

**IMPLEMENTING THE CHOICE ON TERMINATION OF  
PREGNANCY ACT, NO 92 OF 1996: THE PAIN AND TRAUMA OF  
THE ABORTION EXPERIENCE.**

**DEVIKA GOVENDER**

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## **DECLARATION OF ORIGINALITY**

I hereby declare that this dissertation, unless specifically indicated to the contrary in the text, is my own original work.

Devika Govender  
University of Natal, Durban  
February, 2000

## **ABSTRACT**

The research is a descriptive study of the unique and diverse experiences of women who terminated their pregnancy according to the Choice on Termination of Pregnancy Act, No 92 of 1996. It traced the psycho-social experiences of the participants from the point of discovery to the actual abortion.

The decision to terminate their pregnancy was not an easy one, yet participants chose this plan of action on the basis of their socio-economic circumstances. Moral and financial support was offered to participants from their partners, friends and/or significant others whilst no therapeutic counselling was provided prior to their making the decision to terminate their pregnancy, or the actual termination. Pre-abortion counselling was offered pre-dominantly at private health care institutions whilst none of the health care facilities provided post abortion counselling. Many of the participants had to not only endure the emotional pain of their decision but also the judgmental attitudes of the health care professionals who performed the abortion procedure. Participants were unable to make informed choices regarding the choice of abortion methods. As a result they were also unprepared for the intense physical pain they endured during the procedure.

The study used the descriptive research design and a qualitative methodology.

Purposive sampling technique was used to select the thirteen participants. Data were obtained through the semi-structured interview schedule. The ages of the participants ranged between 19-31 years.

The study concluded that the Choice on Termination of Pregnancy Act, No 92 of 1996 was necessary but that inadequate resources hampered provision of holistic services. In addition the Choice on Termination of Pregnancy Act, No 92 of 1996 does not stipulate that pre and post abortion counselling should be a pre-requisite to access abortion services. This lack of counselling resulted in participants reliance on the medical professionals choice of abortion technique which in most cases was not what participants preferred. This research therefore, advocates the need for medical professionals to provide adequate information to as well as attending to the psycho-social implications for women who request to terminate their pregnancy.

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# CHAPTER ONE

## INTRODUCTION

The mere mention of the word abortion creates controversy and neutrality and is, therefore, often difficult to maintain. Amidst the complexity and the sensitivity of abortion, people appear to be certain about their stance on abortion based on their particular belief system. The controversy surrounding abortion stems from the notion that sexual behaviour is still considered taboo and an accidental pregnancy means a woman admitting inadvertently about her sexual practice. Also there is the life-death dichotomy fervently expressed by pro-life supporters whilst pro-choice supporters fight to secure reproductive rights of women. Abortion is a multi-faceted issue which has political, legal, social, moral and psychological implications and should therefore be seen in its totality. "It is the removal or expulsion of all/any part of the membranes that surrounds the foetus in the uterus and may include the removal of the foetus" (Cohen and Parry, 1981, p.65).

Universally abortion evokes strong emotions of either support or opposition against the legalisation of abortion. South Africa's history of abortion was based on inequality and women being denied their basic human rights, that is, reproductive rights. Since the Abortion and Sterilisation Act, No 2 of 1975, women in South Africa were subjected to 24 years of reproductive restrictions. This changed with the introduction of the Choice on Termination of Pregnancy Act, No 92 of 1996 which met fierce opposition from pro-life lobbyists. In spite of this opposition, a six month review between February 1997 - July 1997 on the Choice on Termination of Pregnancy Act, No 92 of 1996 by Reproductive Rights Alliance (1997) revealed that 12000 terminations of pregnancies were performed and recorded in health institutions around South Africa. Evidence therefore exists, that there is a need for abortion on demand.

The Choice on Termination of Pregnancy Act, No 92 of 1996 proved effective in curbing the high incidence of fatalities due to backstreet abortion. According to Reproductive Rights Alliance (1998) approximately 44686 women received medical treatment for incomplete abortions, attributed mostly to illegal abortions. However, the promulgation of the Choice on Termination of Pregnancy Act, No 92 of 1996 has raised questions, in terms of, infrastructure and relevant available resources. Cohen and Parry (1981) stated that “changing the law doesn’t cure social ills, it merely removes legal encumbrances,” and this holds true for abortion (p. 70). The Choice on Termination of Pregnancy Act, No 92 of 1996 allows women to have legally permitted abortions on demand but it does not automatically remove societies negative attitudes about abortion. The beliefs of abortion by society, and more especially, service providers, will ultimately determine the quality of treatment women receive (Cohen and Parry, 1981). Therefore, even though Choice on Termination of Pregnancy Act, No 92 of 1996 is a relevant piece of legislation for women requiring abortion on demand, it is still insufficient in ensuring that holistic treatment is made available to women. The law states that women are entitled to terminate their pregnancies but in reality many problems exist, such as, inadequate resources and attitudes of professionals, in the quality of treatment provided to women.

An examination into current literature on abortion in South Africa, revealed that very little, if any, research has been conducted on the topic. Research that had been undertaken thus far did not examine the effectiveness of abortion services provided to women. The researcher discovered that a gap existed in abortion literature in South Africa with regards to evaluating termination of pregnancy services to women. The dearth of literature can be attributed to abortion on demand only being legalised in February 1997 and therefore evaluating the implementation of services available would not have been possible. The dearth of studies on the effectiveness of services to women needing to terminate their pregnancies in South Africa has meant the denial of crucial information to consumers and service providers. Whilst the issue of abortion has been researched extensively there is a tendency to focus too much attention on certain aspects

and ignore other aspects (Faria, Barret and Goodman, 1986). For example: many studies have looked at service providers and their roles but none have examined how women access termination services even though the services available are accessed from a consumers perspective and not from the service providers perspective.

Abortion is an emotional and traumatic experience for women, yet it has been shown scant attention by social workers in South Africa. This can be attributed to the fact that only in 1997 was abortion on demand legalised in South Africa and the Choice on Termination of Pregnancy Act, No 92 of 1996 stipulates that social work services were not required with regard to women who request abortions. The researcher was only able to locate three studies on the topic from a social work perspective. One of the studies by van Rooyen (1998) examined the responses of senior social work students to abortion while Le Roux and Botha (1997) looked at the importance of abortion counselling by social workers to teenagers and women. The dissertation by Forrest (1994) explored the emotional distress of women before and after therapeutic termination of pregnancy. The findings of van Rooyen's (1998) study revealed a somewhat conservative attitude from the students because they stated that women should be allowed to have an abortion only on certain grounds, which was similar to the restrictions in the Abortion and Sterilisation Act, No 2 of 1975. Le Roux and Botha's (1997) study concluded that social workers do have an important role to play in the provision of counselling services to women and teenage girls needing abortion. Forrest (1994) administered a questionnaire and interviews to 40 women at the Groote Schuur Hospital, in Cape Town to determine the woman's level of stress before and after the abortion. The study revealed that women's stress levels were lower after the abortion rather than before and, therefore, did not require post-abortion counselling.

The researcher also relied upon international literature which explored the role that social work could serve to women who have had abortions or were deciding to have an abortion.

Gameau (1993) discussed the implementation of a high risk screening and counselling programme in an Adelaide hospital in Australia, which was developed by the hospitals Social Work Department. The programme resulted in medical personnel providing better quality abortion services to women who requested an abortion. Faria, Barret and Goodman's (1986) study of women considering having an abortion examined the attitudes, social networks and decision-making skills of 517 women, from abortion clinics around Kansas in the United States of America. The purpose of the study by Faria, Barret and Goodman (1986) was to improve the type of services social workers provided to women deciding to have an abortion. Finally, Lowry and Blank (1972) offered detailed steps as to how abortion counselling should be provided by social workers in the United States of America.

All these articles concentrated on the counselling aspect of social work intervention. According to Rylka-Bauer (1996) accounts of the experiences of women who undergo abortions are lacking in literature. Hence, this research aimed to explore the experiences of women who had abortions since the implementation of the Choice on Termination of Pregnancy Act, No 92 of 1996, thereby contributing to the knowledge base of social work, consumers of abortion services, other service providers, policy makers and society at large.

## VALUE OF THE STUDY

For women who access abortion services, this study has immense value for their situation. The abortion debate almost always focuses on the moral, religious and legal dilemma whilst ignoring a very important component, namely, the consumers and potential consumers of such services. Advocates of pro-choice or pro-life almost always present their own personal beliefs and never inquire about how women who have experienced termination feel about abortion. In this way women who are contemplating abortion or who have had abortions are not provided with an accurate account of the dynamics of abortion. The examination of the effectiveness of termination of pregnancy services from the woman's perspective will inform potential users of what to expect and how to prepare themselves for having an abortion. Based on the outcomes of this research, it may prompt service providers to rethink their strategies and may lead to an overall better experience for potential consumers of termination of pregnancy services.

The social worker like all the professionals (nurses, doctors) who come into contact with a woman requesting termination of pregnancy, has an important role to play. Yet they are omitted from the Choice on Termination of Pregnancy Act, No 92 of 1996. It must be noted that The Termination of Pregnancy Bill No. B80 of 1996 stipulated that doctors could consult social workers if a woman requested an abortion and the gestational period of her pregnancy was between 13-20 weeks, in the following circumstance: if the pregnancy was the result of a rape, sexual abuse or if the pregnancy would seriously affect the social/economic circumstances of a woman (van Rooyen, 1998.). The reason provided by parliamentarians for the omission of social workers from the Choice on Termination of Pregnancy Act, No 92 of 1996 was attributed to the fact that women living in rural areas would experience difficulty in accessing social workers. (Stuurman-Moleleki, 1996).

More specifically social workers should be involved in determining whether a woman is eligible for termination of pregnancy based on socio-economic circumstances, since social issues are often central to the decision to terminate the pregnancy. Currently the decision to grant a woman termination of pregnancy on socio-economic grounds is made by a physician. According to Davies (1991) doctors do not address the psychological concerns of women who request abortions because of time constraints. Also doctors are trained to treat illnesses and not psychological problems (Davies,1991). A holistic provision of abortion services is possible if social workers and doctors collaborate.

A core function of the social work profession is helping individuals, groups and communities change their situations through the problem-solving process. Hence, the skills and knowledge social workers possess will be invaluable in counselling women contemplating terminating their pregnancies. According to Liberman and Davis (in van Rooyen, 1998) women who have reproductive rights and control over their own bodies operationalize social work principles of self determination, empowerment and dignity. This research is concerned with how women contemplating abortion arrive at their decision. Thus knowledge and values about abortion are important in guiding their decisions. In addition to providing services to women considering terminating their pregnancy, or those who have already had an abortion, social workers can facilitate interdisciplinary liaison amongst the different professions involved in service provision. Reproductive Rights Alliance (1997) reported that in the Free State the Department of Health collaborated with the Department of Welfare to ensure that women requiring termination of pregnancies were provided with appropriate counselling services. The Department of Health was responsible for the training of social workers and nurses on how to counsel clients. Social workers have an important contribution to make towards termination of pregnancy services and policy makers need to take cognisance of this and consider amending the current Choice on Termination of Pregnancy Act, No 92 of 1996, to include social workers.



The two primary professionals that provide services to women requesting termination of pregnancies, are nurses and doctors. They are responsible for the medical aspects of abortion. For women wanting an abortion, doctors and nurses represent a vital link in the abortion procedure. In other words, women are dependant on doctors and nurses to perform the abortion. Sometimes the only professionals, women wanting an abortion, will encounter, are doctors and nurses. Therefore, it is important that these service providers are aware of the quality of service they provide to women.

Abortion poses ethical and moral dilemmas for doctors and nurses about whether or not to perform them. When the Choice on Termination of Pregnancy Act, No 92 of 1996 was introduced in 1997, a significant proportion of doctors and nurses in South Africa denounced the Act. A survey conducted by Doctors for Life revealed that 82,49% of doctors refused to perform abortions on demand (Christian News, 1997). Nurses also expressed similar feelings of not wanting to partake in abortion procedures. For example, after 9 months of implementation of the Choice on Termination of Pregnancy Act, No 92 of 1996, only 3 nurses out of 300, in Empangeni Hospital in Kwa-Zulu Natal, agreed to participate in abortion procedures (The Pro-Life Infonet, 1997). The Choice on Termination of Pregnancy Act, No 92 of 1996 stated that doctors and nurses can exercise their constitutional rights not to perform abortions but on condition that they refer the woman to another physician who is willing to terminate the pregnancy.

Doctors and nurses who believe that performing an abortion is contrary to what they believe, can be prejudiced in their interactions with patients. A study conducted by Tanner et al (in World Health Organisation, 1978) revealed that the negative attitudes of doctors and nurses can have detrimental effects on women. This research by providing insight into the experiences of women who had abortions also reflects values and attitudes of service providers regarding abortion. Value clarification workshops involves self - assessment of the individual's beliefs, attitudes and feelings concerning a sensitive issue. When Marais (1997) conducted a values clarification workshop on abortion, for medical

professionals, she explored the participants occupation, their religion, previous experience and their attitudes towards abortion. The participants were asked to rate their level of comfort with abortion. About 70% of the participants gained clarity about their values regarding abortion and stated that they would now provide better quality treatment to women who requested abortion. Values clarification workshops about sensitive issues, like abortion, allows participants exploration of the issue from a different perspective.

Provision of services is an integral aspect of abortion experience. Therefore, a research of this nature has value and relevance for both recipients of services and service providers.

In order to understand women's experiences with regard to the termination of their pregnancy this research focussed exclusively on the process involved in having an abortion and the utilization of services. The researcher decided to concentrate on consumers of termination of pregnancy services because consumers experiences or perceptions are important to develop more responsive and effective services.

## **THEORETICAL FRAMEWORK**

The bio-psycho-social model and feminist theories will be the guiding frameworks in the research.

Berger, Federico and McBreen (1991) stated that human behaviour is determined by biological, psychological, socio-structural and cultural factors. No one factor solely predicts human behaviour. All five factors are inter-related and do not exist in isolation (Berger, Federico, and McBreen, 1991). Biological, psychological, socio-structural and cultural factors could present itself as either obstacles or resources to human behaviour. The bio-psycho-social model will enable the researcher to analyse the research from the biological, psychological, socio-structural and cultural dimension to gain a holistic view of the experiences of women who have undergone termination of pregnancy.

Biologically women have the ability to reproduce. Berger, Federico and McBreen (1991) recognised that the capabilities of the human physiology, is to an extent, influenced by psychological, socio-structural and cultural factors. Pregnancy does not often result from planning. An unexpected pregnancy could perpetuate a host of problems. In deciding whether or not to have a baby, the woman will have to consider if she is ready to become a parent (psychological), if she has the socio-economic resources to rear and support her child, how her family (social) and friends will react to her unplanned pregnancy and if she is a single person, falling pregnant would be deemed to be an inappropriate behaviour (cultural) by society.

Technological advances in the medical profession has contributed to significant alterations in human biological functioning (Berger, Federico and McBreen, 1991). Abortion is an example of medical improvement in controlling population. Legalised abortions have meant that women no longer have to resort to abortifacients to terminate their pregnancy. If a woman chooses abortion she could face further ostracism because of the controversial nature of the issue. The beliefs and attitudes of service providers may affect the treatment a woman requesting termination of pregnancy may receive. Women's religious beliefs concerning abortion may cause internal (psychological) conflicts about having an abortion. The bio-psycho-social model provides a relevant and applicable framework from which to analyse the experiences of abortion services by women.

Reproductive freedom is deeply entrenched in liberal feminist theories. However within reproductive freedom, there are two opposing perspectives, that is, women have control over their bodies and reproductive abilities and the other view is that because women have the ability to bear children, they are automatically assigned roles of care-taker of children or home-maker. These roles that women assume entitle them to decide whether or not to have children (Petchesky, 1980). However, in reality for women these rights are not enforced causing women to experience discrimination and oppression in almost all aspects of life. Petchesky (1980) is of the opinion that reproductive freedom is not exclusively individual or social. Rather it is a combination of both views. The researcher acknowledges various dimensions to the feminist theories but has focussed on one of the aspects, that is, women's control over their bodies and its application of the theoretical framework is limited.

According to Nye (1998) reproductive rights is not even in the decision making equation of women who terminate their pregnancies. Rather these women take into account the implication of their decision to have an abortion on significant others and themselves. Liberal feminists advocate for reproductive rights yet women are not concerned with their

rights when they decide to have an abortion but with the practical difficulties of becoming pregnant accidentally.

## **AIMS OF THE STUDY**

This study aims to examine the experiences of women seeking termination of pregnancy and their impact on the decision-making process. In order to achieve these aims this study will explore:

1. The criteria to qualify for an abortion.
2. The nature, location and procedural aspects of the abortion process.
3. Participant's perceptions of the impact of these services.
3. Participant's perception of the adequacy of services.

## **RESEARCH QUESTIONS**

1. What is the decision-making process that participants follow, when contemplating an abortion?
2. What is the role of the social support system in the decision-making process?
3. What services are available to participants who request an abortion?
4. What requirements do women have to satisfy in order to be provided with a service?
5. What were the experiences of the participants?
6. What were the participants views of the services that they received?

7. What recommendations did the participants offer to improve the termination of pregnancy services?

## **RESEARCH DESIGN**

The research used a descriptive research design. Descriptive research design “describes, records and reports phenomena as objectively as possible” (Marlow, 1993, p. 25). According to York (1997) the purpose of descriptive strategy is to describe events with accuracy.

Qualitative methodology was used to analyse data in the research. Marlow (1993) defined the qualitative method as “the non-numerical examination of phenomena. It focuses on the underlying meanings and patterns of relationships” (p. 66). Qualitative approaches enable the researcher to study certain issues, cases or events thoroughly (Patton, 1987). Narrative techniques were used to present the results. The research methodology will be discussed in detail in chapter three.

## **CONTEXT**

Abortion in South Africa, until 1 February 1997, operated according to the Abortion and Sterilisation Act, No 2 of 1975. The Abortion and Sterilisation Act, No 2 of 1975 was restrictive and abortion on demand by women was prohibited. According to Clark and van Heerden (1992) women had to satisfy the following stringent requirements if they were to be granted an abortion: if the pregnancy would cause physical harm to the woman’s life, if the mental health of the woman would be permanently damaged by the continued pregnancy, a possibility of the child (in utero) suffering mental/physical harm, if it is established in court that the woman was raped or if the pregnancy was the result of an incestuous relationship. The implementation of the Abortion and Sterilisation Act, No 2 of 1975 saw only a few hundred abortions being performed predominantly on white

women, according to the Womens Health Project (1998). In addition to women having to meet the rigid requirements of the Abortion and Sterilisation Act, No 2 of 1975, authorisation had to be provided by two independent physicians and a psychiatrist from a government hospital (Womens Health Project, 1998). The Abortion and Sterilisation Act, No 2 of 1975 failed to consider women who could not comprehend this Act because they were illiterate, those women who had no access to state health facilities and women who could not afford the services of three doctors (Womens Health Project, 1998).

Despite the enforcement of the Abortion and Sterilisation Act, No 2 of 1975, illegal abortions flourished, inspite of the grave dangers to a woman's health. Due to the illegal manner in which pregnancies were terminated, there was no way of exactly knowing the number of abortions performed. Clark and van Heerden (1992) have estimated that about 200 000 illegal abortions were performed annually. Medical studies revealed that in 1997, 35882 corrective surgeries were performed to remove residues of the pregnancy (Nash, in van Heerden, 1992). In 1989, the Department of Health and Population Development showed a similar proportion (33 000) of corrective operations performed (Loenig, in van Rooyen, 1998). The research conducted by the Medical Research Council of South Africa in 1994, revealed that illegal abortions cause pelvic infection, haemorrhage, toxic shock, sepsis, scarring of the cervix and death (Reproductive Rights Alliance, 1998). These ailments could lead to the woman becoming infertile, enduring chronic pelvic pain, incontinence and infirmity. Besides illegal abortions posing a grave danger to the woman's health, it placed a heavy burden on the Department of Health to rectify problems caused by poorly performed abortions. The findings by the Medical Research Council in 1994 stated that approximately R18 695 948 p.a. was spent by the state to address incomplete abortions (Reproductive Rights Alliance, 1998). The danger to a woman's health due to illegal abortions was one of the many reasons that prompted a change in legislation.

With the demise of apartheid, the rights of individuals were highlighted. In the South African Constitution, The Bill of Rights recognises the need for reproductive rights to be upheld. According to the Reproductive Rights Alliance (1998) reproductive rights is based on “the protection and well-being of both men and women” (p.1). More specifically, in relation to women, reproductive rights have meant that they have absolute control over their bodies and free to make their own decisions concerning their bodies without any coercion. Women also have the right to be provided with proper reproductive information and services to help them make the best decision (Reproductive Rights Alliance, 1998). Reproductive rights have legally done much to improve the status of all women in South Africa. However equal access to reproductive health services still remains an issue. In reality, there is a deficit between demand and supply of services due to a lack of medical facilities and resources especially in rural areas.

Pro-choice lobbyists used the reproductive rights argument to advocate for the legislation of abortion on demand. The government of national unity recognised the need to amend the Abortion and Sterilisation Act, No 2 of 1975. An ad hoc select committee was established to examine the relevance of the Abortion and Sterilisation Act, No 2 of 1975. The committee received 452 letters and heard oral testimony from women, (Reproductive Rights Alliance, 1998). It is interesting to note that very few African people presented information. The committee concluded that new legislation concerning abortion should be formulated. It stated that women should be provided with abortion on demand up to 14 weeks of the gestation period and between 14-24 weeks dependent on broadly stipulated circumstances. The circumstances are as follows: if the doctor after examining the woman is convinced that the pregnancy poses a risk to the woman’s health, the foetus may suffer an abnormality, if the pregnancy resulted from a rape or incestuous relationship or if the woman would experience socio-economic problems due to the continuation of the pregnancy. According to the Reproductive Rights Alliance (1998) women should not be subjected to having to ensure the authorisation of two doctors since this is highly bureaucratic and oppressive.



An increase in redeployment and training of health officials to areas that lack health services and an upgrading of current health facilities were suggested, so as to ensure equal access to women in areas where no services previously existed. Counselling should be available to women wanting to terminate their pregnancy but this service should be optional. Women do not require the consent of their spouses or in the case of minors their parents/guardians approval to terminate their pregnancy. Statistics regarding abortion can be collected by a central organisation without divulging the names of the women. Any medical staff who is not comfortable in engaging in the abortion procedure due to personal beliefs should be free to exclude themselves from providing treatment. However, before disengaging themselves, he/she must refer the women to another doctor. The ad hoc select committee's findings was extremely pertinent in the restructuring of the Choice on Termination of Pregnancy Act, No 92 of 1996 (Reproductive Rights Alliance, 1998). In February, The Choice on Termination of Pregnancy Act, No 92 of 1996 was proclaimed.

## **DEFINITION OF CONCEPTS**

**ABORTION:** According to the Choice on Termination of Pregnancy Act, No 92 of 1996, an abortion is “the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman” (p.235).

**TERMINATION OF PREGNANCY:** It is a synonym for abortion and has been used in the research interchangeably.

**SPONTANEOUS ABORTION:** “is often referred to as a miscarriage, abortion is caused by the natural process” (Cohen and Parry, 1981, p. 65).

**THERAPEUTIC ABORTION:** “performed by physicians or other medically trained persons using proper instruments” (Cohen and Parry, 1981, p.65).

**SURGICAL ABORTION:** “surgery is needed to terminate the pregnancy” (Paul, 1999, p.291).

**MEDICAL ABORTION:** “the use of medication to induce a miscarriage” (Paul, 1999, p.291).

**PROSTAGLANDINS:** “Hormone like substances which cause contraction of the uterus to induce labour” (Davies, 1991, p. 219).

**RU486:** “A new drug which blocks the nourishing action of progesterone in the pregnant uterus causing the fertilized egg to miscarry” (Davies, 1991, p. 219).

## **FORMAT OF THE DISSERTATION**

CHAPTER 1: Introduction. This chapter begins by discussing the rationale for the study, followed by the objectives of the study, research questions, value of the study, theoretical framework, research design and the context of the research.

CHAPTER 2: Literature Review. The literature review is divided into four sections, namely: interpretation of the Choice on Termination of Pregnancy Act, No 92 of 1996, alternative choices, decision-making process and services. The services section is subdivided into medical aspects, psychological aspects and social aspects.

