

**DEMAND FOR MEDICAL ABORTION:
A CASE STUDY OF UNIVERSITY STUDENTS IN
DURBAN, KWAZULU-NATAL, SOUTH AFRICA**

by

ASHLEY GRESH

November 2010

DECLARATION

Submitted in partial fulfilment of the requirements for the degree of Master's in Development Studies, in the Graduate Programme in the School of Development Studies, University of KwaZulu-Natal, Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master's in Development Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

Student signature

Date

Abstract

Abortion remains one of the most controversial sexual health topics and yet is a common experience for women around the world. Making sure that women are practicing safe abortions is integral to women's sexual and reproductive health as well as their sexual rights. South Africa has one of the most progressive and liberal abortion laws in the world, yet women still face major barriers in accessing these services.

Introducing medical abortion as another termination of pregnancy option could potentially save women's lives, while reducing the number of unsafe abortions in South Africa. Medical abortion also contributes to fulfilling women's sexual and reproductive rights, providing more choices to best suit their needs. In 2001, the South African Medicines Control Council (MCC) approved the use of mifepristone in conjunction with misoprostol for termination of pregnancy. Currently there is no formal national policy that allows for the provision of medical abortion in public health facilities, and the Department of Health is considering introducing it into the public sector.

In order for any public health intervention to be successful it must be acceptable to potential clients and the context in which it is being implemented must be assessed. This study first looks at women's attitudes toward abortion; following Eaton's model of sexual behavior it examines the personal, proximal, and distal environments that influence reproductive decision-making, specifically regarding abortion. With this background information, the study then aims to assess women's knowledge of medical abortion and whether or not they find it to be an acceptable method for the South African public health system and South African women.

The findings suggest that there is a demand for medical abortion among this sample of women. The majority of women find medical abortion to be an acceptable method, and would choose it if they were ever faced with having to terminate a pregnancy. The overwhelming majority of women felt that medical abortion should be introduced into the public sector and efforts should be made to ensure that this method is affordable, accessible, and available for women in South Africa in order to expand their sexual and reproductive health rights.

Acknowledgments

This dissertation is dedicated to all those that have come in to my life during the course of my studies. It is dedicated to the late Siyanda Ndlovu for the love, laughter, and passion for life that he shared with me. He inspired me to keep this project alive. It is also dedicated to all of the women that struggle to have the right to choose and to live free.

I would like to thank all of the women in this study that shared their experiences with me. I was continually humbled and inspired throughout the interviews. Your stories and insights made this work possible, and reveal the hard work that is needed to improve women's sexual and reproductive health care.

I would also like to thank my family for giving me support and letting me lean on them in times of need; while oceans apart, they still remained close to me to offer encouragement and continue to inspire me. From Durban to New Hampshire and many places in between, I'd like to thank all of those people who have discussed and debated abortion issues with me, from casual encounters to in depth discussions. While there are too many individual names to mention in this space, I want to express thanks to those people that I have met here in Durban that have shared their love with me and supported me, I am forever grateful.

This work would not have been possible without Rotary International who provided me with the opportunity to study at the University of KwaZulu-Natal, and for giving me the foundation and support to produce this dissertation.

Finally, I would like to thank my supervisor, Professor Pranitha Maharaj, for challenging me, and encouraging me to delve into the case study that you are about to read.

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Committee on the Elimination of Discrimination Against Women
CESCR	Committee on Economic, Social, and Cultural Rights
CRC	Committee on the Rights of the Child
CTOP	Choice on Termination of Pregnancy Act
D&C	Dilation and Curettage
D&E	Dilation and Evacuation
DoH	Department of Health
EC	Emergency Contraception
ERPC	Evacuation of Retained Products of Conception
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
ICMA	International Consortium for Medical Abortion
ICPD	International Conference on Population and Development
KZN	KwaZulu-Natal
LMP	Last Menstrual Period
MCC	Medicines Control Council
MDG	Millennium Development Goal
MRC	Medicine Research Council
MVA	Manual Vacuum Aspiration
NAF	National Abortion Federation
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NGO	Nongovernmental Organization
RHRU	Reproductive Health & HIV Research Unit
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy
TRC	Truth and Reconciliation Campaign
UKZN	University of KwaZulu-Natal
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Table of Contents

DECLARATION	II
ABSTRACT	III
ACKNOWLEDGMENTS	IV
ACRONYMS AND ABBREVIATIONS	V
TABLE OF CONTENTS.....	VI
TABLES AND FIGURES	VIII
CHAPTER 1: INTRODUCTION	1
1.1 Introduction: Background and Problem Statement.....	1
1.2 Family Planning: Global Unmet Needs	4
1.3 Expanding Sexual and Reproductive Health Rights: A History of Abortion in South Africa	7
1.4 Medical Abortion and its Place in the History of Abortion Developments	10
1.5 Structure of the Thesis	16
CHAPTER 2: LITERATURE REVIEW	17
2.1 Unsafe Abortion and Development	17
2.2 Making Abortion Safe: Public Health Imperatives.....	19
2.2.1 Abortion Reform in South Africa: Progress and Problems.....	21
2.3 The Abortion Debate in a Developing Areas Context: The Personal, Proximal, and Distal Contexts of Reproductive Decision-Making.....	24
2.4 “Pro-Choice”: Abortion Methods in Developing Countries	36
2.4.1 Women’s Perspectives on Medical Abortion: Choice and Acceptability.....	39
2.4.2 Provider Perspectives on Medical Abortion.....	41
CHAPTER 3: THEORETICAL FRAMEWORK AND RESEARCH METHODOLOGY	43
3.1 Introduction	43
3.2 Theoretical Framework.....	43
3.3 Target Population and Study Sample.....	45
3.4 Collection of Data.....	47
3.5 Ethics.....	49
3.6 Analysis Techniques	49
3.7 Limitations.....	50
3.8 Summary.....	51
CHAPTER 4: RESULTS.....	52
4.1 Introduction	52
4.2 Attitudes toward Abortion.....	52
4.3 Making Abortion Safe: Perspectives on Illegal Abortions in South Africa.....	65
4.4 “Pro-Choice”: Perspectives of Abortion Methods.....	67

4.4.1 Medical Abortion: Advantages and Disadvantages	69
4.4.2 Introducing Medical Abortion to Public Facilities in South Africa.....	76
4.5 Summary	78
CHAPTER 5: DISCUSSION AND CONCLUSION	80
5.1 Discussion.....	80
5.2 Recommendations.....	85
5.3 Conclusion.....	88
BIBLIOGRAPHY.....	90
APPENDIX I: MEDICAL ABORTION VERSUS SURGICAL ABORTION.....	99
APPENDIX II: INFORMATION SHEET: MEDICAL ABORTION.....	100
APPENDIX III: INFORMED CONSENT FORM.....	102
APPENDIX IV: 1996 CHOICE ON TERMINATION OF PREGNANCY ACT ...	104
APPENDIX V: PRINCIPAL INTERVIEW SCHEDULE.....	110

Tables and Figures

Figures

FIGURE 3.1: Eaton's Theory of Sexual Behavior.....	44
FIGURE 4.1: Photograph: Smith Street, Durban, KwaZulu-Natal.....	65
FIGURE 4.2: Photograph: Smith Street, Durban, KwaZulu-Natal.....	66

Tables

TABLE 3.1: Sample Characteristics of Participants	47
---	----

Chapter 1: Introduction

“Abortion, contraception, and sex education strike at the heart of the most intimate areas of life, challenging our perceptions of what it means to be human and what women’s role in society should be.” (Knudsen, 2006, 1).

“We used to talk about development with a human face. We should be talking about development with a body.”

-Arit Oku-Egbas, Africa Regional Sexuality Resource Center, Nigeria (Cornwall and Jolly, 2006, 10).

1.1 Introduction: Background and Problem Statement

Abortion remains perhaps one of the most controversial sexual health topics, and yet despite the long-standing stigmas and opposition to its practice; termination of pregnancy remains a common experience for women around the world. Every year the World Health Organization (WHO) estimates that approximately 210 million women become pregnant throughout the world; and of these one in three pregnancies ends in stillbirth, spontaneous, or induced abortion (WHO, 2007, 1). Of these abortions, an estimated 20 million are conducted in unsafe environments or performed by unskilled individuals, putting millions of women at risk every year (UNFPA and Guttmacher, 2009a, 4). As a result of these unsafe contexts, nearly 70,000 women die per year, representing 13% of pregnancy-related deaths (UNFPA, 2004). To frame these facts in another manner, somewhere in the world a woman dies every eight minutes as a result of an unsafe abortion (The Lancet, 2009, 1301).

Sexual and reproductive rights, including access to safe abortion services, are increasingly recognized as integral to human rights. While sexual and reproductive health varies around the world in definition, scope, and practice depending on cultural, political, economic, social and historical factors, it is an issue that affects everyone and therefore is a developmental concern for countries around the world. The International Conference on Population and Development (ICPD) in 1994 defined sexual health and sexual rights as the following:

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the

right of all persons, free of coercion, discrimination and violence to the highest attainable standard of sexual health, and to access to sexual and reproductive health care services.” (Shapiro and Ray, 2007, 67)

In accordance with the above definitions of sexual health and sexual rights, and considering the high risks of unsafe abortion, the need for safe abortion services that are acceptable, available, accessible, and affordable for women are vital to reduce morbidity and mortality associated with unsafe abortion.

The development of medical abortion in the 1980s increased options for women to realize their sexual and reproductive health rights. Medical abortion, using a regimen of mifepristone and misoprostol, is essentially the use of pills to induce a miscarriage. It has been shown to be an effective, acceptable and safe alternative to surgical abortion in many countries (Cooper et al., 2005). Making medical abortion available in public health systems will expand women’s sexual and reproductive health options and thereby fulfill women’s sexual rights.

There is no proclaimed “best method” for the termination of pregnancy; it is highly dependent on individuals and various local, regional, national, and international contexts. Medical abortion, as a sexual and reproductive health technology, represents an advance for women. Advocates suggest that it has the potential to be beneficial particularly in developing country contexts, where approximately 97% of deaths from unsafe abortion take place, because no surgical procedures are required (Sedgh et al., 2007, 1338). It has the potential to be cost effective, and safer for women in resource poor settings (Sedgh et al., 2007).

Whether or not this method is used depends on various factors, depending on the national, regional, local, and individual contexts. At the time of writing, 35 countries have approved the use of medical abortion. In those countries where it is legal, it depends on the level of acceptance of the method in society, and individual’s preferences, to determine whether or not it is used (NAF, 2009a). However, there is limited research examining the acceptability of medical abortion among women and providers

Expanding women’s options to realize their sexual and reproductive health rights, including access to safe abortion, is vital in order to achieve the Millennium Development Goal 5 (MDG) to reduce maternal mortality by 75% by 2015 and to prevent unnecessary morbidity and mortality among women. Putting plans into action to address

sexual and reproductive health prove challenging; every region and country faces different obstacles depending on local contexts and the myriad of factors that shape sexual health and behavior.

In order to be successful and effective any public health measure must be holistic in nature. When integrating abortion methods into health systems, these measures should take into account why women have abortions, what kind of services are required, the type of service providers that are needed, staff training, cost of services, counseling issues, and user's preferences and acceptability of methods (Berer, 2000).

This case study explores women's attitudes toward abortion, and the complex contexts in which reproductive decision-making occurs, what influences women's decisions and shapes their opinions of abortion. The central aim of the study is to examine the acceptability of medical abortion as a method for pregnancy termination among female, university students under 30 years old in Durban, KwaZulu-Natal, South Africa. The study further investigates the potential demand for medical abortion in the public sector, and whether or not it is a viable option for women making choices about termination of pregnancy.

University students are used for this sample because students often become agents of social change in society, and can serve as an indicator as to whether or not there will be a demand for medical abortion. Critical consciousness, coined by educational theorist Paulo Freire, fostered in a university setting sets the stage for change; this educated population often creates markets for new medical technologies to be introduced to a population or sub-population (Freire, 1996). In addition, studies have found that for developing regions as a whole unsafe abortions peak among women aged 20-29 years old (Grimes et al., 2006, 1909; Shah and Ahman, 2004, 9). Age patterns of unsafe abortion are important to look at in order to tailor effective interventions to prevent the occurrence of unsafe abortion and ensure services are provided for women. Focusing on women under 30 years is important in order to target the population that is most at risk.

The key research questions examined fall into three main categories:

1. *What influences women's decisions surrounding abortion?*
2. *What are women's perceptions of medical abortion?*
3. *To what extent are women supportive of medical abortion?*

In order to assess the demand for medical abortion it is necessary to understand the context in which these choices are being made. This study further looks at female university students' perceptions of and attitudes toward medical abortion. The study contributes to ongoing research on the viability of medical abortion as an option for women, expanding their choices in sexual and reproductive health.

In the South African context of high rates of unwanted pregnancies, and abortions happening in unsafe environments by illegal providers, there is an urgent need to expand women's options to reduce abortion related morbidity and mortality and fulfill women's sexual and reproductive health rights.

1.2 Family Planning: Global Unmet Needs

"...voluntary family planning is the best protection against abortion, as well as a major contributor to saving women's lives and a human right."

-Fred Sai, former president of IPPF, excerpt from Open Letter to Pope John Paul II (David, 1992, 18).

"Reproductive health strategies are built around a core insight that is at once simple and deeply revolutionary: that women as full, thinking, feeling personalities, shaped by their particular social, economic, and cultural conditions in which each of them lives, are central to their own reproduction."

- (Freedman and Isaacs, 1993, 18).

Unsafe sex is classified as the second leading risk for burden of disease globally, measured in disability-adjusted life years (DALYs) (WHO, 2009). The top global disease risk factors are as follows: underweight (6% of DALYs); unsafe sex (5%); alcohol use (5%); and unsafe water, sanitation and hygiene (4%) (WHO, 2009, v). There are many effective interventions available to practice safe sex, prevent unintended pregnancy, and provide safe abortions; however referring back to figures given from WHO, 45 million pregnancies per year end up in abortion, and more than one half a million women die from pregnancy related complications (Glasier et al., 2006, 1595).

In the last decade international funding and commitment to family planning has waned. There is a need to prioritize this agenda because of its potential benefits for societies around the world. Approximately 215 million women around the world who wish to avoid pregnancy are currently not using effective contraceptive methods (UNFPA and Guttmacher, 2009a, 4). It is a fundamental right for women to have the ability to

choose the number and timing of bearing children, which means having access to contraceptive methods, through national family planning programs.

The lack of priority placed on family planning programs exacerbates the high levels of unmet need, specifically in sub-Saharan Africa. Unmet need is most commonly defined as:

“The proportion of fecund married women who wish to avoid further childbearing altogether or postpone their next child for at least two years but are not using contraception.” (Cleland et al., 2006, 1814).

The major barriers to family planning and contributing factors to unmet need are: lack of knowledge about contraceptive methods and sexual health; fear of social stigma; fear of side effects; and women’s fear of partner resistance (Cleland et al., 2006). The use of family planning services is often correlated with education, economic status, and place of residence (Gribble and Haffey, 2008). In parts of sub-Saharan Africa unmet need exceeds 30% in all married women (Gribble and Haffey, 2008, 1). This highlights the broader socio-economic context that greatly influences access to services and further sexual practices and behaviors. It also highlights the need to link family planning services with broader systemic issues.

Family planning programs have the potential to have population-wide health benefits; help poverty reduction; improve gender equality, human rights and education; and improve environmental sustainability (Cleland et al., 2006). By increasing access to contraceptives, and increasing birth intervals, family planning programs have the potential to reduce maternal mortality rates by approximately 69% annually (UNFPA and Guttmacher, 2009b).

Meeting women’s needs for family planning would have immediate health benefits, and would reduce unintended pregnancies by 77% annually (UNFPA and Guttmacher, 2009b). Meeting the unmet need would also reduce unsafe abortions from the estimated 5.2 million per year to 1.2 million (if there is no change to national laws) and reduce the number of women needing medical care from abortion complications from 2.2 million to 500,000 annually (UNFPA and Guttmacher, 2009b). Currently, in sub-Saharan Africa in gynecological wards, patients with abortion complications occupy up to 50% of beds (UNFPA, 2004). Unwanted pregnancy is a serious problem that is occurring throughout the world, and unmet need should be urgently addressed.

Family planning needs to be made a priority in order to reduce the high rates of death and disability among women and children, as well as prevent the large number of unwanted pregnancies that often result in termination. This can be done through a variety of methods, such as through health facilities, community based approaches and media (Cleland et al., 2006). Providing safe abortion services should be looked at in conjunction with family planning needs to create holistic and comprehensive programs.

Focus on South Africa: Family Planning

Reproductive rights in South Africa are characterized by extremes, which are demonstrated by the stark health inequalities. With 48 million people, the majority black African (79.2%), alongside minority populations that are white (9.2%), Colored (9%), Indian (2.6% “the terms used for the different races are consistent with those in common use and employed by the national census and do not imply acceptance of racial attributes of any kind”) and 11 official languages, health inequalities are still existing along racial lines even 16 years after apartheid (Coovadia et al., 2009, 1).

When the apartheid government came into power in 1948, it claimed that the black population was draining the country’s resources, and in 1974 began a vertical family planning program (Knudsen, 2006). Patients received contraceptives or sterilization free of charge, and in rural areas injectables (Depo Provera) were the only available form of contraceptives (Knudsen, 2006). Multitudes of women were given Depo Provera without consent and sometimes without knowledge immediately after childbirth in public hospitals (Knudsen, 2006).

Contraception then became looked at as a form of “population control”, and it was not integrated in to the primary health care system. In 1998, four years after apartheid ended; the Truth and Reconciliation Campaign (TRC) discovered a research initiative for an infertility vaccine that the South African Defense Force had undertaken through the Chemical and Biological Warfare Program (Knudsen, 2006). Because of family planning programs imposed in such a forceful nature, many women lost trust in the contraceptives and the health system that distributed them.

In the transition to a new democratic government in 1994, the government inherited a divided, fragmented, and extremely inequitable health system (Cooper et al.,

2004). The landmark conference, the International Conference on Population and Development (ICPD) occurred during the same time period as South Africa's democratic transition. The ICPD was the first international conference South Africa participated in as a democratic government. In accordance with ICPD, South Africa adopted some of the most progressive legislation in the world relating to sexual health, specifically abortion, and was praised for integrating its reproductive health policies in line with the ICPD (Knudsen, 2006). The ICPD, in a groundbreaking consensus, stated that women should have access to treatment for abortion-related complications, post-abortion counseling, education, and family planning services, regardless of the legal status of abortion (UNFPA, 2004).

The primary health care approach that the South African health system took on emphasizes health as a human right, decentralized services, and community involvement (Cooper et al., 2004). However, despite the progressive legislation in sexual and reproductive health, there are still many challenges putting these policies into practice due to shortages in human and financial resources and an increase in use of public services (Cooper et al., 2004). This draws attention again to the broader socio-economic and political context, and systemic inequalities that need to be overcome in order to implement these progressive policies that were created in 1994.

1.3 Expanding Sexual and Reproductive Health Rights: A History of Abortion in South Africa

“Recognizing the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognizing that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognizing that both women and men have the right to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognizing that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counseling program and services;

Recognizing that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control;

This Act...promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

-Preamble of 1996 Choice on Termination of Pregnancy Act (CTOP)
(Republic of South Africa, 1996) [See Appendix IV for complete Act]

Starting in the 1900s abortion was considered a “crime against the state” in South Africa (Knudsen, 2006, 13). In 1975, under apartheid, the Abortion and Sterilization Act was passed which made abortion illegal with the exception of certain circumstances: if there were dangerous medical conditions for the mother; if the fetus was handicapped; or the pregnancy was a result of rape or incest (Knudsen, 2006). Some women were able to get around the bureaucracy to obtain safe and legal abortions with the help of doctors, however this was limited to mainly wealthy, white women that could pay for private services (Knudsen, 2006). In 1990 white women made up 800 out of 1200 legal terminations (Knudsen 2006, 13). As a result of the legal restrictions and lack of access to health services most individual women’s desires were unmet.

Responding to the recommendations of the ICPD, and pressure from national and international civil society organizations, in 1996, during major constitutional reform in South Africa, the Choice on Termination of Pregnancy Act was enacted. The 1996 Act gives women the right to request termination of pregnancy (TOP) up to and including the 12th week of pregnancy and under certain circumstances between the 13th and 20th week of pregnancy, to be provided by a certified nurse practitioner or doctor (See Appendix IV). Under the 1996 Act, manual vacuum aspiration (MVA) is available free of charge through designated public health facilities for termination of pregnancy up to 12 weeks (Kawonga et al., 2008). Studies have shown that since 1996, there has been a reduction in maternal deaths from unsafe abortions, although they are still occurring (Mhlanga, 2003).

South Africa is one of the only countries in the world to address abortion as a matter of social equity and justice, rather than just on health grounds alone, stating that women can request services in the case of socio-economic problems, incest, rape, and

reasons related to the health of the pregnant woman and the fetus (Cook and Dickens, 1999; Jewkes et al., 2005b) (See Appendix IV).

In the past 50 years, premarital, often teenage pregnancy has become common for women in South Africa, and until after the 1996 Act, unsafe abortion was a major cause of reproductive morbidity and mortality (Coovadia et al., 2009). Although the 1996 Act made abortion more available, access to services for many women continues to be a problem (Varkey et al., 2000). This is related to underlying issues such as gender inequities, power imbalances, and violence against women, which are major barriers for women to access sexual and reproductive health care. These challenges compromise women's rights to make decisions about their sexual and reproductive health (Fredrick, 2007).

The recent amendment to the 1996 Act in 2004 was added to attempt to make termination of pregnancy services more available and accessible for women. The amendment allows for any health facility that has a 24-hour maternity service to offer first trimester abortion services without ministerial permission that was formerly required. It also allows registered nurses that have completed a TOP training course to provide first trimester terminations, expanding the base of providers for TOPs.

In 2005 the anti-abortion group Doctors for Life challenged the amendment in Constitutional Court (Ipas, 2007). The case claimed that Parliament failed its obligation to consult the public and therefore the amendment should be rendered invalid (Hoffman et al., 2006). The court mandated public hearings in all provinces about the amendment. The amendment was not reinstated until 2008, which has caused confusion among health providers (Harries, 2009).

The confusion about the legislation affects what services are available. Currently, there is a general lack of abortion facilities and shortages of trained health care providers to carry out services around the country, despite measures taken legally in the Amendment Act (Cooper et al., 2005). According to the Department of Health, as of 2003, only 61% of TOP facilities were functioning nationally (Health Systems Trust, 2009b). In the province of KwaZulu-Natal only 30.4% of all TOP facilities are functioning (Health Systems Trust, 2009b). This demonstrates that legislation is not always sufficient to ensure women's access to safe abortion services (Fredrick, 2007).

Despite the encouraging statistics on decreased mortality and morbidity rates for abortion related complications, health providers recognize that the number of legal abortions performed each year make up only a small number of abortions done in South Africa (Knudson, 2006). Studies have found that even after 1997, when the 1996 Act came into effect, many women were still aborting outside of health facilities in South Africa (Jewkes et al., 2005b).

1.4 Medical Abortion and its Place in the History of Abortion Developments

*“Women often give birth at home.
Women often miscarry at home.
Women often induce abortion at home too.”*

-Toni Belfield, Medical Abortion Meeting, London,
27 September 2004 (Berer, 2005a, 6)

Abortion is a common practice dating back to the origin of medicine and surgery itself, documents show its presence even centuries before Christ; Hippocrates in the 5th century B.C. placed an oath to prohibit the induction of an abortion in a pregnant women (Benagiano and Pera, 2000). Over 5,000 years ago, in China, the Emperor Shen Nung described using mercury to induce abortion (Grimes et al., 2006). This shows just how long the controversial history of abortion dates back.

Although surgical methods have existed from ancient times, they did not become integrated in the field of gynecology until the mid nineteenth century. The first widely practiced method was a form of surgical abortion, dilation and curettage (D&C), developed in France. D&C became the most widely used method for termination of pregnancy by the end of the nineteenth century. This method, although effective, proved dangerous to women when performed in unsafe environments or by unskilled providers and it can be equally as dangerous to women today (NAF, 2009b).

