how much did you pay?
- Can you share with me what you know about the legal provision of TOP services?
- Were you aware about the places you can go for TOP?
- Can you share with me your main reasons that you decided not to use the legal services?
- Now that you have had an abortion, how are you feeling?
- Have you considered discussing your TOP with someone? If so who?
- Have you considered consulting a professional, like a social worker about the issue?

## **Appendix B: Uhlelo lemibuzo ngesiZulu**

### **Isihloko: UKUCUBUNGULWA KWEMITHELELA NEZIZATHU ZOKUTHI ABESIFAZANE ABASEBANCANE BAKHETHE UKUKHIPHA IZISU EZINDAWENI EZINGEKHO ENTHETHWENI**

#### **Inxenye yokuqala: Iminingwane ngozibandakanyayo**

- Ubulili
- Uneminyaka emingakhi?
- Yiluphi ulwimi olukhuluma ekhaya?
- Iyiphi inkolo okholelwa kuyo?
- Yiluphi usiko mpilo ongaphansi kwalo?
- Ushadile noma ungayedwana?
- Wake wasikhipha isisu ngaphambilini?
- Abantwana unabo? Uma unabo bangakhi?
- Kungabe uyasebenza?
- Kungabe uyafunda? Uma ufunda, wenza liphi ibanga?

#### **Isigaba sesibili: Imibuzo eqondene nophenyo ngesihloko**

- Wathola nini ukuthi uzithwele?
- Wathola kanjani ukuthi uzithwele?
- Wawuhlelile yini ukuthi uzithwale?
- Wazizwa kanjani okokuqala uthola ukuthi uzithwele, wenzenjani?
- Waba naye ongakhuluma naye ngokuzithwala kwakho?
- Yini oyicabangayo ngokukhishwa kwesisu?
- Ngokubona kwakho, uthi abantu bayibona kanjani indaba yokukhipha isisu (umdeni, abangani nabanye)?
- Ngesikhathi ucabanga ngokuthi usikhiphe isisu, kungabe ukhona yini umuntu owakwazi ukuxoxisana naye ngalesisinqumo?
- Ungangixoxela kabanzi ngokuthi wafinyelela kanjani ekutheni uyofuna usizo lokukhipha isisu ngaphandle kwesibhedlela noma umtholampilo?
- Usizo owaluthola lapho lwalunjani?
- Kwase kuyisikhathi esingakanani uzithwele?

- Ubani owakusiza ngokukhipha isisu?
- Kungabe unolwazi lokuthi kwasetshenziswani ukusikhipha isisu?
- Kungabe walukhokhela lolusizo? uma kunjalo wakhokha malini?
- Ungangixoxela kabanzi ukuthi unaluphi ulwazi onalo ngosizo olusemthethweni lokukhipha isisu?
- Kungabe ubunalo yini ulwazi ngezindawo ezisemthethweni zokukhipha izisu?
- Ungangixoxela kabanzi ngezizathu ezenze wangaya kulezi ndawo ezisemthethweni uyofuna usizo uma ubunolwazi ngazo?
- Njengoba ususikhiphile isisu uzizwa kanjani?
- Ubuke wacabanga ukuthi uxoxisane nomunye umuntu ngokuthi usuke wakhhipha isisu? Uma kunjalo ubani lowo?
- Ubuke wacabanga ukuxoxisana noma nosozonhlalakahle ngokudlula kwakho kulesimo?



## **Appendix C: Informed consent for individual interviews**

### **To whom it may concern**

My name is Nompumelelo Ndlovu, and I am currently registered for my Social Work Masters at the University of KwaZulu Natal. I am conducting a research study which focuses on exploring and understanding factors impacting the choices of young women who do backstreet abortion. The hope of this study is that it would be used to make recommendations aimed at improving services to women with unplanned pregnancies.

I therefore kindly invite you to participate in an interview to share your own experience with backstreet abortion. Since I would like to give you my full attention during the interview(s), and since I might forget some of the valuable information that you share with me, I would like (with your permission) to record the interview(s) on tape. After the interview(s), this audio-recordings will be written out word-for-word. When the interview is written out, all information that might identify you personally will be removed so that no one will be able to link you to any of the information that you have shared during the interview(s). The audio-recording will then be erased. Some of the information that you have shared will be documented in a research report and nowhere will your name or any personal information be shared; this will make it possible for anybody to identify you.