CHAPTER 3: Methodology. This chapter begins with a brief introduction of the research and is followed by the sample, sample technique, sample procedure, data collection tools, data analysis, reliability and validity of data collection instruments and ends with the limitations of the study.

CHAPTER 4: Case Profiles. This chapter provides data on the profiles of the participants of the study. A description of the participant's experiences are included in this chapter.

CHAPTER 5: Discussion of Results. In this chapter the findings are described and discussed. The background information, discovery of pregnancy, decision-making process and the types of services are discussed using the bio-psycho-social model and liberal feminist theories.

CHAPTER 6: Conclusion and Recommendations. Conclusions are drawn from the research and literature review, followed by recommendations.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **INTRODUCTION**

This chapter deals with the termination of pregnancy according to the following sections:

**INTERPRETATION OF THE ACT:** it is important to include this section because the Choice on Termination of Pregnancy Act, No 92 of 1996 is the foundation upon which this research is built.

**ALTERNATIVE CHOICES:** A woman who is faced with an unplanned pregnancy, will usually consider the options at her disposal before making a decision.

**DECISION-MAKING PROCESS:** This information is central to the entire research because women who contemplate having an abortion, go through a tumultuous period of decision-making to have an abortion. Also included were the reasons women provided for having an abortion.

**SERVICES:** This section is further subdivided into medical aspects, psychological aspects, and social aspects. Medical aspects will look at professional personnel who provide women with services for terminations, the service providers, the abortion procedures, the risks involved in having an abortion and pain management. The psychological trauma women face before and after having an abortion will be explored in the psychological aspects. Finally, social aspects looks at social support systems women turn to before and after the abortion.

## INTERPRETATION OF THE ACT

Although the Choice on Termination of Pregnancy Act, No 92 of 1996 allows for abortion on demand, certain criteria must be satisfied in order for the pregnancy to be terminated. A woman can choose to terminate her pregnancy in the first 12 weeks of the gestation period without any obstacles. A woman can terminate her pregnancy between 13-20 weeks based on the opinion of the doctor. The Choice on Termination of Pregnancy Act, No 92 of 1996 stipulates that the operation must be carried out by a medical practitioner/midwife. In the case of women who are mentally incapacitated or in a coma, her family, spouse or guardian can request for an abortion on the grounds that the pregnancy is a risk to the woman's mental/physical health or that the foetus may be exposed to dangers. Minors, can be persuaded by the doctor/midwife to inform their parent/guardian but it is entirely the minors' decision. The doctor/midwife must record the event and all information must be kept confidential. The Director General must be informed of all the terminations that occurred at health care facilities. Failure by medical professionals to comply with the guidelines set forth by the Choice on Termination of Pregnancy Act, No 92 of 1996, could result in a fine or being sentenced to a maximum of 10 years in prison (Stuurman-Moleleki, 1996).

According to Stuurman-Moleleki (1996) the Termination of Pregnancy Bill No. B80 of 1996 had to undergo several changes before it was proclaimed. The word "carnal" was later replaced with the word "sexual" to allow for easier comprehension. The Termination of Pregnancy Bill No. B80 of 1996 stated that during 13-20 weeks of the gestational period a social worker should be sought for help. The need for social work service was removed from the Choice on Termination of Pregnancy Act, No 92 of 1996 since it is difficult for rural and peri-urban women to gain access to social work services which is scarce in rural communities.

Counselling was not made compulsory so as to respect the wishes of women wanting to terminate their pregnancy. Women contemplating having an abortion or those who have had an abortion do not want to be lectured on the advantages or disadvantages of abortion. Thus, women are not compelled to receive counselling but can choose whether or not to receive it. Finally, due to the religious and moral convictions of medical personnel, they can refuse to offer their termination of pregnancy services or refer the woman to another doctor. This allows physicians to exercise their right of conscience (Stuurman-Moleleki, 1996).

The Choice on Termination of Pregnancy Act, No 92 of 1996, provides women with control over their own lives and an alternative option to make informed decisions when confronted with an unplanned pregnancy, which they were previously denied. Westmore (1977) is not entirely convinced that changing abortion policy is the way to proceed because it will not guarantee women that safe abortions will be performed by qualified medical practitioners in appropriate institutions. For the effective implementation of policies, the provision of relevant and appropriate supportive services is essential.

## **ALTERNATIVE CHOICES**

Several authors agreed that when a woman is confronted with an unplanned pregnancy, she can only pursue three options, namely, continuing with the pregnancy and keeping the child either in a relationship or as a single parent, adoption or abortion. Although women have different choices, it is by no means straightforward. Each alternative has some degree of difficulty attached to it (Davies, 1991). Various socio-economic and cultural factors will influence the decision made by the woman (Voydanoff & Donnelly, 1990).

A woman may choose to have her baby if she has the support of either her family, spouse or friends or if she is in a financially stable position (Davies, 1991). There has been a significant increase in the number of single parent families and according to Davies (1991), one out of every 8 families is a single parent family. Voydanoff and Donnelly (1990) stated that particularly poor adolescent women were likely to keep their baby and rear them in a single parent household. This can be attributed to strong religious convictions and cultural backgrounds of women (Voydanoff & Donnelly, 1990). Moore and Rosenthal (1993) suggested that the decision to have the baby could be due to an attachment or bond that develops between the mother and the unborn child. Therefore, based on these studies a woman choosing to have and keep her baby was more likely to be influenced by her moral beliefs as opposed to economic stability.

Adoption is very often the choice that lies between having the baby and abortion. Some women may not be able to proceed with an abortion due to moral beliefs and at the same time may not be able to keep the baby because of a lack of resources or finances. In the United Kingdom women who have ambivalent feelings about their pregnancy, choose adoption (Davies, 1991). If a woman decided on adoption she did not require the permission of the father (Davies, 1991). In the South African context, there still seems to be some controversy around the rights of the mother and her right to give her baby up for adoption. In the case of Fraser versus Naude as cited in the South African Law Report (1997), the natural father of an illegitimate child applied to the courts to prevent the child's mother from placing the child up for adoption. The father's application was dismissed but he was allowed to apply to adopt his child. High vocational aspirations contributed largely towards adoption (Voydanoff & Donelley, 1990). This was prevalent amongst teenagers of school going age who did not want to discontinue with their education. For teenagers adoption has long been a favourable option but this has been reversed with the legalisation of abortion (Moore & Rosenthal, 1993).

According to two pro-choice advocates, the reason women decided to follow the abortion route and not adoption was because adoption caused a permanent separation between the mother and the child and the issue of abandonment arose (Alcorn, 1992). However, Alcorn (1992) was of the opinion that adoption was not meant to cause women to suffer emotional turmoil because of their decision to give up their baby but it should be seen as a relief for women in difficult predicaments. A study conducted by the National Committee for Adoption revealed that 1.5 million couples in the United States of America wanted to adopt children. However, each year 1.6 million children were being aborted and only 50000 new children were available for adoption. Therefore, for each potential case of adoption, 30 other foetus were being terminated (Alcorn, 1992). This suggests that a need exists for children to be adopted yet, women chose to terminate their pregnancy which, in most instances, was an extremely difficult decision to make. Alcorn (1992) attributed the insufficient number of children available for adoption to the high figures of children that were aborted and to women not being furnished with all the options available to them, during counselling, to make an informed decision. Research by Mech (in Alcorn, 1992), showed that 40% of counsellors made no mention of adoption as an alternative, whilst another 40% of counsellors provided women with false information regarding adoption. Women need to know that the option of adoption exists, as well as a comprehensive understanding of adoption procedures but, on the other hand they should not be pressured into choosing adoption. They must be able to weigh the strengths and weaknesses of each option before arriving at a decision that best suits their circumstances.



Women often chose abortion as a last resort option. The strongest denominator in the abortion equation was the attitude of the woman towards abortion (Voydanoff & Donnelly, 1990). Associated with attitude was women's religious, moral and cultural beliefs which influenced their attitude towards or against abortion. According to Leibowitz, Eisen and Chow (in Voydanoff & Donnelly, 1990), women who were economically stable were more likely to choose to terminate an unplanned pregnancy. Studies conducted in the United States of America, by Eisen et al (1983); Klerman et al (1982); Leibowitz, Eisen and Chow (1986); Moore, Simms and Betsey (1986) and Olson (1980), revealed that powerful educational aspirations will influence women in choosing to abort their pregnancy (in Voydanoff & Donnelly, 1990).

## **DECISION-MAKING PROCESS**

The introduction of legalised abortion may on the one hand offer women an alternative choice but it does present women with more dilemmas. At first abortion may appear as a quick and simple solution but it has long-term and distressing effects (Hudson and Ineichen, in Moore & Rosenthal, 1993).

In the situation of an unplanned pregnancy women are in a state of complete disarray, panic stricken and shocked. In the midst of this crisis they have to make a life changing decision which is irreversible (Davies, 1991). Most women are afraid to confide in their family/friends for fear of being judged. Eventually they will have to make a decision whether or not to terminate their pregnancy and accept responsibility for the consequences of their choice.

It must be borne in mind that the woman must take into account how her decision to terminate her pregnancy will affect her family, friends and spouse (Davies, 1991). In addition she must deal with the everyday pressures at work, school and at home. It is extremely difficult for the woman to decide to terminate her pregnancy and it requires the individual to be in a rational frame of mind. However this is not the case with an unplanned pregnancy, where the woman is in a vulnerable state. Therefore, “the decision is not simple” (Davies, 1991, p.47).

According to Himmelweit (1988) by legalising abortion a new choice is forced upon women. In addition to other alternatives women had regarding an unplanned pregnancy, they are now faced with an even more complex choice. For women who experience difficulties in making any decision, this choice presents more problems. Himmelweit (1988) argued that legalising abortion created ambiguities for women. On the one hand it was meant to create a sense of freedom amongst women and yet at the same time it caused a wealth of problems.

Davies (1991) developed a seven step decision-making process which can be followed by women contemplating abortion:

- the decision is an individual one and should not be made by another person;
- each option must be carefully analysed;
- be aware of body changes which will make the body susceptible to stress and emotions;
- recognise signs of tensions and address them;
- be cognisant of ‘shoulds’ and ‘oughts’ learned in childhood;
- do not ignore bodily and everyday requirements, which include eating and sleeping well;
- time should be taken to relax; do not be afraid to ask for help (p.49).

Davies (1991) acknowledged that there were no set guidelines for making decisions but she encouraged women to confide in someone they trusted. It helps women to gain a wider perspective and an objective understanding.

### **Reasons for having an abortion**

Research conducted on the cultural perspectives of abortion in Nigeria by Renne (1996) and Johnson, Horga and Andronach (1996) in Romania revealed that socio-economic reasons were the most common factors cited by women for having an abortion. Women in these countries were able to abandon their moral feelings about abortion and make a decision based on practical realities of everyday life. Cohen and Parry (1981) stated that when women opt for an abortion based on economic factors, they usually make comparisons about the short term expenses incurred by having an abortion in relation to the long term costs of rearing a child, for 18 years. In instances where women have other children, they may choose to have an abortion because having another child would create a financial burden on the woman (Sobo, 1996). Women were, therefore, more likely to have an abortion for practical reasons rather than moral religious reasons.

### **SERVICES**

The types of abortion services that are offered is indicative of the prevailing health care system (World Health Organisation, 1978). For maximum safety and efficiency, services should exist that allow for early abortion by skilled doctors. Failure to meet these criteria will pose a health threat to women (World Health Organisation, 1978). Problems associated with the provision of services may be due to, too many second trimester abortions, repeated abortions and the use of 'backstreet abortions.'

In order for the effective provision of abortion services the following issues must be addressed. Firstly organisational factors must be given careful consideration such as geographical locations, resources, legislation and cultural norms. Lieberman and Davis (1992) stated that women who live in rural communities experience difficulties in accessing services. Also indigent women are unable to afford the services of private clinics which charge an exorbitant amount of money (Lieberman & Davis, 1992). Secondly, planning must occur to ensure an equal distribution of the number of services and the types of services (World Health Organisation, 1978). Finally, staff must be selected after rigorous training. This is important because there have been reports that the cold and indifferent attitudes of doctors and nurses can be detrimental to the physical and mental well-being of women (World Health Organisation, 1978). These feelings were reflected by the women interviewed by Davies (1991) for the research of her book called *Abortion and afterwards*, that unsympathetic medical staff caused them undue emotional stress.

### **Professional personnel**

Women who request termination of pregnancies are dependent on professional personnel for the provision of services. Doctors and nurses are the primary service providers of termination of pregnancy services since they are responsible for performing the abortion procedure. Social workers in South Africa, have previously offered women who request abortions their services and need to take an active role in making their services available to these women.

The implementation of the Choice on Termination of Pregnancy Act, No 92 of 1996, saw nurses experiencing moral and ethical dilemma's regarding the abortion procedure (Barometer, in Poggenpoel, Myburgh and Gmeiner, 1998). The Pro-life Infonet reported that in Empangeni Hospital, in Kwa-Zulu Natal, only 3 out of 300 nurses agreed to assist with termination of pregnancies. Cultural beliefs were the reason the nurses refused to provide services to women requesting termination of their pregnancy. The Choice on Termination on Pregnancy Act, No 92 of 1996, to some extent, offers nurses protection if they choose not to assist in the termination of pregnancies, on the condition, that they refer the woman to another health care professional. The right of conscience, stipulated in the South African Constitution, entitles nurses, on the grounds of their particular belief system, to refuse to be part of the abortion procedure.

The majority of nurses in South Africa, are not in favour of the legalisation of abortion and the provision of abortion services to women yet their profession is built on the principles of care and empathy towards the patient (Walker and McKenzie, 1995). Haddof (in Poggenpoel, Myburgh and Gmeiner, 1998) was of the opinion that even though the issue of abortion conflicts with the personal beliefs of nurses, they have a responsibility to provide their patient with treatment. Paul (1999) held a similar belief to Haddof, that irrespective of the service providers beliefs, regarding abortion, he/she has a professional duty to provide the client with the necessary knowledge regarding abortion.

In a study conducted by Poggenpoel, Myburgh, and Gmeiner (1998), nurses recognised that they did not possess the relevant knowledge on how to deal with women requesting termination of pregnancies. The nurses wanted to be trained on how to counsel women and for the establishment of support groups for nurses, so that they could provide women with quality treatment. Following a values clarification workshop on abortion for health care professionals, by Planned Parenthood Association, 70% of the 110 that attended, indicated that the workshop was beneficial to them. The workshop helped to clarify their values which would allow these professionals to provide their clients with better

treatment in the future (Marais, 1997). Those nurses that do agree to assist in the abortion procedure, must possess the necessary skills and they need to re-examine their values regarding abortion, before they are allowed to treat women. It is not sufficient that nurses merely provide a service to women requesting an abortion, their treatment needs to be free of any judgements.

The doctors ability to perform the abortion procedure, is one of the most significant functions in the abortion process, without which the procedure can not be performed. A woman who decides to have an abortion will require the services of a doctor on two occasions: the general practitioners diagnosis or confirmation of a pregnancy and when the doctor performs the termination procedure. Davies (1991) offered the following suggestions to women wanting to terminate their pregnancy to take heed of in the doctor-patient relationship. A woman should expect to be questioned by the general practitioner about her motives for wanting to have an abortion. The attitude of the general practitioner may be understanding or uncaring towards the woman's situation. Judgmental attitudes can even arise from general practitioners who have treated the woman on previous occasions. If the woman has encountered an insensitive general practitioner, then she must assure the general practitioner, that she has given the decision considerable thought and reflection (Davies, 1991).

According to Paul (1999), the doctor that performs the abortion must ensure that the woman was aware of all her options and that she is absolutely certain of her decision to have an abortion. A woman's permission to have an abortion must be obtained by the doctor before the procedure is performed. An explanation of the different abortion techniques as well as the strengths and weaknesses of each technique must be provided to the woman, by the doctor, prior to the procedure (Paul, 1999). Davies (1991) stated that research has that revealed women who are equipped with the necessary information regarding abortion procedures are able to cope with the decision better than women who are not given any explanation. If women are not told by the doctor what is going to

happen during the procedure, then they need to ask the doctor for an explanation. According to Davies (1991) this was not an easy task for any woman due to the unequal relationship between the doctor and the patient. Even women who have professional vocations and are assertive individuals find themselves in a compromising position and are unwilling to question the doctors' authority (Davies, 1991). A doctor is not only responsible for performing the abortion but also providing women with valuable information about the procedure so that females are not oblivious to what is happening to their bodies.

The reaction of doctors in South Africa to the Choice on Termination of Pregnancy Act, No 92 of 1996, was largely negative. According to Life Institute (1997) a study conducted by the Doctors for Life showed that 82,49% of doctors have refused to perform abortions. The Choice on Termination of Pregnancy Act, No 92 of 1996 permits doctors to refuse to perform abortions provided that they refer the women to practitioners that are willing to perform abortions.

Prior to the Choice on Termination of Pregnancy Act, No 92 of 1996 being implemented social workers provided a service to women, requesting an abortion in terms of the Abortion and Sterilisation Act, No 2 of 1975. They were responsible for assessing women to determine if the woman satisfied the requirements of the Abortion and Sterilisation Act, No 2 of 1975. They also offered women pre-abortion counselling and if required, post-abortion counselling (Forrest, 1994). Despite not being mentioned in the Choice on Termination of Pregnancy Act, No 92 of 1996 as a service provider, van Rooyen (1998) is of the opinion that social workers will be drawn in to help women due to the social implications of abortion.

The primary reason that women decided to have an abortion in the United States of America and abroad was due to the socio-economic factors (Shultz, 1972). Social workers considered experts on social issues, can make significant contributions regarding abortion services. Yet, doctors do not consult social workers when making decisions on whether to deny or approve abortion requests (Shultz, 1972). According to Shultz (1972) doctors make poor assessments of women who request abortions on socio-economic grounds because their time is limited, they lack psycho-social skills and they make no effort to understand the problem in context. Social workers complacency regarding abortion services has meant that women are indirectly denied crucial social work services (Shultz, 1972). As a human profession social workers have an ethical responsibility to provide services to those in need of help. According to Shultz (1972) social workers must take an active stance in providing services to women who request abortion on demand. In South Africa, even though the Choice on Termination of Pregnancy Act, No 92 of 1996 makes no reference to social workers, they can still make their services available to women confronted with an unplanned pregnancy, in government hospital settings where social workers are employed. In hospitals in Mpumalanga, Free State and Northern Province, social workers have been included in intervention strategies together with doctors and nurses (Reproductive Rights Alliance, 1997).

Social workers in this sector of service provision (as in any other) must be encouraged to attend value clarification workshops on abortion. If the social workers values are in conflict with abortion on demand being legalised then he/she has an ethical responsibility to refer the client to another worker. According to Lowry and Blank (1972) social workers need to be neutral and impartial in the interview with the client. Lowry and Blank (1972) conceded that social workers are human and it may be impossible for them to be completely neutral about abortion.



Professional personnel that provide services to women who request abortions need to be aware of their attitudes regarding abortion since this could severely hamper the quality of the service they provide. Therefore, support structures must exist to address their attitudes and emotional needs.

### **Service providers**

Termination of pregnancy services are offered by public and private health care institutions. In South Africa, abortions are performed by government hospitals and private clinics, such as Marie Stopes Clinic. The guiding philosophy of Marie Stopes Clinic was used to illustrate the termination of pregnancy services that are offered by health care facilities.

Marie Stopes South Africa, which has its roots in Marie Stopes International, was launched in 1997 following the implementation of the Choice on Termination of Pregnancy Act, No 92 of 1996. Marie Stopes Clinics is a private clinic built on the philosophy of allowing women to control their reproductive functions. Although Marie Stopes Clinics are non-profit organisations, women are charged a fee of either R600 at regional clinics or R450 at the satellite clinics for the purposes of maintaining the clinics and to offer poor communities a free service (Reproductive Rights Alliance, 1997). A six month review of Marie Stopes Clinics in South Africa by Reproductive Rights Alliance (1997) indicated that 3477 abortions were performed at their clinics. According to Tancred (in Poggenpoel, Myburgh and Gmeiner, 1998) Marie Stopes Clinics regards counselling as a vital aspect in the provision of services to women requesting abortions. Marie Stopes Clinics according to Tancred (in Poggenpoel, Myburgh and Gmeiner, 1998) stated that “the quality of counselling a woman receives beforehand will determine how she copes afterwards” (p.6). Marie Stopes Clinics offer women wanting to terminate their pregnancy an alternative health care facility, which performs abortions for a substantial amount of money.

Le Roux and Botha (1997) believed that social work counselling services will prove invaluable to women before and after termination of their pregnancy. Between the previous restrictions on abortion on demand and the recent legislation of abortion, there is a paucity of literature devoted to social workers and abortion services in South Africa. Therefore, international literature that dealt with social workers and abortion was drawn upon. According to Gameau (1993) the purpose of social work intervention with termination of pregnancy is to help patients resolve the situation in a healthy manner.

Gameau (1993) stated that for the woman requesting termination of pregnancy, psychological factors is equally as important as the actual abortion procedure. Abortion is a multi-faceted issue and termination of pregnancy services should offer comprehensive health care. Social workers have a significant role to play in implementing termination of pregnancy services together with other health care professionals (Gameau, 1993). Social workers have much needed skills to provide services to women confronted with an accidental pregnancy yet, social work services together with other helping professionals, are under utilised (Faria, Barret and Goodman, 1986). The reason for the under utilisation of social services may be attributed to the many potential clients being unaware of the services social workers provide. Faria, Barret and Goodman (1986) suggested that social workers must increase their efforts to ensure that women are made aware of social work services should they fall pregnant accidentally. The quality of treatment social workers provided to women who have unplanned pregnancies depended on three elements, namely: the attitude of the counsellor, the attitude of the client and the availability and realities of services (Lowry and Blank, 1972).

Gameau (1993) discussed how social workers can develop intervention strategies by using the example of the termination of pregnancy programme at the Queen Elisabeth Hospital in Australia. The programme comprised of a group of health care professionals, namely, doctors, nurses, social workers, theatre staff and clerical staff. When a woman who has an unplanned pregnancy presents herself at the hospital, an initial screening is conducted by the social work receptionist (trained social work assistant) to determine if there are any indications of the woman being a high risk patient. The high risk criteria are: the woman is uncertain about her decision to terminate, she is an adolescent, the woman is in the advanced stage of her pregnancy, socio-economic grounds, the woman is seeking information regarding termination of pregnancy, she wants to talk about her decision and if the woman is experiencing post-abortion difficulties on a psychological level. The woman will be referred to the social worker if she meets any of the high risk criteria. The client can refuse to see the social worker and this will not exclude her from having an abortion. Before referring the woman to the social worker the receptionist will explain to the client the role of the social worker. Approximately 90% of the clients who displayed high risk symptoms chose to see the social worker (Gameau, 1993).

Before any kind of service is provided to women with unplanned pregnancies, social workers must view the circumstances of the potential consumer of services as being unique (Faria, Barret and Goodman, 1986). Social workers must be alert to any tension present between the client's general and personal beliefs about abortion, how much social support she is receiving since discovering her unplanned pregnancy and the reasons for her wanting to terminate her pregnancy (Faria, Barret and Goodman, 1986). In other words during the assessment of the client the social worker must gain a holistic perspective of the client's situation before deciding on the type of service to be provided to the woman.

The social worker must recognise that the woman who is faced with an unplanned pregnancy is in a state of crisis. The woman will thus be operating on a lower level of functioning. Zakus and Wilday (1987) suggested that crisis intervention strategy must be used by social workers to enable the woman to return to a normal level of functioning. Problem-solving techniques must also be utilised to help the client weigh her options and make the best possible decision.

The social worker must also be cognisant of the clients' attitude regarding her unplanned pregnancy. According to Lowry and Blank (1972) for a woman who has fallen pregnant accidentally, it is not easy for her to seek out help. The social worker must recognise that it took a considerable amount of strength to approach a stranger for help. The client may be afraid to ask for help because she may be judged. Social workers must be "supportive and reassuring" to the client (Lowry and Blank, 1972).

In the helping relationship social workers must first provide the client with all her options, that is, adoption, keeping the baby, foster care and abortion (Lowry and Blank, 1972). If the client is interested in abortion, then the social worker must explore the clients' feelings concerning abortion and her reasons for wanting an abortion. The social worker must ensure that the client is absolutely certain about her decision to terminate her pregnancy, that the client takes responsibility for her decision and help the client deal with her decision (Gameau, 1993).