The next significant development in abortion technology was the dissemination of the vacuum suction machine. This was introduced in Russia in the early twentieth century, and then circulated to China, Japan, and reintroduced in Eastern Europe, then was used widely in the 1960s in the United Kingdom and the United States (NAF, 2009b). The vacuum suction machine offers a more simple procedure that lowers the risk of complications compared to the use of D&C (NAF, 2009b). Due to a lack of training

and appropriate equipment, abortion in developing nations are still done by curettage, which leads to higher injury rates (NAF, 2009b).

Manual vacuum aspiration (MVA) or “menstrual regulation” moved away from the vacuum suction machine to use a “handheld vacuum syringe, a Karman or similar soft cannula, and a valve that prevents air from entering the uterus.” (NAF, 2009b). This technology does not depend on electricity or anesthetics, so is more suitable for resource poor settings (NAF, 2009b). It is also used as a way to circumvent anti-abortion laws in some countries, under the cover of “menstrual regulation” (NAF, 2009b). The development of these technologies has made it possible for women to terminate their pregnancies surgically in hospital settings in many countries around the world, preventing a large number of pregnancy-related deaths.

In the 1980s, an alternative to surgical abortion was developed in France by researchers working at Roussel Uclaf, a pharmaceutical company (NAF, 2009b). Medical abortion, as it is known now, formerly RU-486, is a combination of two drugs (“abortion pills”) that essentially induce a miscarriage. The medical definitions of both mifepristone and misoprostol are given below:

Mifepristone: ‘[a] synthetic steroid drug used under various trade names (e.g., RU-486, Mifegyne, Mifeprex) to induce abortion in the early weeks of pregnancy. Mifepristone is an antiprogestin; that is, it blocks the action of progesterone, a naturally produced hormone that prepares the inner lining of the uterus for implantation of a fertilized ovum and support of a growing embryo and placenta. The drug is taken orally in a prescribed dose during the first seven to nine weeks of pregnancy, and within two days the uterine lining begins to deteriorate, usually causing bleeding similar to that experienced during normal menstruation. The mifepristone is then followed up by a dose (taken orally or as a vaginal suppository). of the synthetic prostaglandin misoprostol, which stimulates the uterus to undergo contractions. The embryo and other uterine contents are expelled in a process very similar to spontaneous abortion, or miscarriage.’

Misoprostol: ‘administered in prescribed doses either orally or as a vaginal suppository, causes the uterus to contract much as it would at the beginning of labor or during a miscarriage. Taken alone, it is rarely sufficient to expel the embryo and placenta from the uterus, but as a sequel to treatment with mifepristone or methotrexate it is very effective.’

(Encyclopedia Britannica, 2009a, b)

The drug regimen, mifepristone and misoprostol, can be used from very early in pregnancy up to 24 weeks from the first day of the last menstrual period (LMP) (ICMA,

2009b). However the regimen changes at nine weeks, but most studies have found that it is most effective early in pregnancy up to nine weeks LMP (ICMA, 2004b). Millions of women around the world have used mifepristone and misoprostol to terminate pregnancy with safety and efficacy (NAF, 2009c). More than 22 million women in China and over four million in the rest of the world have found it safe and effective (ICMA, 2004d, 4).

Medical abortion remains the only alternative to surgical abortion. It differs in many ways. How one speaks about abortion has to change when discussing medical abortion as a method; for example, health workers do not “carry out” a medical abortion like a surgical one (Berer, 2005a, 7). Unlike surgical abortion, midlevel providers, which include nurses, physician assistants, family planning workers, and midwives, can be trained to provide early medical abortion services (ICMA, 2004c). WHO suggests using a regimen of 200 mg of mifepristone orally and 400 mcg of misoprostol taken orally for medical abortions up to eight weeks of pregnancy. Medical abortion can be used earlier in pregnancy; it can be done at home; involves more clinic visits; no anesthesia is needed, but pain medication should be available; and is a longer process than surgical abortion (ICMA, 2004b) (See Appendix I for more detailed comparison of medical versus surgical abortion).

In 2004, the International Consortium for Medical Abortion (ICMA) held an international forum on policies, programs and services related to medical abortion in Johannesburg, South Africa. The aim of the conference was to promote medical abortion worldwide. The conference showed that the details of medical abortion are not widely known or understood among providers and policymakers (Berer, 2005a). The ICMA agreed to develop training programs that can be adapted to various contexts, and create information pamphlets to increase knowledge about medical abortion.

Studies done in Great Britain, France, and Sweden found that the proportion of women choosing medical abortion rose steadily each year after the drug was approved, most likely because women and providers become more familiar with the method (Blanchard et al., 2006). In other parts of the world a high percentage of women choose medical abortion: in the United States approximately 25% of women choose medical abortion; in France and Scotland 60-70%; in China 30-70%; and in India a study showed a range of 0-80% depending on the provider (Harper et al., 2007, 68).

In the history of abortion developments, medical abortion presents a unique opportunity to expand the base of abortion providers to reach more women, especially in developing countries with high rates of unsafe abortions occurring each year. Research is ongoing assessing the acceptability and feasibility of integrating medical abortion into public health systems around the world.

Medical Abortion in South Africa

“The inclusion of these [mifepristone and misoprostol] drugs to the essential drug list is a real addition to the therapeutic alternatives for women who have to undergo abortion, especially in developing countries where surgical facilities are less easily available. We are aware that many women in developing countries die from unsafe abortion, and we are very confident that these medicines will help prevent such unnecessary and tragic death.”

-Director of Medicines Policy and Standards WHO (Berer, 2005a, 6)

“Once medical abortifacients become available in South Africa they should be introduced into the health services to farther decentralize services in a safe and effective manner.”

- Guidelines for Termination of Pregnancy (TOP). Implementation, Maternal, Child and Women’s Health Directorate, April 1997 (NAF, 2009a)

In 2001, the Medicines Control Council (MCC) of South Africa approved the use of mifepristone in conjunction with misoprostol for the termination of early pregnancy up to 56 days from the last menstrual period (LMP) (eight weeks) (NAF, 2009c). South Africa was the first country to approve the regimen without explicitly instructing that women have to return to the clinic to collect misoprostol (Blanchard et al., 2006). This means that there is an option for the use of misoprostol at home versus a designated health facility.

The recent amendment to the 1996 Act in 2004 (mentioned above) included the provision of medical abortion as a viable option for women (Cooper et al., 2005). By expanding the availability of TOP services and qualified providers, the amendment allows for medical abortion to be administered at designated health facilities (Cooper et al., 2004). The amendment, now that it has been reinstated, has the potential to help address the uneven distribution of abortion services across the provinces (Ipas, 2007).

The Department of Health is considering introducing medical abortion into the public sector, but as of now there is no formal national policy that allows for the provision of medical abortion in the public sector in South Africa (NAF, 2009a).

Polymakers and providers feel that medical abortion could relieve the burden of current abortion services, and offer a viable alternative to MVA (Cooper et al., 2005). Providers in South Africa recognize that certain prerequisites such as staff training and education of potential users are needed in order to integrate medical abortion in to the public sector (Kawonga et al, 2008).

The proclaimed advantages of medical abortion are as follows: some women prefer it; increases access to services; requires less staff input and health care workers may be more accepting if they do not have to initiate abortion; some consider it a more “natural” method; avoidance of surgery; there is more privacy when misoprostol can be taken in one’s home; and avoids hospitalization, which frees hospital beds making operating rooms available for other emergencies (Moodliar et al., 2005; Kawonga et al., 2008).

Concerns and barriers around the use of medical abortion include the high cost of medication. The MCC approved a regimen of 600 mg of mifepristone and 400 mcg misoprostol orally for medical abortions up to eight weeks of pregnancy. Mifepristone can cost up to US\$150 or €130 (for three tablets (600 mg)), whereas misoprostol is significantly less expensive, US\$0.50 per tablet (200mg). WHO suggests the use of 200 mg of mifepristone to be taken orally and 800 mcg of misoprostol used vaginally. If South Africa’s guidelines corresponded with this recommendation, it would reduce the cost of medical abortion (Cooper et al., 2005).

Another major issue related to cost using medical abortion is whether or not ultrasounds are necessary to determine pregnancy duration (Blanchard et al., 2007). In various studies, including one in South Africa, found that it might be possible to screen women using clinical examinations in public health services to determine eligibility for medical abortion without access to ultrasound (Blanchard et al., 2007).

Other concerns in introducing medical abortion in the public sector are that women attend abortion services too late in their pregnancies in South Africa, which would rule out medical abortion as an option; however research has now disproved this concern (Cooper et al., 2005). Other barriers to implementation include transport issues; two clinic visits are required for medical abortion, which could dissuade clients. The first

visit is for counseling and provision of medication and the other is to confirm that the termination is complete (Cooper et al., 2005).

The side effects resulting from using medical abortion could include pain and bleeding, as well as nausea and vomiting (Obstetrics and Gynecology Forum, 2002). Studies have shown that approximately 2-10% of medical abortions require surgical aspiration to complete the termination of pregnancy, which is another concern if surgical abortion is not accessible to women opting for the use of medical abortion (Obstetrics and Gynecology Forum, 2002).

Although the drug regimen is not yet available at pharmacies in South Africa, there has been an increase in use by private sector health facilities since 2002 (Cooper et al., 2005). A study done on private physician's provision of medical abortion concluded that medical abortion providers find the method acceptable and that staff are supportive of the method (Blanchard et al., 2006). In 2006 the distributor of South African mifepristone (Mifegyne™), Medi Challenge, listed 104 private physicians or clinics that purchase mifepristone directly from them (Blanchard et al., 2006).

A study done in Durban, KwaZulu-Natal found medical management of abortion to be cost-effective and associated with fewer complications (Moodliar et al., 2005). In addition, in a recent pilot study in South Africa 60-70% of participants when given the choice between medical or surgical abortion chose medical abortion (Kawonga et al., 2008, 163).

Research on perceptions of potential users of medical abortion in South Africa is limited. Studies done in Gauteng, Mpumalanga, and the Western Cape indicate that both women and providers are interested in medical abortion as an alternative to surgical abortion, and women have been satisfied with the results after using the medical abortion method (Cooper et al., 2005; Kawonga et al., 2008). In a study evaluating the integration of medical abortion into public services in the three provinces listed above found that 93% of women had a complete abortion, and 96% of women found their experiences to be "satisfactory" or "very satisfactory" (NAF, 2009c). Based on these studies and findings from other countries indicate that medical abortion has the potential to be an important service for women, especially in developing countries such as South Africa (Harper et al., 2007).

In order for medical abortion to be widely used, it needs to be acceptable to women and providers. Research needs to be done in each place that it is available to assess the acceptability and the perspectives of women and how they perceive the different methods (Ho, 2006). The beliefs of potential clients play an integral role in choosing abortion methods and using new medical technologies (Harvey et al., 1995).

1.5 Structure of the Thesis

The first chapter outlines the background of sexual and reproductive health rights in both a global and South Africa context. It further discusses family planning movements and the history of abortion developments globally and in the South African context. This introduction lays the ground for the presentation of the case study.

The second chapter is a comprehensive literature review which outlines unsafe abortion and development; public health policies surrounding abortion; the personal, proximal, and distal contexts in reproductive decision-making, specifically abortion; and medical abortion developments both globally and in South Africa.

The third chapter presents the theoretical framework and research methodology used in this case study. It outlines Eaton's theory of sexual behavior; the target population and study sample; the selection process; the collection and analysis of data; the ethics; and limitations of the study.

The fourth chapter presents the results. The in-depth interviews are analyzed and presented. The chapter looks at the personal, proximal, and distal contexts that shape the decisions of this sample of female university students in Durban, South Africa. The chapter also examines women's reactions to medical abortion, and whether or not they find it an acceptable method for the South African public health system and South African women.

The final chapter ties together the background, context, theoretical framework, and analysis drawn from the case study to conclude, and provides recommendations for the introduction of medical abortion in the public health system in South Africa.

Chapter 2: Literature Review

2.1 Unsafe Abortion and Development

“All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health aspect of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services.”

-ICPD Consensus Statement, 1994 (WHO, 2007, 1)

“Pregnancy-related deaths...are often the ultimate tragic outcome of the cumulative denial of women’s human rights. Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving.”

-Mahmoud Fathalla, former Director of the UNDP/UNFPA/WHO/World Bank Special Program of Research, Development and Research Training in Human Reproduction (Grimes et al., 2006, 1917)

There is a growing realization that abortion is a social reality that does not stop despite legal restrictions; and abortion is something that is closely connected to the empowerment of women that cannot be ignored despite the controversy that continues to surround it (David, 1992). Unsafe abortion remains one of the most neglected public health issues in the world today, and ending the pandemic of unsafe abortion is integral to uphold human rights (Grimes et al., 2006).

The World Health Organization (WHO) defines unsafe abortion as:

“A procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.” (Guttmacher Institute, 2008)

This definition cannot begin to convey the desperation and struggle women feel who face unwanted pregnancies and who often resort to unsafe methods performed by unskilled providers to resolve their personal problems (Hord and Wolf, 2004).

Not only is it difficult to convey the struggle women face daily, it is also difficult to accurately estimate the prevalence of unsafe abortions around the world. Estimations can only be done with indirect techniques such as using information on abortion-related complications in hospitals, women’s reports in surveys, data for fertility rates in relation to contraceptive prevalence and trends, and unmet need for family planning (Sedgh et al., 2007). Most often community studies indicate a higher magnitude of unsafe abortions than do national health statistics, capturing those that are not officially reported (Grimes et al., 2006). For example, in Zambia a study found that of women interviewed, 69% of

respondents knew one or more women who had died from an unsafe, illegal abortion (Grimes et al., 2006, 1909). These deaths are not accurately represented because they often happen under illegal or clandestine procedures, and no one reports them.

According to the 2009 Guttmacher Institute report the abortion rate has fallen worldwide; however maternal mortality due to abortion remained static at 70,000 deaths per year (Lancet, 2009, 1301). The actual methods that women resort to fall into several broad categories: oral and injectable medicines (turpentine, laundry bleach, acid, assorted herbal medications); vaginal preparations (potassium permanganate tablets, herbal preparations, misoprostol); intrauterine foreign bodies (sticks, knitting needles, rubber catheter, coat hanger, ballpoint pen); and trauma to the abdomen (lifting heavy weights, abdominal or back massage) (Grimes et al., 2006). Complications from these methods include hemorrhage, sepsis, infection, and trauma to the uterus, vagina, and cervix. In the developing world, an estimated five million women annually are brought to the hospital for treatment of complications from induced abortions, which only show the small proportion of women that reach a hospital after using such unsafe methods (Singh, 2006).

On the basis of WHO estimates, if this continues, women in the developing world will have an average of one unsafe abortion before reaching the end of their reproductive lifetime (Grimes et al., 2006; Shah and Ahman, 2004). This is a striking estimate, highlighting the necessity to address the multiple factors that lead to unsafe, illegal abortions. A comprehensive approach needs to be taken to make efforts on international, national, and local levels to prevent these unnecessary deaths from occurring.

Costs of Unsafe Abortion

Unsafe abortion has serious consequences for societies, affecting women and their families, putting a strain on public health systems, and ultimately in the larger picture, economic productivity (Singh, 2006). The direct costs associated with unsafe abortion are most importantly the loss of tens of thousands of women every year. Along with that, the complications that arise and need to be treated drain health care systems, especially those in resource-poor settings. The costs of health personnel, blood, medications, equipment, overnight stays in hospitals, all take away from other needs in the hospital (Grimes et al., 2006). A model developed using African data found that treating abortion complications

in tertiary facilities ends up costing ten times more than if abortions were carried out at primary health centers (Hessini, 2005). For example, in South Africa a study estimated that the annual cost of treating unsafe abortion in public hospitals was ZAR 9.74 million (about US \$14 million) (Grimes et al., 2006, 1914).

The indirect costs of unsafe abortion are more difficult to put into numbers. The loss of the productivity of women and their households can cause far-reaching effects for the community. Estimates of the disability burden of unsafe abortion (disability adjusted life years [DALYs]) are the loss of about five million years of productive life or 14% of all DALYs from pregnancy-related conditions (Singh, 2006, 1887).

An estimated 220,000 children in the world lose their mothers to abortion-related deaths every year (Grimes et al., 2006, 1914). Losing a mother affects children's health and education. These losses are particularly notable in developing countries and take particular effect in stressed economies. By investing in safe abortion services and availability, governments will not only save tens of thousands of women every year, but also invest in the improvement of national productivity (Grimes et al., 2006).

When investigating how to invest and improve women's sexual and reproductive health, it is important to identify those most in need of interventions to improve health outcomes. Two-thirds of women in developing countries engaging in unsafe abortions are between the ages of 15 and 30 years old (Shah and Ahman, 2004, 9). In Africa, in particular, almost 80% of unsafe abortions are happening among women under 30 (Shah and Ahman, 2004, 9). In places where safe abortion services are restricted, unmarried women, particularly adolescents are vulnerable because there is little or no access to reproductive information or counseling (Shah and Ahman, 2004). Interventions should be targeted at these specific age groups.

2.2 Making Abortion Safe: Public Health Imperatives

“Article 14: 2 c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.”

-2005 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Equality Now, 2010)

In light of recent international mandates, and with the variety of contraceptive and abortion technologies that are available, prevention of unsafe abortion should be a public health priority (Sedgh et al, 2007). Attention to the connections between human rights and reproductive rights including abortion have been addressed now by the United Nation's Human Rights Committee (HRC), the African Charter on Human and People's Rights, the Committee on Economic, Social and Cultural Rights (CESCR), the Committee on the Rights of the Child (CRC), and the Committee on the Elimination of Discrimination Against Women (CEDAW) (Hessini, 2005).

However, despite the recent mandates of intergovernmental organizations in Africa, an estimated 92% of women of childbearing age live in a country with restrictive abortion laws (Guttmacher Institute 2009). Cape Verde, South Africa, and Tunisia are the only African countries where abortion is allowed legally without restriction on an elective basis, but with gestational limits (Guttmacher Institute, 2009). Zambia is the only African country that provides abortion on socio-economic grounds, as well as to preserve mental health, physical health or to save the life of a woman (Guttmacher Institute, 2009). Seventeen countries allow abortions to preserve the physical health and/or to save a woman's life, eight of which allow abortion if the woman has been raped, seven of which allow abortion on the grounds of incest (Guttmacher Institute, 2009). Nine countries allow for abortion to save the life of a woman (Guttmacher Institute, 2009). And 14 countries prohibit abortion altogether and have no explicit legal exception to save the life of a woman (Guttmacher Institute, 2009). In most African countries, women face legally restrictive settings for reproductive decision-making.

Studies show if women have legal access to abortion services their sexual and reproductive health improves (Grimes et al., 2006). After legal reforms are passed to make abortion safe and accessible, it does not increase demand, but rather shifts previously illegal, unsafe procedures to legal, safe ones (Grimes et al., 2006). When countries such as Barbados, Canada, South Africa, Tunisia and Turkey liberalized their abortion laws, there was not an increase in abortion, there was a decrease in abortion related morbidity and mortality (Grimes et al., 2006).

It is important to note that liberalizing abortion laws and implementing legal access to abortion is not sufficient to prevent unsafe abortions from happening. These

restrictive measures may in fact contribute to an increase in morbidity and mortality associated with pregnancy (Benagiano and Pera, 2000). For example, Zambia has one of the most liberal abortion laws in Africa, after South Africa, but it has not yet been translated into safe services. Deaths from unsafe abortion in Zambia are still just as high as other countries with restrictive legislation (Brookman-Amissah and Moyo, 2004). Other examples such as Guyana, India, South Africa, and even the USA show that legalization is not sufficient to ensure women's access to termination of pregnancy services (Fredrick, 2007).

Progressive legal frameworks are an important step to realize human rights and development; however when these laws differ from the majority of people's everyday beliefs and practices, that is when challenges arise (Cornwall et al., 2008). A holistic, comprehensive approach should be taken in addressing unsafe abortions to overcome the challenges that arise in implementing safe abortion services. When states liberalize laws on access to abortion services there is a responsibility on the part of the government to ensure that these services are accessible, affordable, and available to all that need them (Cook and Dickens, 1999). The liberalization of abortion laws should be priority, and then efforts should be made to ensure that the provision of services is safe, available and effective (Oye-Adeniran et al., 2004). All of this will help to create an environment in which women have the right to decide the number and spacing of children, exercising their human rights.

2.2.1 Abortion Reform in South Africa: Progress and Problems

“‘Abortion’ For Sale”
-*The Sowetan* headline 30 November 2009

Currently the top five primary direct obstetric causes of death in South Africa are: hypertension (45.9%); postpartum hemorrhage (15.7%); antepartum hemorrhage (9.7%); ectopic pregnancy (2.7%); and abortion (3.4%) (NCCEMD, 2007, 12). The numbers of deaths due to abortion have increased in the last triennium (from 2002 to 2007), which is partly attributed to the lack of access to TOP services (NCCEMD, 2007). The number of TOPs performed in the public sector has been falling since 2002, and the number of public institutions performing TOPs is declining (NCCEMD, 2007).

During the apartheid era, when access to abortion and family planning was constrained, clandestine abortions were often the only option (Guttmacher et al., 1998). Women would resort to the previously mentioned methods of termination of pregnancy such as taking Disprin, medicinal herbs, aloe, cleansing products and Dutch remedies (Jewkes et al., 2005b). Other methods still used today include tablets (by the description suggest misoprostol), anti-malarials, tetracycline, soap, traditional medicines and the use of metallic objects (Moodley and Akinsoto, 2003). A study by the Medical Research Council (MRC) found that an average of 425 women died annually from unsafe abortions before legalization (Knudsen, 2006). With the legalization of TOP, this was supposed to change, however studies have shown that women are still using unsafe methods outside of health facilities (Jewkes et al., 2005b).

A study done in Gauteng found that two thirds of women presenting at the hospital for abortion complications had self-induced termination or had consulted a traditional healer (Jewkes et al., 2005b). Another study done in Durban, KwaZulu-Natal, assessing whether or not the 1996 Act had decreased admissions resulting from mid-trimester abortions whether they were spontaneous, illegally or legally induced, found that the change in laws regarding TOP had resulted in a decrease of cases of incomplete abortion. However illegal TOPs are still prevalent for a variety of reasons (Moodley and Akinsoto, 2003).

A recent article in the *Sowetan*, “‘Abortion’ For Sale”, publicized the problem of illegal abortions that are still occurring in South Africa. The article focused on the sale of pills, Cytotec™, better known as misoprostol, to induce labor. The sale of these pills outside of clinical settings is prevalent around South Africa. One provider interviewed said the following:

“Business is good. I have even left work because I make more money than I used to get where I worked. I was introduced to this business by Doctor West who operates an abortion clinic in Kempton Park Square.” (Mapumulo and Nkosi, 2009)

While misoprostol is not a dangerous drug, and not an unsafe method of abortion, it can be dangerous when used improperly. The sale or possession of misoprostol is illegal unless in a clinic or pharmacy setting with a doctor’s prescription (Mapumulo and Nkosi, 2009).

Underlying Reasons for Unsafe Abortion: Challenges and Barriers

The continuing high rate of unsafe abortions is due to a variety of interconnected factors. For example: women may be unaware that safe abortion services are available (in countries where legislation has been passed); women may lack the financial resources; women may lack the time to access health services; they may lack the decision-making power to choose termination, due to lack of empowerment; there may be inadequate health care resources and infrastructure; the negative attitudes of health providers may be a deterrent; and the political and social stigma surrounding abortion silence the issue (Hord and Wolf, 2004; Jewkes et al., 2005b; Shah and Ahman, 2004, 10; Varga, 2002).