Please note that participation in the research is completely voluntary (you are free to participate or not participate). You are not forced in any way to take part in this research project. Your decision to participate, or not to participate, will not affect you in any way now or in the future. If you agree to take a part, you still have the right to change your mind at any time during the study and to withdraw from the study. I am well aware that abortion is a very sensitive topic, if I see that the information that you have shared has left you feeling emotional upset, or anxious, I will refer you to the social worker for counseling (if you agree).

You have the right to ask questions about the study at any time. If you have any questions or concerns about the study, please contact the following numbers:

Supervisor's no: **031 260 1216**

Researcher's no: **083 979 6257**

HSSREC Research office (Ms P. Ximba): **031 260 3587**

If you agree to participate in this study, I would like you to sign the consent form that follows.

Yours sincerely

N.M. Ndlovu (Miss)

I \_\_\_\_\_ hereby confirm that I understand the contents of this documents and the nature of the study, and I agree to participate in the research project.

PARTICIPANT SIGNATURE AND DATE

\_\_\_\_\_

RESEARCHER SIGNATURE AND DATE

\_\_\_\_\_

## **Appendix D: Isivumelwano sokuzibandakanya ngesiZulu**

### **Kulowo eqondene naye:**

Igama lami nguNompumelelo Ndlovu, ngingumfundi owenza izifundo zeZenhlala kahle Masters eNyuvesi yaKwaZulu Natal. Ngenza uphenyo olumayelana nokufuna ukuqonda izizathu zokuthi abesifazane abasebancane bakhethe ukuyofuna usizo lokuhushulwa kwezisu ezindaweni ezingekho emthethweni. Loluphenyo luqonde ekutheni kutholakale izindlela zokuthuthukisa izimpilo zabesifazane abakhulelwe bengakuhlelelanga.

Ngicela ukukumema ukuba ube yinxenye yaloluphenyo, ukuze uxoxe kabanzi ngodlule kukho ngesikhathi uthola usizo lokuhushula isisu ngaphandle kwesibhedlela noma emtholampilo. Awuphoqekekile ukuzibandakanya kuloluphenyo, futhi unelungelo lokujika umqondo nanoma yinini uma ungasathandi ukuqhubeka uzibandakanye kuloluphenyo, igama lakho angeke lisetshenziswe ukuze uvikeleke, futhi nokuzoxoxwa angeke kusetshenziswe ukulimaza isithunzi sakho. Ngenxa yokuthi ukukhuluma ngalesisimo kunga kungabuyisa ubuhlungu, ngiyaqinisekisa ukuthi usizo lokululekwa ngenqondo uzobakhona uma uzoludinga. Nginesicelo futhi sokuthi inxoxo yethu ngiyiqophe ukuze ngikwazi ukuqaphela konke esizokuxoxa. Okuqoshiwe kuzogcinwa kukhiyeliwe endaweni evikelekile, futhi emuva kweminyaka emihlanu kuzoshiswa.

Unelungelo lokubuza nanoma yini ngaloluphenyo, nanganoma yisiphi isikhathi. Uma unemibuzo ungashayela lezi zinombolo ezilandelayo:

Eyomqondisi/ umboneleli: **031 260 1216**

Eyomphenyi: **083 979 6257**

HSSREC Research office (Ms P. Ximba): **031 260 3587**

Uma uvuma ukuzibandakanya kuloluphenyo, ngicela usayine lesisivumelwano.

Ozithobayo

Nkozazana: N.M. Ndlovu

Mina \_\_\_\_\_ ngiyavuma ukuthi ngiyakuqonda okulotshiwe kulengcwajana, ngiyaluqonda nohlobo lophenyo oluzokwenziwa, ngakhoke ngiyavuma ukuzibandakanya kuloluphenyo.

ISIGINESHA (ovumayo)

USUKU

ISIGINASHA (umphenyi)

USUKI

## Appendix E: Letter addressed to the Hospital requesting permission to conduct a study



H897 Lalela Grove

Ntuzuma

4359

29 April 2014

The Hospital Manager  
Prince Mshiyeni Hospital  
Private bag X 07  
Mobeni  
4060

Dear Sir/Madam

### **RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT PRINCE MSHIYENI HOSPITAL**

My name is Nompumelelo Ndlovu, and I am presently completing my Social Work Masters at the University of KwaZulu Natal. I seeking permission to conduct a research study with patients, particularly focusing on young women admitted for incomplete abortion complications. I am interested in doing a study on illegal termination of pregnancy among young women. The aim of the research study is to explore and understanding factors impacting the choices of young women who do backstreet abortion.