Following the decision by the client to have her pregnancy terminated, the social worker must then provide her with various kinds of information. The abortion act/policies must be explained to the woman so that she is made aware of her rights (Lowry and Blank, 1972). Thereafter, she must be told about the different abortion methods utilised and the risks involved in having an abortion. The woman must be given names of the hospitals/clinics where abortion procedures are carried out and the cost of the procedures (Lowry and Blank, 1972).

It is not sufficient that the client only be exposed to therapeutic support from the social worker. The client should be encouraged by the social worker to speak to someone whom she trusts about her experience (Lowry and Blank, 1972). The person whom the client chooses to tell can offer her a different kind of support which could be in the form of physical comfort, accompanying the client to the hospital for the abortion procedure or even arrange to accompany the client home (Lowry and Blank, 1972).

Finally, social workers should provide post abortion counselling if it is required. Social workers should work through the client's feelings following the abortion. Information concerning the use of contraceptives can be offered if needed (Lowry and Blank, 1972).

## **Medical aspects**

### *Pain Management*

The degree of physical pain women experience during the abortion according to Alcorn (1992) depended on what method was used to perform the abortion. Davies (1991) stated that 95% of women do not suffer physical pains. If pain occurs it is due to the following factors: the length of the pregnancy; the type of abortion procedure; the competence level of the surgeon and how much the cervix is dilated (Davies 1991).

The scraping of the uterus during the dilation and curettage techniques can cause some women to feel pain. In the suction abortion technique, the foetus and placenta are sucked out into the tube which cause pain in the cervix (opening of the uterus). The poisoning of the foetus by the saline solution injected into the amniotic fluid will cause the foetus to die after a few hours. The writhing of the foetus will cause physical suffering to the woman. When prostaglandins or other hormones are given to women to induce an abortion, it causes the uterus to contract which can be very painful for the woman (Alcorn, 1992).

Anaesthesia can be applied to women to effectively control the pain they may experience during the abortion procedure. General anaesthesia according to Paul (1999) required extensive equipment and staff to administer and is therefore only offered in large hospitals. Local anaesthesia is often affordable, becomes effective quickly and does not cause allergic reactions. In the United States of America, paracervical anaesthesia is commonly used in abortions. Paracervical anaesthesia can be administered safely by the physician when the patient is either in a conscious or unconscious state. Despite paracervical anaesthesia being safe, there have been incidents where excessive dosages of the anaesthesia have caused women to die. It is also much safer for women to be consciously sedated during the procedure since the patient cannot be deprived of oxygen (Paul, 1999).

#### *Abortion methods*

Physicians either perform medical or surgical abortions on women based on their preference (Paul, 1999). Medical abortion according to Paul (1999) is “a medication induced miscarriage” (p.29). The physician provides the woman with drugs such as misoprostal to administer on her herself to cause an abortion. The duration of medical abortion may last between a few days to a few weeks. The patient will have to constantly visit the hospital to have her progress monitored. The patient must be prepared for the possibility that misoprostal and methotextrate may not work. If the abortion fails to occur then the patient must have surgical abortion performed (Paul, 1999). Patients who choose to have medical abortions have control over the abortion procedure and control over their bodies (Paul, 1999). Surgery and anaesthesia is not required for medical abortion. Medical abortion allows the patient privacy since the abortion occurs outside the medical facility.

Surgical abortion is a quick process which lasts a few minutes. It is a surgical process and is performed under local/general anaesthesia. Patients choose this procedure because it is “effective and convenient” (Paul, 1999, p.291). The physician has control over the process (Paul, 1999).

There are several different abortion techniques available but the method chosen by the physician will depend on how far along the woman is in her pregnancy, that is, the gestational stage which is determined from the moment of the woman’s last menstrual period. The various procedures are as follows: menstrual extraction, vacuum aspiration, dilation and curettage, dilation and evacuation, intra amniotic instillation, prostaglandins, RU486 (mifeprostene). Edelman and Berger (in Costa, 1991) defined menstrual extraction as “ any procedure used to determine a pregnancy no later than 14 days after the expected onset of a menstrual period”(p. 108). It involves removing all of the uterine contents prior to pregnancy being established (Costa, 1991). Hern (in Costa, 1991) identified many discrepancies with this particular technique. Since it takes place very early in the pregnancy, the embryo may not be detected and the chances of the pregnancy continuing increases. Research has indicated that if this procedure is carried out at less than 7 weeks of the last menstrual period, there is an increased risk of complications. Many women who undergo this procedure, are not pregnant and have made themselves susceptible to dangers. As compared to other techniques that are performed later, menstrual extraction has a high rate of not removing all uterine contents. Menstrual extraction does not acknowledge the pregnancy so it does not address the issues of proper use of contraception to avoid future unplanned pregnancies and more importantly it does not attend to the emotional distress the woman may be experiencing (Costa, 1991). Despite the problems associated with this procedure it does have some strengths, (Hern, in Costa, 1991). It is relatively uncomplicated and can even be performed by the woman, herself. By women not being informed as to whether or not they are indeed pregnant, they are prevented from being subjected to emotional distress. The instrument used to perform menstrual extraction is the flexible cannula and a syringe. Dilation and

anaesthesia are not required (Costa, 1991).

According to Costa (1991) vacuum aspiration is performed not later than the fourteenth week of the gestational period. It can take place using either general or local anaesthesia. According to the World Health Organisation (1978) it is the most commonly used technique in most countries where abortion is legal. A vacurette attached to an aspirator (a sucking mechanism) is passed through the cervix (opening of uterus) into the uterus. The suction pressure dismembers the foetus and it is pulled into the tube and discarded (Davies, 1991). Prior to the vacurette being inserted into the uterus, the cervix must be expanded. It can be done in one of two ways, namely, with dilators or with laminaria tents. Dilators are two metal rods whose diameters are large. One at a time each rod is passed into the cervix, until the cervix is made wide enough for the vacurette to enter. Laminaria tents are basically sticks constructed from seaweed stems. If exposed to moisture they will enlarge to 2-3 times its original size. It is left inside the cervix for a few hours to overnight so that the cervix becomes dilated. The length of this procedure is less than five minutes (Costa, 1991).

Vacuum aspiration is usually conducted under local anaesthetic because it is much safer. The single most cause of abortion related deaths is due to anaesthesia difficulties (Hern, in Costa, 1991). General anaesthesia as opposed to local anaesthesia will twice as likely cause cervical injury or puncturing of the uterus. When local anaesthesia is utilised the risk of complications occurring is reduced. Here the patient is awake and will report if they experience any pain which will result in a quick response by the doctor to attend to these complications. Also the use of general anaesthesia removes the doctor-patient relationship during the operation which prevents the doctor from understanding the pain the patient may be experiencing (Hern, in Costa, 1991).



During the mid 70's dilation and sharp curettage was the most preferred technique for first trimester abortions (Costa, 1991). In this procedure the cervix is dilated, by manual dilators and a sharp curette is used to remove the contents of the uterus under general anaesthetic. The advantages of this procedure is that it is over quickly, allows for the complete removal of all the uterine contents, the amount of blood lost is decreased and few serious problems arise (Hodgson, in Costa, 1991).

Dilation and evacuation rose to prominence in the late 70's and it has become the most commonly used technique for pregnancies which are between 13-20 weeks (Costa, 1991). The cervix must be widened more because the abortion is being performed late in the pregnancy. Laminaria tents are used to dilate the cervix. Following the dilation of the cervix, the foetus and placenta are removed, using a vacuum suction, forceps and a sharp curettage. This procedure could result in the uterus being punctured, scarring of the cervix, excessive bleeding, infections and the abortion not being completed (Costa, 1991). The duration of this technique lasts between 5-20 minutes (Davies, 1991). According to Davies (1991) this procedure is highly complex and must be performed by skilled physicians.

Amnioinfusion with a saline solution usually occurs from 16 weeks and onwards of the gestation period (Costa, 1991). It has since been replaced by the dilation and evacuation procedure. Saline abortions require hospitalisation. In this operation 100-200 millilitres of amniotic fluid is removed from the uterus and is replaced with a similar amount of saline solution. It causes the caseation of the foetus's heartbeat and induces labour so that in one and a half hours the woman will deliver a dead foetus. The dangers of saline abortions are that the foetus may be born alive, accidental injection of the saline solution into a vein, an increase in blood sodium levels, blood coagulation disorders, water intoxication, injury to the cervix and haemorrhage (Costa, 1991, p. 112).

Prostaglandins, which is, naturally occurring hormones or hormone like substances may be used intravenously to cause the uterus to contract and thereby lead to the discharging of the foetus (Costa, 1991). Laminaria tents may be used to dilate the cervix and reduce the amount of contractions required to discharge the foetus. They tend to reduce the likelihood of blood clotting and an increase in blood sodium levels from occurring (Costa, 1991). The length of the procedure from the moment of insertion is short.

Misoprostal according to Paul (1999) is a type of prostaglandin. Misoprostal causes the uterus to contract. Once misoprostal is taken orally it is quickly absorbed into the system. Paul (1999) stated that tests have shown that misoprostal is more effective if it is taken vaginally rather than orally. Studies have also shown that misoprostal takes long to work (Paul, 1999). The use of misoprostal may affect the kidney, cause infertility, abdominal pains and heavy bleeding (Panafrican News Agency, 1999). Failure to terminate the pregnancy results in one in out of twenty cases, where there is the possibility of the baby being disabled (Panafrican News Agency, 1999).

The final type of abortion procedure is the use of RU 486 which is also referred to as the French Abortion Pill. It has only been in existence since mid 1990 (Costa, 1991). The woman's body produces progesterone (hormone) midway during her menstrual cycle, which alerts the uterus to create a lining to accepting and nourishing a fertilised egg. If the egg is not fertilised, the hormone is not given off. As a result the egg is not produced and neither is the lining by the uterus, which is expelled during menstruation. RU 486 acts to stop the production of progesterone and in turn will prevent the uterus from developing a lining. Also it serves to increase the production of prostaglandins, the softening of the cervix and contraction of the uterus. This will allow for the discharging of the embryo. According to Costa (1991) if it is taken during the early stages of the pregnancy it is said to be 90% effective. RU 486 poses very few dangers which include: continuous bleeding which could last up to 2 weeks, cramps, nausea and haemorrhage are extremely rare. The administration of this drug in France requires three visits to the

physician. In the first visit, the woman will be tested to determine if she is indeed pregnant, followed by counselling and the signing of contractual documents. During the second visit the woman is given the pill to take orally. Finally the woman will receive either a prostaglandin injection or vaginal suppository.

The abortion pill (RU486) would only be made available to patients in South Africa in mid 2000. It will firstly be administered by the doctor and two days later accompanied by the misoprostal. RU486 can only be provided if the gestational period is less than nine weeks (Panafrican News Agency, 1999).

### *Risks*

According to Alcorn (1992) the primary cause of abortion related deaths is directly linked to the use of general anaesthesia. With the legalisation of abortion there is a tendency by health officials to stop investigating abortion related deaths because it is unfathomable that these deaths could be due to the abortion since it has been made legal (Alcorn, 1992). According to Costa (1991) the number of deaths due to abortion is relatively low and the risk of death involved in having an abortion is half as compared to the total danger involved in having a tonsillectomy. In response to the claim made by Alcorn (1992) that abortion related deaths is covered up, Costa (1991) claims that evidence showing deaths caused by abortion is based on individual case studies.

The difficulty in establishing the actual number of abortion related deaths is due to the fact that these deaths do not usually occur during the abortion but after the operation (Alcorn, 1992). Alcorn (1992) identified six medical complications as a result of abortions, namely, ectopic pregnancy, pelvic inflammatory disease, breast cancer, internal bleeding, miscarriages and placenta previa. An ectopian pregnancy occurs when the foetus develops outside the uterus and in the fallopian tubes. It is not life threatening but it does account for 12% of all pregnancy related maternal deaths (Alcorn, 1992). For a woman whose has had an abortion the chances of her having an ectopic pregnancy is twice as high and four times as high for women who have had 2 or more abortions (Alcorn, 1992). Pelvic Inflammatory Disease is an infection that causes fever and infertility. It occurs amongst 30% of women who have had an abortion (Alcorn, 1992). Women who terminate their pregnancies in the first trimester are twice at risk of having breast cancer (Alcorn, 1992). During pregnancy the breast tissue is increasing and the abrupt ending of the pregnancy will lead to unnatural conditions. Thus women who have terminated their pregnancy are vulnerable to breast cancer. However, the Economist (1996) is not convinced that a link exists between abortion and breast cancer. Studies conducted reveal no correlation between breast cancer and abortion (Economist, 1996). According to Alcorn (1992) internal bleeding is considered to be normal after an abortion takes place but it becomes dangerous when it is severe due to a ruptured uterus.

A perforate uterus resulted in 24 women dying in the United States during 1972-1979 (Alcorn, 1992). Research has shown that women who have had abortions are more likely to have miscarriages. Also if they do conceive the chances of them giving birth to a premature or malformed baby is possible. Placenta previa occurs when the placenta blocks the cervix thus preventing the child passing into the birth canal. A caesarean section is needed to rectify this complication and it could pose a threat to the mother's and the child's life. In addition to all these serious health risks, women also experience excruciating pain resulting from the procedures (Alcorn, 1992).

## Psychological aspects

Women who have had abortions, not only experience physiological difficulties but also deep seated psychological problems. According to the American Medical Association and the American Psychological Association (APA) the most common emotion expressed by women is that of relief (Costa, 1991). A study conducted by the APA showed that psychological trauma does not necessarily accompany an abortion but it is likely to occur if the woman is not supported in her decision or if the pregnancy was meaningful to her. Women who have the abortion late in their pregnancy have a higher risk of psychological distress (Costa, 1991). After analysing a psychological report on abortion, the British Medical Journal stated that the short term symptoms experienced by the women were relief and depression, which lasted for 8 weeks. Symptoms also included guilt, nervousness, regret and not being able to sleep. On the other hand, 10-30% of abortion recipients experienced ongoing psychological problems (Alcorn, 1992).

Both the medical and scientific fraternities, according to Arthur (1997) have concluded that women who have undergone abortions suffer from negligible or no psychological effects. On the other hand anti-abortionists claim that women who have terminated their pregnancy experience “post abortion syndrome,” the symptoms of which are guilt, depression, anger, social and sexual dysfunction (Arthur, 1997).

In 1989 an investigation into the methodologies of 76 research studies based on the psychological effects of abortions concluded that pro-choice and anti-abortionists selected cases that favoured their stance to advocate their positions (Arthur, 1997). As a result this was not a true reflection of the psychological effects of abortion, if any, were experienced by women. In certain instances, women had to prove that they were mentally incompetent, to ensure that they could have their pregnancy terminated. Therefore, studies that are in keeping with anti-abortion views were fraught with errors because findings were distorted, small samples were used, no control groups, data was not

effectively analysed and research questions were irrelevant (Arthur, 1997).

One of the shortcomings of research conducted by physicians or scientists was researcher bias (Arthur, 1997). When investigating the psychological effects of abortion on women, they expect women to experience certain symptoms and they inadvertently project it onto the sample. Hence, the researchers predicted far graver emotional reactions by women who had their pregnancies terminated than was actually experienced (Arthur, 1997).

Dagg's (in Forrest, 1994) examination of 225 articles on the psychological effects of therapeutic abortions revealed that only a small number of women experienced adverse emotional reactions after having an abortion. The symptoms that women displayed was usually a re-occurrence of an unresolved situation that happened prior to the abortion. Dagg (in Forrest, 1994) incurred from the study that psychological trauma is caused when women have an abortion for medical reasons, the women have a history of psychiatric problems, the termination occurred in the second trimester and when women experienced difficulty in reaching the decision to have an abortion.

Forrest (1994) a social worker, conducted her dissertation in Groote Schuur Hospital, Cape Town, to determine the need for women to have pre and post-counselling before and after the abortion. The purpose of the study was to compare the levels of psychological trauma before and after the abortion and to establish the needs of the woman for post-counselling. The finding of the study was that the women were able to cope in a healthy manner after the abortion, in the short term. The unplanned pregnancy created a crisis in the life of the women and was only resolved by having an abortion. Finally, women who were offered pre-abortion counselling were able to adapt their lives following the abortion and they did not require post-abortion counselling. Therefore, pre-abortion counselling is an important intervention technique in the abortion process.

According to Davies (1991) feelings per se is difficult to measure quantitatively and therefore the findings of studies examining post-abortion counselling, was not very conclusive. Each woman's experience was unique and different to her individual circumstances (Davies,1991).

## **Social aspects**

### *Social support systems*

When an individual experiences a problem, they usually have an informal network of people whom they can turn to for support and help, like family members, friends, spouse/partner. For a woman forced with an unplanned pregnancy it may not be so easy to turn to significant others for help, for fear of being judged (Davies, 1991). In the study conducted by Faria, Barrett and Goodman (1986) which examined the attitudes, social networks and decision-making process of women who had an abortion, it was found that women consulted informal social networks when contemplating the route to pursue with regard to an unwanted pregnancy.

Women chose different people to talk to based on the level of trust they shared with these individuals (Faria, Barrett and Goodman, 1986). Less than half of the women interviewed turned to their partners for help. It was interesting to note that most of the women relied on the help and support from people other than their family. These people included their friends, partner or doctor (Faria, Barrett and Goodman, 1986). Conclusions reached by Faria, Barrett and Goodman (1986) was that where help was received, it was adequate to make decisions concerning their pregnancy. Those women who did not have support systems turned to professionals for help (Faria, Barrett and Goodman, 1986).

In 1997 following the implementation of the Choice on Termination on Pregnancy Act, No 92 of 1996, the Western Cape Provincial Department conducted a research to investigate the accessibility of services for the termination of pregnancy (Reproductive Rights Alliance, 1997). Data gathered about social support networks revealed that 66 participants did receive help from more than one social support system. More than half of the “women (62%) spoke to their partner, whilst 33% spoke to their family and the other 33% spoke to their friends” (Reproductive Rights Alliance, 1997). Each and every woman confronted with an unplanned pregnancy turned to different support systems because of their individual backgrounds and their relationships with support systems.

## **SUMMARY**

The literature review began by discussing the underpinnings of The Choice on Termination of Pregnancy Act, No 92, of 1996 and its deconstruction to gain a better understanding. It is pertinent that women considering having an abortion, have a thorough understanding of what the Choice on Termination of Pregnancy Act, No 92 of 1996 stipulates, so that they are aware of their boundaries. For women faced with an unplanned pregnancy, knowing their options, is critical to their making an informed decision, with which they are comfortable. The literature revealed that, deciding to terminate a pregnancy, was a complex and difficult choice to make. Finally, the services aspect looked at the bio-medical, psychological and social implications of having an abortion. The literature review examined the process involved in women deciding to have an abortion and services needed for its effective implementation.

The following chapter deals with the research methodology.



## **CHAPTER THREE**

### **METHODOLOGY**

In this chapter the sample, sampling techniques and the research process are discussed. The research methodology, data analysis, validity and reliability of the study as well as limitations of the study are included in this chapter.

#### **SAMPLE**

The researcher while formulating and developing the research topic, anticipated a problem regarding access to women who had their pregnancies terminated so as to gain their consent to participate in this research. Termination of pregnancy is a highly sensitive and emotional issue and women who had an abortion are less likely to share their experience with a stranger. The researcher was at a disadvantage in that she was not employed in a clinical setting and, therefore had no contact with women who had abortions. Consultation with the researcher's supervisor revealed various possibilities, some of which were followed through. It was suggested that the participants could be accessed from the various tertiary institutions in Durban by placing advertisements on student notice boards. Letters were sent to the heads of various health institutions to gain their permission to ask women who utilized termination of pregnancy services if they would consent to participating in the interview.

Data for this research were gathered from 13 female participants who had terminated their pregnancies between 1997-1999 according to the Choice on Termination Act, No 92 of 1996. The 13 participants had received treatment from various health institutions in and around Durban. Three participants received treatment from Addington Hospital, one from King Edward Hospital, one from Prince Mshiyeni Hospital, five from Marie Stopes Clinic, one from Chatsmed Hospital and two participants received treatment from private

general practitioners and Addington Hospital for the completion of terminations.

### **Sampling technique and procedure**

The population of this research includes all women who have legally terminated their pregnancies from the 1 February 1997 in terms of the Choice on Terminating of Pregnancy Act, No 92 of 1996. Non-probability purposive sampling method was used in this research. According to Marlow (1993) purposive sampling enables the researcher to choose the sample in relation to the issue being studied. The disadvantage of this type of sample is that it does not allow for the generalizing of data since the sample is not truly representative of the population. The advantages of purposive sampling is that it is cost effective, not complicated and can be done spontaneously (Bailey,1982).

The researcher realized that due to the sensitive nature of abortion women, who had their pregnancies terminated would not be willing to participate in a research study. Since the researcher had no contact with women who have had abortions, one of the ways to gain consent from these women was by using typical case sampling. According to Marlow (1993) typical case sampling “is when typical cases can be found by consulting with relevant groups” (p.142). After writing to various health institutions surrounding Durban, the researcher was provided with permission from Marie Stopes Clinic and Addington Hospital to recruit participants from their organisations.

Another way of selecting purposive sampling was to recruit participants through the medium of advertising. According to Padgett (1998) advertising is a purposive sampling technique and can be used to recruit elements of a vulnerable population. The researcher placed advertisements in the local newspaper and in female toilets on campus's to access women who had an abortion, to be interviewed for the research. The reason for placing the posters in the female toilets was to ensure privacy to potential participants. Initially it was estimated that the size of the sample would be between 10-20 participants. A small

sample was decided upon because intense rich data were required for the research. The total number of women who participated in the research was thirteen. Padgett (1998) stated that in qualitative research, the size of the sample “can range from one to as many as the researcher requires” (p.52). The age of the participants ranged between 19-31 years and the geographical area was Durban and the surrounding areas.

Posters were placed in the University of Natal, Durban, University of Durban-Westville, University of South Africa, Natal Technikon, Berea and M.L. Sultan Technikon. No participants were recruited from the University of Natal, Durban and the University of South Africa. Of the five participants recruited from tertiary institutions, three were from Natal Technikon, one from the University of Durban-Westville and one from M.L.Sultan Technikon. One participant responded to the advertisement placed in the Sunday Tribune.

Letters (see appendix B) were sent to King Edward Hospital, R.K. Khan Hospital, St Augustines Hospital, Addington Hospital, Amalgamated Hospitals Limited, Entabeni Hospital and Marie Stopes Clinic. Out of these various institutions, only Addington Hospital, R.K. Khan Hospital and Marie Stopes Clinic responded positively. R.K. Khan Hospital allowed the researcher to place posters in the gynaecology ward.

The manager at Marie Stopes Clinic decided that the nurses would inform clients of the research during pre-counselling and if the client wished to participate in the research she would write down a contact number. The researcher had to visit Marie Stopes Clinic frequently to see if any clients were interested in participating in the research. Two participants were recruited from Marie Stopes Clinic. The population of women who terminated their pregnancies at Marie Stopes Clinic between January-December 1999 was 1870.

Five participants were recruited from Addington Hospital. The population of women who had been provided with abortions at Addington Hospital between April-December 1999 was 141. At Addington Hospital the nurse on duty asked women who had undergone the abortion procedure if they wanted to participate in the research.

Participants who responded to the posters from the various tertiary institutions and the newspaper advertisement, telephoned the researcher to enquire about the research. The researcher explained what the purpose of the research was and the reasons for conducting the research. The researcher assured the women that if they decided to participate in the research their names would not be asked to ensure their confidentiality and anonymity. Also the researcher read out some of the questions to the women to see if they would be comfortable with the type of questions being asked. A similar process occurred when the researcher telephoned clients from Marie Stopes Clinic who left their contact numbers, as an indication of their interest, in the research.]

The researcher obtained permission from participants to use a tape-recorder during the interview. The researcher explained the need for a tape-recorder because of the voluminous size of the data and the contents of the tape would be erased once the information were written down. According to Gochros (1981) if tape-recorders are used, participants must be made aware and they may or may not consent to its use. All participants agreed to the use of a tape-recorder during the interview. Tape-recording gathers information accurately and precisely (Gochros, 1981).