A study done in the Western Cape found that 32% of women did not know that abortion is legal as of 2004/2005 (Morrone et al., 2006, 1). Another study found that 54% of women presenting at a hospital for incomplete abortions had not used legal services because they did not know about the law (Jewkes et al., 2005b, 1236). A study further found that age, level of education, and employment, were not necessarily associated with awareness of legal abortion services, instead it was associated with location (urban versus rural), awareness of emergency contraception (EC), and the use of consistent contraception (Morrone et al., 2006).

There is clearly an unmet need among women for information on abortion in South Africa. In order for women to use safe abortion services, they must be informed about their rights under the law. One doctor stated “The average woman still has no idea of the law about abortion in this country, and how liberal it actually is.” (Knudsen, 2006, 31). This knowledge has the potential to empower women to make choices about their reproductive health.

Not only are some women unaware of the legislation around abortion, a study done in KwaZulu-Natal found that 68% of participants were not aware of any existing facility for TOP (Moodley and Akinsooto, 2003, 36). In addition there is often confusion over the fee status of abortion in South Africa; most women are unaware that the service is provided for free in public facilities (Varga, 2002).

While abortion services are provided for free, finances still limit access to health services and family planning. In general, poverty is a barrier for South African women to access health care (Knudsen, 2006). Costs such as transportation, time off from work, and

medications are often unaffordable to women. A lack of confidentiality and anticipation of provider rudeness is also a major barrier (Jewkes et al., 2005b). The lack of privacy and health providers' negative attitudes has been cited in numerous studies as a deterrent for using public, safe abortion services (Knudsen, 2006; Morroni et al., 2006; Varga 2002).

Private clinics often fill in the gap and charge fees, and make themselves more accessible (Knudsen, 2006). For example, Marie Stopes offers more flexible hours of operation than public clinics. However all too often women resort to referring to illegal providers and methods and pay for these illegal procedures, putting themselves in danger because the illegal providers are prevalent and more accessible.

These findings support the need for improvement of TOP services to make them accessible, affordable, and acceptable to women to prevent the use of unsafe methods and improve women's reproductive health. In order for the 1996 Act to be successful reducing morbidity and mortality from unsafe abortions there needs to be: expansion of services; patient outreach, provider education, and monitoring on regularly how these services are progressing (Guttmacher et al., 1998).

2.3 The Abortion Debate in a Developing Areas Context: The Personal, Proximal, and Distal Contexts of Reproductive Decision-Making

*“Why do people have unplanned pregnancies?
Why do people abort?
How can religion and abortion be reconciled?
Is it in [our] culture?
Who are the abortionists and how are illegal abortions procured?”*
(Jewkes et al., 1997, 417)

In order to expand women's sexual and reproductive health rights, it is important to understand the personal, social, political, cultural, and economic context in which her decision-making occurs. The following section will present the literature surrounding the factors that influence reproductive decision-making at the individual, personal level; within one's proximal context; and finally within the distal context, following Eaton's theory of sexual behavior (See Section 3.2). The questions that continue to arise in the abortion debate worldwide are listed above. Struggling with these questions involves not only epidemiology, but rather need to be explored through the social, political, economic,

and personal contexts in which for whatever reason make it unacceptable to carry a pregnancy to term (Bankole et al., 1999).

Research has become more sensitized that it is difficult to classify or categorize people as being “pro-choice” or “pro-life” (Patel and Myeni, 2008). These two categories tend to oversimplify the debate and the complex issues and conditions which surround abortion. Often the “...gap between words and actual behavior [is often] striking... [and the difference] between [the] ideal and reality is no coincidence.” (Varga, 2002, 283) One has to consider “what people say, what people do, and what people say about what they do” because often these do not coincide (Varga, 2002, 283).

The concept of “dual morality” has been used to refer to people who in public discourse oppose abortion, but would seek abortion services if faced with an unwanted pregnancy (Hessini, 2005). This dual morality underscores how what people say, what people do, and what people say they do is not always the same, especially in relation to an issue that is conditioned by social and cultural norms (Hessini, 2005). There is a large gap between ideals and real life circumstances. Trying to reconcile the ideological and practical realities related to abortion decision-making is seen cross-culturally and is shown in recent qualitative studies on induced abortion in Bangladesh, Ghana, Jamaica, Kenya, Nigeria, and South Africa (Varga, 2002).

The Personal: Attitudes toward Abortion, African Perspectives

Attitudes toward Abortion: Developing Countries Context

Perceptions and attitudes of young people toward abortion and reproductive choices are limited in the literature (Patel and Johns, 2009). Ambivalence toward abortion is the general finding in most literature, while many women condemn abortion they also practice it often (Johnson-Hanks, 2002). For example, in a Cameroonian study most women view the social and moral consequences of abortion to be better than early entry into motherhood, so abortion is considered the lesser shame and practiced (Johnson-Hank, 2002).

In South Africa, opinions of abortion among Zulu adolescents were divided (Varga, 2002). Many saw abortion as a sin, immoral, like murder, or socially irresponsible (Varga, 2002). In another South African study female university students

tended to disapprove of abortion, with almost 55% against abortion (Patel and Myeni, 2008, 745). This was often due to conservative morals, and religion. Others thought that regardless of its acceptability, abortion is a social reality and should be made safe and available (Varga, 2002).

Abortion is often accepted under certain, exceptional contexts such as rape. Other conditions such as HIV infection, poverty, absence of family or paternal support, or inability to face responsibility of parenthood have been reasons for accepting abortion in another study (Varga, 2002). These conflicting opinions of particular circumstances highlights the ambivalence of attitudes in relation to abortion in South Africa, when individuals are opposed to abortion, but end up choosing to terminate a pregnancy when faced with an unwanted pregnancy (Braam and Hessini, 2004).

A consistent finding in the literature is that females often have more positive attitudes toward abortion compared to males (Patel and Johns, 2009). Abortion has social, psychological, and health consequences for not only women but men as well, even though there is very little research done examining men's role in women's abortion decision-making (Dudgeon and Inhorn, 2004). Men often directly affect women's decisions about abortion, and play an important role in the decision-making process (Dudgeon and Inhorn, 2004).

Looking at personal views is important to understand individual contexts; both male and female, in order to further implement interventions that take into account the contexts in which reproductive decisions are made (Varkey et al., 2000).

Reasons Why Women Induce Abortions: Developing Country Context

The reasons for seeking abortion services are varied and often multiple and differ from individual to individual. Outlined below are some of the most common reasons cited in the literature for why women induce abortions in developing countries on a personal level.

Rape, intimate partner violence, and incest are all too often cited as personal reasons for seeking abortion services (Harrison et al., 2000; Heise, 2002; Hord and Wolf, 2004; Grimes et al., 2006; Knudsen, 2006; Urgur and Erkaya, 2001). Globally, one in five women have been physically or sexually abused in her lifetime (Hessini, 2005).

Violence directly impacts pregnancy outcomes and is linked to increased abortions, miscarriages, and fetal distress (Heise et al., 2002). Intimate partner violence has been noted in 3-13% of pregnancies in studies around the world with increased risks of negative outcomes to mothers and infants (Campbell, 2002, 1331). Violence affects women's self-esteem, and leaves them compromised in such a way they are unable to assert their reproductive rights and are exposed to sexually transmitted infections (STIs) and unwanted pregnancies (Knudsen, 2006).

South Africa has a long history of extremely high levels of rape and sexual violence. From 2008 to 2009, sexual offenses have risen by 10% in South Africa, which highlights the huge problem of sexual violence (BBC, 2009). Many cases are not reported, but South Africa has the highest number of reported cases of rape per female population in the world (Cooper et al., 2004; Knudsen, 2006). Again sexual violence and rape lead to high levels of STIs and unwanted pregnancies. While this does not mean that abortion services will be sought after, it does suggest that abortion services should be available and accessible for women that choose to terminate unwanted pregnancy, particularly in a country such as South Africa.

Individual's opinions tend to change when discussing abortion in relation to cases of rape or incest. Rape is often considered beyond the control of a woman, so therefore people feel this justifies termination of pregnancy and is reflected in many national laws (Harrison et al., 2000). The reasons underlying sexual violence and rape highlight the challenges of gender and socio-economic inequality that can compromise women's rights to make decisions about their SRH health, and highlight the need to address and expand women's SRH rights (Fredrick, 2007).

Many women in resource poor areas choose to terminate their pregnancies because of socio-economic concerns (Braam and Hessini, 2004; Gallo et al., 2004; Grimes et al., 2006; Harrison et al., 2000; Hord and Wolf, 2004; Jewkes et al., 1997; Moodley and Akinsooto, 2003; Uygur and Erkaya, 2001; Varga, 2002). Many women are unable to support a child and choose abortion because of economic hardships. These very economic pressures may be the reason for unwanted pregnancies in the first place (Braam and Hessini, 2004). Many women in African countries are pressured into prostitution to survive financially and end up with unwanted pregnancies (Braam and Hessini, 2004). A

study in Mozambique found that 86% of women seeking abortion were poor (defined as not having either potable water or electricity at their place of residence) (Gallo et al., 2004, 220).

Other studies show that women request abortion to postpone childbearing (Grimes et al., 2006; Hord and Wolf, 2004; Jewkes et al., 1997; Moodley and Akinsooto, 2003; Uygur and Erkaya, 2001). Reasons to postpone childbearing include women's young age, and the desire to continue their educational careers (Moodley and Akinsooto, 2003; Varga, 2002). In a study done analyzing why women seek abortion services, 65% gave birth timing and family size control as the most important reason, while young women under 25 years old said they wanted to postpone childbearing (Uygur and Erkaya, 2001, 212).

Women also request abortion because they do not want children, or they do not want more children (Hord and Wolf, 2004; Grimes et al., 2006; Moodley and Akinsooto, 2003; Uygur and Erkaya, 2001). A study done in developing countries found that 47.6% of women requested abortion because of this reason (Uygur and Erkaya, 2001, 212).

The risk to either maternal and/or fetal health is another common reason for terminating a pregnancy (Grimes et al., 2006; Uygur and Erkaya, 2001). For this reason many countries have liberalized their laws to allow for abortion services to be provided if either the mother or fetus is in danger.

Finally relationship problems are also cited in the literature as a reason for a woman to seek abortion services (Hord and Wolf, 2004; Grimes et al., 2006; Moodley and Akinsooto, 2003; Varga, 2002). A fear of abandonment or broken engagements, refusal of paternity, and pressures from partners all influence women's decisions to terminate a pregnancy.

All of these reasons are common to many women around the world. Women's reasons for choosing to have an abortion and their attitudes toward abortion are also greatly influenced by their proximal environment.

The Proximal: Interpersonal and Environmental Factors from Sexual Education to Stigma

Knowledge Base: Sexual Education

“People are not counseled about the effects of contraception and there are all sorts of myths and misconceptions,” says the former head of the Reproductive Health and HIV Research Unit (RHRU). (Knudsen, 2006, 21).

A lack of knowledge of reproductive physiology and general information on sexual and reproductive health is often cited as a reason for unwanted pregnancies (Varkey et al., 2000). A lack of knowledge about reproductive health and especially around contraception results in unwanted pregnancies and can further spread STIs.

In South Africa, sex education is still limited in scope and availability (Knudsen, 2006). A gynecologist in Cape Town commented:

“There is been a great divide between education levels and different groups of the population. But even in the very privileged schools sex education has been at best very erratic.” (Knudsen, 2006, 16)

Sex education is sometimes withheld from schools because of conservative community leaders, which addresses the more structural factors that influence the dissemination and production of knowledge (Knudsen, 2006). A study done in 2000 found that 47% of women that missed their period once knew that it could signify pregnancy, and only 47% knew the symptoms of early pregnancy (Knudsen, 2006, 19).

Due to the lack of sexual education and information on reproductive options, many myths and rumors surround family planning, which can deter women from seeking health services (Maharaj and Rogan, 2008). Myths such as contraceptive side effects, for example “injectables will make me fat”, decrease libido, or cause infertility, contribute to negative attitudes toward many family planning methods (Maharaj and Rogan, 2008, 359). Another problem is the inconsistent use of contraceptives. In the last ten years there has been an increase in the number of women using contraceptives, but a decreased rate of consistent use (Knudsen, 2006).

Ignorance and lack of awareness about emergency contraception (EC) is also common among women in South Africa (Knudsen, 2006). A study found that 40% of women seeking termination of pregnancy were not aware of emergency contraception (Maharaj and Rogan, 2008, 352). This lack of awareness might directly contribute to the

number of abortions requested. If there were more awareness around its availability, there would be a decline in both legal and illegal abortions (Maharaj and Rogan, 2008). In South Africa, emergency contraception is available at any public hospital free of charge or directly from a pharmacy without a prescription, but is not frequently used. There are also problems of misinformation and misperceptions about what emergency contraception is, as it is often confused for an abortifacient drug.

This lack of knowledge is dangerous for women's health and restricts their reproductive freedom. Without having the power of knowledge to make decisions about childbearing in particular can lead to unsafe abortions and endanger women's lives.

Gender Relations and Power Dynamics

"Shared responsibility between men and women in matters related to reproductive sexual behavior is essential to improving women's health." (United Nations, 1995)

Not only do gender relations affect personal decisions and individual relationships, but they also shape the way power plays out at social, economic, and political levels (Braam and Hessini, 2004). Unequal gender relationships in many societies are often related to economic and social inequalities, which can prevent women from being able to make decisions about their bodies. Access to and control over resources influences to what degree women feel they can exercise their rights (Varkey et al., 2000). In a South African study done on women seeking abortion services, 58% said they were in relationships where they were unable to negotiate protected sex (Varkey et al., 2000, 105). In African settings men play an important role in sexual and reproductive decision-making and also remain dominant in policymaking and health management (Varga, 2002). Financial support from older men also influences why women have unprotected sex and face unwanted pregnancy.

The role of paternity and acceptance of fatherhood is an important part of many African societies, which has social, legal, and economic effects, especially in South African Zulu society (Varga, 2002). If a man refuses paternity, the woman then bears financial and social burdens of rearing the child on her own, with the risk of social marginalization (Varga, 2002).

The role of men in reproductive decision-making is an important one and it is important to include men in sexual and reproductive health interventions. Equally as important is looking at the relationships between men and women, and the dynamics that shape sexual behavior. These power dynamics are linked to broader social, economic, cultural, and political contexts, and can either empower or disempower women to make decisions about their bodies.

Stigma: Women's Silence and Secrecy Surrounding Abortion

The decision-making around reproductive health involves multiple actors, and is heavily influenced by women's environments. Social acceptability plays a large role in determining women's decisions surrounding abortion and abortion methods (Urgur and Erkaya, 2001). Social taboos are major challenges both for women who seek abortions and those who provide them in countries where it is legal and illegal (UNFPA, 2004).

The secrecy and stigma surrounding abortion stems from a conflict of interest between individuals and groups, as well as between opposing social values and norms (Rossier, 2007). The socio-psychological consequences of stigma have been shown to impair health and indirectly hinder access to medical care (Grimes et al., 2006). The secrecy often leads to illegal, unsafe abortions because of fear of disapproval from society, shame and disapproval from communities (UNFPA, 2004). Women cite stigma as a reason for why they are reluctant to seek termination in their own communities for fear of becoming outcasts (Turner et al., 2008).

In South Africa, historically termination of pregnancy has been viewed as controversial and socially unacceptable (Varga, 2002). Despite the current legal status, abortion is still resisted on moral and religious grounds, creating yet another barrier to accessing safe abortion services (Varga, 2002). The evidence of continued stigma around abortion can be seen by the fact that in one study, a quarter of women did not discuss their decision to have an abortion with anyone (Cooper et al., 2005). One woman said in a similar study, "Most abortions are done backstreet because girls do not want the community to know what they are doing." (Varga, 2002, 288) Further, women still try to conceal that they had an induced abortion outside of a health facility when they present at

a hospital or clinic with complications from an incomplete abortion (Jewkes et al., 2005b).

Keeping abortion a secret maintains a public image for a woman that is consistent with dominant social norms (Rossier, 2007, 230). This highlights the need to address and include communities in public health interventions in order to create a safe environment for women to make decisions about their sexual and reproductive health.

Clinical Environments: Health Provider Perspectives on Abortion

Resulting from the stigma and social taboos associated with abortion, one of the most common reasons that women do not seek abortion services in a clinic setting is the fear of abuse and disapproval by health professionals (Jewkes et al., 2005b). Clinics have reputations of being rude to patients during TOPs, and women fear judgment and shame (Knudsen, 2006). In South Africa, one study found that most nurses feel that patients are irresponsible (Knudsen, 2006). Another study found that very few nurses in KwaZulu-Natal supported abortion upon request, most health workers supported abortion in the case of rape or incest, or if it would endanger a woman's health, but few supported it for social or economic reasons (Harrison et al., 2000; Harries et al., 2009).

Beyond negative attitudes, health care provider's knowledge of the 1996 Act varies. The 1996 Act allows for providers to refuse performing abortions, however they are obliged to inform women of their rights to choose abortion and refer them to another provider or facility (Harries et al., 2009). Some admission clerks at clinics have blocked admission for TOPs, sometimes just throwing away referral letters and refusing to give women treatment (Harries et al., 2009). Often providers assert conscientious objection and ignore the legal obligation to refer women to other facilities, creating a barrier to care (Cooper et al., 2004). This leads women with no other option but to try and self-induce (Jewkes et al., 2005b).

Another great challenge in making abortion services accessible is the shortage of health care providers that are both willing and trained to provide abortions (Cooper et al., 2004). The lack of abortion providers undermines the availability and accessibility of safe, legal abortions (Harries et al., 2009). Again the stigma and fear connected to

providing or even assisting with abortion services becomes a barrier to carry out training for TOP services (Harries et al., 2009).

In order to change providers' attitudes, values clarification workshops have been initiated in several countries. WHO has recommended these abortion-training programs have the following guidelines:

“Programs should use a variety of teaching and learning methodologies and should address both technical and clinical skills as well as attitudes and beliefs of the service provider. This may require a values clarification process which allows health providers to differentiate between their own values and the rights of the client to receive quality services.” (Turner et al., 2008, 109)

The aim of the workshops that have been initiated in different countries has been to move providers towards acceptance, tolerance and support for abortion and related sexual and reproductive health rights (Turner et al., 2008). In 2002, the international NGO, Ipas held a series of workshops around South Africa, in the hopes of advocating for more providers to start offering safe abortion services for women. These workshops are attempts to make services are available, accessible, and comfortable for women that seek them.

The Distal: Culture and Structural Influences

Abortion and Religion

The resurgence of fundamentalist religious beliefs and conservative attitudes on sexuality are at the core of today's debates around sexual and reproductive health rights (Cornwall et al., 2004). Political, religious or other leaders often censure the subject of abortion (Grimes et al., 2006). Religion has significant power to challenge the right of women to exert control over their bodies, founding many social constructions of sexuality and sex, which often shape both policy and practice (Braam and Hessini, 2004).

Different religions have different effects on sexual behavior and abortion related decision-making. Christianity idealizes visions of virginal, chaste, and loving figures such as the Virgin Mary and other female saints, particularly in Catholicism (Braam and Hessini, 2004, 46). Catholicism upholds the “consistent life ethic” or “seamless garment” that all life is sacred and should be protected by law; it opposes legal abortion, capital punishment, economic injustice and euthanasia. The visions and constructions of women and motherhood in most Christian traditions are often against termination of pregnancy.

Islamic tradition has varying views of family planning and abortion, however most often the interpretations of women's reproductive choices are placed in the hands of male interpreters and husbands (Braam and Hessini, 2004).

Religious fundamentalism has led to policies that inhibit women's sexual and reproductive health rights. At an international level, religion has the power to influence policies and programs regarding sexual and reproductive health. One such example was the longstanding "Global Gag Rule" which was initiated under the United States' Reagan administration in 1984. The policy forbade any foreign organization receiving assistance from USAID to work on the topic of abortion (Knudsen et al., 2006). This policy had far reaching effects in developing countries that were receiving a significant portion of aid from United States' based organizations. The policy limited sexual and reproductive health rights, specifically in countries depending on foreign aid to implement health policies. Not only did it affect foreign aid organizations, but it also stopped significant abortion-related research (Knudsen, 2006). The policy was rescinded in the 1990s during Clinton's administration, then was reinstated in 2000 under George Bush, and has just recently been rescinded again in January 2009 under Barack Obama.

At a national level religion influences politics and legislation surrounding abortion services. In South Africa, religious groups opposed the legalization of abortion, specifically the Dutch Reformed Church. Not only did they oppose it, but also preached that the white population had to grow in order to maintain supremacy (Guttmacher et al., 1998). And as mentioned previously, family planning became associated with the racist policies of the apartheid era. Both Christian and Muslim churches and professional groups such as Doctors for Life were active in opposing the legal reforms. In South Africa the legislation was successfully passed, but not without struggle against prevailing religious beliefs.

Religion has far reaching effects; at an individual level it is often a predictor of one's views on family planning, abortion, and reproductive decision-making (Patel and Johns, 2009). At a local level, organized religion has the power to influence communities and create or dispel stigma on abortion decisions. And at a national level it influences both policy and practice.

Abortion and HIV/AIDS

In developing countries with a high burden of disease, there is a constant struggle to prioritize services, especially countries with a high prevalence of HIV/AIDS (Hord and Wolf, 2004). Given the increasing HIV rates, particularly in South Africa, the high numbers of unwanted pregnancies and low consistent condom use is alarming (Cooper et al., 2005). This puts particular importance on the need to promote dual protection for women to prevent pregnancies and STIs and HIV/AIDS that result from unprotected sex. It is unclear exactly how the HIV epidemic has affected women's demand for abortion, but it does underscore the importance of addressing unmet need for contraception to prevent both HIV/AIDS and unwanted pregnancies.

Abortion and Culture

Many issues surrounding sexual behavior involve questions about culture. Around the world, laws and social norms converge and diverge with societal culture (Cornwall et al., 2008). In South Africa, the legal framework seems to be ahead of general beliefs and practices, particularly in relation to abortion (Cornwall et al., 2008). In other countries the legal norms reflect more of the conservative attitudes of everyday beliefs in the restrictions placed on accessing abortion services. The boundaries of 'culture' are constantly changing and evolving in relation to the evolution of communities and beliefs and significantly effect people's attitudes.

The cultural values placed on fertility in many African countries are an important factor to consider when looking at reproductive decision-making (Braam and Hessini, 2004). The importance placed on motherhood as a prerequisite to becoming a woman, puts pressure on women to have children, and makes the decision to terminate a pregnancy difficult. Abortion is often seen as an intervention to a culturally important event, becoming fertile and a mother (Braam and Hessini, 2004).

Historically in South Africa, midwives and traditional healers have helped women use local herbs for both contraception and abortion (Knudsen, 2006). However abortion has never really been accepted as a part of cultural beliefs. By the 19th century abortion was not uncommon among Afrikaner, "Colored", and Xhosa women, despite the presence of missionaries preaching against the practice (Knudsen, 2006). In contrast,

myths spread among the rural Pedi and Tsonga men were that if a woman had an abortion the rains would not come, and abortion was considered abnormal and witchcraft (Knudsen, 2006). Due to the diverse cultures in South Africa there are a range of opinions and attitudes around abortion and sexual and reproductive health rights.

The ambivalent attitudes toward abortion, and the gap that is often cited between actual practices and expressed beliefs present an opportunity to shift cultural thinking about the issue of abortion which should be explored.

2.4 “Pro-Choice”: Abortion Methods in Developing Countries

After considering the personal, proximal, and distal contexts in which reproductive decision-making occurs, and examining the legal, social, political, and cultural contexts, it is now important to look at the methods and technologies that are available and most importantly acceptable to women to fulfill their sexual and reproductive health rights. For several decades a range of contraceptive methods have been available for women and men, and choice and acceptability are considered important for sexual and reproductive health (Berer, 2005b). However, methods for abortion have received less priority and have not fully been addressed.

“It is like putting a lifejacket on in a boat. You do not want to run for it but you have to have the option to save yourself in a given moment. It is not that you want her to get pregnant or...to have an abortion, but there have to be options.”

