Ukukhishwa kwezisu - „Taking out the stomach':

Young women‟sconversations about abortion in KwaZulu-Natal.

By

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COLLEGE OF HUMANITIES

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Supervisor

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DEDICATION

I dedicate this work to my late mom, Mrs. Makhosazana Manana. I always remember you with love, tears, smiles and laughter. You are always the wind beneath my wings. I love you so much Mama!!!

I acknowledge that this is my own work and that it has been duly referenced.

Thenjiwe Manana, March 2015.

Signed……

Contents

LIST OF ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome

CTOP: Choice on Termination of Pregnancy

DOH: Department of Health (South Africa)

DramAidE: Drama in Aids Education

FGD: Focus Group Discussions

HIV: Human Immunodeficiency Virus

HSRC: Human Sciences Research Council (South Africa)

IPV: Intimate Partner Violence

KZN: KwaZulu-Natal

MDG: Millenium Development Goals

MEDUNSA: Medical University of South Africa

NGO: Non-Governmental Organization

NPPHCN: National Progressive Primary Health Care Network

SEM: Social Ecology Model

STI: Sexually Transmitted Infection

TOP: Termination of Pregnancy

WGNRR: Women‘s Global Network for Reproductive Rights

WHO: World Health Organization

WHA: World Health Assembly

ABSTRACT

The World Health Organisation (WHO) (2004) estimates that 68 000 women die a year from injuries sustained during unsafe abortions. 38,000 of those women are estimated to be from Africa. 19 million of the 46 million abortion procedures are performed in unhygienic settings by unskilled practitioners. Roughly, just under half of all abortions carried out globally are unsafe. Women who survive the procedure do not emerge unscathed. Many women endure chronic health complications that result from the procedure. Unsafe abortions are a pertinent issue for discussion in light of the immense consequences for public health.

The South African health sector is struggling with the high rate of unplanned pregnancies. The Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996) legalised abortion with the hope that the regulation and legalisation of the procedure would provide vulnerable women with a safe recourse instead of turning to unskilled practitioners. Despite this Act, the practice of women and girls having unsafe abortions continues. This study investigates this phenomenon.

The parameter of this investigation is around the Amahlongwa and Amandawe areas in the UGu district within the Umdoni Municipality in KwaZulu-Natal (KZN). The need for the study was highlighted during discussions held in 2011 after entertainment-education interventions in the area focused on reproductive health (Gumede and Delate n.d.: n.p). The data collected during those dialogues revealed that few women use condoms or oral contraceptives to prevent pregnancies. In the event of an unplanned pregnancy, many women opted to undergo an unsafe or ‗backstreet[1]' abortion procedure. The objective of this study is to establish how young women understand abortion, how they talk about it in their community and where do they get information about abortion from?

This study later in the findings reveals that abortion, irrespective of whether it is legal or backstreet, is not a topic that is commonly talked about by the community and youth in rural areas like Amahlongwa and Amandawe. When women do talk about abortion, it is often in a way that is judgmental, and is mostly in the realm of local gossip. The findings from the focus groups also highlight that stigma attached to abortion in health institutions is another factor leading to the high rate of backstreet abortions in the area. The study shows that young women are not comfortable using the spaces created for legal abortion in hospitals. Based on these findings, the study concludes with recommendations for public health campaigns on the topic,

[1] The term 'backstreet' does have emotional and socio-economic connotations, however, it is used in this thesis as it is a colloquial term used by the informants of this study.

and suggests ways to improve abortion services so that the continuing problem of young women opting for backstreet abortion is reduced.

CHAPTER ONE: INTRODUCTION

The rates of ‗backstreet abortions' have soared in South Africa within the last few years from 2009 to 2012 (Stevens 2012). According to Haddad and Nour (2009), it is estimated that backstreet or unsafe abortion contributes to the deaths of 13% of pregnant women globally. South Africa is rated amongst the countries with the highest rates of HIV infection. This incidence is associated with abortion choices. Unprotected sex has a direct link to both HIV and abortion, both of which result in the deaths of young people (Stevens 2012). According to WHO, approximately 68,000 women die annually as a result of complications. Between five million and seven million women each year survive unsafe abortions but sustain long-term health complications or succumb to disease.

It is difficult to discuss the topic of abortion as there are a myriad of strong religious and cultural stances globally (Department of Health 2007). The South African government legalised abortion as a means of reducing the number of deaths of young women and children caused by unsafe abortion through Act 92 of 1996. Yet whilst the number of girls under 18 having abortions at state hospitals has more than doubled in South Africa since 2001, it appears that backstreet or illegal abortions are proliferating, especially in major cities (Hammond 2003).

Safe abortion, on the other hand, utilises safe medications and surgical procedures. The large number of women who risk death, injury, and social or criminal consequences associated with unsafe abortion, demonstrates clearly how desperate they are to delay or avoid pregnancy.

Backstreet abortion in South Africa is commonly characterised by unhygienic surroundings and dangerous techniques, such as insertion of a solid object (e.g. a root, twig or catheter) into the uterus, ingestion of harmful substances, the use of external force, or incorrectly performed dilatation and curettage procedures (Knudsen 2006). In community dialogues conducted by DramAidE in 2011, women across Kwa-Zulu Natal districts confessed to taking dangerous mixtures to get rid of the unwanted pregnancies: ―we use bleach, disinfectants, (gobho) traditional muti, permanganate, stametta, crystal potassium, aspirin added to boiled coca-cola etc." (Gumede and Delate n.d.: n.p.).

The silence around abortion in communities exacerbates the tendency for desperate pregnant young women to choose to end their pregnancy by opting for backstreet abortion rather than safe, legal abortion. It has been found that young women in rural South African communities in particular do not have platforms to discuss sexual reproductive health issues (Gumede and Delate n.d.). This leaves young women with confusion around contraception, falling pregnant, and their options of dealing with an unplanned pregnancy; which leads to them making uninformed decisions.