The location of the interview was negotiated and decided upon by the researcher and the participant. Deciding where to conduct the interview will depend on what is available or in which location the participant feels comfortable being interviewed (Gochros, 1981). Five interviews were conducted in Addington Hospital, five in enclosed study rooms in tertiary libraries and three interviews were conducted in the Art Gallery in City Hall. Except for the interviews that occurred in Addington Hospital, neutral settings were

chosen by participants because no one knew their identity.

## **DATA COLLECTION INSTRUMENTS AND PROCEDURES**

Interviews were conducted with 13 participants between 20 April 1999-17 September 1999. It was not easy for the respondents to decide to participate in the research since it would mean reliving painful memories. The duration of the interviews lasted between 30-40 minutes. The participants did not display any reluctance to speak about their experience, once they decided to participate. Most of the participants required very little prodding and were willing to talk about their experiences regarding the services they were provided.

The semi-structured interview was used to obtain data for this study. The semi-structured interview was the most appropriate data collection instrument for the research since it yielded rich descriptive data.

According to Marlow (1993) semi-structured interviews allow the interviewer flexibility and it can be accompanied by an interview schedule. Marlow (1993) identified the following advantages and disadvantages of semi-structured interviews which were evident in the present study. If the participants experienced difficulties in understanding the questions, the interviewer rephrased the question or simplified the question so that clarity was gained. The response rate of semi-structured interviews was high. It allowed for more open-ended questions but this required more time for analysing the responses. The negative aspects of the interview was that it was very expensive with regards to costs and time. According to Bailey (in Grinnell, 1981) there are four central disadvantages of interviews: respondents may intentionally be dishonest because they do not know the answers, they may make mistakes without admitting it, may provide incorrect answers because they experience difficulty in understanding the question and finally the respondents may be unable to recall their memories.

The semi-structured interview schedule creates a natural situation in which to conduct interviews (Gochros, 1981). Participants are comfortable and at ease answering questions verbally than writing the answers down. It also accounts for people who can not read or write. Gochros (1981) stated that “semi-structured interviews are used for participants who have shared a common experience” (p.262). With regard to this research the participants have shared a common experience, that is, they have all terminated their pregnancies.

According to Gochros (1981) interviewers are more likely to get better results from the same sex participants. In this research both the participants and the interviewer were females. It is important that the interviewer speak the same language as the participants. In this research because the interviewer was only able to communicate in English, only English speaking participants were interviewed with all racial groups. The researcher recognised that this affected the type of data that were collected from participants who were unable to communicate well in English. However all the participants were to some degree able to speak English.

## **Semi-structured interview schedule**

The researcher used one semi-structured interview schedule (see appendix A) to gather data from the participants. The interview schedule comprised a set of questions which helped to guide the researcher during the interview.

The semi-structured interview was designed keeping in mind the objectives of the research. The interview was conducted in English. The researcher designed the semi-structured interview schedule. Various techniques were employed during the formulation and implementation of the semi-structured interview schedule. The researcher used the funnelling technique when asking the participants questions. The funnelling technique allowed the researcher to start with broad questions and then proceed to narrow/specific questions. Rapport was achieved between the participant and the interviewer because of this technique. Questions that were specific and easy to answer were asked first such as background information (age, marital status, occupation and religion/culture). Open-ended questions which required considerable thought and which covered sensitive issues were asked in the latter part of the interview. Questions followed a logical manner (Gochros, 1981).

This researcher used probes during the interview. The purpose of probes was to gain a detailed understanding or clarity about the information. Bailey (in Grinnell, 1981) suggested the following ways in which probes can be used:-

- repeating the question if the respondent appears unsure;
- repeating the answer if the interviewer requires clarity from the respondent;
- the interviewer indicating that he/she has understood what has been said and cues the respondent to continue;
- neutral questions such as “tell me more” or “what do you mean” will encourage more information from the respondents and

- if the answers appear to be incomplete then the interviewer should pause and allow the respondent to continue.

When designing the interview questions, the language must be simple, double barrelled questions should be avoided, double negatives should be avoided, biased responses should be discouraged, interviewer bias should be avoided and respondents answers should be reinforced (Gochros, 1981).

The semi-structured interview was divided into five sections namely: background information, decision-making, abortion process, post abortion process, perceptions and recommendations.

Section A which dealt with background information required the participant's age, marital status, occupation and religion/culture. According to Patton (1987) background information provided insight into the participant's identifying details. These questions allowed the researcher to view the participant in relation to other people (Patton, 1987).

The researcher then asked participants what happened once they discovered they were pregnant. The open-ended nature of the question allowed the participants to tell the researcher about their experience about having an abortion. According to Patton (1987) experience/behaviour questions enquires about what "a person does/has done" (p.115). The purpose of these types of questions is to get the participant to paint a detailed picture of the entire experience (Patton, 1987).

The semi-structured nature of the interview served the researcher's need more than the participant. It allowed the researcher to ask certain questions during the interview which were not covered by the participants.



Feeling questions were asked about strategic points during the interview like when the participant found out about her pregnancy, how she felt about making the decision to abort and how she felt after the procedure. According to Patton (1987) these questions were asked to gauge the interviewee's emotional state in preceding situations. Feelings originated internally and they were a natural aspect of being a human (Patton, 1987). Feeling questions warrant "adjectives responses" (Patton, 1987, p.118). The feeling questions allowed the researcher to measure whether or not the participant was comfortable about their decision to terminate their pregnancy.

In order to ascertain the procedural aspects of having the abortion, knowledge type questions were asked. Knowledge questions provided factual information (Patton, 1987). Questions were asked by the researcher about the type of services women requiring termination of pregnancies were provided and the criteria that women must satisfy in order to be provided with termination of pregnancies, the cost of treatment, as well as the accessibility of services.

Finally, the researcher asked opinion/beliefs questions to elicit responses from participants concerning their perceptions about termination of pregnancy services. Opinion/beliefs questions enables the researcher to make sense of how the participant thinks and processes information (Patton, 1987). The research was also concerned with the availability of termination of pregnancy services that existed. Hence, by asking questions some information regarding the accessibility of services was ascertained through participant's sharing their experiences.

## DATA ANALYSIS

Data were analysed qualitatively in chapter four and chapter five. Interviews with the 13 participants were presented in case profiles which generated themes such as background information, the types of services available, perceptions of services and suggestions for improving services.

According to Ruckdeschel, Earnshaw and Firrek (1994), clients have been central to social work research, yet scant attempts have been made to truly understand the world in which clients come from. Case studies were used to organise and record the interview data. Patton (1987) defined case study as “individuals, groups, communities significant events or programmes” (Patton, 1987, p.147). Gilgun (1994) stated that data collected from case studies can be used to understand how stages in processes operate or to understand the situation in relation to its environment. The use of the case study method was to facilitate the in depth collection of data and not to generalise the findings. The case study method was chosen for both its intrinsic and extrinsic value.

The purpose of case study was to represent the case not the world (Stake, 1994). Collective case study was used to examine one issue by using more than one case. The researcher studied 13 cases of women, who utilized termination of pregnancy services, to gain insight into the process, describe their experiences, to determine the nature and accessibility of abortion services. The recording of cases profiles in chapter four revealed diversity and uniqueness of each case as well as certain commonalities.

Patton (1987) recommended that when analysing case study data, first, each case should be understood separately and holistically. Thereafter, comparison can be drawn between cases to establish themes and categories.

Following the case profiles in chapter four a descriptive discussion and analysis is followed in chapter five. Patton (1987) suggests that the researcher must attempt to create a balance in the description which will lead to interpretation. “Detailed descriptions and in-depth quotations are the essential qualities in qualitative reports” (Patton, 1987,p.163).

Bolgar (in Shaughnessy and Zeichmiester, 1990) stated that “ the power of a case study lies in its ability to open the way for new discoveries”(p.300). It is used in studies where information about the issue being studied is scarce (Shaughnessy and Zeichmiester, 1990). Data that result from case studies may lead to improvements like new programmes or adjustments to programmes, (Shaughnessy and Zeichmiester, 1990). Case studies create opportunities to study rare phenomena, (Shaughnessy and Zeichmiester, 1990). No research from the South African context had looked at the experiences of women who terminated their pregnancies according to the Choice on Termination of Pregnancy Act, No 92 of 1996. Therefore case studies was an appropriate technique to use in this study since the issue of the abortion experiences was not explored.

## **VALIDITY AND RELIABILITY OF THE DATA COLLECTION TOOL**

Data collection instruments need to be valid and reliable if the data collected are deemed to be worthy. Bailey (1982) stated that validity tests whether an instrument measures what it sets out to measure and if the measurement is correct. Reliability, according to Bailey (1982) tests whether the instrument produces the same results time after time.

The possibility exists that the semi-structured interview schedule may not yield valid results. Interviewees may provide untruthful data when they provide answers that are socially acceptable but not true in their circumstances or they may be embarrassed to admit to the interviewer that they do not understand the question (Bailey, 1982). By asking the participants about their perceptions of abortion services, the participants were likely to provide socially acceptable answers due to their feelings of gratefulness towards service providers, without whom they would not be able to have an abortion.

This, however did not occur in the research because the researcher was able to encourage the participants to feel comfortable so that they could share sensitive and personal details about their abortion experience. The reasons for the participants providing accurate accounts of their experiences can be attributed to the researcher being a female, in the same age group as most of the participants and more importantly that the researcher was not seen in an authoritative light. The participant-researcher relationship was equal because the participants were not threatened by the researcher's position. Most of the participants were students and could identify with the researcher being a student. The students who volunteered to participate in the research indicated that they responded to the advertisements because they understood how difficult it would have been for the researcher to access women who have had abortions because of the ethical issues attached to it. The researcher emphasised prior to the commencement of the interview that the participants names were not required for the research and they could choose not to tell the researcher even their first names. Some of the participants gave their first names

whilst others chose not to but this did not stem the flow of information. Another reason that rich information was generated was that the research did not address the moral, ethical and religious debates surrounding abortion. In fact, some of the participants felt so at ease during the interview that they entered into a moral debate on their own accord. The friendly demeanour of the researcher helped the participants to feel at ease during the interview.

When interviewees are asked about past events, there is a tendency to provide incorrect data possibly as a result of forgetfulness. Yet, when participants are asked about current events they are more likely to provide correct data (Bailey, 1982). Out of the thirteen participants, three participants had their pregnancies terminated in 1998 whilst two participants had an abortion in 1997. These five participants had to recollect their experience since the abortion occurred more than a year ago.

According to Bailey (1982) the interview was considered more valid than the mailed questionnaire. This can be attributed to the interviewers control over the interview. The interviewer ensures that each question is answered and if the answer appears irrelevant, then the interviewer can re-phrase the question to ensure relevant answers are provided (Bailey, 1982). The interviewer can also jeopardise the data gathered if he/she introduces biases or errors during the interview. According to Bailey (1982) the interviewer can cause the responses of the participants to be biased if he/she misinterprets the response. To avoid misinterpretation during the interview, the researcher asked the participant if her understanding of what was being said was what the participant meant. By tape-recording what was being said in the interview and transcribing the data, the researcher was able to avoid ignoring certain data that were not similar to the researchers beliefs. Researchers bring their own perspective into the research and these views can influence the researcher's interpretation of the data (Gilgun, 1994). The researcher was also able to control researcher bias during the interview by not interrupting the participants during the interview and offering her perspective of the treatment received. The researcher did not

ask leading questions which might have projected her views on the participants response.

In qualitative research often what is required is people's feelings and perception of issues. In this sense it is difficult when the same research is replicated over time to achieve the same results because people think and feel differently. It is possible to maintain some degree of reliability by asking the same questions over time.

## **LIMITATIONS OF THE STUDY**

1. The inability of the researcher to communicate in other languages posed an understanding problem in certain interviews where the participant was not English speaking. The researcher was unable to retain the services of an interpreter due to financial constraints.
2. Subjective bias may have occurred by excluding service providers. There is no way of establishing whether or not accurate accounts of the abortion experiences were presented by the participants.
3. Even though open-ended responses were required from the participants, the design of the interview schedule which was semi-structured was devised to obtain an account of the experiences of the participants. Sometimes participants did include religious/moral beliefs.
4. Since the research sought women who had already terminated their pregnancies, it meant that they probably had no further use for such services from hospitals or clinics. This presented a problem in recruiting the participants.

5. Abortion is an issue shrouded in secrecy and is considered taboo. Women who had terminated their pregnancies were naturally reluctant to speak to a stranger (researcher) about their experience for fear of being judged by the researcher. The participants understandably took a long time to decide whether or not to participate in the research.

The next chapter includes case profiles of the 13 participants, followed by descriptive analysis and discussion of data in chapter five.

## **CHAPTER FOUR**

### **CASE PROFILES**

In this chapter the cases will illustrate the process that participants followed in order to be provided with abortion services. Common themes that occurred throughout the case profiles were the discovery of their pregnancy, treatment by the general practitioner, the social support systems that the participants confided in before the abortion as well as after the abortion, the decision-making process, the actual abortion procedure and their feelings after the abortion. To protect the identities of the thirteen participants, they were given fictitious names. The participants were not given the name of the abortion procedure that was performed on them. The researcher received this information from the nurses at the various health care facilities accessed. In Marie Stopes Clinic the manual evacuation technique was used whilst in the public hospitals, misoprostal tablets were issued to the participants to induce abortion and the technique used to complete the abortion was manual vacuum aspiration.



## ANN

Ann was a 19 old student who discovered that she was pregnant by visiting McCords Hospital, with her mother for the treatment of an ulcer. Ann was shocked and cried uncontrollably when she learnt of her pregnancy. She was embarrassed and ashamed of the disappointment she caused her mother. It was difficult to accept that she was pregnant and she questioned the validity of the test results, but the doctor assured her that the test was correct. At the time of conception, Ann and her boyfriend had not used contraceptives. Ann did take the morning after pills to safeguard herself from an unwanted pregnancy. The gestational period of the pregnancy was less than eight weeks.

Ann rejected the doctor's offer to inform her of her options. She decided at that moment that she was going to have an abortion. Time was not going to alter her decision because she knew that if she fell pregnant accidentally, she would have an abortion. The doctor provided her with names of health care facilities that performed abortions.

Ann's mother was the only person, other than the doctor who knew of her pregnancy. Her mother's belief about abortion was that it was a wrongful act but she compromised her beliefs by supporting her daughter's decision to have an abortion. She transported Ann to Marie Stopes Clinic the same day and paid for the cost of treatment, which was between R700-R900.

Ann was able to reach a decision immediately, about having an abortion because she did not consider the foetus as a baby and therefore, did not have feelings towards it. She was afraid of her fathers reactions if he found out that she had fallen pregnant. Other factors that influenced her to have an abortion was the disruption of her education, her family's and society's reaction to her pregnancy out of wedlock.

She knew how abortions were performed from the videos she was shown at school, which she regarded as being disgusting. She was aware that abortion on demand was legal in South Africa.

Treatment at Marie Stopes Clinic began with the nurse giving Ann pre-counselling. The nurse questioned Ann about her decision. She enquired if Ann's boyfriend was aware of her pregnancy to which Ann replied, she was "not concerned about his opinion." Ann sensed that the nurse wanted to scare her into changing her mind but this tactic was ineffective. No questions of a personal nature was asked and she was warned about the dangers of AIDS. The session ended with a pelvic-vagina examination which caused Ann some discomfort. Ann's assessment of the nurse was that she did not move beyond the boundaries of her prescribed role.

Forty five minutes later, Ann was provided with a gown and led with other women, to a room, where she waited for her name to be called. The atmosphere in the waiting room was filled with tension. Another nurse led her into the operating room and offered to hold her hand during the procedure. The friendly demeanor of this nurse had a calming effect on Ann. Ann was told that the procedure was not too painful. When the male doctor entered the room he greeted her in a friendly manner. Ann appreciated the fact that he knew her name. She was instructed to place her legs in the stirrups and not to look at the contents in the dish. Whilst performing the procedure, the doctor explained the procedure. Ann knew that she could change her decision at the last moment and could ask questions if she had any. According to Ann forceps were inserted into her to widen her cervix and a steel tube was used to suck out the contents. The pain was unbearable and Ann screamed out in pain. She was shouted at by the doctor to lie still, as he would not deal with her screaming. The procedure lasted four minutes.

She was immediately asked to leave the room following the procedure but experienced difficulty in walking because of the intensity of the pain. She was led into a recovery room, where she was given two painkillers and rested on a dentist-like bed. The bed was not suitable for relaxing and ensuring the ease of the pain. The pain subsided in ten minutes and Ann left. She declined post-counselling and was told to return for a check-up in two weeks.

Ann did not expect to experience pain and thought that the process would last longer. The physical check-up consisted of her urine being tested to determine if there were any remains of her pregnancy and information on the use of contraceptives.

Ann expressed relief after the abortion. There were no regrets about her decision but she was not keen on facing her mother.

Later that day, Ann telephoned her best friend to share the news of the abortion. Her best friend was shocked about what Ann told her. She told Ann that she would have had an abortion if she was confronted with a similar fate. It was apparent to Ann that her friend did not know what to say and speaking over the telephone was restrictive. Her friend was neither judgmental nor supportive and Ann wanted her friend's approval as well as physical support.

The next day Ann's boyfriend was told of her actions. He was shocked about Ann's decision and angry that she had not told him earlier. Later he felt guilty about the hardship she had to endure and treaded carefully so as not to upset her. In the end he realised that having an abortion was the right decision. Their relationship ended amicably.

## **BETH**

Beth was a 30 year old professional woman who visited her doctor to determine the nature of her illness. The news of her pregnancy was unexpected. She reacted with shock about her unplanned pregnancy. Her pregnancy presented a huge disruption to the stability of her life. The gestational period of her pregnancy was between four to six weeks..

Beth informed her doctor that she did not want to have a baby. He gave her the name of Chatsmed Hospital, which is a private health care facility. Initially, the doctor made Beth feel comfortable but after Beth informed him of her decision to have an abortion, his treatment became hurried. Beth felt that his understanding of the Choice on Termination of Pregnancy Act, No 92 of 1996 was limited and he did not show any initiative to find places that offered abortions at cheaper rates.

When Beth informed her brother of her decision to terminate her pregnancy, he displayed support. He understood her reasons for not wanting to keep the baby. Beth's brother financed a portion of the expenses for the abortion procedure and transported her to the hospital on the day of the procedure.

Beth's partner reacted angrily upon learning of her decision to have an abortion. An argument ensued and he wanted to change her mind regarding her decision. She explained her reasons for wanting to have an abortion and he later accepted her decision. Beth's partner provided the balance of the abortion expenses.

At the time of the abortion, Beth was a student, not working and therefore, financially insecure. She was not emotionally committed to her partner, whom she considered a friend. Beth was afraid of her family's reactions to her pregnancy out of wedlock. She was also previously married. Beth felt guilty and ashamed about her decision to have an abortion.

She was aware that abortion on demand was legalised. Her attitude toward abortion was that it was a wrongful act based on her religious beliefs and it is an issue surrounded by secrecy. Beth did not have an understanding of the abortion procedure.

An appointment was required by the hospital to schedule the procedure. The hospital's management section seemed only interested in the payment of expenses in full, before the treatment could be provided. An internal examination occurred on the day of the abortion to confirm her pregnancy. The examination was conducted by the female doctor who was also performing the abortion procedure. The attitude of the doctor was cold, mechanical and gave Beth the impression that she was doing Beth a favour by performing the abortion. Beth could sense that the doctor was judgmental of her decision. The doctor offered no explanation of the procedure and the risks involved and neither did Beth ask any questions, considering that she had no understanding of the abortion procedure. The anaesthesiologist appeared friendly. The duration of the process was two hours and Beth experienced no physical pain when she was awoken. No post-counselling was offered by the staff. Beth did not know what to expect since no information was forthcoming from the doctors.

Following the abortion, Beth felt ashamed and guilty about her decision. She interpreted her decision as killing a life. Beth expressed her emotions by crying constantly. She regretted her decision to end her pregnancy.

The feeling of guilt and regret Beth experienced caused her to seek informal counselling from her pastor. Counselling took place over one or two sessions. Her pastor was not judgmental towards her. His attitude towards her was responsive, positive and compassionate. Beth was able to share this information with her pastor because of the trust they shared. The counselling included praying with Beth for forgiveness. This allowed Beth to release some of her guilt. She learnt to deal with her actions but was unable to forget her experience.

## **CARRIE**

Carrie was a 25 year old student, who took a home pregnancy test because of the physiological changes she was experiencing. She reacted with shock about her unplanned pregnancy because the timing was inappropriate. Confirmation of her pregnancy was done at Marie Stopes Clinic but they were unable to detect the gestational period of her pregnancy. The nurse at Marie Stopes Clinic informed Carrie that they charged R770 for abortions, which was too expensive for Carrie. Carrie asked the nurse to refer her to a place where abortions are performed at lower prices. They informed her of a private doctor who charged R350 to perform abortions. This price was also beyond Carrie's financial scope. Carrie was eventually referred to Prince Myshiyeni Hospital by a friend. No pre-counselling was offered by the nurse at Marie Stopes Clinic. Carrie was merely asked what direction she was going to pursue, regarding her pregnancy. She informed them that she was going to have an abortion.

At first Carrie's boyfriend rejected her decision to have an abortion. When Carrie explained that she would not be able to maintain the child, her boyfriend understood and accepted her decision.

The decision to have an abortion was made entirely by herself but she felt guilty about her decision. Carrie's reason to have an abortion was financial constraints, she was a student as well as being parent to her three year old son.

Carrie only knew that abortions were legal. She did not know the procedure involved and was under the impression that this information would be provided at the hospital.

The cost of the abortion at Prince Myshiyeni Hospital was R9 only but travelling however was expensive. She had to travel between Chesterville and Umlazi for ten days. This included four trips a day using public transportation.

When Carrie arrived at Prince Myshiyeni Hospital, she was asked the purpose of her visit by the clerical staff. Carrie was not comfortable disclosing this information to a stranger since having an abortion would become public knowledge to the hospital staff. She was instructed to go to the gynaecology ward, where a nurse enquired about her reasons for having an abortion. The nurse told Carrie that having an abortion was a traumatic experience. Carrie was questioned in the presence of another nurse, which caused Carrie to feel hurt by the lack of privacy shown to her and other women who requested an abortion. She had to adapt to the situation by not complaining and acting grateful for the services offered by the hospital. Carrie was able to take comfort in the fact that she was not the only woman treated in this manner. No information was provided about the procedure. The purpose of Carrie's visit to the hospital was to determine the gestational period of her pregnancy. The ultra sound machine was not working so she had to return two days later. It was frustrating to come in every day and be told that the scanner was not working. In one incident, Carrie was told by the nurse to go to the emergency room, which was equipped with a scanner. Upon arriving at the emergency room, Carrie was curtly told by the nurse on duty that her situation did not constitute an emergency. Carrie was deeply affected by this incident and it compounded her feelings of guilt.



When she was eventually scanned it revealed that she was eight weeks pregnant. In order to be provided with an abortion at Prince Myshiyeni Hospital, women must be under thirteen weeks pregnant. Waiting to be scanned took three hours. The following day Carrie had to submit her blood to be tested for reasons unknown to her. Misoprostal tablets were given to her the next day to induce the miscarriage. The nurse provided her with six tablets and instructions on how to administer them, which Carrie found not clear.

Carrie administered the tablets on her son's birthday, which was symbolically significant. She had to display discretion when taking the tablets since none of her family were aware of her decision to abort her pregnancy. Three tablets were taken orally and three hours later four tablets were taken vaginally. The nurse told her that she might see her foetus. At 4.a.m she began bleeding and discharged her foetus. She examined the foetus carefully before wrapping it in toilet paper and placing it in the bin. At this stage Carrie was over come with guilt.

She went to the hospital in the morning and was referred to a social worker, who took down her personal details. The social worker was pre-occupied with other activities, whilst colleagues were in and out of her office constantly. According to Carrie, the social worker did not appear concerned with Carrie's predicament.

Thereafter, Carrie was led to the gynaecology ward where she was internally examined by the attending doctor, which caused Carrie some discomfort. The doctor enquired if Carrie had discharged her foetus, to which she replied yes. She was told to place her legs in the stirrups. The nurse appeared impatient in her treatment of Carrie. She was verbally abusive and judgmental towards Carrie which made Carrie feel more guilty. Carrie regarded the doctor's treatment as being "nice" because he made her feel comfortable and told her to relax prior to the procedure being performed.