-Man from Mexico’s view on medical abortion
(Gould et al., 2002, 417)

Medical Abortion: Advantages and Disadvantages

As of the 1980s new and proven effective technologies were developed for abortion methods. However, due to the political, cultural, social, and historical contexts, these methods are not available in most countries because of the socially controversial nature of the medical procedure (Joffe and Weitz, 2003). Many countries could potentially benefit from the availability of medical abortion, but have not yet incorporated it into their public health systems (ICMA, 2004c). Where both medical and surgical abortion methods are available women should have the right to choose between them, not necessarily to promote one method above the other, but expanding options so that it can best suit a woman’s needs (ICMA, 2004c).

In the context of high mortality rates, results have shown that medical abortion can reduce abortion related mortality by 15% if 20% of procedures are misoprostol induced; and up to a 45% reduction if 60% of procedures are misoprostol induced, which represents 30,500 lives saved annually (Harper et al., 2007, 68). This demonstrates the great advantages that this technology represents for women's health and rights.

Not only can medical methods for termination of pregnancy help to reduce unnecessary abortion-related deaths, but it is also a safer way of treating the thousands of women that present at hospitals or clinics with incomplete abortion complications. Surgical evacuation of retained products of conception (ERPC) is often the most common way to treat abortion complications (Moodliar et al., 2005). However this occurs in an operating room (which increases costs) and risks complications such as: perforation, cervical trauma, hemorrhage, and intrauterine adhesions (Moodliar et al., 2005).

The alternative use of misoprostol to medically manage these incomplete abortions is cost effective and associated with fewer complications (Moodliar et al., 2005). This method has a high success rate in the United Kingdom, and could be beneficial in countries with limited resources (Moodliar et al., 2005). Switching to medical management of incomplete abortions decentralizes services and decreases overall costs to a health care system, helping to manage the continuing self-induced, illegal, or unsafe abortions happening outside of health facilities.

Not only does medical abortion help treat incomplete abortion complications, but providing it in public health systems has a number of advantages such as: avoids surgery; increases access potentially when providers are reluctant to provide surgical abortion services; health care workers might have more positive attitudes towards the method; requires less staff input; and most importantly increases women's options (Cooper et al., 2005).

Historically surgical methods for termination of pregnancy (D&C, D&E) require specialized skills by providers. Today with MVA, it requires more basic skills, which allows a greater number of providers to be trained in abortion methods. In Vietnam, Cambodia, Mozambique and South Africa, midwives and trained medical assistants are allowed to provide first trimester surgical abortions (Yarnall et al., 2009).

Medical abortion does not require any surgical skills, and most mid-level providers practicing reproductive health care already possess the requisite skills to provide medical abortion services to the public (Yarnall et al., 2009). Referral networks are still needed to manage any complications but these are the same networks that are necessary for spontaneous miscarriage, ectopic pregnancy or infections.

Women's health advocates have hoped that the availability of medical abortion would increase the number of abortion providers by expanding the realm of eligible providers beyond surgical facilities (Blanchard et al., 2006). The results of a study done in South Africa found this to be true, 25% of the medical abortion providers looked at were not surgical abortion providers (Blanchard et al., 2006, 289). Expansion of abortion providers has the potential to improve the sexual and reproductive health care of women all over the world, to improve accessibility to services (Yarnall et al., 2009).

Different regimens of medical abortion are used with both mifepristone and misoprostol. Cost is often cited as a barrier to using medical abortion. In South Africa, the recommended 600mg of mifepristone (three tablets) can cost up to US\$150 (Blanchard et al., 2006, 289). Whereas misoprostol is relatively inexpensive, it costs approximately US\$0.50 per tablet (200mg). Different regimens involve different doses of each drug, and therefore can be made more or less expensively depending on what regimen is used.

A study done in South Africa found that the main cost drivers of medical abortion in the public health system were the dosage of mifepristone, the type of provider involved (doctor versus mid-level provider), whether it is administered in a primary or secondary level facility, and the currency exchange rate because the drugs have to be imported (Berer, 2005b). The study found that using alternative management pathways, medical abortion methods could be cost effective (Berer, 2005b).

Other barriers to using medical abortion in public health systems include repeated clinic visits for follow up, and accessing clinics to obtain medical abortion (Shah et al., 2005). The distance women have to travel, and the cost of travel are barriers especially in developing countries.

The right to choose needs to encompass not only the right to decide whether or not to terminate a pregnancy, but also what method is used as an important aspect of

quality of care, and of realizing sexual and reproductive health rights. This ensures that women can benefit from advances in medical technology and decide what best suits their needs.

2.4.1 Women's Perspectives on Medical Abortion: Choice and Acceptability

"...Being outside of a doctor's office makes you feel more in control, like you are not under somebody's command. That this is my body, I am in charge. I think actually the fact that you insert (misoprostol) yourself is a feeling like...this is my choice...my decision. There is so much more power in it."

-Woman from the United States (ICMA, 2004b, 4)

The choice of abortion method is important, and along with that the acceptability of new methods is equally as important. The beliefs of potential clients play an integral role in choice of contraceptive methods and use of new medical technologies (Harvey et al., 1995). In order for medical abortion to be widely used, it needs to be acceptable to women and providers. Research around perceptions of potential users in many countries, particularly in African countries is limited.

The research that has been done has found that the acceptability of medical abortion among women around the world is high (Blanchard et al., 2006; Cooper et al., 2005; Kawonga et al., 2008; Moodliar et al., 2005; ICMA, 2004d; Ramachandar and Pelto, 2005). Studies done in Great Britain, France and Sweden found that the proportion of women choosing medical abortion has risen every year since the drugs were approved in each country respectively (Blanchard et al., 2006). This demonstrates that as both women and providers become more comfortable with medical abortion as a method they are more likely to choose and offer the method (Blanchard et al., 2006). In the United States an acceptability and feasibility study found the 96% of women would recommend the use of medical abortion (Virgo et al., 1999, 145). In addition, studies done in countries such as Germany, Sweden, United Kingdom, Norway, and Finland have found that acceptability of medical abortion is very high (Berer, 2005b). Studies in South Africa have also found that women believe medical abortion is acceptable and would be willing to try it if available (Cooper et al., 2005; Kawonga et al., 2008).

The reasons women around the world cite for choosing medical abortion and its advantages fall into several broad categories. The first is that many women feel it is more natural because it happens in the body (Berer, 2005b; ICMA, 2004b; Lafaurie et al.,

2005). Women have reported they feel more in control because the process is happening in their bodies, and it feels like a miscarriage (ICMA, 2004d; Kawonga et al., 2008). Other women compare the procedure to a form of menstrual regulation, which helps them cope with their decision, as if they are just inducing a period (Lafaurie et al., 2005).

The second reason cited is it avoids surgery and anesthesia (Berer, 2005b; Gould et al., 2002; Kawonga et al., 2008; Lafaurie et al., 2005; ICMA, 2004d). When comparing medical and surgical procedures the uterine blood loss is in fact the same, however women experience it differently (Berer, 2005b). The surgical method suctions most of the blood and products of pregnancy out, whereas with medical methods it induces a heavy, menstrual like period.

The third reason is some women believe the procedure is safer and more effective (Berer, 2005b; Gould et al., 2002; ICMA, 2004d; Lafaurie et al., 2005). The method can be used as soon as a woman has missed her period. Medical abortion is more effective than aspiration up to seven weeks gestation (Berer, 2005b). Millions of women around the world have completed safe medical abortions.

The final reason is increased privacy and confidentiality because women have the option of terminating the pregnancy at home versus the clinic (Berer, 2005b; Gould et al., 2002; Kawonga et al., 2008; Lafaurie et al., 2005). Some women prefer to have family or a partner present at home with them, and others prefer to be alone. In Tunisia, there was a strong preference to stay at home because it is more confidential and easier for most women (Berer, 2005b). In France, having access to the advice of health care providers by phone at any time of day, greatly reduces any anxiety about aborting at home, and increases women's acceptance of the method (Berer, 2005b, 28).

Although there are many women who accept and choose medical abortion there are also those who prefer to use surgical methods. Fear of side effects is a deterrent for some women, and the length of the procedure. Some women fear infertility, hormonal changes, hemorrhage, or death mostly due to unfamiliarity with the method (Gould et al., 2002). Surgical abortion is much quicker, and some women prefer the process to be over in a short amount of time.

It appears from the studies summarized above from diverse countries such as Colombia, Ecuador, France, Mexico, Peru, India, South Africa, Sweden, Tunisia, and the

USA that medical abortion is a method that many women consider acceptable and therefore on this basis alone should be made available, especially in those countries where legislative frameworks are in place to support and disseminate the method.

2.4.2 Provider Perspectives on Medical Abortion

“...if medical termination of pregnancy can be made to be successful it actually decreases the workload of the staff. That reduces stress...and makes people more willing to help...You should be able to [choose] a less invasive procedure...”

-Health care provider from South Africa
(Cooper et al., 2005, 40)

When using new medical technologies, patients depend on providers to be experts in their field (Berer, 2005a). This is especially true in the realm of sexual and reproductive health. However some studies have shown that among reproductive health care providers, those interviewed knew relatively little about medical abortion (Berer, 2005a). Spreading knowledge about medical abortion is important, especially on the side of providers to ensure women are aware of their options and rights. Due to a shortage of trained providers, access to medical abortion is constrained (ICMA, 2004d).

Those providers that are familiar with medical abortion are generally positive and accepting of the method (Blanchard et al., 2006; Cooper et al., 2005; ICMA, 2004d; Kawonga et al., 2008; Patel et al., 2009). Health professionals played a large role in advocacy campaigns to make abortion legal and promoting access to medical abortion in developing countries such as: China, Cuba, India, South Africa, Tunisia, Turkey, and Vietnam (ICMA, 2004d).

Providers often have positive attitudes toward medical abortion methods because it puts less strain on health services by decreasing the workload and is easier to perform (Cooper et al., 2005; ICMA, 2004d; Kawonga et al., 2008). Medical abortion is also associated with lower rates of complications (ICMA, 2004d).

Using medical abortion as a method changes the role of the provider. Using this method, the role of the provider is: to give information, dispense pills, support women during the abortion process and monitor progress, and check that the abortion is complete (Berer, 2005b; ICMA, 2004b). The changing nature of the procedure and role of the provider has the potential to change the prevailing negative attitudes of health care workers because they are not required to initiate it (Berer, 2005b; Kawonga et al., 2008).

In order for medical abortion to be available and accessible and integrated into any public health system there should be staff training, and education of users about the method (Kawonga et al., 2008). Providers are a key entry point into any public health system, to ensure that quality and comprehensive services are given to clients, and women can again realize their sexual and reproductive health rights.

Chapter 3: Theoretical Framework and Research Methodology

3.1 Introduction

This chapter will outline the design of the study, the theoretical framework used, and the methodology employed to carry out this research. This case study was designed to determine what influences women's decisions about abortion; the knowledge women have about abortion and its methods; and explore the perspectives of these women as potential clients of the relatively new method of termination of pregnancy, medical abortion in South Africa. The study was conducted at the University of KwaZulu-Natal in Durban, South Africa.

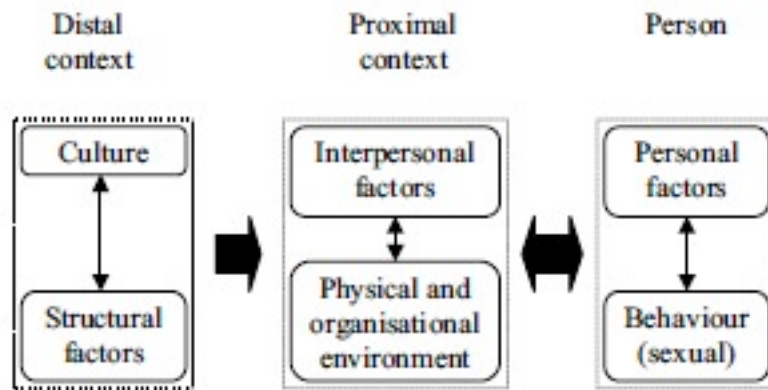
Research shows that there are strong social and cultural forces that shape sexual behavior and there are many complex factors that influence individual's sexual decisions (Marston and King, 2006). There is a need to reframe development to look at people as a whole, not only in terms of their capacities and utility for economic or social needs or political and civil rights but to look at what fully makes us human (Cornwall et al., 2008).

“[Sexuality] is about the social rules, economic structures, political battles, and religious ideologies that surround physical expressions of intimacy and the relationships within which such intimacy takes place.” (Cornwall et al., 2008, 5)

3.2 Theoretical Framework

The principal theoretical framework on which this research study is constructed around is Eaton's model of sexual behavior. The model was established recently, based on several major theories of behavior, which include the Health Belief Model; the Theory of Reasoned Action; the Theory of Planned behavior; and Social Cognitive Learning Theory (Eaton et al., 2003). These socio-cognitive theories focus mainly on behavior, personal factors, interpersonal factors and processes (Eaton et al., 2003). Eaton et al. (2003) adapted these theories to fit in a developing countries context, and expanded them to look at social, economic, environmental, and political factors that shape sexual behavior.

Figure 3.1: Eaton’s Theory of Sexual Behavior. Examining the relationship between personal factors, proximal and distal contexts and sexual behavior.



(Eaton et al, 2003, 150)

The model looks at sexual behavior on three levels: within the person, within his or her proximal context, and within the distal context (Eaton et al., 2003). The personal factors include knowledge and beliefs, thoughts about one-self (self-efficacy and self-esteem), and intentions to carry out behaviors. The proximal context examines interpersonal relationships, and the physical and organizational environment surrounding a person. The distal context takes into account structural factors and culture such as traditions, societal norms, the social discourse within a society, and shared beliefs and values across different segments of the population. Together all of these factors, the socio-cognitive, the proximal environment and the broader social context interact to influence sexual behavior and often present challenges to realizing SRH rights.

Applying Eaton’s theory of sexual behavior to the demand for medical abortion, this case study looks at the various factors that shape women’s sexual and reproductive health decisions through qualitative methods in order to try and understand the inner experiences of women and determine how meanings are formed on the individual, proximal and distal levels, specifically surrounding abortion and abortion methods. Due to the sensitivity and complexity of sexual behavior, specifically abortion related issues, qualitative research methods were deemed the most appropriate in order to discover the multiple factors and meanings that shape reproductive decision-making for young women.

The main research method used was in-depth, open-ended interviews. Interviews were used as the main research tool understanding the sensitivity of the topic to allow flexibility and explore women's perspectives on abortion related issues, specifically abortion methods. Interviews, as a tool, also allow participants to share and contribute their experiences and communicate the multiple realities and many truths that a woman within the university setting faces surrounding abortion.

The in-depth interviews examined knowledge and beliefs surrounding medical abortion and abortion in general; perceptions of risk associated with medical abortion and other factors that affect termination of pregnancy decisions; and self-efficacy, the expectations associated with medical abortion, and how that shapes the decision to use it as a method. The proximal context is examined to determine interpersonal factors such as what or who influences abortion decisions; what type of access women have to health facilities and abortion services; and other environmental factors that shape a woman's decision to use medical abortion. The final level, the distal context is examined by looking at issues of culture and societal discourse around abortion and how that affects the demand for medical abortion; and socio-economic status and demographic factors that influence the demand for medical abortion.

Together all of these factors are taken into account and analyzed to assess the demand for medical abortion among female university students in Durban, South Africa. Based on Eaton's model of sexual behavior as the overarching theoretical framework and employing qualitative research methods, data was collected over a three-month period from October to December 2009.

3.3 Target Population and Study Sample

Sample Size Considerations

The study was conducted at the University of KwaZulu-Natal (UKZN) in Durban, South Africa. University of KwaZulu-Natal was chosen as the study site as it is one of the largest public universities in South Africa. It is situated in the province of KwaZulu-Natal, which over the past ten years has one of the highest rates of termination of pregnancy and the lowest rate of functioning TOP facilities (Health Systems Trust, 2009a). KwaZulu-Natal also has the highest rate of HIV/AIDS in the country, and faces

major sexual and reproductive health challenges (Health Systems Trust, 2009c). The case study is based here to examine and explore this aspect of women's health and well being assessing women's perspectives surrounding abortion, specifically methods of abortion.

The study uses university students for this sample because students often become agents of social change in society and can serve as an indicator as to whether or not there will be a demand for medical abortion. Critical consciousness, mentioned previously, fostered in university settings can set the foundations for change in society, and in this case in the field of new medical technologies.

In addition to targeting university students, the study targeted sexually active females under 30 years old to explore their attitudes and perceptions of medical abortion. The study focused on female students because they are the potential users of this method of termination of pregnancy. So in order to set the foundation for the viability of medical abortion in public health systems as potential clients, females' opinions are the main focus of this study.

The study uses only sexually active participants because the potential users of termination of pregnancy services will be only those who are sexually active.

Women under 30 years old were chosen because research has found that the majority of unintended pregnancies occur among women under the age of 25 (Shah and Ahman, 2004, 15). In addition, the majority of unsafe abortions occur among women aged 15 to 30 years old in developing countries, and in Africa 80% of unsafe abortions are done among women under 30 (Shah and Ahman, 2004, 9). Recognizing that public health interventions are most successful when targeted at the most at risk population, the study focused on those who are most likely to seek termination of pregnancy services namely sexually active females less than 30 years of age.

Selection Process

Twenty female, university students less than 30 years old were recruited to participate in the study. Purposive sampling, specifically snowball sampling was employed to recruit participants falling under the above stated criteria. Participants were recruited via student associations, email list serves, and word of mouth. This method sometimes referred to as chain referral sampling uses participants that have already been

contacted and uses their social networks to recruit future participants that are able to contribute to the study. As abortion is a sensitive topic snowball sampling was deemed most appropriate in order to ensure that participants were comfortable and willing to participate, and to reach women willing to share their experiences about this sensitive and often controversial topic. The sampling continued until there were no further ‘in-scope’ candidates to interview and no further members were obtained.

Description of Population

The following table summarizes the sample characteristics of each participant in the study:

Table 3.1: Sample Characteristics of Participants

Sample Characteristics of Participants							
	Age	Hometown	Race	Faculty/Department	Partner status	Previous Pregnancy	Children
1	23	Durban	White	Humanities/Linguistics	Single	No	No
2	23	Pretoria	Black	Politics/Economics/ Philosophy	Single	Yes	Yes (1)
3	21	Durban	White	Linguistics	Engaged	No	No
4	21	Richmond	Black	Law	Boyfriend	No	No
5	22	Durban	Black	Law	Boyfriend	No	No
6	21	Durban	White	Law	Boyfriend	No	No
7	23	North of Durban	Black	Social Work	Boyfriend	Yes	Yes (1)
8	25	South Coast	Black	Social Work	Boyfriend	Yes	Yes (1)
9	23	Durban	White	Film Studies/English	Boyfriend	No	No
10	25	Durban	White	Sociology	Single	No	No
11	22	Durban	Indian	Development Studies	Single	No	No
12	25	Durban	Black	Film Studies/English	Boyfriend	No	No
13	21	Pietermaritzburg	Black	Population Studies	Single	No	No
14	23	New Castle	Black	Population Studies	Single	No	No
15	23	Pietermaritzburg	Black	Law	Boyfriend	No	No
16	22	Durban	White	Development Studies	Single	No	No
17	23	Newlands	Indian	Business	Boyfriend	No	No
18	23	Durban	Black	Development Studies	Boyfriend	No	No
19	22	Jozini	Black	Population Studies	Boyfriend	Yes	No
20	28	Durban	Indian	Psychology	Married	No	No

3.4 Collection of Data

The data was collected through 20 open-ended in-depth interviews with women aged less than 30 years old. As stated previously in-depth interviews were used as the main research tool in order to explore the multiple levels and factors that influence opinions, perspectives, and experiences with abortion, specifically methods used for

termination of pregnancy. The study instrument was designed to examine the personal, proximal, and distal factors that shape women's reproductive decision-making, specifically looking at their attitudes and opinions of abortion in general, and further medical abortion as a method in the context of South African society. An informed consent form was signed by each participant prior to the interview to assure confidentiality, and inform her of the general overview of the study.

Each interview began assessing the demographic profile and reproductive history of each participant. Questions covered history of partners, contraceptive use, pregnancy history, religious views, knowledge of abortion legislation, and abortion methods. If participants had no previous knowledge of medical abortion as a method, an information pamphlet was provided to guide discussion and inform women of the method. The pamphlet was based on the Planned Parenthood's recommendations for mifepristone and misoprostol use (See Appendix II). The pamphlet gave the participants an overview of a medical abortion regimen and the steps that are taken in the process from start to finish, citing potential side effects. The pamphlet was designed to explain what medical abortion is, how it is used, and explain the process as a method for termination of pregnancy in order to guide discussion.

After reading the pamphlet participants were asked to state their reactions to the method, and give their opinions of it in the South African context. Questions covered the potential advantages and disadvantages of medical abortion as well as its potential acceptability to women interviewed and their perceptions of other women's perspectives in South Africa.

The majority of interviews took place at the university in a private office. Some interviews were conducted in their rooms at the university residences by the request of participant. Each interview, with the exception of one, was conducted privately one on one with only the interviewer and interviewee present. One interview, at the request of participants was done jointly, with two participants present in the room during the interview.

The duration of each interview ranged from 40 minutes to one and a half hours. All interviews were digitally recorded and transcribed.

3.5 Ethics

Before conducting the research, a proposal was written and passed through the School of Development Studies, and the Faculty Higher Degrees Committee, and Ethics Committee at the Faculty of Humanities, Development and Social Sciences at the University of KwaZulu-Natal.

Recognizing the sensitive nature of women's sexual and reproductive health all measures were taken to ensure that the interactions between the researcher and participants were respectful, always ensuring that the autonomy of participants was upheld. All interactions were voluntary on the part of the participants with only those willing to participate recruited. Each participant was required to sign an informed consent letter, which was written to ensure that participants understand what it means to partake in this study. Each woman was then able to decide whether they want to participate. Each participant was informed of the purpose of the research, what is expected of her, how confidentiality will be ensured, and contact details of the researcher and supporting institution (See Appendix III).

Confidentiality was maintained in the private interview settings, and each interview was transcribed with no names cited to ensure that individuals were not exposed, and confidentiality was not breached. No names are recorded anywhere throughout the transcriptions or write up. Digital recordings will be destroyed after the research has been completed in order to ensure the lasting protection of confidentiality of each participant.

3.6 Analysis Techniques

"...metasyntheses are integrations that are more than the sum of parts, in that they offer novel interpretations of findings. These interpretations will not be found in any one research report but, rather, are inferences derived from taking all of the reports in a sample as a whole."

-Margarete Sandelowski (Thomas and Harden, 2008, 3)

The data was collected through digital recordings and note taking and then transcribed and further analyzed using thematic analysis. After transcriptions were completed key concepts and themes were identified to create a coding framework to base the analysis, to make comparisons and organize the data.

The data was coded into analytic themes to apply initial codes or labels to segments of the data. Fourteen themes were drawn out falling under the following key words: 'contraceptive use', 'dual morality', 'partners', 'sexual education', 'abortion legislation', 'unsafe abortion', 'stigma', 'health provider', 'religion', 'HIV/AIDS', 'culture', 'medical abortion', 'surgical abortion', and 'advantages/disadvantages of medical abortion'. Participant's responses from interviews were taken, coded, and translated into themes and synthesized to carry out the analysis.

These themes were then analyzed to create a synthesis of recorded data from participants and relay the results from the study. The themes were further organized around Eaton's theory of sexual behavior categorizing the data on three levels: the personal, the proximal, and the distal contexts that shape these individuals sexual behavior based on each participants responses. Selective coding took place in which the data was scanned and selected to illustrate the major themes for the final analysis. After coding and translating, the data was then brought together to produce the results and analysis that are presented in the following chapter.

3.7 Limitations

The case study is limited firstly in the sampling technique; while snowball sampling was used to find a sample of women willing to talk about abortion and their experiences, it also limits the sample to particular social networks. And while the university setting holds a diverse population, it lacks the opinions of women from a broader range of backgrounds. In addition, as mentioned previously, one interview was conducted with two participants simultaneously upon the request of the participants. This might have influenced their responses due to a possible desire for social acceptance or approval. [Note: This was done due to requests of participants.]