This study will be beneficial for women seeking to terminate their pregnancy, as it will help in seeking ways to improving TOP services. The findings will contribute to knowledge that will inform strategies aimed at transformative women's reproductive health intervention. It will also inform policy and implementation plans of on TOP services in South Africa.

I wish to interview about fifteen young women or girls admitted at the hospital presenting with incomplete abortions.

Since abortion is a very sensitivity issue I will make sure that the participant do not feel judged, and I will also treat each discussions with confidentiality and anonymity in order to protect their identity.

Thank you.

Yours Sincerely,

**Nompumelelo Ndlovu (Miss)**

**Researcher**

**Contact details:**

Supervisor: **031 260 1216**

Researcher: **083 979 6257**

HSSREC Research office (Ms P. Ximba): **031 260 3587**

**Appendix F: Letter addressed to the Department of Health requesting permission to conduct a study**



H 897 Lalela Grove  
Ntuzuma  
4359  
21 August 2014

KwaZulu Natal Department of Health  
Private bag X 9051  
Pietermaritzburg  
3200

Dear Sir/Madam

**RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT ETHEKWINI MUNICIPALITY**

My name is Nompumelelo Ndlovu, and I am presently completing my Social Work Masters at the University of KwaZulu Natal. I seeking permission to conduct a research study with patients, particularly focusing on young women admitted for incomplete abortion complications at Prince Mshiyeni Hospital. I am interested in doing a study on illegal termination of pregnancy among young women. The aim of the research study is to explore and understanding factors impacting the choices of young women who do backstreet abortion.

This study will be beneficial for women seeking to terminate their pregnancy, as it will help in seeking ways to improving TOP services. The findings will contribute to knowledge that

will inform strategies aimed at transformative women's reproductive health intervention. It will also inform policy and implementation plans of on TOP services in South Africa.

I wish to interview about fifteen young women or girls admitted at the hospital presenting with incomplete abortions.

Since abortion is a very sensitivity issue I will make sure that the participant do not feel judged, and I will also treat each discussions with confidentiality and anonymity in order to protect their identity.

Thank you.

Yours Sincerely,

**Nompumelelo Ndlovu (Miss)**

**Researcher**

**Contact details:**

Supervisor: **031 260 1216**

Researcher: **083 979 6257**

HSSREC Research office (Ms P. Ximba): **031 260 3587**



## Appendix H: Approval letter from the Hospital



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

PRINCE MSHIYENI MEMORIAL HOSPITAL  
SENIOR MEDICAL MANAGER OFFICE  
DR. MYINT AUNG  
Private Bag X07; Mobeni 4060  
Mangosuthu Highway  
Tel.:031-907 8317/ 8304  
Fax.:031- 906 1044  
Email.:myint.aung@kznhealth.gov.za  
www.kznhealth.gov.za

Enquiry: Dr M AUNG  
Ref No: 23/RESH/2014  
Date: 03/10/2014

TO: Ms Nompumelelo Ndlovu

**RE: LETTER OF APPROVAL TO CONDUCT RESEARCH AT PMMH**

Dear Researcher;

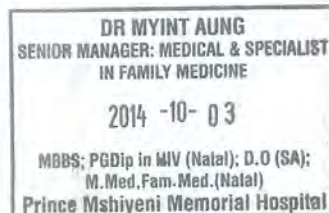
I have pleasure to inform you that PMMH has GRANTED to conduct research on "Factors influencing the choice of a backstreet abortion by young women from a township in Durban" in our institution.

Please note the following:

1. Please ensure this office is informed before you commence your research.
2. The institution will not provide any resources for this research.
3. You will be expected to provide feedback on you finding to the institution.

With kind regard

  
Dr. M Aung  
Senior Manager; Medical & Consultant in Family Medicine  
MBBS(Rgn), PGDip in HIV (Natal), DO(SA)  
M.Med.Fam.Med (Natal)



uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

## Appendix I: Approval letter from the Department of Health



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component  
10 – 103 Natalia Building, 330 Langalibalele Street  
Private Bag x9051  
Pietermaritzburg  
3200  
Tel.: 033 – 3953189  
Fax.: 033 – 394 3782  
Email.: [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Reference : HRKM 249/14  
Enquiries : Mr X Xaba  
Tel : 033 – 395 2805

Dear Ms N. Ndlovu

**Subject: Approval of a Research Proposal**

1. The research proposal titled 'Factors affecting the choice of a backstreet abortion by young women from a township in Durban' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Prince Mshiyeni Memorial Hospital.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

**Dr E Lutge**

Chairperson, Health Research Committee

Date: 18/05/14