The abortion method which was used was the manual vacuum aspiration technique. The pain she experienced was unbearable. The procedure lasted about two minutes. No post-counselling was offered. Carrie was given nothing to ease the pain. She had no expectations of the procedure because she was not given any information. The duration of the entire process was seventeen days.

Carrie felt angry after the process, at the treatment she received from the nurses. She was also feeling guilty. Carrie told her family (sister and mother) that she had an abortion. They offered her support during this difficult period. She was made to feel as if she had made the right choice. Although Carrie can talk about her experience the memory is not pleasant.

## **DORRIS**

Dorris was a 21 year old student, who immediately informed her boyfriend about her suspicions that she might be pregnant. She visited her general practitioner who confirmed her suspicions. Her gestational period was two weeks. Dorris felt bad when her worst fears became a reality. The doctor instructed Dorris to terminate her pregnancy, which caused Dorris to become angry because he had no right to tell her what to do. The doctor was neither friendly nor warm and he did not discuss with her what her options were at this stage. He referred her to King Edward Hospital for further treatment.

Dorris took three months to decide what route to pursue. She consulted with her boyfriend about the decision but she ultimately made the final decision. Dorris grappled with the decision to have an abortion because she would have liked to have the baby. Her reasons for deciding to have the abortion were as follows: her young age, having a baby would disrupt her education, she was financially insecure, she had proven to be a disappointment to her parents and was a member of a church choir. During this period Dorris felt depressed, moody, alone and withdrew from people. Dorris' boyfriend was confused about whether Dorris should keep that baby or not. In the end he supported Dorris' decision and was concerned about the disruption of the pregnancy to her studies.

She expressed difficulty in telling her older sister, whom she lived with, about her pregnancy because her sister had a baby as a young girl and would have been disappointed with Dorris' reckless behaviour. According to Dorris, her sister would have felt that she had failed in her duty as an older sister, to protect Dorris from making the same mistake.

Her mother broke down in tears when Dorris told her of her unplanned pregnancy. Dorris' father later learned of her pregnancy when she returned home for the holidays. Both her parents, discussed with her at length, the positives and negatives of having a baby. Ultimately the final decision lay with Dorris and they indicated that they would support whatever decision she chose.

Dorris knew that abortions were legalised because her friend had an abortion. She informed Dorris that she was provided with post-abortion counselling. Dorris' understanding of the abortion procedure was vague.

On her first visit to King Edward Hospital, Dorris was issued a termination of pregnancy card by a nurse who sensed that Dorris was depressed and gave her an earlier appointment. Dorris ensure that she arrived early on the day of the appointment because they operated on a quota system of accepting not more than ten women a day for termination of pregnancies. On this particular occasion Dorris, together with six other women were selected, on account, of their arriving first. While waiting to be treated Dorris developed a bond with the other women, by sharing their experiences. Dorris was overcome with relief, following her discussion with these other women because she realised that by telling her parents of her decision to have an abortion, she did not have to shoulder any more guilt than she already felt.

After being selected she was led by a nurse into another building that served as a clinic. When the women entered the clinic, they were stared at and cynical remarks were directed at them, by the nurses. The nurses told the women directly to their faces that they were abusing the Choice on Termination of Pregnancy Act, No 92 of 1996. According to Dorris this was an incorrect assumption because each woman's situation is different. Thereafter, an internal examination was conducted on Dorris, by a doctor, which caused her discomfort.

The nurse recorded Dorris' personal information, like age, occupation, contraceptive history, number of abortions and reason for having an abortion. Dorris assessed the attitude of the nurse as being judgmental because she labelled Dorris as being promiscuous. No privacy was shown to Dorris during this question and answer session and it was conducted while Dorris was standing.

Dorris returned the next day for pre-counselling which comprised of two components. In the first component, she was spoken to on an individual level. Dorris felt as if she had to justify her reasons for having an abortion, to the nurse offering the counselling. She was made to feel guilty by a judgmental and unfriendly nurse. The nurse did not explore Dorris' feelings surrounding her decision to have an abortion. In the end Dorris was asked to sign a consent form.

The second component of the pre-counselling, involved all the women sitting in a large room and the nurse explaining the termination procedure, in a lecture type style. The risks were briefly stated and the women were prepared to expect the procedure to be painful. First three pills (misoprostal) had to be taken followed by another two pills eight hours later. After the pills were taken, the women had to return to the hospital to remove any excess contents of the pregnancy. Dorris asked many questions during this session because the nurse spoke in Zulu and Dorris was not Zulu speaking.

Dorris had to administer the tablets on five occasions, over a two week span, because they failed to take effect. She had to return to the hospital on five occasions to receive more tablets and it meant that her time was being wasted. Dorris became anxious when the tablets failed to work because her pregnancy was progressing further along. However on the fifth occasion, Dorris began to experience abdominal pains. When she returned to the hospital, the doctor made the decision to surgically remove the contents of the pregnancy because her pregnancy had terminated but he was unable to determine why the contents were not being discharged. As the time neared for Dorris to have her foetus removed she became scared.

The procedure took place in an enclosed room. Dorris was instructed to sit on the bed and place her legs on the stirrups, by the doctor. The manual vacuum aspiration technique was used to remove the contents of the pregnancy. The doctor administered local anaesthesia to Dorris and told her to relax. During the procedure the doctor explained his actions but Dorris was too scared to concentrate on what was being said. Even though she was given anaesthesia, the pain was unbearable. She wanted to pull away but decided against this. The procedure lasted twenty minutes and Dorris was kept under observation before discharge.

Dorris recalled that she felt relieved that the procedure was finally over but also guilty about feeling relieved. After the procedure Dorris experienced abdominal pains so she telephoned the hospital who assured her that this was a normal occurrence following an abortion. Dorris' expectation of the procedure was that it would be performed on the first day, on her arrival at the hospital. No post-counselling was offered to Dorris. The cost of the treatment was free and travelling did not pose a problem for Dorris because she lived near the hospital.

Her boyfriend felt guilty for not being with her during the procedure and was apologetic. Dorris refused to dwell on her experience anymore and wanted to move on with her life.

Dorris' sister provided her with support by telling her that if she had a baby at this stage of her life, she would not enjoy the experience because she is not financially secure. Today, Dorris thinks she made the right choice.

## **ELAINE**

Elaine is a 21 year old single parent of a four year old boy and was residing with her mother because she did not work. When she missed her period, she thought that she might be pregnant. Her boyfriend went to his general practitioner and asked for medical advice on the matter. His doctor told him that Elaine needs to send a sample of her urine to be tested. The test revealed that Elaine was pregnant. Both she and her boyfriend were shocked to discover that she was pregnant and they were confused on what should be done about the unplanned pregnancy. Elaine's boyfriend would have supported whatever decision she would have made. They made a joint decision to terminate the pregnancy, since they were both single parents and Elaine did not work and lived with her mother. It would be a financial strain for both Elaine and her boyfriend to maintain another child. Also Elaine felt it would be selfish to burden her mother with more responsibilities. On an emotional level, Elaine was scared that if she did not have the child with her boyfriend, he would abandon her and another one of her children would be without a father.

Elaine believed that having an abortion was a sinful act, which stemmed from her religious beliefs and she had never considered having an abortion. She knew that abortion was legal but did not know the procedural aspects of abortion.

Elaine's treatment was paid for by her boyfriend who had a medical aid scheme and did not know the expenses incurred from the medical treatment. At Addington Hospital she paid only R9 for the treatment and Elaine's boyfriend transported her to his general practitioner's office and Addington Hospital.



Elaine received treatment from the general practitioner and later at Addington Hospital. When Elaine arrived at the doctor's office, he enquired her name and how she was feeling. He then performed an ultrasound scan on Elaine to determine the length of her pregnancy, which was eight weeks. The doctor wrote out a prescription for Elaine to buy tablets (misoprostal). He did not inform her of the risks involved in having an abortion, using this procedure. Elaine's boyfriend asked her to question the doctor about any concerns she may have and she replied that the doctor would tell her if there was something she needed to know. However Elaine hoped that the doctor would seize this opportunity to explain the procedure, so she could change her decision to have an abortion but the doctor never explained how the foetus would be terminated. He told Elaine to expect bleeding to occur three days after the tablets were taken. According to Elaine, the doctor made her feel comfortable during the consultation and examination.

Elaine administered as per instructions orally and vaginally and knew it would take effect immediately. The tablets took effect after a few hours and it seemed unbelievable she would be able to witness the process as it happened. Elaine did not want to have an abortion but the circumstances dictated that she have an abortion. She began bleeding afterwards and discharged a "lump," which resembled a liver. Elaine felt dizzy at this stage. She managed to telephone her sister and told her what was happening. Her sister suggested that Elaine go to Addington Hospital for treatment. Elaine sensed that something was amiss when the general practitioner did not schedule any more appointments for further treatment.

Her boyfriend drove Elaine and her mother to the hospital. Elaine's mother was oblivious to the fact that Elaine was pregnant and that she was having an abortion. Elaine lied to her mother that she was feeling ill. In the trauma room at Addington Hospital, the doctor asked Elaine if she was pregnant in the presence of her mother and Elaine said she was not. When her mother left to attend to administrative aspects (fetching the file), Elaine admitted to the doctor that she was pregnant and in the process of having an abortion. According to Elaine, he was considerate of her feelings because he guessed that her mother was not aware of her pregnancy and did not persist with the issue when her mother was around. The doctor conducted a pelvic-vagina examination on Elaine and told her that she would be admitted to the theatre in the morning.

The completion of the termination was performed by another doctor. Elaine did not feel any pain and nothing was given for her dizzy spells. Her legs were placed in the stirrups by the nurse. Elaine asked the doctor for an explanation of the procedure but an explanation was not provided. The procedure lasted fifteen minutes and was very painful. She was not provided with any post-counselling by the hospital staff.

Elaine did not experience physical difficulties but emotionally she was distraught over her decision to have an abortion. She regretted her decision and if she had more time to think, she would have acted differently. Elaine expected an operation to be performed to remove the foetus. She was not convinced that having an abortion was as simple as taking tablets.

## **FLORENCE**

Florence was a 26 year old student who stopped taking contraceptive pills because it was causing her to break out in pimples and scarring her once pimple free face. So when she missed her period she knew that she might be pregnant because she had not taken any steps to guard against falling pregnant, after she had discontinued taking the pills. She visited her family doctor to find out the reason for the caseation of her period. Florence's doctor conducted a urine test to determine if she was pregnant or not and the results were positive. Florence was angry with herself with allowing an unplanned pregnancy to occur. She reacted to the news with disbelief and felt terrible. The doctor did not explore with Florence the options available to her. Florence informed the doctor that she did not want to have a child at this moment and pleaded with him to arrange an abortion for her. The doctor did not tell Florence the risks and dangers involved in having an abortion but just provided her with a prescription for misoprostal tablets. He told her that if the tablets did not cause the pregnancy to terminate, he would give her a letter of referral to visit a hospital for further treatment.

Florence decided immediately to terminate her pregnancy. She was able to make a decision because her boyfriend had a child out of wedlock, whom he did not care for and she did not want her child to be exposed to a similar fate. Florence did not believe in having children without being married. If she continued with her pregnancy, it would disrupt her studies and she did not want to neglect her education. As a student, Florence did not have financial resources to support a child. Also Florence, as well as her siblings were conceived out of wedlock.

Florence informed her best friend about her pregnancy and her decision to have an abortion. Her best friend told her that women should not have children who were conceived accidentally. Her best friend was in favour of abortion being legalised. Also she brought to Florence's attention the fact that her boyfriend would not care for the child and would continue with his drinking habits.

When Florence's boyfriend was told that she was pregnant, he said he would support whatever decision she made.

Florence knew that a woman would be granted an abortion if she was raped or if she did not have enough money to support the child. Also she was aware that abortion on demand was legalised.

It cost Florence R220 to have an abortion. She visited two general practitioners and had to purchase the abortion tablets (misoprostal). Treatment at Addington Hospital was free. Florence did not live far away from the general practitioners and Addington Hospital so travelling was not a problem.

After being given the prescription by the first doctor, Florence bought and administered the misoprostal tablets but it failed to induce the abortion. Florence chose to go to another doctor after two weeks because she knew that the first doctor would refer her to the hospital. She did not want to go the hospital because she was busy with her examinations. The second doctor prescribed the same tablets but increased the dosage to six tablets. This time when Florence took the tablets, she began to feel pain. She started bleeding but the contents were not being discharged. She returned to the doctor who determined from an ultrasound scanner that her pregnancy was terminated but it was not being discharged. He could not offer her a reason why this had happened and he gave her a letter of referral to go to the hospital so the contents may be extracted.

Florence came on a Saturday to Addington Hospital and the nurse told her to come back on Tuesday. On Tuesday she arrived at the hospital at 5:45a.m. but was attended to at 11:30a.m. She was sent to gynaecology, to the causality ward, to Poly Clinic and back to gynaecology. Florence was angry at being sent all over the hospital. Finally, she saw the doctor and showed him the letter of referral. He tested her urine and then admitted her to the hospital. According to Florence, the doctor appeared cold and not concerned with her. However, the nurse appeared “nice” to Florence. The completion of the termination was painful when the doctor inserted the instruments into her and removed the contents. The process lasted fifteen minutes. The time span of the entire process was eight weeks. The doctor told her that if she bled profusely, she should return for further treatment.

After the process the nurse told Florence that she must use contraceptives because the hospital would not perform another termination of pregnancy. She was warned about the consequences of not taking precautions if she was sexually active such as contracting AIDS. No pre-counselling was offered at the hospital. Florence expected to bleed and for the termination to occur the same time. She did not know that it would take so long.

## **GLORIA**

Gloria was a 19 year old jewellery consultant who was referred to a female gynaecologist from Parklands Hospital, by a friend, when she missed her period. The doctor revealed that Gloria was five weeks pregnant after she performed an ultrasound scan. Gloria informed the doctor that she was not prepared to have the baby and she was referred to Marie Stopes Clinic. According to Gloria the doctor merely stated what options were available to her. Gloria was told that she could have an abortion at St. Augustines Hospital for approximately R2000 under general anaesthesia or she could have an abortion at Marie Stopes Clinic for R800 without anaesthesia. Gloria was made to feel comfortable by the doctor and she felt at ease with the doctor because she was the same gender. The doctor told Gloria that she had to make the decision on her own about her unplanned pregnancy.

Gloria had been very careful about the use of contraceptives and was on the pill for two years. She remembered that when she had the flu, she took anti-biotics to treat the flu but it cancelled out the effects of the contraceptives. Gloria was emotional about her unplanned pregnancy which caused her to cry for two days. Before visiting the gynaecologist, she thought that if she was pregnant, she would terminate her pregnancy but she was secretly hoping that she would not be pregnant, so she would not have to make the decision. When the doctor confirmed her pregnancy, it became a reality and she had to terminate her pregnancy.

The same day Gloria went to Marie Stopes Clinic to enquire about their fees and if an appointment was needed to have an abortion. She was asked by the receptionist if she wanted to have the abortion the same day. She agreed to have it the following day.

According to Gloria, her boyfriend was supportive and concerned about her well being. He accompanied her to all her appointments. Both decided that having an abortion was the right choice. Gloria wanted to terminate her pregnancy primarily because her parents would react negatively to finding out that she was pregnant and living with her boyfriend.

She told her best friend about her decision to have an abortion and she did not want Gloria to have an abortion because she was also pregnant and both their children would be due around the same time. Her friend knew that the decision was left entirely up to Gloria.

Gloria also informed her boyfriend's sister about her decision to have the pregnancy terminated. She reacted to Gloria's decision with dismay because she wanted Gloria to have the baby so that she could become an aunt because Gloria's boyfriend was old and his parents wanted him to get married and produce a grandchild. Gloria did not believe that her boyfriend's sister was concerned with her well being.

Gloria knew that it was legal to have an abortion. It was now performed in a clean and safe environment by professional individuals. Gloria was against abortion and would not have terminated her pregnancy if the law did not exist.

The expense incurred due to the unplanned pregnancy was R970. The gynaecologist fees amounted to R200 and Marie Stopes Clinic charged R770. She did not have a transport problem because she lived in town.

During the pre-counselling session at Marie Stopes Clinic, the nurse enquired if Gloria was certain about terminating her pregnancy. She informed Gloria of her options. She was shown the instruments to be used in the procedure. Also the nurse enquired if Gloria would inform her parents of her decision to terminate her pregnancy.

In the waiting room, Gloria tried to read a magazine but was unable to concentrate. The nurse introduced her to the doctor who used the ultrasound scan to detect her pregnancy. Whilst performing the termination, the doctor engaged in a conversation, so as to distract her. Sometimes she did not respond but just concentrated on the procedure. According to Gloria the doctor used forceps to open her uterus and a syringe like instrument to vacuum the contents. The pain Gloria experienced was horrible and lasted for three minutes. The entire process took five minutes. Gloria could have changed her mind at any time and she chose not to bring anyone with her to the procedure.

Immediately after the process, Gloria was given two painkillers. When she was about to leave she was given a pamphlet which informed her of what she could/could not do. She could not have sex for two weeks, could not take a bath immediately and her period would become erratic and if post-counselling was required, it will be provided. Gloria could return to Marie Stopes Clinic if she experienced any complications.

Gloria thought that the process would be long and that the doctor's attitude would be cold. She expected to feel pain. After the process she just wanted to be alone because of the pain. She was comfortable with her decision to have the abortion.



## HANNAH

Hannah was a 22 year old student who visited her doctor to determine if she was pregnant. The pregnancy test involved the testing of her blood which revealed four hours later that she was pregnant. Hannah was visibly shocked when she was informed of her pregnancy by the doctor. She was afraid of the consequences of having a baby out of wedlock. When Hannah informed the doctor that she was not ready to have baby, he did not discuss with her what options were available to her, such as adoption, keeping the baby or foster care. Neither did he inform her of the risks involved in having an abortion. He told Hannah that he did not perform the abortion procedure and referred her to King Edward Hospital.

Hannah took the following factors into account, when she was considering what options to follow regarding her unplanned pregnancy. Two weeks prior to discovering that she was pregnant, she discovered that her partner was a distant cousin. This caused an abrupt end to their relationship. For Hannah, having a baby would result in a disruption of her studies or even a discontinuation of her education. Hannah was unemployed and therefore would not be able to maintain the child. These factors led Hannah to have an abortion.

Hannah only informed her room mate of her accidental pregnancy and her decision to have an abortion. Her friend tried in vain to change Hannah's mind, by relating her own experience of having an abortion. She told Hannah that it was a traumatic experience and Hannah should try and tell her parents about her situation, as they may understand and offer Hannah support during this trying period. Hannah was told by her friend that if she had an abortion, she may risk never being able to conceive again. She told Hannah the disadvantages of having an abortion because she wanted Hannah to be absolutely sure of her decision. Hannah appreciated her friend's concern, but this was the best option available to her. The friend understood that Hannah would make the final decision.

Hannah knew that abortion on demand was legal and it was performed at Marie Stopes Clinic, Addington Hospital and King Edward Hospital. Her understanding of abortion was based on her friend's experience of having an abortion.

The cost of the abortion amounted to R110 because she was charged R75 by the general practitioner, R10 for the treatment at Addington Hospital, and R25 for the misoprostal tablets to induce the termination. Travelling was not a problem because she lived in central Durban.

Hannah presented herself at King Edward Hospital, based on the doctor's referral but was promptly refused treatment because she failed to meet their termination of pregnancy requirements. The staff at King Edward Hospital referred her to Addington Hospital, who required a letter of referral from her doctor stating that she was pregnant and proof of her residency. Her address had changed so she went to Foshini to get a statement of her account, on which her address was recorded. Hannah returned to Addington Hospital the same day with the proof of her residency and was scheduled for a 12:30 p.m. appointment with the doctor the following day. The next day the doctor examined her internally to confirm her pregnancy. According to Hannah the doctor did not hurry his treatment of her. He provided clear explanations of how the tablets should be administered. Hannah was given a prescription to buy tablets (misoprostal) since Addington Hospital did not order more tablets. Firstly three tablets had to be taken orally, three hours later three tablets had to be taken vaginally and the final set of tablets had to be taken orally after twelve hours. She was told to expect bleeding to occur in 2-4 hours time. As described by her doctor, Hannah began bleeding soon after taking the tablets and she was helped by a friend to the toilet and with the application of sanitary towels by a friend.

Hannah returned to Addington Hospital in the morning and her blood pressure and temperature was taken by the nurse, followed by the administration of an injection. A female doctor used the manual vacuum aspiration method to complete Hannah's abortion. Hannah did not feel too much pain and was able to deduce that the doctor was a "nice" person from her observation of the doctors treatment of a student nurse. The process lasted about fifteen minutes. The nurse told Hannah to relax and made her feel comfortable. Hannah believed that she could ask questions during the process if she wanted to but chose not. The time span of the entire process was one week.

No pre and post-counselling was offered to Hannah. She did not think that the process would begin so quickly and she did not expect to feel any pain. Afterwards, Hannah felt that she made the right choice and was comfortable about her decision. Hannah would never be able to tell her parents about her actions.

## IRENE

Irene was a twenty year old waitress whose family lived in a different town. When Irene experienced stomach cramps, she immediately visited Addington Hospital's Poly Clinic. The nurse tested her urine to determine the nature of her illness and the test revealed that she was six weeks pregnant. Irene was expecting to be told that she was pregnant and broke down in tears because she became worried about the consequences of her pregnancy. Irene was not convinced that she was pregnant but the nurses assured her that the test was accurate. The nurses suggested that she go to the hospital for further treatment. At the end of July 1999, Irene received treatment from Poly Clinic.

Irene made the decision based solely on her community's judgmental reactions to single women who fall pregnant out of wedlock. Where Irene lives it is considered shameful if a woman had a baby without being married and women who lose their virginity whilst not being married. If she returned home she would be ostracised by her family and community. Another reason for choosing an abortion was that her boyfriend was married and unemployed. Irene considered studying in 2000 and having a baby would interfere with her acquiring an education. It was also not economically feasible to have a baby because she lacked financial resources to maintain a child.

Irene's boyfriend was aware of her unplanned pregnancy. He reacted indifferently to the news, by saying that nothing could be done to improve the situation and she could choose whether or not to keep the baby.

Irene knew that it was legal to have an abortion but she had no understanding of how abortions were performed or the techniques that were used.

In Irene's case the total cost of the misoprostal tablets was R110. She paid R20 to have her blood tested and she had to buy the misoprostal tablets because Addington Hospital's stock was depleted and more tablets had not been ordered by management. Irene did not experience travelling problems because she lived nearby.

When Irene visited Addington Hospital, she was asked by the clerk the purpose of her visit to which she replied, termination of pregnancy and was directed to gynaecology where she was asked to sign a form so that the hospital had her formal consent to perform the abortion. An ultrasound scan was used by the doctor to determine her gestational period, which revealed that she was six weeks pregnant. A prescription to buy tablets (misoprostal) was given to Irene which could be obtained from any local pharmacy. The doctor told her to return to the hospital when the bleeding commences. He instructed Irene to take two tablets, followed six hours later by another two. Irene's assessment of the doctors treatment was good.

One of the nurses asked Irene her reasons for having an abortion and she explained that her parents would not accept her if she was pregnant and she was not married to her boyfriend. Irene administered the tablets at home but nothing happened, so in the beginning of August, she returned to Addington Hospital and was informed by the attending physician that she was still pregnant. He also issued her a prescription for the same tablets (misoprostal) but once again the tablets failed to induce the abortion. She returned for a third occasion to the hospital in early September to inform the doctor(s) of her condition. Irene was scared that she may not be able to terminate her pregnancy. Yet again she was given a prescription for the same tablets which still proved ineffective.

On her fourth visit to the hospital, the doctor on duty decided to admit her to the hospital where he administered the tablets vaginally and orally to Irene. Two hours later, Irene began to experience pain. She discharged her foetus but there was no bleeding. The nurse removed the foetus and cleaned Irene up. The entire process lasted about 12 hours. The nurse advised Irene to return home now that her pregnancy was terminated. According to Irene, the nurse constantly checked on her to see if any complications had arisen. The time span for the entire process was six weeks.

Afterwards, Irene felt that it was the wrong decision to have pregnancy terminated and felt guilty. She was provided with no pre and post-counselling at the hospital.