Other limitations lie in the method of analysis, thematic analysis is a method that relies on the interpretation of the researcher and could lead to biases. However the analysis was conducted systematically according to codes in order to draw out major themes and use them in the context that they were given.

The results are not nationally generalizable, although it provides a good case study of whether or not medical abortion is a viable option for the public sector health

facilities, and has the potential to aid policymakers. The results, it could be argued, are only applicable to a specific context within the setting the research took place, however it still stands as a case study that could be applied to a broader spectrum of women. The results have the potential to be useful to inform policy and practice.

3.8 Summary

The study is designed to explore and understand the multiple realities women face when confronting sexual and reproductive health problems, specifically surrounding abortion. The qualitative methodology employed through open-ended in-depth interviews was organized to investigate the personal, proximal and distal contexts that shape women's decisions and opinions of abortion and abortion methods based on Eaton's model of sexual behavior. To reiterate, the aim of the study is to explore women's attitudes toward abortion in general, and more specifically women's knowledge of medical abortion and their perspectives of it as a method for termination of pregnancy in the context of South Africa.

The study design and results will help to assess whether or not there is a potential demand for medical abortion, and if it is an acceptable method to use to expand women's reproductive health choices to realize their sexual and reproductive health rights in South Africa.

Chapter 4: Results

4.1 Introduction

In order to examine women's awareness of and attitudes toward medical abortion, this study first looks at the context in which women make reproductive decisions. It explores the personal contexts of women: their reproductive histories, their attitudes toward abortion; perceived barriers to abortion; and finally their views and reactions to medical abortion as a method.

Sample Characteristics

In total, 20 interviews were conducted. The mean age of the women interviewed was 23 years old. The ages of women ranged from 21 to 28 years old. All of the women were from KwaZulu-Natal, with the exception of one. In the sample of women 55% were black African, 30% white, and 15% Indian. The students included both undergraduates and postgraduates. Just under half of the women claimed a religious affiliation; the majority was Christian.

Over half the participants (65%) had a regular partner; one participant was engaged, one participant was married, each of the women was living with their partner at the time of the interview. The rest of the women did not have a regular partner. Three women had a child; one woman experienced a miscarriage; and one woman has had two previous abortions. All of the women who had previous pregnancies reported that the pregnancies were unintended, and unexpected.

4.2 Attitudes toward Abortion

The abortion debate is often classified into two broad categories, for and against abortion. However, this study found that there was no definitive dividing line between these two broad categories. Throughout the interviews it became apparent that there are multiple factors that influence decisions about and attitudes toward abortion, making it a complex issue to investigate.

None of the women were planning to become pregnant in the near future. When asked what they would do if they found out they were unexpectedly pregnant, the responses varied and changed when discussing different scenarios. The majority (65%) of

women said they would not have an abortion if they were to become pregnant, and most of them were against the act of abortion for themselves. Two participants were uncertain what their decision would be, depending on their situation. The remaining women (25%) reported they would have an abortion if they became unexpectedly pregnant.

While on the one hand the majority of women were against abortion for themselves, the majority of women (92%) felt that all women have the right to choose whether or not to have an abortion based on individual contexts. The idea of being “pro-choice” was a reoccurring theme.

“...I hope that I do not judge people that have abortions, but for me it is something that I will never do...” (P13)

“It [abortion] would probably pop into my mind, but although I am pro-choice, I think this is the correct term? I do not think I would be able to do it myself.” (P1)

“...I am pro-choice, but I just think for myself personally it is [abortion is] not a choice that I would make...” (P16)

While the majority of women were against abortion, their responses changed when presented with different scenarios, showing more ambivalent attitudes toward abortion. The vast majority (92%) said that under certain circumstances, namely rape or dangerous medical conditions, they would consider terminating the pregnancy.

“...no one would say I am for abortion. They always act as if abortion is a wrong thing, but they do it. Because I do not want to be seen as a bad person in the public.” (P8)

A gap between ideals and real life practices seems to happen in relation to abortion. On the one hand women say they are against abortion; but on the other hand, when an unexpected pregnancy occurs, the reality might be different.

It is difficult to make any concrete statements as to whether or not women would have an abortion, but women’s responses highlight the complexity of the decision, and the many factors that influence attitudes and decisions around sexual and reproductive health. The following sections will outline the top reasons women reported for inducing an abortion, as well as reasons inhibiting abortion.

Reasons Why Women Induce Abortion

The reasons given for having an abortion were multiple and vary from woman to woman depending on different contexts women find themselves in. The top five reasons women gave for terminating a pregnancy are described below.

Rape

The most common reason for seeking abortion services was in the case of being a victim of rape. If a pregnancy resulted from such an act of violence, the majority of women would have an abortion, and would be supportive of other women making the same decision.

“If I got raped I would definitely have an abortion.” (P20)

“If I got raped, I would not want that baby because I know it is not its fault, but it is the product of hate.” (P3)

“For rape victims I can understand [having an abortion].” (P14)

When a woman is forced to have sex with a man, she does not control over her bodies. A pregnancy resulting from rape is not one that a woman consents to; so the majority of women felt that women should then have the right to choose whether or not to have an abortion. The pregnancy is not a product of two consensual partners, and therefore abortion was thought of as a justifiable act.

South Africa is a country with high levels of rape and sexual violence compared to other countries. Many women mentioned that rape is a serious problem in South Africa, and so for this reason abortion services should be made available for women to access in case of such acts of violence happening to them. Providing abortion services in these circumstances is crucial to uphold women’s rights.

“If you think of women that are raped...what could they do? It [abortion services] were not available, and that is why they resort to illegal abortions in some cases.” (P11)

When abortion services are not available, accessible, and affordable to women, women often resort to illegal abortion providers out of desperation, especially in the case of rape. An unwanted pregnancy by a rapist is traumatizing to say the least, and the social stigma that surrounds abortion further compounds this trauma, which can be dangerous to women’s health and well being.

Continuation of Studies

The second most common reason for seeking abortion services was an expressed desire to finish one’s study and establish a career before commencing childbearing. Many

women's visions of success were dependent on finishing their university degree, and having a child was seen as a barrier to this success.

"...I still have a career to choose, and I need to be more stable before I choose to do something like that. And now is not the time [to have children]." (P17)

"...I was a student, so I knew that if I do not have the abortion then it will be over for me...so I had to do the abortion, even though I did not like it. For me, I had no choice."
(P8)

Many women felt that they needed a university degree that would create better employment opportunities for them. Having a child at this time in their lives was something that many women thought would interfere with their life goals of becoming successful in whatever career path they choose.

In conjunction with wanting to finish their studies and start a career, some women said they would have an abortion to postpone childbearing. They were not ready to have children at this point in their lives, and so they would have an abortion if confronted with an unwanted pregnancy.

Finances

The third most common reason for having an abortion was a lack of finances. Some women said they were not financially independent, as they did not have a stable job and for this reason they did not want to have a child. Without resources to support a child, many women said they would rather have an abortion than raise a child without the proper means to ensure that their child would be provided for.

"I think it would depend on the finances. I think everything boils down to the finances."
(P18)

Two women, who have a child already, said they were not in a financial position to support another child. Having more children requires more time and resources, which these women do not have to offer another child, while also being in school.

Many women are not financially independent as demonstrated by South Africa's high rates of poverty, inequality, and unemployment. Finding the resources to support multiple children in this context is extremely challenging, and many families struggle on a daily basis to survive and maintain the basic necessities for their children.

“I think that if someone doesn’t have the money to raise a child, and I think that there are really so many children that do not have homes or parents in this country, and not all of those children can be adopted.” (P16)

“If it [abortion] is not available then it increases people...kids coming to this world in poverty and unemployment.” (P17)

Some women believe that children should not be brought up with a low quality of life, in poverty, and therefore abortion is justified in order to try and stop the cycle of poverty from continuing. And if abortion services are not available, then more children will be born into poverty stricken families and struggle to survive. So with a lack of finances to support a child, some women are of the opinion that abortion should be an option for women.

Partner Issues

The fourth most common reason for having an abortion was related to their relationship status. Some women felt that they were not in a stable relationship, and were unsure if the father of the child would support an unexpected pregnancy. Relationships are never static and often change; in these situations some women said if they have a problem with their partner they would not want to carry to term an unexpected pregnancy.

“I had this boyfriend, so I did not use the condom. So I got pregnant, and then we were no longer in love; so I thought I cannot have the baby for him, if we were not in love. So I did not want to have another baby.” (P8)

Some women also reported having friends who had abortions because their partners either physically or emotionally abused them. If some women found themselves in situations where their partner is already compromising their health, these women would not want to risk the health of a child as well.

“He used to hit her, and so it was not really a great environment to bring a child in to [so she had an abortion].” (P1)

If a woman’s partner is not able to support a future child, or abusive towards a woman, then some women reported that in these situations an abortion was justifiable and would be the best option for a women’s overall well being.

Medical Conditions/Disability

The fifth most common reason for terminating a pregnancy was dangerous medical conditions that posed a risk for the mother or the child. Some women felt that the risk of a child being born with birth defects or another serious disability was an acceptable reason for opting for an abortion.

“...if I found out that my child was deformed in any way I would have an abortion.” (P6)

“...people that have a disorder or anything and they feel like they will pass it on to the child, why would they bring up the child that way?” (P17)

“I have bipolar disorder in my family. If I turn out to be bipolar, I do not want children, I do not.” (P3)

Some women mentioned genetic disorders in their families such as: multiple sclerosis, Down syndrome, bipolar disorder, and depression. Some women said that they would not want to transmit these disorders to their children, so under these circumstances their attitudes toward abortion would change from being against abortion to being for abortion.

Reasons against Abortion

As stated earlier, the majority of women were generally against abortion. Just as the reasons vary and are multiple for having an abortion, they are also varied and individually based against abortion. Many regard abortion as “murder” and are “morally opposed” to it.

Religion

The top reason cited against abortion was religious beliefs. Religious affiliations were reported to greatly affect women’s reproductive decision-making. Religion often shape social constructions of sexuality and influence the choices of women. Religious influences range from personal to environmental contexts.

“It is religious beliefs themselves, and just moral, killing someone, a human being; you are killing a human being.” (P14)

“Under the circumstances I was scared to do an abortion. I am always scared because of many things, religion and everything, and you are thinking to kill this thing that is your baby. So I decided to keep it and something happened [miscarriage].” (P19)

Some women were Catholic, and described abortion as murder, in accordance with the “consistent life ethic”. Their families and the churches they attend influenced

many of these women's beliefs. Some women, although they did not describe themselves as Catholic, attended Catholic primary and secondary schools, which influenced their attitudes toward abortion. Women's discourse around abortion is greatly influenced by religious beliefs, especially when sex education is taught according to religious ideals to young people.

"I do not believe in abortion. I am religious, I am Catholic, and so as much as I have sex, committing adultery, I would feel like I am killing my own baby." (P14)

"I went to a Catholic school that was very anti-abortion actually. They would show you a picture of a baby at one week, or a fetus...I think we learnt abortion was evil, number one." (P10)

A few women also discussed Islamic beliefs about abortion. According to one woman, Islam views life as sacred, and also looks at abortion as a sinful act. However, this woman also stated that there are certain circumstances where abortion is acceptable: if a woman is raped or there is a danger to the mother's health. She further said that under Islamic beliefs a fetus develops a soul at four months gestation, so in certain circumstances abortion is only approved of before that time.

Religious institutions are very powerful influences in personal decisions, as well as abortion legislation as addressed earlier in the literature presented in Chapter 2.

The Role of the Male Partner

Some women said they would not have an abortion because of the role of the male partner in the decision about whether or not to terminate a pregnancy. While some women cited issues with male partners as a reason to have an abortion, other women cited male opposition as a deterrent. The nature of a relationship between partners as well as the attitude of the partner toward abortion is an important factor in determining whether or not to terminate a pregnancy. Many of the women in this study perceived men as holding negative attitudes toward abortion.

"The thing that prevented me from doing that thing [abortion] was my boyfriend suspected that I was pregnant. So he prevented everything because I couldn't go on...with the abortion because he knew that I was pregnant." (P8)

"Some [men] ask a woman to keep the baby; even they know themselves that they won't support that baby. They run away, and women will be left alone to raise the kid." (P19)

Men exert a large influence over the reproductive decision-making process. This means that they are likely to have an influence over whether or not a woman terminates a pregnancy. Many women felt that men are against abortion but they are not always willing to support a child resulting from an unintended pregnancy, which means the responsibility of the child stays with the woman.

In addition, some women stated that in the past they would have chosen to have an abortion but now they are in a stable relationship with a supportive partner; so with their current partners they would choose to have a child in the event of an unintended pregnancy. These women's opinions changed based on their present situation, however this might not be the same if they were not with their current partners and faced with a different scenario.

Family Attitudes

Many women reported that their family was against abortion. Most families were against abortion because of religious or cultural beliefs. Not only did many women report feeling uncomfortable discussing the topic of abortion with their families, some women said that their families would prevent them from having an abortion. Women expressed a desire to uphold their families' values. One woman said when she became pregnant for the first time, her family persuaded her to not have an abortion.

“Abortion, no abortion. I think the biggest mistake I did was tell my mother. By telling my mother there was no way I could have decided to have an abortion, she would not have allowed it.” (P2)

The reasons inhibiting abortion are varied, and are contextually based. In addition to personal beliefs against abortion, women's partners and families greatly influence a woman's decision about whether or not to have an abortion.

Barriers to Accessing Abortion Services

In addition to reasons given against abortion, the majority of women said there are many barriers to accessing TOP services, which inhibit women from having an abortion. South Africa has one of the most liberal abortion laws (See Appendix IV), yet many obstacles remain to access abortion services for many women. Women identified a

number of barriers ranging from lack of awareness of abortion legislation to stigmas attached to abortion.

Knowledge of the 1996 CTOP Act

The majority of women (90%) were aware of the 1996 Act; however most of them had limited knowledge of the abortion legislation. Most women were aware that abortion is legal in South Africa, however they did not know where to access services, the cost of services and whether or not TOP services are available at public facilities. Few women were unaware of the legality of abortion in South Africa, of which one of them had an abortion outside of a health facility through an illegal provider.

A few women pointed out that there exists a gap in knowledge, particularly between urban and rural areas. They thought that rural women in general knew less about abortion legislation and where to access abortion services. According to them, women who live in rural areas face more challenges to access abortion services than women in urban areas. Some women said one of the main reasons for this was a lack of awareness of abortion laws in rural areas.

A few women mentioned that if one is not aware of abortion's legal status and where to access it, many women resort to unsafe methods and practices, which impacts negatively on their sexual and reproductive health. The legalization of abortion in South Africa was important to most women in this study in preventing the use of unsafe methods. Although one woman was unsure of how she felt about the abortion laws, overall she believes that making abortion legal, and raising awareness about safe services is important to avoid the risks that many women take when terminating a pregnancy.

“...a part of me thinks that it was wrong for legalizing abortion, a very big part of me, but another part of me says maybe it is the only possible way to overcome some of the challenges we face, you know? A lot of people do abort, but most of them do illegal abortions...not enough people know about abortion, that it is legal...as much as the government has done [legalizing abortion]...it has not taken enough steps, or sufficient steps so show that legal abortions [are available].” (P13)

If women are aware of abortion laws, it gives them the power to choose how they terminate a pregnancy, and where to access TOP services safely in order to avoid harming themselves and engaging in unsafe practices. Many women were of the opinion

that students should be educated about abortion laws and methods to empower them and uphold their constitutional rights.

Stigma: Women's Silence and Secrecy Surrounding Abortion

In general pregnancies before marriage are viewed as taboo mainly due to religious and cultural beliefs, which places heavy emphasis on marriage. Unmarried, pregnant women often face stigma and discrimination.

“I think if you are unmarried and you are to become pregnant, I think in most cultures here that is really stigmatized...For that reason I think some young women would consider having one [an abortion]...to avoid getting kicked out of home, or people not accepting you anymore.” (P20)

Because women fear the disapproval of their communities, they will have an abortion to avoid going against social norms. However this puts women in a very difficult position because while pregnancy before marriage is stigmatized, abortion is also heavily stigmatized in many communities.

“If you fall pregnant, it is like what were you doing in the first place? And now you are killing this baby? And so no one is really forthcoming with it, like oh I had an abortion. Not a cool thing to do.” (P5)

Abortion is something that is not often talked about in communities, within families, or even among friends. It is often shrouded in a veil of secrecy. The majority of women are against abortion for themselves, and further said that the majority of people they know are also against abortion, making it a socially unacceptable act.

“I think abortion is still largely frowned upon, but I think in societies like ours, it is a necessary evil.” (P20)

A few women said that there are serious social consequences for having an abortion because of the stigma and disapproval attached to the act, women face being outcast from their communities if they have an abortion. Some women felt that stigma is also likely to be higher in rural areas than in urban areas.

The stigma that is attached to abortion makes it a taboo subject. The silence around abortion often deters women from seeking services in public facilities. Because of the stigma, many women seek alternative abortion methods, and the stigma ends up perpetuating a cycle of unsafe and illegal methods, which women resort to in order to conceal the fact that they are having an abortion.

Abortion and Culture

Stigmas that are attached to abortion often stem from cultural beliefs and practices. It is often cultural beliefs that influence women to stay away from health facilities for abortion services and instead seek alternative methods. Historically methods of TOP have been used outside health facilities by traditional healers, and the legacy continues today. People are still seeking traditional methods for terminating pregnancies that are often unsafe and lead to severe complications.

“I think that there are a lot of cultural complications. Abortion in general being socially taboo...I know that traditional healers have some sort of plant that you can take that terminates pregnancy.” (P16)

“I think that they [cultures] limit women...from going to the hospitals, because there is always those ways that they say to abort...you know different cultures have different ways, methods that they think you can use to abort.” (P13)

According to the majority of Zulu women interviewed, in Zulu culture, which is predominant in KwaZulu-Natal, does not accept abortion, which can be a major barrier to seek abortion services. There is an emphasis placed on women’s virginity and chastity in the Zulu culture. One example of this is the annual reed dance, or virginity testing, that is still practiced in some areas, idolizing women’s chastity and purity. If they are to be found pregnant, women risk being cast out of their communities and are faced with ostracism.

“This [abortion] is just a taboo thing for many people. Firstly people do not talk about it, I know in Zulu...that if you have an abortion you are *khipha ingane*...*Khipha* is to take out, and *ingane* is a baby, it is just not accepted.” (P18)

“Men seen themselves as the guardians of our culture will always say this [abortion] is against our culture, right? But I do not know any part of Zulu culture that is against abortion. It is not written anywhere...it is men who have always been the people who decide what happens in our society, South African society. And I do not think anyone has stopped to consider that men could be wrong.” (P12)

“And there is the whole reed ceremony thing, they go for virginity testing and what not. And if you are having sex you are going to be isolated from the whole community, so you are going to keep quiet. And if you are pregnant also, everyone would know...But there are these crazy things, because they [communities] scare them [women] from going to hospitals or clinics.” (P19)

These cultural beliefs are passed down from generation to generation, and become a part of the discourse around sexuality. These beliefs are not always challenged and greatly influence the way women behave. These taboos discourage women from seeking care in

health facilities because they want to try and preserve this image of purity and be socially accepted in one's community.

In addition, the role of ancestors in Zulu culture was also mentioned as a reason preventing women from having an abortion for a fear of reactions from their ancestors. Many people believe that one's ancestors can intervene in one's life either positively or negatively.

“You know we have this cultural thing of the ancestors, because when I was doing the abortion, I thought maybe my ancestors would punish me for this, maybe something would happen to me.” (P8)

If a woman has an abortion, in the Zulu culture, some believe that there will be negative repercussions from the ancestors. For example, one woman said that she might fall ill or something would happen to her family if she had an abortion because of the reactions from the ancestors.

Culture affects women's personal beliefs and their reproductive decisions, especially around abortion and abortion methods, and often creates a barrier to accessing health facilities.

Clinical Environments: Perspectives on TOP Services

Another barrier that was often reported beyond stigma and cultural beliefs was the negative attitudes of health care providers. The majority of women made reference to the negative attitudes of health care workers as a major deterrent in seeking sexual and reproductive health care. Many women recounted experiences of judgment and disapproval when seeking SRH services from the part of the staff at clinics and hospitals.

“They [nurses] are so hostile down there [clinics]. They would not allow a kid to come for contraceptives, even for your condoms. They will be asking what, you are having sex at this age?” (P19)

“Some nurses are judgmental, you know that? I know because I know so many people who have done abortion...It is that thing that abortion is murder.” (P7)

Some women say that nurses and other health care workers are deeply judgmental and often impose their own views of abortion on to their patients, which makes many women uncomfortable. Women then seek providers outside health facilities that will be less judgmental and allow them to feel comfortable in their choice to have an abortion. Seeking services outside the health facility then puts them at risk of unsafe practices.

In addition, the perception that public health facilities do not provide quality care was cited as a reason why women would seek care in either the private sector or services from illegal providers. Some women do not trust the public health system to deliver quality care, and so turn to alternative methods, particularly when seeking abortion services. Many women who have the financial means would choose to go to the private sector rather than public hospitals because of the standard of care received. Those who do not have the financial resources for private health care turn to illegal providers, who are within their budget range.

“I do not trust the public system. And I would rather go to a private doctor...There are too many patients. There is an insufficient amount of doctors. I think the stand of care is substandard.” (P20)

The public health system is burdened with an overload of patients and a lack of resources in terms of both a shortage of staff as well as equipment. For abortion services in particular there is a lack of public providers, and hospitals take a limited amount of patients per day, making it very difficult for the majority of women to access TOP services. The following is one woman’s description of her experience of the TOP services in a public hospital in Durban:

“And the first time I went there because they take 10 people a day. So you have to wake up early in the morning, maybe about 5 o’clock you have to be there. And it was not easy, waking up at that time. Maybe at 4 you are at your home, what are you going to say, you are going there [to the hospital]? I go there, and then I come back, it was so full. They have their 10 people. So I have to come back...I slept on the hospital bench, yeah, so that I could wait there, wake up early, instead of going home. So I was there at that time. For the first time they tell us about the abortion, and then they check you, how many weeks, cause they only take 12 and down. So and then, you sign some papers about doing the abortion, and then they do not give you the pills that day, you have to come another day to take the pills and then come back another day for cleaning.” (P8)

Many women travel long distances to reach hospitals where TOP services are available, and because of the limited number of patients taken per day they are often unable to access these services. The lack of beds and time makes it difficult to use public facilities for TOP services.

All of these barriers often lead to unsafe methods and illegal practices of abortion. These barriers also represent barriers to women’s rights, as outlined in the 1996 Act. This right is not fully exercised judging from the accounts of women in this study.

4.3 Making Abortion Safe: Perspectives on Illegal Abortions in South Africa

The barriers that women face accessing abortion often lead women to resort to unsafe and illegal methods that have been mentioned throughout this chapter. Every woman in this study knows of someone who has had an abortion. Although the central focus of this study was not the unsafe abortions happening in South Africa, in each of the interviews conducted the subject of unsafe, illegal abortions was a common, recurring theme that was brought up by each participant. Every woman interviewed had a story to tell about unsafe abortions, ranging from personal experiences to media coverage of other women's experiences with abortion.

“Although I am against abortion in principle, there are circumstances, look even if abortion is not legalized; people are still going to do it. And then it raises the question should you rather have it where they can do it in a safe environment? Or do it in the toilets where they are at risk as well.” (P20)

“And the reason why we initially did termination of pregnancy [law] was because of all the backstreet abortions that were being done. And they did studies that show that people are still going for backstreet abortions now.” (P6)

The following are photographs of abortion advertisements that are ubiquitous throughout Durban and the surrounding areas. The signs are found posted on walls, poles, and garbage bins; they also are circulated to people in the form of flyers handed out by representatives of illegal providers.

Figure 4.1: Smith Street, Durban, KwaZulu-Natal



Figure 4.2: Smith Street, Durban, KwaZulu-Natal



Many women voiced concern about the signs advertising abortion, because they feel that many of the providers are exploiting women in vulnerable situations. Some women commented that the signs looked legitimate, and if they did not know otherwise and were desperate they would call the phone numbers written on the signs.

“...they [abortion advertisements] disgust me, but when I see it on every poll, every garbage bin in town, and they are saying it is pain free. And I do not believe it, because I do not trust the methods or whatever that they use.” (P19)

“...I think the people that are involved that are making good bucks out of women in troublesome situations, they are trying to capitalize on it...they [women] have no options, maybe they can not have access to certain places, like maybe clinics or hospitals, so they do backdoor things, or maybe they also want to keep the secrecy and silence, not be seen.” (P11)

The following is a description of a woman’s personal experience having an abortion outside of a health facility because she was turned away at the hospital for being too far along in her pregnancy at 13 weeks:

“Okay, I do not know but, it was this old lady, like when we were there in the hospital, maybe a lot of girls talk, so and so is doing an abortion, and so you take numbers and so I go to that...I do not know, it is an old lady. She’s the one that insert me with the pills, and then you go, and that is it for her...for me it did not take too long, maybe it was like five hours...After the baby comes out, you are just thinking and bleeding.

They say that she used to work in surgery, with the doctor that was doing abortions, but she retired, and she used to get the pills from the surgery. And I do not know what kind of pills she's using." (P8)

The information about where to access abortion services outside of health facilities is channeled through a variety of networks, including networks in health facilities. The illegal market is kept alive through advertisements and social networks.

Women reported a variety of unsafe methods that are often used for termination of pregnancy such as: pills (oral and vaginal insertions); coat hangers; drinking Coke and taking Disprin; drinking gin; drinking bleach; laxatives; using physical force with a belt; and traditional methods, *umuthi*. Using these unsafe methods can often have life-threatening complications.

"She told me they put the pills there [in her vagina], and told her to go home, and then eventually that will come out, eventually dead. And she almost died. And we wanted to take her to the hospital, and she refused, she was like, no. Because the whole idea was like if you go then they will ask did you do it? And all those questions. [She was] like I would rather die here, I am not going to hospital." (P19)

These methods endanger women's lives, especially when women do not want to turn to public facilities if complications arise because of the fear of social stigma.

A few women referred to an episode on *Carte Blanche*, which was aired on television in June 2008, which informed them about the high prevalence of illegal abortions in KwaZulu-Natal. The episode documented the high number of illegal providers in Pietermaritzburg and Durban, with providers doing TOPs up to 38 weeks. At the end of the report the journalist suggested that the matter be taken up by the Department of Health (DoH), but since then, the government has not responded and no action was taken against these illegal providers.

These experiences and stories recounted during the interviews of unsafe, illegal abortions highlights this often neglected issue and measures should be taken to find ways to reduce the prevalence of unsafe abortion methods and fulfill women's sexual and reproductive health rights.

4.4 "Pro-Choice": Perspectives of Abortion Methods

When women were describing their knowledge of abortion methods, it was often referred to as a "cleaning" process. Referring to abortion as "cleaning" implies that there

is something unclean or dirty about the process. This suggests that the stigma and taboos around abortion shape some of the discourse around abortion, specifically when talking about the actual physical practice of abortion methods.

“So and then, you sign some papers about doing the abortion, and then they do not give you the pills that day, you have to come another day to take the pills and then come back another day for cleaning.” (P8)

“And the nurses are like no, we do not need this, because after you have put in the pill...then you have to as soon as it starts happening, in the morning you go back to the hospital, where they will clean you. But most girls, some, not most, some of them, there are complications.” (P7)

The attitudes of women towards different methods of abortion are all shaped by a variety of factors from personal to distal environments, which informs their knowledge of abortion methods and reactions to medical abortion specifically which will be outlined in the following section.

In South Africa, the majority of hospitals practice manual vacuum aspiration (MVA). A few women described the TOP services in South Africa, saying that hospitals book 10 to 15 clients per day, send them for a scan, give them pills (description likely to be misoprostol) to take offsite and then they are instructed to come back the next day for “cleaning” otherwise known as MVA. As mentioned earlier, there is no national policy regarding medical abortion in South Africa, which is only available in private facilities.

The choice of abortion method is an important part of sexual and reproductive health services along with its acceptability among women. After exploring the factors that affect women’s decisions whether or not to have an abortion and establishing the context the decisions are made in, the interviews came to the central part of the study, to explore attitudes toward different abortion methods and investigate knowledge of and attitudes towards medical abortion among this sample of women.

The case study found that the acceptability of medical abortion was high among participants. The majority found it to be an acceptable method with the exception of one participant. Less than one third of women had some knowledge of medical abortion as a method, but those that had heard of it before had limited knowledge.

“No. I do not think, okay, no I do not know anything. I tried to ask this other pharmacy lady sometime if they sell abortion medication over the counter and she told me no, no, the pharmacy does not do that. I am not sure.” (P19)

“You take a pill...which is medical...and then I suppose you...I am not sure. I know that you take a pill and then you vacuum and so it is the waste removal that I am not sure about. I suppose you bleed. I am not sure how they check that everything is gone.” (P12)

“Basically it flushes your system out, forces a period and then restricts your womb, so the thing has nothing to implant, and then out.” (P3)

“I think I did not know about its existence, but I did not know the name.” (P1)

“Okay, I know that it is a, you take a tablet, to sort of induce a miscarriage, which is quite off putting...” (P6)

Many women’s previous knowledge was restricted in the sense they understood that the term medical abortion meant that it was a pill that induced abortion, but the details were unknown as well as where to obtain the medication and its availability in South Africa. One woman had taught herself about the method through Internet sources. Others had heard about it through other media sources, friends, and word of mouth. No one had been educated about medical abortion in any formal manner.

4.4.1 Medical Abortion: Advantages and Disadvantages

After reading an information sheet (See Appendix II) explaining the process of medical abortion, participants had varied reactions to it as a method. The majority (65%) of women would choose medical abortion as a method if it were available, accessible, and affordable. The following section will outline the advantages and disadvantages of medical abortion from the perspective of women.

Advantages

The reasons women gave for potentially choosing medical abortion as a method and its advantages fell into several broad categories.

Privacy

The most common advantage women mentioned was medical abortion is private and women can do it in their own home. The importance placed on privacy stems from the previously discussed issues of stigma and taboo surrounding abortion in South African society. Medical abortion allows women to turn to a broader selection of providers. Instead of having to go to a hospital or Marie Stopes (which many women correlate with abortion services), medical abortion can be administered by a general

practitioner. Many women said they would prefer an abortion method that can be done discretely without revealing their actions to people in their community. It can be done at home versus a clinic, which reinforces the privacy aspect of the method.

“I guess, medical abortion, the advantage is you can do it on your own, you get the pill, and you just take it.” (P4)

“...so if you are young, you have religious background, nobody is going to judge you because they would not even know it happened. Which can be a good thing, because you know, if you made a mistake, you know you made a mistake and you do not need other people to sh** on you for it.” (P3)

Many women said they would prefer to be at home during the process because of the previously mentioned uninviting clinical environments in public facilities. Women perceived medical abortion to have the potential to avoid the negative attitudes and judgment of health professionals, and allow them to go through the process in their own homes. For some women their home is a more safe and comfortable environment with privacy to discuss the process with whomever they choose to, and maintain confidentiality.

“Less Invasive”, “Easy”

Introducing medical abortion into health systems changes the language that is used. A health professional, for example, no longer performs an abortion but rather administers pills to induce an abortion. Multiple women said that they would prefer medical abortion because there was “no operation” and seemed “less invasive”. Taking medication versus having a surgical procedure was more appealing to some women, as they do not like the idea of surgical operations and spending time in hospitals.

“...someone was like oh; you can take a tablet to make the baby go away, which sounds appealing when, instead of going to a doctor and having surgery...The option of taking a tablet sounds much better.” (P6)

“...I guess it is less dramatic or less intrusive than MVA.” (P12)

“I obviously do not want to be cut, and the less invasive something is, the better.” (P9)

“I think surgical is more traumatic...The actual procedure, I think, I think the pills are much better.” (P2)

Avoiding surgery was appealing to many women, to avoid anesthesia, and avoid a procedure happening to their bodies.

Some women felt that medical abortion seemed “easier” and “simpler” than surgical abortion. To have a medical abortion, the process involves obtaining medication rather than relying on health professionals to do a procedure for you.

“I just think it seems easier to do a medical abortion. It is a lot easier to get a pill than to find a surgical procedure.” (P6)

“I think it is also that it is like a normal, menstruate later, but just normal, you know, it is not hectic or having to do another thing, just drink a pill.” (P13)

“Also I do feel that it is easier, and it feels more like a miscarriage. So I think you think to yourself well it is more acceptable doing it this way.” (P20)

For some women, another way that medical abortion seemed easier than surgical abortion was that it seems more natural. A few women said medical abortion would be easier psychologically, one can think of it as a miscarriage, as it is more similar to a woman’s menstrual cycle. For these reasons medical abortion is a more acceptable method than a surgical abortion for many women.

“In Control”, “Early On”, “Life Saving”

Some women felt medical abortion would give them greater control over the termination process as opposed to surgical abortion where a health care worker is the one in control over the procedure. Being able to take the pill on your own, at home, would give some women a greater sense of control over their actions, and therefore it would be a more acceptable method for them.

“...and you feel more in control. I suppose once you have made the decision to have an abortion, you should feel in control.” (P12)

After making a choice to have an abortion, some women felt that with medical abortion you are then able to control this choice by using medication as opposed to a surgical procedure. Then women can feel and see what is happening to their body throughout the entire process.

Adding to the fact that women are in control, another advantage a few women mentioned is that medical abortion can be done earlier than surgical abortion, as early as four weeks since a woman’s last menstrual period (LMP). Women said that they would prefer to terminate as early as possible to avoid psychological and physical stress later on. Some women said that psychologically it would be easier to terminate earlier in gestation

because it seems less like taking a life away. In addition other people are most accepting of abortion earlier in pregnancy because conceptually the fetus seems less lifelike than further along in gestation.

Most women did not just cite one advantage of medical abortion, but rather multiple reasons why medical abortion is an acceptable method for the reasons stated above such as: privacy; avoiding surgery; ease; and most importantly medical abortion has the potential to save women's lives who would otherwise turn to illegal, unsafe methods outside of health facilities.

“The advantages are that it is [medical abortion is] saving those women that die from abortion.” (P14)

Disadvantages

Although there were many women with favorable attitudes and who accepted medical abortion, there were also concerns and reservations about the method. These were recounted when respondents were asked to describe the foreseeable disadvantages of medical abortion.

Side Effects/Complications

The most common concern about medical abortion was the fear of adverse side effects and complications. While some women reported that being in the privacy of one's own home was an advantage, others said they would fear the possible side effects. There was a worry expressed by some women that they would not be able to reach health services either because they did not want to disclose what they were doing to others, or because they were unable to readily access health facilities. Some women were afraid of what would happen if there were complications and they did not know how to handle them. Additionally while privacy is important, some women were afraid if they had not told anyone, nobody would be there to help them in the case of an emergency.

“I do not know, maybe I'd feel like, not that it is dangerous, but it is like you do not really know if it is working...What if there is a problem, like with the bleeding, you do not, I mean there is no way of you personally knowing it is out now, you know?...also something else that I always worry about is the side effects of the actual medication.” (P9)

“...I do not think it is the right thing because you never know what could go wrong, you may need medical assistance. I mean at home, with people, but you would probably be alone because you do not want people to know that you are about to abort.” (P13)

“Doing something at home, and something going wrong, and not knowing enough about it, to know that something is wrong. Being too scared to ask for help, I do not know.” (P6)

The fear of the unknown and possible complications in the worst-case scenarios was a deterrent for a few women who preferred surgical abortion to medical abortion.

A few women mentioned the inequities between facilities in urban versus rural areas suggesting that rural facilities might not be able to handle complications or side effects of medical abortion.

“I think we do have good hospitals, but it depends where you are. And what kind of facilities are available, you know? Because I think when you are here [in Durban], most of the tools are here, or but then you should go to rural areas, where I am from, there is only one clinic, a very small clinic.” (P13)

These fears of side effects and complications highlight the need for counseling when using medical abortion as a method. Women need to be informed about what is going to happen to their bodies and how to handle possible side effects or complications that could arise.

“...she had to go to this funeral; she was told that it will only bleed like a few days. And then when she went there, the blood and stuff started, you know, coming out in front of people right there. She did not have any pads or anything like that.” (P4)

In the situation described above the woman was not counseled and so was unprepared to handle the termination process, as reported by one woman. A few women reported that friends of theirs found themselves in situations that were embarrassing and potentially harmful to their health because they were not made aware of what the abortion process entailed and counseled on how to handle the situation.

Finances

A lack of financial resources was another barrier reported to accessing medical abortion. Finances, as mentioned previously, are often a reason why women decide to have an abortion. If medical technologies are expensive and only available in the private sector, for example medical abortion, it limits women’s choices, which often leads them to turn to illegal or unsafe methods.

“Especially for the teenagers who do not have money...Private consultations fees are so high. Because most of the people who are falling pregnant now are teenagers, those ones

who are at school, that is why they prefer to do the other route, the R300 written all over town. So you know, I think the barrier would be finances.” (P19)

”

“I think the biggest problem is the freeness. I suppose among people, among people who do have abortions, it is largely for financial reasons....And if you are not rich yourself, then trying to get a hold of R1000 is not easy.” (P1).

Young women who fall pregnant are most often not financially independent. Further those women who are falling unexpectedly pregnant and are unaware of the abortion legislation, specifically the fact that abortion services are free in public hospitals, often turn to methods outside of health facilities. These methods that are used are mostly through illegal providers because private facilities are too expensive for the majority of women in South Africa, so they turn to providers with cheaper alternatives.

If women have to pay the suggested amount for medical abortion, most women would be unable to afford it. A lack of economic resources inhibits people in many ways, and in this particular issue inhibits women’s choice in the area of SRH, and can lead to negative outcomes when engaging in unsafe abortion practices.

Follow-up?

Follow-up visits are an important part of the medical abortion process, to give women their second dose of medication as well as to ensure that the pregnancy is terminated completely without any complications. Some women felt that follow-up visits would not always be carried out, and therefore the method would not be effective, and be unsuitable for women in South Africa. There was a fear that if there was not proper counseling, women would not realize the importance of follow-up, and if they did not complete the regimen of medication there could be adverse side effects.

“...I do not know, if you were not properly told what would happen, and do not come back. You could just chicken out and decide that you do not want to go through with it anymore.” (P1)

In addition to concerns about proper counseling and personal willingness to do follow-up, systemic concerns about the health system and transport system were raised. The public transport system makes it difficult in some areas to reach a hospital or clinic easily. Not only that but as mentioned previously, many women do not have the finances for transport to access hospitals.

In addition because most hospitals are understaffed and under-resourced makes follow-up difficult, to ensure that there are enough resources to accommodate follow-up visits.

“But you know, the problem with public hospitals is that people never do follow-ups...So with this, I think that the government, I think I would be a bit skeptical. Because people might not do follow-up or finish their meds, and that would cause problems because I do not think our clinics or our health care can actually have the capacity to deal with what is going out, giving pills and making sure that people take them and come back and what not.” (P2)

“That is the thing as far as South African context, obviously you know transport is expensive, and sh**ty, and for people, so how do you make sure that someone has the proper follow-up?” (P16)

There was skepticism about whether or not all of the visits would happen, so some women were concerned that medical abortion would not work in the public health system in South Africa.

“Long Process”

Women noted that medical abortion is a long process. This was not appealing to some women because of the potential adverse psychological effects. While some women thought that medical abortion would be easier to handle mentally, others thought it would be more difficult. Processing a termination of pregnancy not only physically but also mentally would be difficult for a few women. The longer the time period of physically going through the abortion process, it seemed harder to go through.

“But the disadvantages would be long, and I think it would put you into depression I think.” (P17)

“...day after day after day you would be doing the abortion, and I think it would drive me crazy. It goes through such a long and protracted time, and maybe if I wanted to change my mind in the middle of it, I would not be able to.” (P12)

One woman described her experience with medication (the pills described were similar to misoprostol) as being a long process and the entire time she was thinking about the “baby” that was being aborted making it a very difficult process. The longer the time period of an abortion, some women also had a greater fear of side effects.

Regulation?

A few women raised concerns that medical abortion would end up being “too accessible” to women and abortion would be made “too easy”. The majority of women were against abortion, except under certain circumstances, so a few of these women mentioned that if abortion methods were made too available to women, women would take advantage of this method and neglect other measures of preventing pregnancy.

“Well usually people who do abortion as a way of contraceptive and have a way of abortion that is really an abuse, because now then with this, this will become a contraceptive.” (P15)

Not only would women themselves take advantage, but also women mentioned a fear that health professionals could take medication out of the hospitals and sell it outside of health facilities, contributing to the already large market of illegal abortions happening in South Africa. This concern is supported by the account mentioned earlier of a woman who used to work in a surgery but was now conducting illegal abortions in her home.

Overall, the majority of women would choose medical abortion, with suggestions on how to ensure it is accessible and affordable. This indicates a potential demand for the method among women in South Africa. Among this sample, women would want to have medical abortion as an option in public health facilities if faced with wanting to terminate a pregnancy.

The following section will look at the potential of introducing medical abortion to public health facilities in South Africa from the point of view of the women in this study.

4.4.2 Introducing Medical Abortion to Public Facilities in South Africa

There are multiple factors to take into account when deciding whether or not to have an abortion, and similarly there are multiple factors to examine when choosing medical technologies, specifically related to sexual and reproductive health. For this intimate and central part of women’s lives, choices should be made available to ensure that women are able to fulfill their diverse needs, as far as technology can allow, from contraceptive choices to abortion methods. For a long time a range of contraceptive methods have been available for women to choose from, but there have not been the same options available for abortion methods.

“It [medical abortion] needs to be available, again you cannot say that there is one right way to have an abortion.” (P16)

The majority of women argued that medical abortion should be available in public facilities in South Africa with the exception of one participant. The reasons women gave were similar to the advantages listed in the previous section. One reason some women gave to justify making medical abortion available in the public sector was that abortion method options should be equitable and available to any woman that wishes to choose it.

“I think it is so unfair, that these things [medical abortions] are only open to people who have money for them.” (P1)

One important part of making medical abortion accessible is to ensure that it is also affordable. In order for it to be integrated into public facilities, most women in this study emphasized that it must be free or subsidized by the government to make it truly accessible. The idea that medical abortion is accessible to only certain sectors of the population was highlighted as being unfair to the general public. This perpetuates the existing inequities in South Africa’s public health system.

A few women said another reason medical abortion should be available in public facilities is it could potentially reduce patient loads in overcrowded hospitals and clinics.

“I think it [medical abortion] would save a lot of working time for doctors. They just have to dispense medication, and do an examination; I think it would save a lot of work, time, and nurses and doctors can be used for other serious problems.” (P12)

Some of the barriers to accessing abortion mentioned earlier such as long wait times at hospitals and the limited number of patients taken per day could be potentially avoided with this method, especially in a health system that is faced with many other challenges.

Another reason mentioned by some women is that if medical abortion is made available and accessible to women, it could potentially help avoid the unsafe abortions that are happening in South Africa.

“They [medical abortion] should be [available in public health facilities]. I do not see they shouldn’t be because there are different women with different backgrounds, if this [medical abortion] could help women, like that people are doing abortion, unsafe abortion...I think it could work...” (P14)

“...at least this [medical abortion] is safer than people who go to all those backdoor abortion places...” (P15)

Medical abortion was seen by some women to be a safer option for women to choose. All of the women in the study talked about the unsafe abortions happening around South Africa, and some women thought that medical abortion has the potential to reduce the prevalence of these unsafe methods. It provides an alternative to surgical abortion and increases women's options to allow them to make a choice based on their preferences and individual contexts.

Not all women were completely in favor of integrating medical abortion into the public health system and a few women had some reservations.

“I think they should not make it available, cause I think they will abuse it, like how do you know where you get it...You won't need to go on oral contraceptives cause you would know I can just take my medical abortion pills.” (P4)

“I can go there and just ask for like 10. It is making it too easy.” (P5)

The concerns about bringing this method into the public coincide with the disadvantages that were addressed earlier. The idea that there would not be proper regulation of the medication by health professionals and the government, as well as women would abuse its availability was a concern for a few women.

While some women thought that medical abortion has the potential to help reduce patient loads, others were concerned about the process of follow-up and the capacity of the hospitals and patients themselves to follow through with the termination process.

Although there were reservations voiced by women, there was still an overwhelming feeling that they [women] should have a choice in abortion methods. Regardless of their personal beliefs or what personal decisions they would hypothetically make, there was a general consensus that choices such as medical abortion should be available, accessible, and affordable for women in South Africa.

4.5 Summary

The findings reveal that decisions around termination of pregnancy are complex and involve a variety of factors. The majority of women recognize that it is a context-driven choice and one that they would have to make when confronted with an unintended pregnancy. There is often a gap between ideals and reality, which makes it difficult to hypothesize future decisions. Ultimately a decision on whether or not to have an abortion will be made in the moment, depending on the circumstances. This decision will depend

on the personal, proximal, and distal environments that influence sexual behavior, as outlined in Eaton's model of sexual behavior presented in Chapter 3.

Similarly, when a decision is made to have an abortion, what method a woman decides to choose depends on a variety of complex factors. The context that these women find themselves in would influence their decision on whether to have a surgical or medical abortion. The options should be there to make sure women have a choice to make.

The general consensus was that women have the right to choose what happens to their bodies with regard to abortion methods. The idea of being "pro-choice" extends beyond the decision whether or not to have an abortion, but also what methods can be used. Although there are reservations and concerns around medical abortion as a method, there is a general acceptance of it as a method. The principle of choice is important to the majority of women and for that reason many women believe medical abortion should be available in public facilities. This reveals a hypothetical demand for medical abortion in public health facilities in South Africa.

Chapter 5: Discussion and Conclusion

5.1 Discussion

Sexual behavior lies at the core of what makes us all human, and maintaining sexual and reproductive health is important to ensure that we are able to contribute productively to society. The aim of this study was twofold: firstly to explore what influences women's attitudes and decisions about abortion, and secondly investigate women's awareness of medical abortion and whether or not women view it as an acceptable method to use in the public health system in South Africa. The study is framed around Eaton's model of sexual behavior to explore women's attitudes to abortion and abortion methods on three levels from within the person, the proximal environment, and the distal context, which influences sexual and reproductive health decisions. While the study is based on a relatively small sample of women and is not generalizable to an entire population, it has produced several notable results.

Unintended pregnancies place women and men in a situation where they must choose whether or not to have an abortion. The majority of women in this study were against the idea of abortion for themselves. However, consistent with other findings, this study found that there are often gaps between ideals and reality of women's attitudes toward abortion, often referred to as dual morality (Hessini, 2005; Patel and Myeni, 2008; Varga, 2002). While the majority of women say that they are against abortion, there are certain circumstances in which abortion is justifiable. Conversely there are also women that say they are supportive of abortion, "pro-choice", but would not have an abortion themselves.

Understanding the complex nature of these decisions around abortion, which is so heavily influenced by social and cultural norms, makes it impossible to predict women's behaviors when faced with an unintended pregnancy. But measures should be taken to ensure that all options are available to suit women's needs during these difficult moments when decisions need to be made.

While the nature of the debate around abortion is complex, in this study one of the notable themes was that of choice. What one woman felt personally about their own life decisions and experiences was different from what they thought should be legal and

available to the greater population of women in South Africa. The general consensus among this sample of women was that all women should have the right to make choices about abortion, not only whether or not to have one, but also what method to use. When faced with an unintended pregnancy, and one makes the decision to have an abortion, the available medical technologies such as medical abortion should be offered in both the public and private sector.