## JANE

Jane was a 23 year old graduate who visited the general practitioner under the pre-conception of having a urinary infection. When the doctor informed that she was pregnant, she laughed, thinking that the doctor had lied to her. The doctor did not know too much on The Choice on Termination of Pregnancy Act, No 92 of 1996 because it just been implemented when Jane had her abortion. He did not explore with Jane her available options and neither did he explain the risks involved in having an abortion. The doctor provided Jane with contact numbers if she decided to have an abortion. Jane's pregnancy was eight weeks old.

Jane was confused in the first few days of discovering her unplanned pregnancy. She had to choose between acquiring an education or having a baby. Two years prior to this, Jane had been studying accountancy but was not successful at it and as soon as she changed her curriculum, she unexpectedly fell pregnant. Her parents had given her due warning that unless her grades improved they would discontinue financing her studies. Under these circumstances, she decided that having an abortion, would be the best option.

She informed her boyfriend about her pregnancy and her decision to have an abortion but he was adamant that she have the baby because he wanted to become a father, irrespective off the circumstances of the child's conception. Jane's boyfriend later displayed confusion about which route was best to follow. In the end, Jane decided to have the abortion and they should each contribute half of the cost to have the abortion.

When Jane informed her friends that she was going to have an abortion, they respected her right to make her own decision. They helped to search for places where abortions were being performed because she had misplaced the contact numbers given to her by her doctor.

Jane discovered Marie Stopes Clinic through the advertisements placed on rubbish bins. One of Jane's friends who had an abortion explained the process to her. Her friend had an abortion at Marie Stopes Clinic for a cost of R600. According to her friend the procedure took just three minutes to complete. Jane was told that the blood or a blood clot would be vacuumed and if the baby had developed, then the vacuum method would not be used. She described the pain to Jane as being ten times as worse than menstruation cramps. According to her friend it was a worth while process if she was not ready to have a baby. Jane's friend stated that having an abortion in a public facility would mean, a long and drawn out process because women were given tablets or injections to induce the termination and the doctor had to clean up the woman after the tablets had taken effect. Speaking to her friend was extremely beneficial to Jane because she gained a better understanding of the process. This particular friend also accompanied Jane to Marie Stopes Clinic on the day of the procedure.

The various explanations that Jane had gathered from different sources accounted for her having different understandings of the procedure. On the one hand, she thought that the termination occurred by the doctor injecting the women with a saline solution that killed the foetus whilst on the other hand she thought that women could bleed to death from having an abortion.

Jane and her boyfriend had a mutual understanding of how the procedure would be financed, that is, they would each contribute R300. When her boyfriend failed to fulfill his end of the agreement, Jane experienced problems in raising the R600. She eventually managed to borrow the money from one of her girlfriends. Travelling to Marie Stopes Clinic did not present a problem because she lived nearby.



The pre-counselling at Marie Stopes Clinic began by the nurse determining Jane's level of certainty about having an abortion, followed by an explanation of the procedure. The nurse enquired if Jane's boyfriend was aware of her decision and his reactions. She told Jane that if any complications arose after the abortion she should return for further treatment. According to Jane, the nurse made her feel comfortable during the session. Jane, however, did not consider what the nurse told her as constituting proper counselling because no new information was provided. The nurse briefly stated that Jane could consider giving her child up for adoption. For Jane, this was not a viable option because it meant abandoning her baby. The nurse was not able to convince her to change her mind about having an abortion.

The doctor conducted a quick pelvic-vagina examination prior to the procedure. During the procedure, Jane held onto the nurse's hand. The doctor and the nurse tried to distract Jane by engaging her in a conversation. The doctor explained the procedure while he was performing the abortion. She could have asked questions if she wanted and she could have changed her mind at the last moment. The doctor was not insensitive to her but he treated her like any other patient. The pain was terrible and it felt like heavy period pains. The procedure lasted about three minutes. Thereafter, Jane was led to recovery room even though she was too weak to stand. She stayed in the recovery room for thirty minutes. When she was about to leave she was given a pamphlet informing her that if any complications occurred, she should contact them.

Jane expected to experience pain and to bleed heavily. After the abortion Jane felt like a murderer and felt guilty. According to Jane not attending counselling caused her life to spiral out of control after the abortion. She was deeply affected by her boyfriend's lack of concern. He did not even telephone to enquire about her well being. Jane decided to telephone him later in the night but he was not at home. When she was unable to reach him she decided to go and see him in Pietermaritzburg. He offered some feeble excuse which she did not accept. The entire weekend he did not stay with her and she received telephone calls late that night from different women. One night she decided to leave him but he did not want to let her go, so she jumped three storeys to the ground. She was badly injured and had to be hospitalised. At this stage Jane told her mother that she had an abortion. Her mother was supportive and wished that Jane had told her earlier.

Jane sought out psychological help from student counselling. The counselling she received from the psychologist was extremely helpful. The psychologist was able to work with Jane through her feelings concerning the abortion and her relationship with her boyfriend. Her values about having children have changed. She desperately wants to have a baby even though she is not married.

## **KELLY**

Kelly is a 31 year old paramedic, who suspected that she might be pregnant because she and her partner had not used contraceptives on one occasion of sexual intercourse. Her suspicions were also almost confirmed when she missed her period because her menstruation cycle was always regular. She went to Wentworth's Family Planning Clinic to seek out professional advice from a nurse she was acquainted with. The nurse informed Kelly that if the gestational period of her pregnancy was less than six weeks, a urine test would be ineffective and a blood test would provide a more accurate diagnosis. The nurse suggested that she should give adoption some consideration because it was a better choice but Kelly stopped her abruptly by saying that she had made up her mind. Kelly admitted to be in denial at this stage.

The more Kelly contemplated what option to choose regarding her pregnancy, the more complex the decision became. Kelly decided to have an abortion because she believed that a child must have two parents to help rear him/her. Also she was not financially stable and would not be able to provide her child with the best opportunities. Kelly's sister was single parent to an eight year old boy and she could not see herself as a single parent. The pregnancy resulted from an adulterous affair so Kelly did not foresee any future with her partner. The decision to have an abortion was entirely Kelly's but she admitted to being ambiguous about her decision.

Kelly did not know how to tell her partner about her unplanned pregnancy because she did not know how he would react. He reacted with silence when he was told the news and told Kelly that he did not want to become a father. According to Kelly, she only informed her partner of the pregnancy because she needed him to pay a portion of the expenses for the abortion procedure.

When Kelly's best friend was told about her pregnancy, he laughed because he did not see Kelly as a mother. He knew that it was Kelly's decision to make, so he offered no suggestions. Although he did not offer any moral/financial support Kelly knew that if she needed his help he would be there for her.

Kelly's medical background equipped her with the necessary medical knowledge about abortion procedures but she did not know how women requesting abortions were processed. Her view of the Choice on Termination of Pregnancy Act, No 92 of 1996 was that it provided women with freedom of choice and she believed that she had total responsibility over her body and no one had the right to dictate to her what she should do if it concerned her body.

The cost of the abortion procedure at Marie Stopes Clinic was R770 of which she contributed R550 and her partner R220, plus the cost of petrol and lunch. Kelly had her own transportation, so, travelling to Marie Stopes Clinic did not present a problem.

She telephoned Marie Stopes Clinic to enquire about their address and if an appointment was needed to access their services. She was told that she should just come to Marie Stopes Clinic and immediate treatment would be provided. Kelly was informed that she would not be well enough to drive herself home after the procedure. Kelly insisted that her partner accompany her to Marie Stopes Clinic on the day of the procedure since he was also responsible for the predicament.

Upon arriving at Marie Stopes Clinic, she was given a form, which required her personal details and her consent to have an abortion. Twenty minutes later she was provided pre-counselling by a nurse. When the nurse questioned her decision, Kelly informed her, that she was absolutely certain of her decision. Kelly directed the session by asking questions that were of some concern to her such as, from which date would she have to count to expect her next menstrual cycle and the length of the procedure. The nurse told her that she would begin counting from the day of the termination and that the process would last about ten minutes. Kelly was told that post-counselling was available after the procedure if she required it. According to Kelly the pre-counselling was not useful to her because her decision was already made but it was necessary for women who have not made up their mind. The nurse showed Kelly the instruments to be used during the session. The session ended with the nurse conducting a pelvic-vagina examination, which revealed that Kelly's uterus was soft and that she was five weeks pregnant. She was given two tablets by the nurse to relax her cervix and was told to expect cramps.

Forty five minutes later, Kelly was prepared for the abortion procedure. She was given a hospital gown and was sent to a waiting room with seven other women. Kelly stated that the clinic allowed a patient to change their mind at the last moment. When she was called to the operating room, the doctor greeted her and asked how she was feeling. He instructed her to get up on the stretcher bed and place her legs in the stirrups, followed by a quick internal examination. According to Kelly's description a steel instrument, similar to that used in a pap smear test, was used to dilate her cervix. He asked Kelly to cough but before she could get a proper cough, he "shoved" another tube into her and started vacuuming. According to Kelly, the pain was excruciating and she wanted the doctor to perform the procedure as quickly as possible. At this stage the nurse offered to hold Kelly's hand but she refused. The procedure took about five minutes. When the procedure ended, Kelly was under the impression that she could take some time to rest and let the pain subside but she was

mistaken because she was immediately led (after a minute) into the recovery room by the nurse even though she was too weak to walk.

Kelly thought that the couch beds were uncomfortable and did not provide any relief from the pain. The nurse gave her two pain tablets to ease the pain but Kelly was upset that the tablets were not given to her twenty minutes earlier before the procedure, so that it could have taken effect after the procedure. Kelly left the recovery room and locked herself in a toilet cubicle, where she was able to relax and get some relief from the pain. When she came out of the toilet thirty minutes later, the pain had not subsided. Kelly thought that she might be given something stronger by the nurse this time, but she never was. Kelly left the clinic an hour after the procedure and had to drive herself home because she had told her partner to leave, when he became bored waiting for her. She regretted sending him home because it was difficult to drive with the throbbing pain. Before she left the clinic she was handed a pamphlet which stated that she could not have sex for two weeks and she could not engage in strenuous activities as this would cause excessive bleeding. Kelly had to return after 2 weeks, to determine if she was no longer pregnant because she was less than six weeks pregnant at the time of the abortion.

Kelly felt relief after the procedure but she still has to come to terms with her experience and make peace with God. She would eventually speak to her priest about her experience. Kelly did not expect the suddenness of the pain. It was worse than any period pain she had ever experienced.

She did not go for psychological counselling because she was unable to afford it but if she needed to talk, she turned to her best friend who was supportive.

## **LINDA**

Linda was a 22 year old graduate who worked part-time as a waitress. She visited a private doctor to determine the nature of her mysterious illness, only to be told that she was pregnant. The news came as a shock to her. The doctor asked her about her intentions towards her pregnancy, to which she replied that she was not ready to have a baby. The doctor suggested that he could perform the abortion but the treatment would be expensive. This was not a viable option for Linda because she did not have a medical aid scheme. According to Linda, the doctor did not discuss what options were available to her and neither did he refer her to places where abortions were being performed at cheaper rates. He mentioned in passing that she should go to the government hospitals and tell them that she wants her pregnancy to be terminated. Linda perceived the doctor as being non-judgmental and understanding of her situation. He offered to provide her a referral letter to show to the health institution that would provide her with treatment but she declined as she had made up her mind. The gestational period of her pregnancy was just 6 weeks.

Linda only informed her boyfriend of her pregnancy and he initially suggested that they get married and she could have the baby. He did not pressurise her to accept his proposal and made it clear that she had to make the final decision, which he would accept whatever the outcome. Linda's boyfriend wanted her to receive treatment at a private clinic but the price was not affordable. For example, he discovered by telephoning Marie Stopes Clinic that they charged R770 and onwards to have an abortion. He was attentive to her needs because he attempted to get her to talk about what was troubling her when she appeared moody and withdrawn.

Linda took a week to decide the fate of her pregnancy. In the beginning she was unsure about which direction to proceed but following a discussion with her boyfriend, she decided that having an abortion was the best option. Her reason for having the abortion was the inappropriate timing of her pregnancy. She had committed herself to numerous activities to have it abruptly disrupted by an unplanned pregnancy. Linda was taking driving lessons to acquire her licence as well as searching for employment. Having a baby would be a strain on her parents because they would eventually look after her child due to the fact that she was not financially stable. Linda chose to receive treatment at a government hospital which provided free of charge termination of pregnancy services.

Linda was aware that abortion on demand was legalised and that it was being performed in private clinics and hospitals.

The treatment at Addington Hospital was free and they also provided her with the tablets (misoprostal). She did not experience travelling difficulties because she lived nearby the hospital. The time span for the process was four days.

Two requirements had to be satisfied at Addington Hospital before termination of pregnancy services can be provided: a letter of referral from Linda's doctor stating that she was pregnant and proof of residence that she lived in central Durban. Upon arriving at the gynaecology ward, Linda was confronted by a nurse whom she considered to be rude. The nurse chastised Linda for not producing a letter of referral from her doctor and informed her that if she did not have proof of residence, she would be refused termination of pregnancy treatment. Linda's attempts to reason with the nurse fell on deaf ears. She caused Linda to feel embarrassed and humiliated.



In order to get a letter of referral, Linda visited Addington Anti-Natal Clinic to have a pregnancy test performed. Waiting for the results of the pregnancy test was a delaying process, so Linda went home and telephoned for her results. When she was informed of her results, she asked the clerk, if the clinic could provide her with a letter confirming her pregnancy. She was told to come to the clinic the following day and a letter would be given to her stating that she was pregnant.

When Linda returned to gynaecology, she was glad that the rude nurse was not on duty. The nurse on duty gave an appointment to see the doctor the following day. When Linda went to see the doctor the next day, he performed an internal examination on her to determine her gestational period. Addington hospital only performs abortions on women who are less than twelve weeks pregnant and Linda satisfied this requirement. Linda was given two sets of tablets (misoprostal) by the doctor and instructed how to administer them. Linda regarded the doctor's treatment as being hostile. She was able to gather from his non verbal behaviour and from what he said he disapproved of her decision to have an abortion. He advised her to go to family planning because having an abortion was not a pleasant experience. Another nurse repeated the instructions on how the tablets should be taken. When bleeding began, Linda returned to the hospital. According to Linda, the doctor that performed the termination procedure, his attitude and treatment was of a better quality than the first doctor. He explained the procedure while he performed the abortion. He realised that the procedure was painful for Linda and tried to make her feel as comfortable as possible. The procedure was short and only lasted fifteen minutes, according to Linda. The procedure used to perform the abortion was called the manual vacuum aspiration technique.

Linda had expected the pain to be much worse but found it bearable. She was overcome with relief after the procedure and did not ponder about the experience. Linda was provided with no pre and post counselling.

## MARY

Mary is a 31 year old self employed career woman, who was on the verge of marrying her fianc`e. When she missed her period, it caused her to panic because she suspected that she might be pregnant, so she bought a home pregnancy test which confirmed her suspicions. She was angry at herself for falling pregnant when she had found success in her career. Mary visited her family doctor whom she had been seeing for eight years, to verify her pregnancy. He told her that her conception was only fifteen days old. He discussed with Mary the options available to her and she indicated that having an abortion was a possibility. Mary asked her doctor to provide her with the names of the health care facility where abortions were performed based on its history of cleanliness and safety. The doctor referred her to Marie Stopes Clinic. Mary stated that her pregnancy was not caused by being irresponsible but rather due to the rupturing of a condom during intercourse.

Mary only informed her best friend and her fianc`e about her unplanned pregnancy. She told her best friend that she was thinking of having an abortion. Her best friend inquired about the certainty of her decision but stated that she would accept Mary's decision.

Mary always knew that if she ever found herself in a similar situation, she would terminate the pregnancy. After discussing the issue at length with her boyfriend she decided that having an abortion was the best option at her disposal because they were finally achieving some level of success in their respective careers when she accidentally fell pregnant. The pregnancy had occurred at an inopportune moment in their lives. The option of adoption was completely ruled out because they were getting married soon. It was not an easy choice for Mary to make but what finally helped her to reach a decision was that the conception was only 15 days. If her pregnancy had been between four to eight weeks, then Mary would not have chosen an abortion.

Mary knew that having an abortion was legal but did not know what the Choice on Termination of Pregnancy Act, No 92 of 1996 stipulated. Two of her friends had their pregnancies terminated in Sweden so she had some understanding of the procedures. The cost of having her pregnancy terminated at Marie Stopes Clinic was R770 and she was transported to the clinic by her best friend.

Upon arriving at Marie Stopes Clinic, Mary was asked to fill in a form which required her personal details and her consent to have an abortion. Thereafter, she was provided pre-counselling by a nurse. Mary had become nervous at this stage about the procedure. She told the nurse that she was feeling nervous but this was not explored by the nurse. The nurse did not respond to what Mary had said and continued with the session. The nurse did not inform Mary about the risks involved in having her pregnancy terminated at twenty one days since conception. Mary found the pre-counselling session unnecessary because her mind was already made up but the pre-counselling session could prove invaluable for women who did not have a healthy support system. The session ended with the nurse conducting a pelvic-vagina examination on Mary. Mary assessed the nurses's attitude as being friendly and warm.

Forty five minutes later, Mary was provided with a gown and had to change in the toilet cubicle. The atmosphere in the waiting room, according to Mary, was filled with sadness. When Mary was called, she was led into the operating room and told by the nurse to sit on the bed. Thereafter, the doctor did an ultrasound scan to detect the embryo. She was then instructed to sit up on the bed and place her feet in the stirrups. At this point Mary was waiting to be given some form of anaesthesia but it was not forthcoming. Whilst performing the abortion, the doctor initiated a conversation with Mary by enquiring about her job. According to Mary, this calming technique employed by the doctor was adding to the level of stress she was feeling and she did not want to reply.

According to Mary, she was not expecting to feel any pain because she was under the impression that she would be given anaesthesia. The pain she experienced was worse than she could have imagined. The procedure lasted for five minutes. Mary sensed that the doctor became irritated with her when she was squirming and screaming because of the pain she felt. According to Mary the nurse tried to calm her down but it was not possible considering the pain. Mary was clearly upset with the treatment provided and felt violated. When the procedure ended, Mary was asked to leave the room immediately and rest in the recovery room. Mary was so overcome with physical pain that she experienced difficulty walking to the recovery room which was next to the operating room. Mary was given two painkillers to ease the pain and she felt that it helped to a certain extent.

Mary did not require any post-counselling following the abortion. She felt good about her decision to have an abortion. She expected the pain to be similar to her period pain but in reality it was worse.

Six participants accessed private health care institutions, five participants accessed public health care institutions, whilst two participants received treatment from their general practitioner and public hospitals. From the case profiles, it can be deduced that having an abortion was a painful and traumatic experience. In some instances, the expectations of the process were different to the actual procedure.

The next chapter will describe and analyse the data gathered from the case profiles.

## **CHAPTER FIVE**

### **DISCUSSION AND ANALYSIS**

#### **BIOGRAPHICAL INFORMATION**

##### **Age**

The ages of the thirteen participants ranged from 19-31 years. Two of the participants were 19 years old, three were 21 years old, two were 22 years old and two participants were 31 years old. The remaining four participants were 23 years, 26 years, 28 years and 30 years respectively.

Only eight of the thirteen participants had terminated their pregnancies in 1999. Three participants had an abortion in 1998, whilst two participants had an abortion in 1997. Hence, the ages of these five participants at the time of the termination was different. Two participants whose abortions occurred in 1997 were 28 years and 21 years old. The other three participants were 18, 20 and 27 years old. Therefore, the mean age of the participants at the time of the abortion was 24 years old. A six month review of the Choice on Termination of Pregnancy Act, No 92 of 1996 revealed that only "17.4% of women who requested for terminations were under the age of 18 and 82.6% were over the age of 18" (Reproductive Rights Alliance, 1997, p.1). All thirteen participants had an abortion when they were 18 years and over.

The ages of the participants were between 19-31 years and it is contrary to the evidence gained from studies conducted in the United States of America by Olson et al ( in Voyandoff and Donnelly, 1990) that girls under the age of fifteen years and between 18-19 years were more likely to have their pregnancies terminated. On a developmental level, adolescent females have not reached psychological maturity which would impact on their decision-making process. It can be deduced that adolescent females terminate their pregnancies impulsively because of societal taboos around becoming pregnant whilst still a teenager and being unduly influenced into having an abortion by their parent/guardians. Hudson and Ineichen (in Voyandoff and Donnelly, 1990) argued that females who were relatively young can not draw from their limited experiences and were targets for manipulation by their family. In these situations young females opt to have an abortion to free themselves from responsibility. Based on studies conducted it was, therefore, surprising that adolescent females did not volunteer to participate in the research. This can be attributed to the places that participants were recruited from, that is, tertiary institutions, public and private health care institutions. Also, young girls are legally regarded as minors and would not be comfortable disclosing their experiences to a stranger, for fear of breaching, their anonymous identity.

It has been established that young females who terminate their pregnancies have not matured on a psychological and cognitive level, which would impact on their decision to have an abortion. So women 19-31 years are older than adolescent females, have accumulated more experience and have reached psychological maturity. Therefore, the participant's decisions were linked to factors that primarily impacted on their soci-economic circumstances and society's attitude toward the unplanned pregnancy but other factors must be considered since it might have impacted on the decision.

## **Marital status**

All thirteen participants were not married. However, one of the participants was engaged to be married and two participants were single parents. The other ten participants with boyfriends had no intentions of marriage. These results regarding the marital status of the participants were similar to the study conducted by Reproductive Rights Alliance (1997) where most of the women who requested an abortion classified themselves as being single.

It is comparatively more difficult for single women as opposed to married women to have a baby due to the financial constraints. The majority of the participants, cited that inadequate financial resources caused them to terminate their pregnancies. Society does not look favourably upon women who are not married and are pregnant. These women are scorned at for engaging in sexual intercourse outside the sanctity of marriage. Most of the participants stated that they chose to terminate their pregnancy because they were not married and were fearful of society's reactions to a single woman who has become pregnant. Thus, soci-economic determinants in addition to other factors impacted on the participants marital status and influenced their decision to have an abortion.

## **Occupation**

The occupational status of the thirteen participants varied. Three participants were professionals: one was a paramedic, one was self-employed and the other merely stated that she was a professional so as not to compromise her anonymous identity. Six of the thirteen participants were students, two participants were waitresses, one participant was a jewellery consultant and one participant was not working. The majority of the participants were in the process of acquiring an education. Findings from a study conducted by Leibowitz et al (in Voyandoff and Donnelly, 1990) revealed that the decision a young woman makes about her

Voyandoff and Donnelly, 1990) revealed that the decision a young woman makes about her unplanned pregnancy was dependant on her income. For example, women who are self-sufficient and autonomous are more likely to terminate their pregnancy. The majority of the participants were not employed and those who were employed were not in an high income category to maintain a baby. Even the three participants that indicated that they were professionals cited either financial difficulties or not being able to sustain the success they had finally achieved in their respective occupations. The participant's income or lack thereof were significant contributing factors but not the sole factor in their decision to terminate their unplanned pregnancy, such as, their attitudes towards abortion, their family, partner and community's reactions to them having an abortion as well as socio-economic factors.

## **Religion**

Christianity was the predominant religion, among eleven of the thirteen participants. Of the remaining two participants, one was an atheist and the other participant belonged to the Hindu faith. According to Voyandoff and Donnelly (1990) many studies have concluded that when a woman contemplates an abortion she takes into consideration various factors such as family's attitude, partners attitude, religion, society's attitude as well socio-economic situation. In this study participants stated that their religious affiliation had not influenced their decision to have an abortion, which was consistent with previously conducted studies. However, after the abortion Beth and Elaine expressed guilt about their decision because of their religious beliefs.



## **DISCOVERING THE PREGNANCY**

Some of the participants suspected that they were pregnant due to the physiological changes to their anatomy whilst the others were completely surprised at being told they were pregnant. Most of the participants had their pregnancies confirmed by their general practitioner. One participant was informed of her pregnancy by a gynaecologist, one by the nurse at Marie Stopes Clinic and another by nurses at Addington Hospital's Poly Clinic.

Almost all the participants used the urine test to confirm their pregnancy. A pregnant woman's urine contains a substance called Human Chorionic Gonadotrophin (HCG), which can be detected with a urine test (Davies, 1991). In the situation where the pregnancy is under six weeks, the urine test becomes ineffective and the participant's blood has to be tested. According to Davies (1991) blood tests can determine a woman's pregnancy approximately seven days after conception. A pelvic-vagina examination was almost always performed on the participants. The purpose of the pelvic-vagina examination according to Davies (1991) is to determine the size of the uterus. Ultrasound scans were used to calculate the gestational period of the pregnancy.