In 2001 the Medical Control Council approved the use of mifepristone and misoprostol in South Africa. As of now it is only being used in private facilities (with the exception of pilot sites in Gauteng, Mpumalanga, and the Western Cape). This means that not all women are able to access their choice and preference of what abortion method best suits their needs, when and if they decide to seek TOP services. This creates a divide between women who are able to access services and have choices with regard to abortion methods. A few women mentioned this inequity during the interviews, and further pointed to the inequities between rural and urban areas as being a problem that needs to be addressed. Living in a rural area makes it harder to access health services in general, particularly abortion services.

In general, the main barriers to accessing abortion noted in this study were: the social stigma attached to abortion often resulting from religious or cultural beliefs; a lack of awareness of the 1996 Act; and negative attitudes of health professionals, which are all consistent with findings in the literature (Hord and Wolf, 2004; Jewkes et al., 2005b; Shah and Ahman, 2004; Varga, 2002). The stigma prevents people from discussing abortion, and often prevents people from seeking abortion services.

Although most women had heard of the 1996 Act, it was most likely due to the fact that the sample of women consisted of students in higher education. It is recommended that further research explore the perspectives of a broader spectrum of women with a range of educational levels.

Consistent with findings in other studies, the negative attitude of health providers was mentioned by many women as a barrier to TOP services (Cooper et al., 2004; Harries et al.; 2009; Harrison et al., 2000; Jewkes et al., 2005b; Knudsen, 2006; Turner et al.; 2008). Health providers' disapproval of abortion, and their negative attitudes to and abuse of patients presents a huge obstacle in ensuring that abortion services are available to

women. It further makes it difficult to introduce a new method, such as medical abortion, if providers are unwilling to accept and tolerate the integration of abortion services in public health facilities.

These barriers often contribute to a high prevalence of unsafe abortions. While this study did not seek to focus on the prevalence of unsafe abortions in South Africa, it did find that all of the women in this sample knew or had heard of a woman who had an illegal, unsafe abortion, suggesting that the prevalence is relatively common in KwaZulu-Natal. These findings support other studies in South Africa that women are still using unsafe methods for TOPs outside of health facilities (Jewkes et al., 2005b). In addition, the fact that only 30.4% of all TOP facilities in KwaZulu-Natal are functioning creates yet another barrier to access abortion services (Health Systems Trust, 2009b).

In the context of unsafe, illegal abortions occurring in South Africa, medical abortion has the potential to reduce the number of unsafe abortions happening. If more options are available to women that are more suitable to their needs there is a great possibility they would seek services at health facilities instead of outside providers for abortion. Some women's statements on the potential advantages of medical abortion are consistent with findings from studies in other countries, that medical abortion has the potential to save lives, to increase access to abortion services for women, and to be more cost effective and time saving for public health facilities (Cooper et al., 2005; Harper et al., 2007; Moodliar et al., 2005).

The acceptability of abortion methods is important to ensure that medical abortion will be used and beneficial to those women who choose to use it. The majority of women in this study said they found medical abortion to be an acceptable method, which is consistent with literature from around the world, in addition to pilot studies done in South Africa (Blanchard et al., 2006; Cooper et al., 2005; Kawonga et al., 2008; Moodliar et al., 2005; ICMA, 2004d; Ramachandar and Pelto, 2005). While some women said they would not use it themselves, in their opinion they believe that other women would find it acceptable and therefore it should be available in public facilities.

The reasons women reported in this study for potentially choosing medical abortion and its advantages were also consistent with findings in the literature. To reiterate the reasons for choosing medical abortion by participants they were as follows:

privacy; it is less invasive and avoids surgery; it is “easy” and more “normal”; women feel in control; it can be done early in pregnancy; and it is life saving, which are all reasons reported from other studies and samples of women (Berer, 2005b; Gould et al., 2002; ICMA, 2004d; Kawonga et al., 2008; Lafaurie et al., 2005).

The number one reason for choosing medical abortion was privacy, because it allowed women to maintain the silence and secrecy around abortion, which often resulted from the stigma and social and cultural norms that shape women’s attitudes to abortion in general. Women’s attitudes to abortion, their reasons for and against abortion, informed their attitudes and acceptance of abortion methods, and as a result medical abortion was found to be highly acceptable. Medical abortion allows women to maintain control and privacy in this intimate aspect of their lives, particularly in a society such as South Africa where abortion is generally not accepted.

While the majority of women would accept and choose medical abortion, there are also a few women who would prefer to choose surgical methods. Consistent with other findings in the literature some women said the fear of side effects and the length of the process of medical abortion were deterrents (Gould et al., 2002). These concerns about the fear of adverse side effects and complications most likely stem from a fear of the unknown. The majority of women in this study were not familiar with medical abortion at the time of the interview, it was their first time learning about the method, and so their responses could be due to the unfamiliarity with the method. Regardless, these fears were reported to inhibit some women from seeking medical abortion as their method of choice.

Aside from personal preferences, many women brought up potential barriers to accessing medical abortion, which were consistent with other findings in the literature (Berer, 2005b; Blanchard, 2006). Many women asked about the cost of medical abortion, and when they heard the variation of prices said that a lack of finances would be a barrier for the majority of women, which is consistent with other preliminary studies done in South Africa on medical abortion (Blanchard et al., 2006). The women that were supportive of medical abortion noted that it would not be a successful intervention if the cost of medication is not reduced in order to make it truly accessible to women.

Another barrier to accessing medical abortion mentioned was follow-up, and accessing clinics to make repeated visits, which is also consistent with other research findings in and outside of South Africa (Berer, 2005b; Cooper et al., 2005; Shah et al., 2005). The distance women have to travel to clinics, the quality of the transport system, the cost of travel, patient willingness to follow through with visits, and the capacity of the health system to handle administering the medication were all mentioned by some women as an interference to repeated clinic visits in order to ensure that medical abortion is carried out safely and effectively.

Other barriers that were not discussed in the literature, which a few women mentioned in this study, were concerns about the regulation of the medication used for medical abortion. With a reported large market of illegal abortion providers in KwaZulu-Natal, women said they feared the medication would be taken outside of health facilities and sold to women by health professionals seeking to earn an income. This would perpetuate the existing large market of illegal abortions. This is an important point that needs to be addressed before integrating medical abortion into the public health system.

In addition to health professionals abusing the medication, a few women mentioned they thought that other women might view medical abortion as an alternate form of contraception and neglect other pregnancy prevention measures. Presumably if there was proper pre and post counseling by health providers administering the medication this misperception of medical abortion could be avoided.

Providing information and raising awareness about medical abortion is an important part of making medical abortion available and accessible to the public. Some women suggested that information regarding abortion methods could be incorporated into sexual education starting from secondary school, or integrated into educational campaigns that discuss sexual and reproductive health. Knowledge about abortion and abortion methods is important to reduce and eliminate the practice of unsafe abortions.

The barriers and concerns around the introduction of medical abortion to the public health sector given by women in this study are valuable insights and should be taken into consideration before introducing medical abortion in the South African context. While there were many reservations, the overall consensus was that this choice should be made available, and integrated into the public health system, provided that

measures are taken to make sure that women receive affordable, quality, comprehensive care.

This study contributes to the findings from diverse countries around the world such as Colombia, Great Britain, France, Mexico, India, Sweden, and the USA that medical abortion is a method that many women find acceptable (Blanchard et al., 2006; Cooper et al., 2005; Kawonga et al., 2008; Lafaurie et al., 2005; Moodliar et al., 2005; ICMA, 2004d; Ramachandar and Pelto, 2005; Virgo et al., 1999). On this basis alone, medical abortion should be made accessible to women. In this study, many women find it acceptable, and the majority of women in this study would choose medical abortion over a surgical abortion, which suggests that there is a demand for medical abortion among this sample of participants should they be confronted with circumstances that push them to have an abortion.

5.2 Recommendations

Education and awareness is an important aspect to any successful public health intervention. A notable finding in this study was that many women reported having no sexual education in school, and only learned about sex from media sources and friends or family. Those women that did receive sex education in school said that it was not in depth and was limited to biological aspects of reproduction, neglecting sexual practices.

Sexual education is an important part of giving people knowledge about safe and unsafe sexual behaviors. A lack of sex education is often cited in the literature as a reason for the spread of STIs and unwanted pregnancies (Varkey et al., 2000). Of the women with no sex education, four experienced an unwanted pregnancy at least once. Without any sexual education there is a high risk of spreading incorrect information and misperceptions about sexual and reproductive health. This can be dangerous to women's health, particularly in relation to abortion and abortion methods. It is recommended that further research be conducted on the sex education programs in schools, and initiatives be started to ensure that women and men are aware of safe and unsafe sexual behaviors.

When introducing medical abortion into the public sector, people need to be aware of what it is and where to access it. Knowledge gives people power. In this case, being aware of medical abortion as an option for termination of pregnancy gives women

power to choose what is happening to their bodies. While the majority of women in this sample found medical abortion to be acceptable, it is recommended that further research explore the attitudes and perspectives of a broader spectrum of women. To quote Paulo Freire:

“Because this view [libertarian education] of education starts with the conviction that it cannot present its own program but must search for this program dialogically with the people, it serves to introduce the pedagogy of the oppressed, in the elaboration of which the oppressed must participate.” (Freire, 1996, 105)

This study is limited to women who are in tertiary education and have more education than the majority of women in South Africa. They were chosen because of the belief that students are often at the forefront of change and raising awareness and consciousness among the greater population. So if there is a demand for medical abortion among university students, this could potentially be applicable to the greater population of women in South Africa.

South Africa has one of the most progressive and liberal abortion laws (1996 CTOP Act). However from the results of this study it seems that abortion services are not yet fully accessible, affordable, and available to all women. This is something that needs to be addressed by the government, the Department of Health, to not only prevent unsafe, illegal abortions, but also to uphold women’s sexual and reproductive health rights.

There are a number of factors that should be addressed in order to create safe abortion services. Interventions should be comprehensive and holistic to overcome the challenges of implementing safe abortion services. Safe abortion should be linked to systemic issues that influence access to services, such as the right to sexual and reproductive health, eradicating poverty, and promoting gender equality and women’s empowerment. The individual contexts of unwanted pregnancies need to be looked at on all levels from the personal to proximal to distal environments in order to create appropriate interventions to avoid unsafe abortions and the risks associated with them.

This study recommends the integration of medical abortion into public health facilities to increase women’s access to abortion services and expand women’s reproductive health choices. This study shows that there is a demand for medical abortion among potential clients in this study; the majority of women found medical abortion acceptable and would choose it over surgical abortion methods. Both surgical and

medical abortion methods are approved for use in South Africa, and therefore both methods should be available for women to choose between, not to promote one method over another, but to expand women's options to best suit their needs.

Unsafe abortions affect women, as well as their families and society, putting a strain on the public health systems and can further affect economic productivity (Singh, 2006). These facts should provide major incentives for the government to take actions to ensure that women do not resort to illegal abortions. If more options are available that are acceptable and preferable to women, it is predicted that the number of unsafe abortions will be reduced.

This study also recommends that when integrating medical abortion into public health systems the barriers should be addressed to ensure that it is a successful intervention. Different regimens, involving different doses of each drug, mifepristone and misoprostol, can make the method more or less expensive depending on what regimen is used. Studies have shown that there are alternative regimens of medication that are recommended by WHO that will make the method safe and cost effective for the South African health system (Berer, 2005b). This should be considered to ensure medical abortion is an affordable option.

Another important aspect to consider in introducing medical abortion in public facilities is the attitude of providers. Providers are the entry point to any public health system, and women depend on providers to be experts in their field, and put their trust in them to provide them with comprehensive, quality care. To make sure medical abortion is successful and widely used; providers must also find the method acceptable. Training providers is an important part of integrating medical abortion into the public health system. The training of providers should include value clarification workshops, as suggested by the International Consortium for Medical Abortion (ICMA), because women repeatedly noted their negative attitudes as a barrier to accessing abortion services.

Studies have found that providers have more positive attitudes toward medical abortion methods because it decreases the workload and puts less strain on health services (Cooper et al., 2005; ICMA, 2004d; Kawonga et al., 2008). More studies should

be done in South Africa assessing providers' attitudes to medical abortion, as they are an important part of its success.

Medical abortion is approved and available in South Africa, now is the time to integrate it into the public health system and ensure that it is available, accessible, and affordable to women around the country.

5.3 Conclusion

Abortion is a social reality despite opposition to its practice, and the stigma that surrounds it; and it remains one of the most controversial sexual health topics around the world and in South Africa. This study explored women's attitudes toward abortion, the various factors that influence decision-making and further whether or not there is a demand for medical abortion from potential clients. The gap between ideals and reality make it difficult to determine women's decisions around termination of pregnancy, but in certain circumstances it was seen as a necessary service to have available and accessible for women in South Africa.

Medical abortion is seen as an acceptable method, and the preferred method of the majority of women in this study. This is consistent with findings in the literature, further enforcing and supporting the idea that medical abortion will be a positive contribution to women's sexual and reproductive health in South Africa.

Providing medical abortion in public health systems has the potential to contribute to the fulfillment of sexual health and sexual health rights for women in South Africa. In terms of sexual health, medical abortion has the potential to not only save lives, but also to expand women's options of abortion methods to ensure that their physical, emotional, mental, and social well being are maintained. In terms of sexual rights, abortion is a constitutional right for all women under South African laws, and therefore all methods should be made available and accessible to them. Medical abortion has the potential to increase women's access to abortion services, and decrease abortion related mortality and morbidity, as it is easier to obtain medication than a surgical procedure, and therefore medical abortion could positively contribute to fulfilling women's sexual and reproductive health rights in South Africa.

The legislative framework exists to support the integration of medical abortion into the South African public health system, and it has been found to be acceptable to women, so the time is now to introduce these services to expand and fulfill South African women's sexual and reproductive health rights.

Bibliography

- Askew I, Berer M. 2003. The Contribution of Sexual and Reproductive Health Services to the Fight against HIV/AIDS: A Review. *Reproductive Health Matters* 11(22): 51-73.
- Bankole A, Singh S., Haas T. 1999. Characteristics of Women Who Obtain Induced Abortion: A Worldwide Review. *International Family Planning Perspective*. 25(2): 68-77.
- BBC News*. 2009. Big Jump in South Africa Sex Offences. News Article. 22 Sept. <http://news.bbc.co.uk/2/hi/africa/8269159.stm>. [Accessed on 6 October 2009]
- Benagiano G, Pera A. 2000. Decreasing the need for abortion: challenges and constraints. *International Journal of Gynecology & Obstetrics*. 70: 35-48.
- Berer M. 2005a. Editorial: Why Medical Abortion is Important for Women. *Reproductive Health Matters*. 13(26): 6-10.
- . 2005b. Medical Abortion: Issues of Choice and Acceptability, *Reproductive Health Matters* 13(26): 25-34.
- . 2000. Making Abortions Safe: A Matter of Good Public Health Policy and Practice. *Reproductive Health Matters*. 10(19): 31-44.
- Blanchard K, Cooper D, Dickson K, Cullingworth L, Mavimbela N, von Mollendorf, C, van Bogaert, LJ, Winikoff, B. 2007. A comparison of women's, providers' and ultrasound assessments of pregnancy duration among termination of pregnancy clients in South Africa. *BJOG An International Journal of Obstetrics and Gynaecology*. 114(5): 569-575.
- Blanchard K, Schaffer K, McLeod S, and Winikoff B. 2006. Medication abortion in the private sector in South Africa. *The European Journal of Contraception and Reproductive Health Care*. 11(4): 285-290.
- Braam T, Hessini, L. 2004. The Power Dynamics Perpetuating Unsafe Abortion in Africa: A Feminist Perspective. *African Journal of Reproductive Health*. 8(1): 43-51.
- Brookman-Amisshah E, Moyo, Josephine Banda. 2004. Abortion Law Reform in Sub Saharan Africa: No Turning Back. *Reproductive Health Matters*. 12(24 Supplement): 227-234.
- Buchman E, Kunene B, Pattinson R. 2008. Legalized pregnancy termination and septic abortion mortality in South Africa. *International Journal of Gynecology & Obstetrics*. 101(2): 191-192.

- Campbell J. 2002. Health consequences of intimate partner violence. *The Lancet*. 359: 1331-1336.
- Cleland J, Berstein S, Ezeh A, Faundes A, Glasier A, Innis J. 2006. Family planning: the unfinished agenda. *The Lancet*. 368: 1810-1827.
- Cook RJ and Dickens BM. 1999. Human rights and abortion laws. *International Journal of Gynecology & Obstetrics*. 65(1999): 81-87.
- Cooper D, Dickson K, Blanchard K, Cullingworth L, Mavimbela N, von Mollendorf, C, van Bogaert L, Winikoff B. 2005. Medical Abortion: The Possibilities for Introduction in the Public Sector in South Africa. *Reproductive Health Matters*. 13(26): 35-43.
- Cooper, D, Morroni, C, Orner, P, Moodley J, Harries J, Cullingworth, L, Hoffman M. 2004. Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status. *Reproductive Health Matters*. 12(24): 70-85.
- Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*. 374: 817-834.
- Cornwall A, Correa S, Jolly S. 2008. *Development with a Body: Sexuality, Human Rights & Development*. Zed Books: London.
- Cornwall A, Jolly S. 2006. Introduction: Sexuality Matters. *IDS Bulletin* 37(5): 1-11.
- David H. 1992. Abortion in Europe, 1920-91: A Public Health Perspective. *Studies in Family Planning*. 23(1): 1-22.
- Dudgeon M, Inhorn M. 2004. Men's influence on women's reproductive health: medical anthropological perspectives. *Social Science & Medicine*. 59: 1379-1395.
- Eaton L, Flisher A, Aaro L. 2003. Unsafe sexual behaviour in South African youth. *Social Science & Medicine*. 56(1): 149-165.
- Equality Now. 2010. *Protocols on the Rights of Women in Africa*. Nairobi: Equality Now. http://www.equalitynow.org/english/campaigns/african-protocol/african_protocol_en.html. [Accessed on 16 February 2010]
- Fredrick B. 2007. Eliminating unsafe abortion worldwide. *The Lancet*. 370: 1295-1296.
- Freedman L, Isaacs SL. 1993. Human Rights and Reproductive Choice. *Studies in Family Planning*. 24(1): 18-30.

- Freire, P. 1996. *Pedagogy of the Oppressed*. London: Penguin Books.
- Gallo MF, Gebreselassie H, Victorino MTA., Dgedge M., Jamisse L, Bique C. 2004. An Assessment of Abortion Services in Public Health Facilities in Mozambique: Women's and Providers' Perspectives. *Reproductive Health Matters*. 12(24 Supplement): 218-226.
- Glazier A, Gulmezoglu AM, Schmid GP, Moreno CG, Van Look PFA. 2006. Sexual and reproductive health: a matter of life and death. *The Lancet*. 368: 1595-1607.
- Goodman S, Rivka G, Eckhardt C, Osborne S, Grossman D, Spiedel J. 2009. Beyond education and training: making change stick. *Contraception*. 79(5): 331-333.
- Gould H, Ellerston C, Corona, G. 2002. Knowledge and attitudes about the differences between emergency contraception and medical abortion among middle-class women and men of reproductive age in Mexico City. *Contraception*. 66: 417-426.
- Gribble J, Haffey J. 2008. *Reproductive Health in Sub-Saharan Africa*. Washington: Population Reference Bureau. <http://www.prb.org/Publications/PolicyBriefs/reproductivehealthafrica.aspx>. [Accessed on 20 September 2009]
- Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, Shah I. 2006. Unsafe abortion: the preventable pandemic. *The Lancet*. 368:1908-1919.
- Guttmacher Institute. 2008. *Facts on induced abortion worldwide*. Washington: Guttmacher Institute, http://www.guttmacher.org/pubs/fb_IAW.html. [Accessed on 7 October 2009]
- . 2009. *Facts on abortion and unintended pregnancy in Africa*. Washington: Guttmacher Institute. <http://www.abortionresearchconsortium.org/report.html>. [Accessed on 20vFebruary 2010]
- Guttmacher S, Kapadia F, Te Water Naude J, de Pinho H. 1998. Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act. *International Family Planning Perspectives*. 24(4): 191-194.
- Harper CC, Blanchard K, Grossman D, Henderson JT, Darney PD. 2007. Reducing maternal mortality due to elective abortion: Potential impact of misoprostol in low-resource settings. *International Journal of Gynecology and Obstetrics*. 98: 66-69.
- Harries, J. 2009. Termination of pregnancy legislation in South Africa: implications for health service providers. *CME: Your SA Journal of CPD*. 27(10) Available at:

- http://findarticles.com/p/articles/mi_6811/is_10_27/ai_n42124099/ [Accessed on 16 February 2010]
- Harries J, Stinson K, Orner P. 2009. Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa, *BMC Public Health*, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2734857/>. [Accessed on 28 November 2009]
- Harrison A, Montgomery E, Lurie M, Wilkinson D. 2000. Barriers to implementing South Africa's Termination of Pregnancy Act in rural Kwa-Zulu/Natal. *Health Policy and Planning*. 15(4): 424-431.
- Harvey SM, Beckman LJ, Castle MA, Coeytaux F. 1995. Knowledge and perceptions of medical abortion among potential users. *Family Planning Perspectives*. 27(5): 203-207.
- Health Systems Trust. 2009a. *Health Statistics: TOPs (Termination of Pregnancy)* Durban: Health Systems Trust. <http://www.hst.org.za/healthstats/47/data>. [Accessed on 20 September 2009].
- . 2009b. *Health Statistics: TOP facilities functioning %*. Durban: Health Systems Trust. <http://www.hst.org.za/healthstats/151/data>. [Accessed on 20 September 2009].
- . 2009c. *Health Statistics: HIV prevalence (%) (total population)*. Durban: Health Systems Trust. <http://www.hst.org.za/healthstats/84/data>. [Accessed on 4 February 2010].
- Heise L, Ellsberg M, Gottmoeller M. 2002. A global overview of gender-based violence. *International Journal of Gynecology & Obstetrics*. 78 Suppl. 1: S5-S14.
- Ho, Pak Chung. 2006. Women's perceptions on medical abortion. *Contraception*. 26 (2006): 11-15.
- Hessini L. 2005. Global Progress in Abortion Advocacy and Policy: An Assessment of the Decade since ICPD. *Reproductive Health Matters*. 13(25): 88-100.
- Hoffman M, Moodley J, Cooper D, Harries J, Morroni C, Orner P, Constant D, Matthews C. 2006. The status of legal termination of pregnancy in South Africa. *South African Medical Journal*. 96(10): 1056.
- Hord C, Wolf M. 2004. Breaking the Cycle of Unsafe Abortion in Africa. *African Journal of Reproductive Health*. 8(1): 29-36.

- ICMA. 2004a. Consensus Statement: Medical Abortion: Expanding Access to Safe Abortion and Saving Women's Lives. *Reproductive Health Matters*. 13(26): 11-12.
- . 2009b. *Information for women*. Chisinau: ICMA. <http://www.medicalabortionconsortium.org/articles/for-women/main-book/?bl=en>. [Accessed on 14 August 2009]
- . 2009c. *Information for women's organizations and NGOs*. Chisinau: ICMA. <http://www.medicalabortionconsortium.org/articles/for-women-advocates-ngos/book3/?bl=en>. [Accessed on 15 August 2009]
- . 2009d. *Information for policymakers*. Chisinau: ICMA. <http://www.medicalabortionconsortium.org/articles/for-policy-makers/default/?bl=en>. [Accessed 15 August 2009]
- Ipas. 2007. *South Africa holds hearings about abortion law amendment*. Chapel Hill: Ipas. http://www.ipas.org/Library/News/News_Items/South_Africa_holds_hearings_a_out_abortion_law_amendment.aspx. [Accessed on 16 February 2010].
- Iyengar S. 2005. Introducing Medical Abortion within the Primary Health System: Comparison with Other Health Interventions and Commodities. *Reproductive Health Matters*. 13(26): 13-19.
- Jewkes R, Wood K, Maforah NF. 1997. Backstreet abortion in South Africa. *South African Medical Journal*. 87(4): 417-418.
- Jewkes R., Brown H, Dickson-Tetteh K, Levin J, Rees H. 2002. Prevalence of morbidity associated with abortion before and after legalization in South Africa. *British Medical Journal*. 324: 1252-1253.
- Jewkes R, Rees H, Dickson K, Brown H, Levin J. 2005a. The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. *BJOG: An International Journal of Obstetrics and Gynecology*. 112: 355-359.
- Jewkes R, Gumede T, Westaway M, Dickson K, Brown H, Rees H. 2005b. Why are women still aborting outside designated facilities in metropolitan South Africa? *BJOG: an International Journal of Obstetrics and Gynecology*. 112: 1236-1242.
- Joffe C, Weitz T. 2003. Normalizing the exceptional: incorporating the "abortion pill" into mainstream medicine. *Social Science & Medicine*. 56: 2353-2366.
- Johnson-Hanks J. 2002. The lesser shame: abortion among educated women in southern Cameroon. *Social Science & Medicine*. 55: 1337-1349.

- Kawonga M, Blanchard K, Cooper D, Cullingworth L, Dickson K, Harrison, T, von Mollendorck C, Winikoff B. 2008. Integrating medical abortion into safe abortion services: experience from three pilot sites in South Africa. *Journal of Family Planning and Reproductive Health Care*. 34(3): 159-164.
- Knudsen L. 2006. *Reproductive Rights in a Global Context: South Africa, Uganda, Peru, Denmark, United States, Vietnam, Jordan*. Nashville: Vanderbilt University Press.
- Lafaurie MM, Grossman D, Troncoso E, Billings DL, Chavez S. 2005. Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study. *Reproductive Health Matters*. 13(26): 75-83.
- Lancet. 2009. Unsafe abortions: eight maternal deaths every hour. *The Lancet*. 374: 1301.
- Mapumulo Z, Nkosi K. 2009. 'Abortion' for sale. *The Sowetan*. 30 Nov. <http://www.sowetan.co.za/News/Article.aspx?id=1093331> [Accessed on 30 November 2009]
- Marston C, King E. 2006. Factors that shape young people's sexual behavior: a systematic review. *The Lancet*. 368: 1581-86.
- Mhlanga RE. 2003. Abortion: developments and impact in South Africa. *British Medical Bulletin*. 67: 115-126.
- Encyclopedia Britannica. 2009. *Mifepristone*. Encyclopedia Britannica Online. <http://www.britannica.com/EBchecked/topic/932785/mifepristone> [Accessed on 7 October 2009]
- . 2009. *Misoprostol*. Encyclopedia Britannica Online. <http://www.britannica.com/EBchecked/topic/935137/misoprostol> [Accessed on 7 October 2009].
- Moodley J, Akinsooto VS. 2003. Unsafe Abortions in a Developing Country: Has Liberalization of Laws on Abortions made a Difference? *African Journal of Reproductive Health*. 7(2): 34-38.
- Moodliar S, Bagratee JS, Moodley J. 2005. Medical vs. surgical evacuation of first trimester spontaneous abortion. *International Journal Gynecology and Obstetrics*. 91: 21-26.
- Morrone C, Myer L, Tibazarwa K. 2006. Knowledge of the abortion legislation among South Africa women: a cross-sectional study, *Reproductive Health*. 3:7 Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1555575/>. [Accessed on 11 November 2009].

- National Abortion Federation. 2009a. *South Africa/Medical Abortion: History and Overview*. Washington: National Abortion Federation http://www.prochoice.org/international/training/south_africa_med_ab.html [Accessed on 5 September 2009]
- National Abortion Federation. 2009b. SURGICAL ABORTION/History and Overview, Washington: National Abortion Federation. http://www.prochoice.org/education/resources/surg_history_overview.html. [Accessed on 7 October 2009]
- National Abortion Federation. 2009c. South Africa/Mifepristone and Misoprostol for Medical Abortion: A Brief Background, Washington: National Abortion Federation. http://www.prochoice.org/international/training/south_africa_mife.html [Accessed on 5 September 2009]
- NCCEMD. 2007. *Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa Expanded Executive Summary*. Pretoria: Department of Health. <http://www.doh.gov.za/docs/index.html> [Accessed 15 February 2010]
- Obstetrics and Gynaecology Forum. 2002. Early option with mifepristone: product news. *Obstetrics and Gynaecology Forum*. 12(4): 28. [Accessed on 13 August 2009] <http://search.sabinet.co.za.ezproxy.ukzn.ac.za:2048/WebZ/FETCH?sessionid=014417998983460&recno=1&resultset=3&format=F&next=/html/t2/fullisap.htmlbad=html/t2/error/badfetch.html&&entitytoprecno=1&entitycurrecno=1>.
- Oye-Adeniran BA, Long CM, Adewole IF. 2004. Advocacy for Reform of the Abortion Law in Nigeria. *Reproductive Health Matters*. 12 (24 Supplement): 209-217.
- Patel C, Myeni M. 2008. Attitudes Toward Abortion in a Sample of South African Female Students. *Journal of Applied Social Psychology*. 38(3): 736-750.
- Patel C, Kooverjee T. 2009. Abortion and Contraception: Attitudes of South African University Students. *Health Care for Women International*. 30: 550-568.
- Patel C, John L. 2009. Gender roles and attitudes to abortion: Are there gender differences? *The Social Science Journal*. 46: 493-505.
- Patel L, Bennett T, Halpern CT, Johnston HB, Suchindran CM. 2009. Support for provision of early medical abortion by mid-level providers in Bihar and Jharkhand, India. *Reproductive Health Matters*. 17(33): 70-79.
- Planned Parenthood. 2009. *The Abortion Pill (Medication Abortion)*. Washington: Planned Parenthood. <http://www.plannedparenthood.org/health>

- [topics/abortion/abortion-pill-medication-abortion-4354.htm](#). [Accessed 15 September 2009].
- Ramachandar L, Pelto P. 2005. Medical Abortion in Rural Tamil Nadu, South India: A Quiet Transformation. *Reproductive Health Matters*. 13(26): 54-64.
- Republic of South Africa. 1996. Constitution and Bill of Rights. Act 92 of 1996. Pretoria: Republic of SA, 22 Nov 1996 www.info.gov.za/acts/1996/a92-96.pdf. [Accessed on 5 September 2009].
- Rossier C 2007. Abortion: An Open Secret? Abortion and Social Network Involvement in Burkina Faso. *Reproductive Health Matters*. 15(30): 230-238.
- Sedgh G, Henshaw SK, Singh S, Bankole A, Drescher J. 2007. Legal abortion worldwide: incidence and recent trends. *International Family Planning Perspectives*. 33:106-16.
- Shah R, Baji S, Kalgutkar S. 2005. Attitudes about medical abortion among Indian women. *International Journal of Gynecology & Obstetrics*. 89: 69-70.
- Shah I, Ahman E. 2004. Age Patterns of Unsafe Abortion in Developing Country Regions. *Reproductive Health Matters*. 12(24 Supplement): 9-17.
- Shapiro K, Ray S. 2007. Sexual Health for People Living with HIV. *Reproductive Health Matters*. 15(29): 67-92.
- Singh S. 2006. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *The Lancet*. 368: 1887-1892.
- Turner K, Hyman A, Gabriel M. 2008. Clarifying Values and Transforming Attitudes to Improve Access to Second Trimester Abortion. *Reproductive Health Matters* 16 (31 Supplement): 108-116.
- UNFPA. 2004. *State of World Population 2004: The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty: Maternal Health*. New York: UNFPA.
<http://www.unfpa.org/swp/2004/english/ch7/page11.htm>. [Accessed on 6 October 2009]
- UNFPA, Guttmacher Institute. 2009a. *Adding it Up: The Cost and Benefits of Investing in Family Planning and Maternal and Newborn Health*. New York: UNFPA.
<http://www.unfpa.org/public/site/global/lang/en/pid/4461> [Accessed on 9 May 2010]
- . 2009b. *Sub-Saharan Africa: Facts on Investing in Family Planning and Maternal and Newborn Health*. New York: UNFPA.

- <http://www.unfpa.org/public/site/global/lang/en/pid/4461> [Accessed on 9 May 2010].
- United Nations. 1995. *Beijing Platform for Action. Chapter IV. C. Women and health*. Beijing: United Nations. <http://www.un-documents.net/bpa-4-c.htm>. [Accessed on 11 October 2009].
- Usdin S, Scheepers E, Goldstein S, Japhet G. 2005. Achieving social change on gender-based violence: A report on the impact evaluation of Soul City's fourth series. *Social Science & Medicine*. 61: 2434-2445.
- Uygun D, Erkaya S. 2001. Reasons why women have induced abortions in a developing country. *European Journal of Obstetrics & Gynecology*. 96: 211-214.
- Varga C. 2002. Pregnancy Termination among South African Adolescents. *Studies in Family Planning*. 33(4): 283-298.
- Varkey SJ, Fonn S, Kethlapile M. 2000. The Role of Advocacy in Implementing the South African Abortion Law. *Reproductive Health Matters*. 8(16): 103-111.
- Virgo K, Carr TR, Hile A, Virgo J, Sullivan GM, Kaikati JG. 1999. Medical Versus Surgical Abortion: A Survey of Knowledge and Attitudes Among Abortion Clinic Patients. *Women's Health*. 9(3): 143-154.
- Weitz TA, Foster A, Ellertson C, Grossman D, Stewart FH. 2004. "Medical" and "surgical" abortion: rethinking the modifiers. *Contraception*. 69: 77-78.
- World Health Organization. 2007. *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*. Geneva: World Health Organization. http://whqlibdoc.who.int/publications/2007/9789241596121_eng.pdf. [Accessed on 7 October 2009]
- . 2009. *Global Health Risks: Mortality and burden of disease attributable to selected major risks*. Geneva: World Health Organization. www.who.int/entity/healthinfo/global_burden_disease/GlobalHealthRisks_report_Front.pdf. [Accessed on 11 February 2010]
- Yarnall J, Swica Y, Winikoff B. 2009. Non-physician clinicians can safely provide first trimester medical abortion. *Reproductive Health Matters*. 17(33): 61-69.

Appendix I: Medical Abortion versus Surgical Abortion

This Appendix is an expansion of section 1.4, comparing medical abortion and surgical abortion using manual vacuum aspiration.

Medical abortion for pregnancy \leq 9 weeks	Surgical abortion using vacuum aspiration for pregnancy \leq 9 weeks
Can be used from 4 weeks LMP.	May not be available before 7 weeks LMP.
Resembles a natural miscarriage.	Involves inserting a tube into the uterus to aspirate the contents.
Abortion usually happens at home. If misoprostol is given in the health facility, abortion happens there.	Abortion happens in a health facility.
Abortion process lasts more than one day.	Procedure is completed within 10–15 minutes.
Takes at least two clinic visits.	Takes one to two clinic visits.
May be painful for 2-3 hours or more after using misoprostol.	May be painful during aspiration and afterwards when the uterus contracts.
Severe complications are rare.	Severe complications are rare.
Longer period of bleeding up to several weeks, although amount of blood lost is the same as with surgical abortion.	Shorter period of bleeding, as most blood is aspirated during the procedure.
Anesthesia is not needed. Pain medication should be available.	Pain medication, light sedation and local anesthesia should be provided.
Most effective for pregnancy of less than 7 weeks.	Most effective in pregnancies of more than 7 weeks.
Woman may see blood clots and the products of conception.	Woman does not see products of conception.

(Reference: ICMA, 2004b, 5)

Appendix II: Information Sheet: Medical Abortion

This information sheet was given to each participant to read during the interview to guide discussion about medical abortion sourced from Planned Parenthood, particularly for those who had no previous knowledge of the method.

Here are some of the most common questions we hear women ask about the abortion pill:

What Is the Abortion Pill?

- The abortion pill is a medicine that ends an early pregnancy. In general, it can be used up to 8 weeks after the first day of a woman's last period.
- The name for "the abortion pill" is mifepristone.

How Effective Is the Abortion Pill?

- The abortion pill is very effective. It works about 97 out of every 100 times. You will follow up with your health care provider after your abortion so you can be sure that it worked and that you are well. In the unlikely case that it does not work, you will need to have an aspiration abortion to end the pregnancy.

What Happens During a Medication Abortion?

- Here's a general idea of how it works and what to expect.
- Medication abortion is a process that begins immediately after taking the abortion pill:
- *Step 1 — THE ABORTION PILL*
 - Your health care provider will give you the abortion pill at the clinic. You will also be given some antibiotics to start taking after the abortion pill.
 - The abortion pill works by blocking the hormone progesterone. Without progesterone, the lining of the uterus breaks down, and pregnancy cannot continue.
- *Step 2 — MISOPROSTOL*
 - You will take a second medicine — misoprostol. It causes the uterus to empty.
 - You and your health care provider will plan the timing and place for the second step. You will take the second medicine up to three days after taking the abortion pill. Your health care provider will give you instructions on how and when to take the second medicine.
 - The second medicine — misoprostol — will cause you to have cramps and bleed heavily. Some women may begin bleeding before taking the second medicine. But for most, the bleeding and cramping begin after taking it. It usually lasts a few hours. You may see large blood clots or tissue at the time of the abortion.
 - More than half of women abort within four or five hours after taking the second medicine. For others, it takes longer. But most women abort within a few days.

- It is normal to have some bleeding or spotting for up to four weeks after the abortion. You may use pads or tampons. But using pads makes it easier to keep track of your bleeding.
- *Step 3 — FOLLOW-UP*
 - You will need to follow up within two weeks. Follow-up is important to make sure your abortion is complete and that you are well. You will need an ultrasound or blood test

(Planned Parenthood, 2009)

Appendix III: Informed Consent Form

Each participant signed the following consent form. Each interviewee read the form before the interview began. One copy of the form was left with the participant, and one copy was signed by the participant and kept by the researcher.

This informed consent form is for university students attending the University of KwaZulu-Natal in Durban, South Africa who we are inviting to participate in research on medical abortion, titled “Demand for Medical Abortion: Case Study of College Students in Durban, South Africa”.

Principal Investigator: Ashley Gresh

Name of Institution: University of KwaZulu-Natal

I am Ashley Gresh, a Master’s student in the School of Development Studies at UKZN. I am doing research on medical abortion, a method for termination of pregnancy that is used in private facilities in South Africa and is being considered for use in public facilities in the near future. I am going to give you information and invite you to be part of this research. If you do not understand any of the following information, please ask me to stop and go through it and I can take time to explain it to you. If you have any questions later, please let me know.

Many unsafe abortions are happening worldwide, and in South Africa, contributing to high maternal mortality rates. The aim of this research is to investigate medical abortion as a method, which will be explained in full detail should you decide to take part in this study. The study will assess women’s knowledge/perceptions of medical abortion and investigate the potential demand for the method, and whether it is a viable option for women making choices about termination of pregnancy in South Africa. We believe that you can help us by telling us your opinion of abortion, and medical abortion as a method, and if you find it acceptable. We want to learn what university students know about medical abortion and whether or not it would contribute to their overall sexual and reproductive health.

This research will involve your participation in an in-depth interview that will take about one hour. You are being invited to participate because we feel that university students are at the forefront of social change and often are integral in informing health policies and practice.

Your participation in this research is entirely voluntary. It is your choice whether or not you choose to participate. If at any point during the interview or afterwards you change your mind, you can stop participating. This will have no consequences to yourself if you decide to withdraw.

If you accept, during the interview we will sit down in a place on campus, or if it is better for you your home or a friend’s home. If there is any information you are uncomfortable sharing you do not have to answer all of the questions asked. We recognize that we are

asking you to share some very personal and confidential information and you may feel uncomfortable talking about this topic. No one else will be present besides the interviewer. The session will be tape-recorded, but no one will be identified by name on the tape. The information recorded is confidential and no one else except my supervisor and I will have access to the tapes. The tapes will be destroyed when the study is completed in March 2010. The information we collect will be kept private, and any information about you will have a number on it instead of your name, which will be kept strictly confidential. There will be no direct benefit to you, but your participation is likely to help us find out more about possible sexual and reproductive health services available to women in South Africa.

If you have any questions, you can ask them to me now or later. If you wish to ask questions later you can contact me:

Ashley Gresh:
Mobile: 076.582.4491
Email: ashley.gresh@gmail.com.

Or for further information please contact:
Professor Pranitha Maharaj
Telephone: 031.260.2243
Email: Maharajp7@ukzn.ac.za.

Certificate of Consent

I..... (Full name).
hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of Participant

Date

.....

Appendix IV: 1996 Choice on Termination of Pregnancy Act

This Appendix is an expanded version of section 1.3 to go more in depth than what was provided in the main text, the full version of the Choice on Termination of Pregnancy Act.

NO. 92 OF 1996: CHOICE ON TERMINATION OF PREGNANCY ACT, 1996.
PRESIDENT'S OFFICE

No. 1891.
22 November 1996

NO. 92 OF 1996: CHOICE ON TERMINATION OF PREGNANCY ACT, 1996.

It is hereby notified that the President has assented to the following Act which is hereby published for general information:-

ACT

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

(Afrikaans text signed by the President.)

(Assented to 12 November 1996.)

PREAMBLE

Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognising that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counseling programmes and services;

Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control;

This Act therefore repeals the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:-

Definitions

1. In this Act, unless the context otherwise indicates-

(i) "Director-General" means the Director-General of Health; (iii)

(ii) "gestation period" means the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last; (iv)

(iii) "incest" means sexual intercourse between two persons who are related to each other in a degree which precludes a lawful marriage between them; (ii)

(iv) "medical practitioner" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974); (v)

(v) "Minister" means the Minister of Health; (viii)

(vi) "minor" means any female person under the age of 18 years; (vii)

(vii) "prescribe" means prescribe by regulation under section 9; (x)

(viii) "rape" also includes statutory rape as referred to in sections 14 and 15 of the Sexual Offences Act, 1957 (Act No. 23 of 1957).; (ix)

(ix) "registered midwife" means a person registered as such under the Nursing Act, 1978 (Act No. 50 of 1978).; (vi)

(x) "termination of a pregnancy" means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman; (i)

(xi) "woman" means any female person of any age(x)

Circumstances in which and conditions under which pregnancy may be terminated

2(1) A pregnancy may be terminated-

a upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

b from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-

- (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
- (iii) the pregnancy resulted from rape or incest; or
- (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

c after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-

- (i) would endanger the woman's life;
- (ii) would result in a severe malformation of the fetus; or
- (iii) would pose a risk of injury to the fetus.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1) a, which may also be carried out by a registered midwife who has completed the prescribed training course.

Place where surgical termination of pregnancy may take place

3(1) The surgical termination of a pregnancy may take place only at a facility designated by the Minister by notice in the Gazette for that purpose under subsection (2).

(2) The Minister may designate any facility for the purpose contemplated in subsection (1), subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act,

(3) The Minister may withdraw any designation under this section after giving 14 days' prior notice of such withdrawal in the Gazette.

Counselling

4. The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.

Consent

5(1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.

(2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.

(3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

(4) Subject to the provisions of subsection (5), in the case where a woman is-

a severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy; or

b in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2, her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2(1) b-

(i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or

(ii) if such persons cannot be found, upon the request and with the consent of her curator personae:

Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.

(5) Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that-

a during the period up to and including the 20th week of the gestation period of a pregnant woman referred to in subsection (4) a or b-

(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

b after the 20th week of the gestation period of a pregnant woman referred to in subsection (4) a or b, the continued pregnancy-

(i) would endanger the woman's life;

(ii) would result in a severe malformation of the fetus; or
(iii) would pose a risk of injury to the fetus, they may consent to the termination of the pregnancy of such woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be: Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

Information concerning termination of pregnancy

6. A woman who in terms of section 2(1) requests a termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this Act by the person concerned.

Notification and keeping of records

7(1) Any medical practitioner, or a registered midwife who has completed the prescribed training course, who terminates a pregnancy in terms of section 2(1) a or b, shall record the prescribed information in the prescribed manner and give notice thereof to the person referred to in subsection (2).

(2) The person in charge of a facility referred to in section 3 or a person designated for such purpose, shall be notified as prescribed of every termination of a pregnancy carried out in that facility.

(3) The person in charge of a facility referred to in section 3, shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the Director-General: Provided that the name and address of a woman who has requested or obtained a termination of pregnancy, shall not be included in the prescribed information.

(4) The Director-General shall keep record of the prescribed information which he or she receives in terms of subsection (3).

(5) The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information.

Delegation

8(1) The Minister may, on such conditions as he or she may determine, in writing delegate to the Director-General or any other officer in the service of the State, any power conferred upon the Minister by or under this Act, except the power referred to in section 9.

(2) The Director-General may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the Director-General by or under this Act or delegated to him or her under subsection (1).

(3) The Minister or Director-General shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to him or her.

Regulations

9. The Minister may make regulations relating to any matter which he or she may consider necessary or expedient to prescribe for achieving the objects of this Act.

Offences and penalties

10(1) Any person who-

a is not a medical practitioner or a registered midwife who has completed the prescribed training course and who performs the termination of a pregnancy referred to in section 2(1)a;

b is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)b or c; or

c prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.

(2) Any person who contravenes or fails to comply with any provision of section 7 shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months.

Application of Act

11(1) This Act shall apply to the whole of the national territory of the Republic.

(2) This Act shall repeal-

a the Act mentioned in columns one and two of the Schedule to the extent\$ set out in the third column of the Schedule; and

b any law relating to the termination of pregnancy which applied in the territory of any entity which prior to the commencement of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993), possessed legislative authority with regard to the termination of a pregnancy.

Short title and commencement

12. This Act shall be called the Choice on Termination of Pregnancy Act, 1996, and shall come into operation on a date fixed by the President by proclamation in the Gazette.

Appendix V: Principal Interview Schedule

The questions below were developed to guide the semi-structured interviews conducted with all the participants. The questions were not necessarily asked in this order or posed as they are written below.

Section 1: Demographic and socio-economic characteristics/reproductive history profile

- How old are you?
- How many years of university completed have you completed?
- Do you have a partner? If yes, married?
- Do you use a contraception method?
 - If yes, what is your current contraceptive method? How often? Where do you access contraceptive methods?
- What do you know about emergency contraception?
 - Where did you learn about it? Have you ever used emergency contraception? Where did you obtain it?
- Have you ever been pregnant?
 - If yes, how many children? Are they still living?
- Access to health services:
 - Do you go to see a gynecologist? How often?
- Did you have sex education in school?
 - If yes, please describe.

Section 2: Knowledge/acceptability of medical abortion

- Describe what your reaction would be to finding out you were unexpectedly pregnant
 - What would your thoughts and feelings around the possibility of having an abortion be?
 - Who would you discuss this decision with?
 - How would your parents/family feel about considering an abortion?
 - What factors do you think would impact this decision?
 - What cultural issues would impact this decision?
 - Are there financial barriers to obtaining an abortion? Societal barriers to choosing an abortion?
 - What do you perceive the reaction of a young woman from a similar background to you would be to finding out they were unexpectedly pregnant?
- Describe your knowledge on abortion laws in South Africa
 - Where would you access abortion services?
- Describe what you know about medical abortion
 - [If have no previous knowledge, provide pamphlet with information about the method]

After reading information sheet.

- Do you have any questions about what you have just read?
- Now understanding what medical abortion is, would you consider it as an option in making a decision about abortion methods?
- In your opinion do you think medical abortion is a method that other women would find acceptable in South Africa?
 - What would your parents' reaction to considering medical abortion?
 - What would your friend's/partner's reaction be to considering medical abortion?
- Do you think the same issues apply to medical abortion and surgical abortion?
- What advantages do you see in choosing medical abortion?
- What do you foresee as potential barriers to using medical abortion as a method?
 - Cultural issues?
- Would you feel comfortable aborting at home?
 - If yes, why?
 - Is privacy important to you?
- Would you feel more in control using medication abortion?
 - If yes, why?
- Would you feel comfortable having a nurse or midwife administer medication abortion for you?
- Are you/or someone who supports you financially able to finance a medical abortion?
- Do you think medical abortion should be available in public health facilities in South Africa?
 - If yes, why?
- Open to questions, comments.