For three of the participants, referrals provided by the general practitioners proved incorrect. Hannah was sent by her doctor to King Edward Hospital but was turned away because of her residential address. She was then sent to Addington Hospital where she met the criteria to be admitted for treatment. In the case of Beth, her doctor referred her to an expensive hospital, which was out of her budget. Beth did not know of any other health care facility that performed abortions, so she had no alternative choice but to raise the funds.

When Linda was offered a referral letter by her general practitioner she declined his offer because she had not reached a decision about her pregnancy. However, when she arrived at Addington Hospital without a referral letter she was refused treatment until she satisfied the hospitals requirements for having an abortion. She had to go the Anti-Natal Clinic for a pregnancy test to verify that she was indeed pregnant.

Lowry and Blank (1972) who offered abortion counselling guidelines to social workers, stated with reference to referrals that correct information must be gathered about the “laws, policies, requirements, restrictions and the cost of legal abortions both within the immediate vicinity and outside the state” (p.140). The general practitioner’s inability to enquire about the requirements that must be satisfied in order for treatment to be provided meant a loss of time and money on the part of the participants, adding to their stress levels.

Almost all the participants were not informed by general practitioners about their options regarding their unplanned pregnancy. When the participants indicated that they were considering having an abortion, the general practitioner did not explain the procedure. Neither did they inform the participants, about the risks involved in having a termination of pregnancy. Only the gynaecologist who treated Gloria, and Mary’s general practitioner elaborated on their options.

In Carrie’s case she was told the price of an abortion by nurses, at Marie Stopes Clinic. Carrie was not provided with any pre-counselling. Only women requesting abortions at Marie Stopes Clinic were provided with pre-counselling. However, with the five participants that did have abortions at Marie Stopes Clinic, the pre-counselling was irrelevant because their decision, was already made. It can be deduced that Marie Stopes Clinic offered pre-counselling at inappropriate times but other factors might have impinged on this deduction. It was most needed, after a woman discovered that she was pregnant, yet it was not offered

at this stage. The incident in which Carrie was not provided with pre-counselling by the staff of Marie Stopes Clinics runs contrary to the philosophy that Marie Stopes Clinics accords to pre-counselling. According to Tancred (in Poggenpoel, Myburgh and Gmeiner, 1998) Marie Stopes states that if a woman is provided with pre-counselling of a high standard, then she will be better able to deal with the effects of abortion.

The general practitioners have extensive medical knowledge from which to draw yet they failed to explain to the participants the abortion procedure and the risks involved in having an abortion. Information general practitioners possessed regarding the places where termination of pregnancies were performed was not updated. General practitioners only tested the participants to determine or verify their pregnancy. He/she failed to address feelings of disbelief and turmoil the participants were experiencing at the time. Treatment provided by general practitioners and nurses followed the bio-medical model and was therefore, not holistic. The bio-medical approach adopted by the medical personnel in addition to other determinants did not allow for holistic treatment. For all the participants, the general practitioner or nurse was the only professional they had received services from, prior to making a decision regarding their accidental pregnancy.

## **DECISION-MAKING PROCESS**

Abortion is a multi-faceted issue and must be seen in totality. All the participants including the two that immediately made their decision, experienced inner conflict in deciding to terminate their pregnancies but socio-economic realities determined their choice. Family and society's reactions to the participants being pregnant whilst not being married also influenced their decisions. In most instances, the participants relationship with their partners became strained because of their decision to end their pregnancy. Medical professionals should have been aware of psycho-social demands on the participants and therefore, needed to see the

participants in relation to their context.

The researcher examined the participants decision-making process by looking at their feelings concerning their pregnancy, their level of understanding of the Choice on Termination of Pregnancy Act, No 92 of 1996 and abortion in general, the social support systems that were relied upon and their reasons for deciding to terminate their pregnancy. To gauge how comfortable the participants were with their decision to terminate their pregnancy, the researcher, enquired about their feelings once the termination was completed.

## **Feelings**

For all thirteen participants discovering that they were pregnant came as a shock. It spelled a disruption in their lives. When Ann discovered that she was pregnant:

...tears just poured out of my eyes. I could not stop crying. I felt as if I had disappointed my mother. I was shocked and ashamed. I kept thinking that this was impossible and could not happen to me.

Irene's reaction about her pregnancy:

I felt very angry because I don't want a baby. It was an accident.

Gloria was emotional upon learning about her pregnancy:

At the doctor's office, I cried especially when I saw the scan. I cried for two days non-stop.

The cognitive ability of the participants was clearly affected by their accidental pregnancy. In the face of adversity, the participants had to decide what route to follow regarding their pregnancy. According to Zakus and Wilday (1987) a woman experiences a crisis because of the accidental pregnancy and displays symptoms of anxiety, sadness and chaos. Zakus and Wilday (1987) suggest crisis intervention as a technique counsellors should employ to help women deal with the crisis. All thirteen participants did not receive any professional counselling prior to making a decision to help them overcome their state of crisis. Therefore, the decision to terminate their pregnancy was made in a state of crisis.

### **Social support systems**

All the participants had a social network in whom they confided before and after the abortion procedure. In most instances the participants informed more than one social support system. The majority of the participants informed their boyfriend/partner and their friends. A study conducted by Faria, Barrett and Goodman (1986) revealed that women contemplating an abortion were more likely to request support from outside the nuclear family, that is, from their partners, friends and physicians. When their boyfriend/partner was informed about the participant's pregnancy, in most instances he wanted the participant to have the baby. Following lengthy discussions with the participant, the boyfriend/partner accepted her decision to have an abortion. Participants stated that even though their partner/boyfriend initially wanted them to have a child, their partners recognised that, ultimately the decision whether or not to terminate lay with them. The reactions of the participant's friends were based on their past experiences and beliefs of abortions.

Only Dorris of the thirteen participants told both her parents about her pregnancy. It was difficult for Dorris to tell her parents about her pregnancy but when she did, they helped her through the decision-making process about which direction to pursue. They discussed with Dorris the positives and negatives of having an abortion as well as having a baby, but told her that she had to make the final decision. According to Dorris, her parents told her that:

Whatever I decide, they will support me, I have to decide what is good for me.

Also when Dorris was waiting in the hospital with the other women in her situation, she said:

I felt relieved and not guilty as compared to these girls because of telling my parents.

I felt free. I didn't want to feel guilty.

Except for Dorris, all the participants were able to inform other support systems, like their mothers, friends and partners. Participants shared their news of their pregnancy and decision to have an abortion with a selected number of individuals because they were able to anticipate that their reactions would not be critical of their sexual behaviour. According to Forrest (1994) abortion is an issue that is surrounded by secrecy and women experience difficulty in revealing this secret, even to significant others. Therefore, women who request to terminate their pregnancy, often do not have a support system, whom they can turn to for help, such as, dealing with their decision to terminate their pregnancy. This was true for some of the participants, who would have liked their parent(s) to have known about their decision to have an abortion so that they could have had their parents support during this trying period. Nevertheless, all participants had informed one or more persons of their decision to have an abortion. However, the support that was offered by the social support systems was financial assistance and moral support. The social support systems was important and it filled a gap as a result of the lack of professional counselling. While the

need for professional counselling is acknowledged, in this study professionals lacked skills to provide empathy, support and appropriate knowledge. The informal support systems were non-judgmental, supportive and provided practical help.

### **Knowledge of abortion**

The participants knowledge of abortions was fairly limited. They had no understanding of how abortions were performed and what methods were utilised. All participants were aware that abortion on demand was legalised in South Africa but they did not know what the Act was called or what was said in the Choice on Termination of Pregnancy Act, No 92 of 1996. Some of the participants knew where abortions were being performed because their friends had abortions.

The participants were at a disadvantage when deciding whether or not to terminate their pregnancy because of their lack of knowledge of abortions and what rights they were entitled to according to the Choice on Termination of Pregnancy Act, No 92 of 1996. Also, not knowing the different methods that can be utilised to perform abortions, the participants were unable to choose the method used that would have suited not only their financial ability but their threshold for pain as well as the length of the abortion process. Not being equipped with reproductive information among other factors reduced the participants control over the abortion process. Participants chose places to have the abortion based on their financial resources and their doctor's referral. The discrepancy inherent in the lack of knowledge perpetuates dependency and violates the principles of self determination.

Although the participants had constitutionally entrenched reproductive rights with the introduction of the Choice on Termination of Pregnancy Act, No 92 of 1996, they were being deprived their right of choice by medical personnel. The Choice on Termination of Pregnancy Act, No 92 of 1996 was meant to remove the reproductive obstacles and provide women with another option, which it has, but it has also given rise to women being denied their right to choose the abortion procedure to be performed. Therefore, the Choice on Termination of Pregnancy Act, No 92 of 1996 as well as other factors such as inadequate resources have not created the ideal situation for women confronted with an unplanned pregnancy and these participants were subjected to the procedure without the right to choose.

### **Reasons for abortion**

The most common reasons provided by the participants to terminate their pregnancy were the disruption of their education, lack of financial stability and reactions of their parents. Similar socio-economic reasons, were evident in studies conducted by Renne (1996) and Johnson et al (1996), where women chose to have abortions based on social and economic factors. In this research socio-economic circumstances did feature as a critical factor in the decision-making process and may be linked to the participants context (South Africa), which is considered to be a developing country. In addition, many participants stated that they were not married and therefore, could not have a child out of wedlock. On the other hand Dorris and Elaine were single parents and did not want another child born out of wedlock. According to Brody (in Sobo, 1996) women who had children were more likely to resort to having an abortion. The extent of the socio-economic implication of not having an abortion was reflected in Kelly's statement:

Having an abortion was a one off payment as opposed to looking after the child right up to school.



When women choose to have an abortion, they make comparisons between the short term expenses of having an abortion in relation to the long term expenses of rearing a child for 18 years (Cohen and Parry, 1981).

Eight of the thirteen participants made the decision on their own to have an abortion. The remaining five participants decided jointly with their partners to have an abortion. Two of the participants decided immediately after finding out they were pregnant, to terminate their pregnancy. Ann said that:

I was in a state of shock about the pregnancy and could not stop crying but I was thinking straight at the time.

Florence stated that:

I was angry and I don't want the baby, it was an accident. I told the doctor that I'm not prepared to have the baby at this moment.

Both Ann and Florence expressed relief following the termination of their pregnancy. The participants who experienced inner conflict about having an abortion, took their time to reach a decision. Most of these participants felt guilty about their actions following the abortion. Horwitz's (in Forrest, 1994) dissertation revealed that women who have terminated their pregnancy experience a loss of either impending motherhood, transitions in her relationships and a loss of her sexuality. In most instances, feelings of depression, denial, ambivalence, guilt and anger are attached to the loss women experience after an abortion. According to Horwitz (in Forrest, 1994) not all experiences are negative, some women feel relieved after an abortion and regard the abortion as a growing experience in their lives. Vogue (1995) stated that "feelings women experience after an abortion do not follow clear-cut lines, there's

no predictable reaction to having an abortion” (p. 118).

All participants exercised their freedom of reproductive right when they made the decision to terminate their pregnancy. Even though eight of the participants partners wanted them to have the baby, in the end the participants made the decision that best suited their lifestyle. The participants demonstrated autonomy over their own bodies. Although the participants were able to control their reproductive abilities, they were influenced by the family and educational institutions. According to Klugman (in Wild and Kunst, 1995) women are in many instances oblivious of their reproductive rights and usually arrive at a decision to end their pregnancy based on family, health and economic factors. Women take into consideration their own needs, the needs of their family and communities needs before making a decision about their pregnancy. The extent of reproductive freedom women really have, their ability to exercise these rights and ultimately to make decisions, is still indirectly influenced by society’s standards as well as their family’s and partners norms.

Liberal feminists may disagree with the above argument and state that because the participants were able to decide the fate of their pregnancies on their own, this indicated that they exercised their constitutionally entrenched reproductive rights. Also the majority of the participants decided to terminate their pregnancy because it would interfere with their education. Liberal feminists would interpret this as a sign of independence on the part of the participants because they chose to control their reproductive abilities to pursue a career. Studies conducted by Eisen et al (1993); Klerman et al (1982); Leibowitz, Eisen and Chow (1986); Moore, Simms and Betsey, (1986); Olson (1980) in the United States of America revealed that, women who have harboured powerful educational aspirations in high school, were more likely to abort their pregnancy (Voyandoff and Donnelley, 1990). In this research educational pursuits of the participants did surface as a major factor amongst other factors in their decision to terminate their pregnancy.

For women confronted with an unplanned pregnancy, the choices she is faced with are daunting and by including the legalisation of abortion in the equation, the choices are made even more complex. One of the participants Gloria, who experienced grave difficulties in reaching a decision, stated that if the Choice on Termination of Pregnancy Act, No 92 of 1996 was not implemented, she would not have had an abortion. According to Himmelweit(1988) legalising abortion created ambiguities for women. On the one hand, it was meant to create a sense of freedom amongst women and on the other hand it created a host of problems.

## **COUNSELLING**

Eight participants received counselling at private or public health care facilities. Six of these eight participants received only pre-counselling, one participant received both pre and post counselling and the remaining participant only received post-counselling.

At Marie Stopes Clinic, the participants were provided with pre-counselling prior to the termination of pregnancy and post counselling was offered if the clients needed this service. In the pre-counselling session, the nurse briefly stated the options to the clients and asked them if they were certain of their decision. The nurse may ask the client who was informed of her decision to have an abortion. None of the participants accessed Marie Stopes Clinic post-counselling service. No pre and post counselling services were offered to Beth at Chatsmed Hospital.

The pre-counselling session was not able to change any of the four participants decision to have an abortion since they had made up their minds prior to coming to Marie Stopes Clinic. According to Jane, the counselling session was not helpful:

I was nervous because this was something out of my morals. She (nurse) told me everything I already knew. She asked me, are you aware that you are deleting a baby. It was not really counselling.

Kelly was able to direct the session because of her medical background. The counselling session appeared to follow a set format for all four participants. The pre-counselling session did not attend to the feelings of any of the four participants. Mary stated:

I was feeling nervous before the procedure and I told the nurse during the pre-counselling but she (nurse) did not try to calm me down.

Both Kelly's and Mary's pregnancy was less than six weeks at the time of the abortion. Only after reading a pamphlet, provided after the abortion procedure, did they realise that there was a possibility that their pregnancy might not have been terminated because of the small size of the foetus. This caused both Mary and Kelly distress at the thought of repeating the procedure and enduring the pain once more. Kelly was under the impression that she had to pay for the procedure again. These issues ought to have been addressed in the pre-counselling session.

The sincerity and timing of the pre-counselling session can be questioned because it was offered to the participants when they had reached a decision. Every participant's situation was different, yet the same type of questions were asked by the nurse. When the participants asked about the severity of the pain, they were told it was like the worst period pain they had

ever experienced. Yet, after the procedure, the participants, stated that the pain was worse than any period cramps.

Counselling offered at private health care facilities in South Africa have international affiliations and need to follow the exemplary service provided at these organisations. There are three central private non-profit clinics, in the United Kingdom, namely, Pregnancy Advisory Service, British Pregnancy Advisory Service and Marie Stopes Centres. Davies (1991) confined her examination of services offered in non-profit abortion clinics to the Pregnancy Advisory Service, (PAS). According to a spokesperson for PAS, once a woman has her urine tested, she is immediately offered counselling and the number of sessions provided will be determined according to the woman's needs. The women determine the pace of the counselling session at PAS and they are given an opportunity to express their feelings. Pregnancy Advisory Service ensures that their staff are provided with counselling training.

No pre-counselling was offered to Hannah, Irene and Linda at Addington Hospital and Carrie at Prince Myshiyeni Hospital. All four participants stated that they should have been counselled prior to the procedure. According to Hannah:

I think that proper counselling is right. I think that first they must ask why? Also with the decision, they should help you and give you other options. I think that social workers should do the counselling for helping with making decisions. They didn't speak to me about my feelings.

According to Irene:

I thought that they (nurses) were going to counsel me but they didn't. I think that social workers should be the one to speak to about what happened because social workers are people to advise.

According to Linda:

Counselling should be available to women from nurses. I don't need counselling now but maybe before. Maybe to explain the procedure so I know what to expect. I think that social workers could offer counselling because nurses have a lot to do. If there is someone there to offer counselling before and after. The nurses have too much to do so they don't finish it properly.

According to Carrie:

I think that counselling should exist and even support groups. When I was sent to the social worker, she asked me why I wanted to do the abortion. The social worker did not give me any counselling. She just filled in some forms. The social worker must know what you are going through and explain the procedures. She must tell you about your options once you discover you are pregnant.

Dorris received pre-counselling at King Edward Hospital. The nurses spoke to her individually about her reasons for terminating her pregnancy and she was asked to sign a consent form. Thereafter, Dorris was led to a larger room with other women where a nurse explained the procedure used to terminate their pregnancies with the help of illustrations.

The nurse provided detailed instructions on how the tablets (misoprostal) should be administered. She mentioned that having an abortion can cause infertility but it was a rare occurrence. Dorris was allowed to ask questions during the session because the nurse was conversing in Zulu and she was not a Zulu speaking person.

Dorris' response of the pre-counselling she received on a one to one basis:

She (nurse) never asked what you are feeling. Only asked why you are doing it. The only time I was asked how I was feeling was after the procedure. Don't ask you about your emotions. Should allocate people to help you, like a social worker to help you with the counselling.

There was a need for pre-counselling amongst all five participants. The four participants who were not offered any pre-counselling, required information about the abortion procedure. They needed to gain an understanding of the procedure so that it might reduce the anxiety of the procedure. In other words, if provided with information, the participants are not helpless recipients of services but they have some control over the process. However, other factors also contributed to the participants not being in control of the process. According to Davies (1991) the more knowledge women are given about the abortion procedure, the more relaxed women become and the tense atmosphere is removed.

All five participants recommended that in the future the services of a social worker should be utilised in the counselling of women requesting termination of pregnancies. According to Navias (in Forrest, 1994) the social worker is central in the multi-disciplinary team of professionals, providing a service to women wanting an abortion because of the skills social workers possess, in providing women with emotional support. Gameau (1993) states that in the pre-abortion counselling social workers can utilise crisis intervention and problem

solving techniques to help women make an informed decision. Also social workers can provide the women with medical information about the abortion procedure, the use of contraceptives and relevant resources available to them (Gameau, 1993). It is possible that the five participants recommended the need for social workers because they had received treatment in a public hospital, where social workers are employed.

Social workers have the relevant knowledge and skills to offer women seeking abortion but they need to be made aware that their services are required. In Carrie's case she was referred to a social worker but was not offered any pre-counselling. Social workers may not only need training in the medical aspects of the abortion procedure but undertake values clarification exercises to assess their attitudes about abortion.

Although Dorris was offered pre-counselling by the nurses, the counselling only focused on the provision of information about the abortion procedure. The nurse did not explore Dorris' feelings about her ambivalent decision to have an abortion, which took three months to reach. According to Davies (1991) in the counselling session, the woman's feelings, thoughts and actions are examined in relation to the abortion. Thereafter, emerging themes and patterns must be discussed so that the woman is able to deal with her decision to have an abortion.

## **TREATMENT**

Six participants accessed private health care facilities to have an abortion. Five of the six participants had their terminations at Marie Stopes Clinic and the other participant had her abortion in Chatsmed Hospital.



During the abortion procedure, the doctor distracted the participants from the procedure by asking them questions of a personal nature. All four participants were irritated at being questioned when they were experiencing intense and severe pain. Mary's impression of this technique was:

I don't know where they got their calming technique from, probably from talk shows. He wanted me to talk about my job. This stressed me out completely. I told him I don't want to talk. I'm actually nervous.

Gloria's recollection of the incident:

The doctor talks to you all the time. He asked me my name and what I do whilst he is working. It takes your mind off things but sometimes you don't want to answer.

No anaesthesia was given to the participants during the procedures so they experienced severe pains. It is understood that the participants would not be able to lie still when feeling pain. When the participants yelled out or squirmed, they were chastised by the doctor. The participants were deeply affected by the insensitive and uncompassionate manner in which they were treated. According to Paul (1999) anaesthesia can be administered to women to effectively control the pain they may experience during the abortion procedure. Local anaesthesia is often affordable, becomes effective quickly and does not cause allergic reactions. Ann stated that:

When I screamed out in pain, the doctor said that he would not take any nonsense and I must lie still.

Kelly stated that:

The doctor shoves this cold anal thing in and opens it up and says to me, cough. Before I could even get a decent cough out, he stuffs the vacuum in. God, the pain!

Mary stated that:

The doctor seemed irritated with me for screaming and squirming. He told me to lie still! No, no, no, you must come down further. You must put your bum down. I felt like I was being a nuisance. The doctor I don't give anything for. I don't think he is a doctor. Not saying he's doing a bad job. Only a butcher can do something so brutal without thinking about it.

Beth's relationship with the female physician was restrictive since Beth was placed under general anaesthesia during the abortion procedure. Prior to the operation, the doctor examined Beth and she was able to gauge the attitude of the doctor. Beth stated that:

The doctor was cold and mechanical in her treatment of me. She acted like she was doing me a favour. I was not allowed to ask any questions. The doctor was helpful because she did not turn me away.

An unequal patient-doctor relationship existed between Beth and the doctor. The doctor exercised a superior attitude over Beth. Beth was not offered any pre-counselling at Chatsmed Hospital. After the abortion, Beth was overcome with feelings of guilt. She was able to turn to her priest for comfort and support. According to a spokesperson for PAS (Davies, 1991) the post abortion difficulties almost never occur but if they do, it is because

of the poor quality counselling that was offered. Therefore, Beth's feeling of guilt and her seeking out help from a religious person can be attributed among other factors to her not being offered any pre-counselling prior to having an abortion.

For the four participants that had an abortion in Marie Stopes Clinic, they encountered five minutes of the worse pain without anaesthesia. This was a traumatic experience for all four participants. They were only provided with two painkillers after the procedure. Kelly who is in the medical profession could not understand the reasoning behind providing the two tablets after the procedure. If the tablets were given ten minutes before the procedure, it would be absorbed into the system and taken effect after the abortion, according to Kelly.

Immediately after the abortion procedure, the four participants at Marie Stopes Clinic were told by the nurse to move to the recovery room. The participants were unable to walk but had to get up from the bed and walk to another room. No consideration was given by the doctor and nurses to the participants inability to walk because of the intense pain they were subjected to. Also the couches on which the participants were expected to relax did not bring any relief from the pain. The participants could not make themselves comfortable on the couches so as to allow the pain to subside. Kelly could only find comfort in the toilet cubicle which helped to ease her pain.

The cost of treatment at Marie Stopes Clinic was R700 which the participants experienced difficulty gathering due to financial constraints. The participants had to provide the money first before they could receive treatment. In Beth's case, management at Chatsmed Hospital were only concerned with her ability to provide the finances for the treatment.

Elaine and Florence accessed the services of their general practitioners and Addington Hospital to terminate their pregnancies. Their general practitioners provided them with prescriptions for misoprostal tablets to induce the abortion. An incomplete abortion resulted and both participants had to complete the abortions at Addington Hospital.

Elaine received treatment from one general practitioner whilst Florence sought out treatment from two different general practitioners because the misoprostal tablets did not cause her to terminate her pregnancy. Neither of the three general practitioners provided Elaine and Florence with pre-counselling. This was particularly relevant in Elaine's case because she was unsure about her decision to terminate.

According to Elaine:

My boyfriend asked me if I didn't want to ask the doctor any questions. I said the doctor will tell me if I needed to know something. I've heard many people say when the doctor explains the procedure, they back off, so I was hoping but he never explained.

The general practitioner who treated Elaine was not in tune with her feelings regarding the termination of pregnancy and neither did he bother to enquire if she was absolutely certain of her decision.

In Florence's case even though the first general practitioner did not provide her with proper counselling regarding her decision to have an abortion, he was able to sense that Florence was anxious that her pregnancy would not terminate. According to Florence:

He told me not to worry, they will come out.

The general practitioner was able put Florence's fears of her pregnancy not terminating to rest.

Elaine and Florence who had no knowledge of abortion procedures, and where abortions were being performed asked their family doctor to help them terminate their pregnancies. The general practitioners had a professional responsibility to inform the patients of the different abortion procedures that were performed so that Elaine and Florence could have decided on the method that most suited them based on the duration, risks and degree of pain. Yet, neither of the general practitioners informed Elaine and Florence of the various methods that could have been used to terminate their pregnancies. The doctors took it upon themselves to decide the type of abortion method that will be performed on Elaine and Florence. According to Paul (1999) doctors have a responsibility to inform their clients of the different abortion methods and the strengths and weaknesses of the different procedures, so that the women can choose which method is appropriate for their situation.

Elaine's general practitioner did not prepare her emotionally to see her foetus being discharged. It was a surreal experience for Elaine discharging her foetus which resembled a "liver." According to Elaine:

I was thinking to myself - I didn't want to believe it. I was telling myself it's not the foetus, its just the blood.

Elaine was told only that she would bleed three days after taking the misoprostal tablets. She was not prepared for the sadness of the process and was afraid that she could be experiencing complications. Her general practitioner failed to provide Elaine with adequate information regarding the use of misoprostal tablets to induce termination. Neither did he make an appointment with her to ascertain if her pregnancy was indeed aborted.

Failure by the first general practitioner to allow Florence to choose the method that best suited her needs, caused Florence inconvenience and anxiety. Florence wanted the abortion to be performed by the general practitioner but because the tablets did not induce the abortion, she had to turn to another doctor for treatment. Even though the second general practitioner increased the dosage of the misoprostal tablets, Florence's pregnancy had still not terminated. Eventually Florence was sent to Addington Hospital by the second doctor for her pregnancy to be terminated.

According to Florence:

I would have liked to have one procedure and not all these things of taking tablets, then going to another doctor, then going to the hospital. If I was at home and I was bleeding and I didn't go back to him, I wouldn't have known that something was wrong. If they (doctors) help you to terminate, they must go through it thoroughly. They must be with you and check you to see that things are happening right. And not to do the procedure by yourself. It is irritating when he gives me the letter to go to the hospital when I went to him for help.

Both Elaine and Florence were treated with compassion by the doctors and nurses at Addington Hospital. In Florence's case the doctor in the trauma room was considerate towards her feelings. He recognised that Elaine had not informed her mother about her pregnancy and did not pursue the issue in the presence of Elaine's mother. The doctor who performed the termination of pregnancy on Florence displayed concern for her when she experienced pain. However, the female doctor who performed the termination of pregnancy procedure on Elaine was judgmental towards her. According to Elaine:

The doctor said you see what you've done is very wrong. Now see what you are going through - I just ignored it. She (doctor) doesn't know what is going on in my life.

Both Elaine and Florence were not provided with the necessary medical information by their general practitioners about the termination of their pregnancies, through the use of misoprostal tablets. They were not prepared for the delaying effects of this procedure, on an emotional level, the possibility of discharging their own foetus and the completion of the termination at a public hospital because the general practitioners do not have the facilities to undertake this procedure. Neither participant exhibited any control over the abortion procedure used, they relied completely on the expertise of the doctor.

Five of the thirteen participants received abortion treatment at government hospitals. Carrie went to Prince Myshiyeni Hospital, Dorris went to King Edward Hospital, whilst Hannah, Irene and Linda went to Addington Hospital.

Both Carrie and Dorris were disturbed by the lack of privacy they experienced in the hospitals. When the nurses recorded their personal details, it was conducted in the open where other staff members could listen in on their conversations. Carrie was questioned about her reasons for having an abortion in the presence of four nurses. According to Carrie:

I volunteered to have an abortion so I couldn't mind. It was painful but I had to adjust.

According to Dorris:

I didn't like this procedure because it wasn't private. It was open and everyone could hear how they teased you.

Abortion is a sensitive issue and many women keep their decision a secret. It is insensitive on the part of the nurses not to take this into consideration when they enquire about the woman's medical history and personal information. Walker and McKenzie's (1995) interviews with women who were granted legal abortions in a Gauteng hospital, revealed that women who encountered a lack of privacy were emotionally affected.

Hospitals provide women who request termination of pregnancies misoprostal tablets to induce the termination. The women have to administer the tablets on their own after they have been examined by the physician. The use of this abortion technique was a delaying process for Carrie, Dorris and Irene. The duration of the abortion process was two and a half weeks for Carrie, three weeks for Dorris and six weeks for Irene. All three participants were perturbed by the duration of the process.



Carrie's delay was the result of a broken ultrasound scan which meant that the gestational period of her pregnancy could not be detected. According to Carrie:

I felt like they (staff) didn't care because I was going to the hospital for two weeks and not knowing if I would qualify for an abortion because my pregnancy was moving along. Also, they don't take full responsibility because if they tell you on Monday to collect the pills on Friday. Why can't they give you the tablets on Monday because it is difficult financially.

For Dorris and Irene the misoprostal tablets did not take effect immediately. Dorris had to administer the tablets on five occasions before it worked. In Irene's case, the doctor had to administer the tablets eventually. According to Dorris:

I was tired of going to the hospital. I was thinking to myself, time is running out and I'm going further along in my pregnancy. I was worrying about my exams which was starting soon.

According to Irene:

When the pills don't work, I was worried and scared.

The delaying process of the misoprostal tablets to induce the abortion was an anxiety provoking experience for Dorris, Carrie and Irene. They were afraid that their pregnancies were progressing and it could mean that they would not qualify for an abortion. It was also disrupting their daily activities. In Dorris' case she was worried about not being able to write her examinations. Also nothing was done by the doctors and nurses to speed up the process or put the three participants at ease. Some of the participants Walker and McKenzie (1995)

interviewed experienced anxiety due to the obstacles they encountered but inspite of these hindrances they were able to access these services. This can be attributed to the women's strong support systems and the ability to communicate which influenced their negotiation skills.

All five participants were informed by the doctor that they could expel their foetus. However, only Carrie and Irene discharged their foetus. Carrie was at home whilst Irene was in the hospital. According to Carrie:

At 4 a.m I felt something on my pad. I thought okay its blood. When I went to the toilet, I was shocked. I had done something wrong, very bad, only to find this tiny thing (gesturing with her hand). Oh! God! I committed a crime. I just killed somebody. I examined it and wrapped it with lots of toilet paper and put it in a plastic bag.

According to Irene:

By 10 p.m it comes out itself, when I was in the bed. I didn't bleed, it just came out. I called for the nurse who came to help me, to clean only. She take that something down.

The sight of their foetus was a traumatic experience for both Carrie and Irene. Even though they were told that they might discharge their foetus it did not prepare them for the flood of guilt and regret. "None of the women expected to give birth to the foetus" (Walker and McKenzie, 1995, p. 57). The women interviewed in the study by Walker and McKenzie (1995) were not prepared to deal with psychological consequences of seeing their foetus. The question that begs to be answered then, should women who access termination of

pregnancy services at hospitals be allowed to administer misoprostal tablets on their own with the distinct possibility of discharging their foetus.

Irene and Hannah were both satisfied with the treatment they received at Addington Hospital. Hannah reached her assessment by comparing the treatment at private and public health care facilities. She arrived at the conclusion that both facilities offer the same treatment with the difference being the cost. Hannah was also pleased with the manner in which she was treated by the doctor who examined her because his treatment was thorough and he conveyed his instructions clearly.

The nurse who treated Irene, displayed concern for Irene's well being. For Linda the legalisation of abortion on demand, was necessary for women who found themselves with an unplanned pregnancy. It gave her peace of mind knowing that it was performed in a clean and safe facility.

However, the treatment that the doctors and nurses provided to Linda was not a positive experience. Dorris and Carrie were also subjected to verbal abuse by the nurses and doctors who provided them with treatment. When Linda failed to meet the criteria required for termination of pregnancy, she was shouted at by the attending nurse. She encountered a similar fate with the doctor. According to Linda:

The sister (nurse) was so nasty. She scolded me. She made me feel awful. She screams loud and doesn't care that other patients are listening.

According to Dorris:

I didn't like the way I was treated by the nurses. Made me feel like a criminal. Law is there but if it is there we have to acknowledge it. Mustn't make people feel guilty. They told me, so you decided that if your sister is working, you will bring guys in your room. It made me think so these people (nurses) think I sleep around. I really didn't feel good about this. At some point I felt I wouldn't say anything but they will make me say something and I will be really, really angry.

According to Carrie:

They took my legs roughly and placed it in the stirrups. They told me, do it man, do it, we (nurses) don't have time for this. You chose this, we don't have time for this, the doctor is in a hurry. This was emotionally painful for me. At the end of the day, I saw this foetus coming out and I felt guilty and now they are telling you, you chose this. Because of the pain I screamed out, Oh my God! They told me how dare you call out that name in this room after what you did. I was so ashamed and embarrassed because I'm a Christian person. This is the stage I hate the most.

All thirteen participants were emotional upon learning of their unplanned pregnancy. None of the doctors or clinics that confirmed the pregnancies addressed these feelings. Whilst feeling distraught, these women were able to arrive at a rational decision on their own to have an abortion. Most women informed their friend, partner or significant other about their pregnancy and these social support networks were able to offer the participants moral and financial support. No pre-abortion counselling was offered at this stage so the participants had to set aside their feelings to make a decision about their pregnancy. The most common

reasons cited by the participants for terminating their pregnancy, was to continue with their education and lack of financial resources.

The majority of the participants who were provided with pre-abortion counselling stated that it was provided at an inappropriate time, that is, when their decision was made. Also pre-abortion counselling was provided by nurses who were ill equipped to offer counselling. The nurses were clinical in the counselling and did not explore the feelings of the participants.

The effects of not being provided with pre-abortion counselling reverberated itself throughout the abortion process. The participants had no knowledge of the different types of abortion methods or their reproductive rights as stipulated in the Choice on Termination of Pregnancy Act, No 92 of 1996. Therefore, the participants did not choose a health care facility that uses an abortion technique which best suited their needs. They relied on the referral skills of their general practitioner.

Dorris, Carrie and Linda were treated in an insensitive manner by the nurses and doctors. The three participants felt that they had to be grateful for being given the opportunity to terminate an unplanned pregnancy and, therefore, they could not respond to verbal attacks. From the responses of the women interviewed by Davies (1991) she was able to deduce that when the women were treated in a negative manner by hospital staff, they were unable to retaliate because they were in unfamiliar surroundings and did not know if the staff member was always rude or was only treating them in a nasty way. The women interviewed by Walker and McKenzie (1995) "felt judged and criminalised, despite having the law on their side" (p. 60). Walker and McKenzie (1995) concluded from these findings the treatment the nurses in South Africa provide to women requesting termination of pregnancy is "wholly inadequate" (p. 60). The two researchers recommended that abortion ethical committees must be established to enable women to have some recourse to address the unprofessional

treatment they endured.

Almost all the participants stated that they did not know what was contained in the Choice on Termination of Pregnancy Act, No 92 of 1996. Their lack of knowledge and understanding of the Choice on Termination of Pregnancy Act, No 92 of 1996 meant that the participants did not know what their rights were and what services they were entitled to. As a result they were unable to offer any responses in their defense because they were under the misconception that they would not have been granted an abortion. This however, was not the sole reason for the participants not responding to the verbal attacks and other factors contributed to them not responding.

Included in the reproductive rights of women is a need for reproductive services and sexual health information to be voluntary and to be of a high calibre (Reproductive Rights Alliance, 1998). Participants made their decision to have an abortion when scant reproductive information was made available to them by medical personnel which might have contributed to the anxiety and trauma experienced in the process.

In the private and public health care facilities, there was some degree of inadequacy in the provision of termination of pregnancy services. In private care there was the issue of the participants not being sedated during the abortion procedure and the immense physical pain the women had to endure. Also the participants were affected by the insensitivity demonstrated by the doctor during the procedure, when they cried out in pain. If participants were sedated with general anaesthesia, the cost of the abortion would have increased as well as the risk involved in monitoring the participants breathing, to prevent them from lapsing into a coma. Kelly who is employed in the medical field, suggested an effective way to address the management of the pain by providing the participants with aspirins before the procedure so that the tablets take effect during the procedure. After the abortion procedure,

the participant would not experience such intense pain. The duration of the treatment at private health care facilities was faster than treatment at public care facilities.

The participants who accessed termination of pregnancy services at public health care facilities did so because treatment was free. They were not prepared for procedural delays and how long it took for the tablets to take effect. The issuing of misoprostal tablets at public hospitals was the cheapest method of abortion and accounted for the free treatment that the participants were provided. These women were deeply affected by the judgmental attitudes displayed by the doctors and nurses. Finally, the women who went to their family doctor for treatment were under the misconception that their doctor would be able to perform the abortion. They too encountered procedural delays.

The following chapter draws conclusions of the research study and proposes recommendations for future services.

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATIONS**

The aims of the study were to determine the criteria the participants had to satisfy in order to access termination of pregnancy services, the termination services that are available and the quality of these services from the participants perspectives. These findings can inform the process women go through when contemplating having an abortion. There are commonalities in the process, like the services available to women, the treatment they receive and the nature of their experiences.

For each participant the decision to have an abortion and the actual experience were traumatic. Although all the participants did have social systems to confide in, they required much more specific information in order to help them make informed choices. The social support systems was nevertheless vital to the participants who were not offered professional counselling. Vogue (1995) described the dilemma that a woman is confronted with if she decides to have an abortion as “women don’t want abortions as they want an ice-cream, they want it as an animal wants to gnaw of its own legs” (p. 117). Although participants exercised their reproductive rights by deciding to have an abortion, it was not an easy decision or experience. However, by making the decision on their own to terminate their pregnancy, the participants demonstrated control over their own bodies. Some of the participants encountered partners/friends who initially did not agree with their decision to have an abortion but this did not deter the participants from changing their minds.



The only professional(s) all the participants were exposed to prior to making a decision, was their general practitioner and in some instances nurses at private/public health care institutions. Most of the participants were not provided with pre-counselling and those who received pre-counselling at the private clinic, felt it was inappropriate. Not receiving pre-counselling as well as other factors placed the participants at a disadvantage, the effects of which reverberated in the process that followed thereafter. Forrest (1994) deduced that pre-counselling is crucial to help women become aware of the psychological factors involved in having an abortion as this allows the woman to better deal with the issues of abortion. Forrest's (1994) study revealed that the levels of stress for women who have an abortion is much higher before the actual abortion procedure and the women are in a state of crisis. Therefore, it is imperative that women who decide to have an abortion are provided with pre-abortion counselling.

The participants received treatment from private, public and a combination of private-public institutions. The participants were not emotionally prepared for having an abortion and neither were they equipped with information about the practical arrangements and had to rely on the referrals provided by their general practitioner. The most important criteria the participants had to satisfy in order to receive termination of pregnancy services was that the gestational period of their pregnancy had to be under 13 weeks. The private health care institutions charged a fee to perform the abortion procedure and the participants had to pay the full cost before a service could be rendered. With the influx of women presenting for termination of pregnancy services at public hospitals, a quota system was employed at King Edward Hospital whilst Addington Hospital required a referral letter from the participants and proof that they lived in central Durban in order to access their services. It was also not an easy process to access services since some participants who used the public health facilities had to meet certain criteria, such as, living within a certain location to qualify for assistance.

Prior to receiving treatment all the participants experienced grave difficulty in choosing to terminate their pregnancy. This initial turmoil was compounded by the poor quality treatment the participants received, which negatively affected the participants psyche. The participants were highly dissatisfied with the treatment they received because they were unable to choose the abortion method used, which caused them physical pain and anxiety due to the delays as well as being subjected to the judgmental attitudes of the doctors and nurses. Only one participant received formal post-abortion counselling, whilst another participant sought help from her pastor. Intervention was direct, primarily from a medical perspective and was treatment orientated.

Although the Termination of Pregnancy Act, No 92 of 1996 is seen to uphold the rights of women, it is clear from the study that personnel directly involved in the provision of services with regard to termination of pregnancies, do not share similar views. Their harsh and callous treatment of the participants seemed intentional and made them feel guilty. Policies, however well intentioned do not necessarily change attitudes and the review and evaluation of attitudes of professional personnel involved in service implementation is imperative.

## **RECOMMENDATIONS**

Services to women needing to have abortions must be holistic, comprehensive and be provided by a multi-disciplinary team of professionals comprising of physicians, nurses, social workers and psychologists. Privacy is a crucial aspect for women who terminate their pregnancies because of the sensitivity surrounding the issue. Abortion is a controversial issue with far reaching consequences for women who terminate their pregnancy and should not be addressed solely from a medical perspective. The physician is responsible for performing the abortion with the assistance of nurses. Nurses need to help women be calm and relaxed prior to and after the procedure. Reasons often cited by women requesting termination of

pregnancies are complex and require skilled intervention by social service professionals for example, social workers. Social workers have counselling expertise which can prove invaluable in helping deal with the traumatic situations such as, when women discover they have become pregnant accidentally. If the woman displays post-abortion trauma or if there is evidence in the pre-counselling session that she has a history of psychological trauma, therapy should be continued. Therefore, abortion services provided by a multi-disciplinary team ensures women are provided with the best treatments since each professional is an expert in their respective fields. Womens Health Project (1999) proposed that reproductive health care for women requesting termination of pregnancies be “holistic, comprehensive and women friendly” (p. 1). According to Schultz (1972) the issue of abortion is as important to social work as it is to other professions. Therefore, this research has immense value for social workers and other professionals who are responsible for providing abortion services and treatment.

Social workers in public hospitals need to intervene at a stage when women discover an unplanned pregnancy. Women need to be referred to social workers who will assess their situation. Crisis intervention counselling needs to be provided to help women reach stable levels of functioning. The various options available to women should be explored, like adoption, having the child, foster care and abortion. The women must be allowed time to make an informed decision, and should be provided with the supportive counselling when the decision is made.

If the woman decided to opt for the abortion route, then the social worker needs to work through the woman's feelings about abortion and she needs to be educated about the various abortion techniques that could be used. The social worker together with medical professionals needs to help the woman decide on a technique that best suits her, in terms of her threshold for pain, duration of procedure, cost of procedure and her gestational period.

Finally, the social worker should refer the woman to clinics/hospitals that offer the type of abortion technique that she has chosen. These interview guidelines follow the pattern offered by Lowry and Blank (1972). Social work intervention should ensure that a woman understands the implications of having an abortion, that she takes responsibility for her decision and that she find ways to deal with her decision (Gameau, 1993). The development of a high risk screening programme by the Social Work Department at an Adelaide Hospital in Australia, has seen a marked improvement in the quality of services offered to women who request an abortion (Gameau, 1993).

Where social workers are not able to offer counselling directly to women who want to have an abortion, they need to pass their counselling skills to other professionals, such as nurses and doctors through training workshops. This is currently being implemented in the Free State, where the Department of Welfare, working in collaboration with the Department of Health, has been offering counselling to health workers (Reproductive Rights Alliance, 1997).

The implementation of more workshops which focus on values clarification needs to be encouraged and attendance to these workshops should be compulsory for all health care professionals who provide a service to women who request abortions. Evidence has shown that negative attitudes of doctors and nurses have detrimental effects on women who request abortions (Tanner et al, in World Health Organisation, 1978). Nurses need to be provided with counselling training. Nurses interviewed for a research conducted by Poggenpoel, Myburgh and Gmeiner (1998) stated that they did not have the relevant skills to counsel women who have terminated their pregnancies and recommended that nurses who provide termination of pregnancy services should undergo training in how to provide pre and post abortion counselling.

Further research needs to be conducted on abortion from the service provider's perspective. This will enable women who access termination of pregnancy services to understand the constraints service providers are confronted with when providing a service, such as lack of resources and limited time.

The research focused on the experiences of participants, albeit negative in most cases, who terminated their pregnancies. Detailed accounts of the process the participants followed in accessing termination of pregnancy services were provided to analyse the quality of treatment that were offered to them. Termination of pregnancy services ought to be available to all women who need it but financial constraint restrict choices and perpetuates violation of women's rights despite the promulgation of the Choice on Termination of Pregnancy Act No, 92 of 1996.

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# APPENDIX A

## INTERVIEW SCHEDULE

### A. BACKGROUND INFORMATION

1. AGE:
2. MARITAL STATUS:
3. OCCUPATION:
4. RELIGION/CULTURE:

### B. DECISION-MAKING:

1. How did you discover that you were pregnant?
  - on your own (home pregnancy test).
  - did you visit your doctor to do a proper test?
  - how were you treated by the doctor?
2. How did you feel when you discovered that you were pregnant?
  - were you alone or with someone?
  - did you inform anyone of your pregnancy?
  - YES- whom? why?
  - NO- why?
3. What did you do after you discovered that you were pregnant? (Explore).
  - did you receive any form of counselling about how to cope with your pregnancy and the options available to you?
  - YES- whom? What actually took place during the counselling session?
  - NO- how did you arrive at the decision to terminate your pregnancy?

### **C. BEFORE ABORTION:**

1. Did you know anything about abortions?
  - YES, what? (Act/general knowledge/medical procedures).
2. Did you know where abortions were performed?
  - YES- how?
  - NO- how did you go about searching?
3. How far did you have to travel to have the abortion?
4. How much did it cost for the operation?
  - were you able to afford it?
  - NO- how were you able to pay for the expenses?
5. What kind of relationship existed between yourself and the doctor when you requested to have your pregnancy terminated?
  - a) what were you asked?
  - b) were you allowed to ask any questions?
  - c) what was his/her attitude towards you?
  - d) did the doctor offer you any advice/counselling? (YES- what?)
  - e) on what grounds were you accepted?
  - f) were you allowed to change your mind at the last minute?
  - g) explain the procedure of filling in forms. (what questions were asked in the form?).
6. Once you were granted the abortion by the doctor, how long did you have to wait before the actual procedure?
  - how long did the operation last?

7. Were you offered any professional counselling prior to the operation?
  - YES- whom? what happened during the session?
8. What operation was performed? (Explain the procedure).
  - did the doctor/nurses explain the procedure to you prior to the operation?
  - were you informed about the risks involved?
9. What were your expectations of the procedure?
  - did they differ from what actually happened?
10. Were you allowed to bring anyone to be with you during the operation?
11. How did you feel just before the operation?
12. How did you feel during the operation?

#### **D. AFTER ABORTION:**

1. Explain what happened directly after the operation.

- what did you do?
- where did you go?
- were you alone/someone?
- how were you feeling at this point?

2. Were you offered any post-abortion counselling?

- YES- explain what happened.

3. Were you asked to come in for check ups later?

- YES- what happened?

4. Did you join any support groups?

- were you aware that any existed?

5. Today, how are you feeling?

6. How are you coping?

- are you still being counselled?

7. Did any of the services you received help you in any way?

- YES- which services? how?
- NO- why?

8. In the future what would you like being done to improve the services for women seeking an abortion?

## APPENDIX B

32 Camphaven Road  
Foresthaven  
Phoenix  
4068

14 April 1999

.....  
.....  
.....  
.....  
.....

Dear sir/madam

### REQUEST FOR CONSENT IN RECRUITING PARTICIPANTS FOR MASTERS DISSERTATION

I am a final year social work masters student at the University of Natal, Durban. I have based my research on the experiences of women who terminated their pregnancies and the bio-psycho-social implications of having an abortion. The aim of the study is to determine what were the effects of the abortion services on the woman, in terms of their decision to terminate their pregnancy as well as the nature and accessibility of the services that were provided to these women. The legalisation of abortion on demand in South Africa, only came into effect in 1997, which means that it is relatively new and little, if any, research had been conducted around the implementation of the Choice on Termination of Pregnancy Act, No 92 of 1996.



This research has immense usefulness for women who are seeking to terminate their pregnancy. Based on the reactions of past recipients, it will hopefully lead to an evaluation of the current services and ultimately an improvement of the services offered to women requesting termination of pregnancy. The participants of this research are women who have had an abortion between 1997-1999. I would like to interview between 10-20 women. In no way are the questions judgmental/offensive to the participants. This is an extremely sensitive issue and the participants absolute confidentiality and anonymity will be guaranteed.

I am writing to you to ask for your consent in allowing me to recruit participants from your institution in one of two ways. Firstly, if it is possible to put up posters in your institution, informing women about my research and if they would be interested in participating. Alternatively, would it be possible to have access to your patient case load with their permission. I have a limited time frame in which to complete my research so I would really appreciate a response from you within 2 weeks.

I would like to re-iterate that at no time will I be judgmental towards the participants. I am fully aware of the sensitivity around the issue of abortion.

I look forward to your prompt reply.

Yours sincerely

D. Govender (Miss)