Traditional and community norms in many South African communities discourage the early sexual debut of young women. Holgate (2006) explains that the Children's Bill gives children of twelve years and above a right to access contraceptives and abortion without parental consent. Ncube supports Holgate's view that the Children's Bill is interpreted as: "children you can have sex and if you can get pregnant you can go for abortion and your parents do not have to know" (Ncube, 2009: 17). This confuses parents' roles. Where communities encourage a culture of delaying sexual debut, the Bill seems to encourage or at least normalize sexual practice as early as twelve years.

Backstreet abortion may prevent South Africa from meeting its United Nations Millennium Development Goals (MDGs). The Millennium Development Goals aimed to improve maternal health by 2015, including reducing the maternal mortality ratio, and addressing the contraceptive prevalence rate, adolescent birth rate and unmet needs for family planning. Reducing the rate of deaths of young mothers and pregnant teens is of particular concern. Through unsafe abortion practices, young women find themselves faced with the irreversible side effects of the concoctions that they have consumed. The South African government faces the challenge of prioritising prevention strategies for unwanted and unplanned pregnancies to reach the Millennium Development Goals of reducing maternal mortality rates by three-quarters and providing universal reproductive health care to women by 2015 (United Nations 2014).

Unsafe abortions that are not professionally and medically performed and monitored can result in the unnecessary death of both mother and infant. This is supported by the speech delivered by the South African Minister of Health, Dr Aaron Motsoaledi, who reported that "premature babies are mostly delivered to teenage girls, some because they were trying to abort babies, many times the premature baby is born with lungs that cannot breathe because the child is not ready to get out of the womb" (Cullinan 2013). These premature births may result in an increase in child mortality, further setting back the MDGs.

Motivation for the study

This study was motivated by the need to alleviate the desperate plight demonstrated by the young women who have opted for unsafe abortions, hence risking their lives, or living with conditions exacerbated by the consequences of a botched backstreet abortion. The *Choice on Termination of Pregnancy Act* (1996) seems to have failed to achieve its expected results: of reducing the dreadful consequences of unsafe abortions. The dangerous methods used by young women to try to escape the results of unprotected sex highlights the ignorance of our young people and put the future of our country at risk of losing future leaders.

In 2011, a situational analysis study undertaken in the Amahlongwa area in KwaZulu-Natal by DramAidE, reports that young women use dangerous objects and instruments as well as consuming poisonous concoctions to get rid of an unintended pregnancy (Gumede and Delate, n.d.). This strongly indicates that the CTOP Act, which is intended for the safety of South African women, needs both a drastic overhaul in communicating its benefits to women and improvements in service delivery to reach its main objective.

Act 92 of 1996 on termination of pregnancy needs to be considered alongside the dual protection strategy (using both condoms and other contraceptive methods) with regard to improving sexual reproductive health, and with the intention of reducing the number of cases of young people engaging in unprotected sex.

Most young women do not seem to be fully aware of their rights that are laid out in the termination of pregnancy legislation. According to Jewkes and Morrell (2012) most women had not used legal abortion because they did not know about the law. This lack of choice on termination of pregnancy (CTOP) information might be linked to lots of influencing factors such as health problems including stigma attached to abortion in general (Jewkes and Morrell 2012) This gap in information leads to women who are experiencing unplanned or unwanted pregnancies to find themselves deciding on what is readily presented via pamphlets on street corners mostly advertising backstreet abortions.

This research attempts to highlight the community conversations and other influences that may indirectly encourage young women to opt for backstreet abortions when terminations of pregnancy procedures are available in government hospitals and clinics in KZN. The

contributing factors of young women's attempts to hide unplanned or unwanted pregnancy through backstreet abortions are also be highlighted.

Location of the Study

The study is located in the Amahlongwa area which falls under the UGu district in KwaZulu Natal. The majority of its 704 028 residents speak *isiZulu* (UGu Municipality Report 2010: 1). UGu District municipality is located in the southernmost part of the KwaZulu Natal province and forms the border between Eastern Cape and KwaZulu-Natal provinces. There are more women than men in the district. An important aspect of this profile is that it reflects a cohort that is vulnerable to HIV and AIDS. The UGu district economy is predominantly rural. The district has a rural-urban split which clearly shows the extent of the development challenges with which that the district is faced (UGu Municipality Report 2010: 1).

Amahlongwa has a high rate of unemployment, a high rate of HIV infections and a lack of health care services (UGu Municipality Report 2010: 2). There is no physical health care facility in the area, which means that there is limited access to resources for safe sexual precautions. The local clinic is based at Park Rynie in Scottburgh, which is about 24 kilometres from the Amahlongwa area. The mobile clinic from Scottburgh comes to this community only once a month. The high unemployment rate suggests that young people have nothing constructive to do. In the community dialogues, participants report that this lack of employment means that young people in the area have more time to engage in unhealthy behaviours, including alcohol consumption and engaging in unsafe sex (Gumede and Delate n.d.). According to Durden (2014) community dialogue is a technique that is used as a tool to bring different stakeholders together to talk about community problems and plan a program of action and advocacy to bring about change in the community. The participants who are part of the study reside in the area where community dialogues were also conducted in the uGu District.

Objectives

The objective of my dissertation is to unpack the communication or conversations that encourage young women to choose backstreet abortion when legal terminations of pregnancy procedures are available in government hospitals. The primary emphasis is on finding out what young women are talking about that encourages them to opt for backstreet abortions, and

whether or not the differences between safe and unsafe abortions are known by young women who opt for backstreet abortions.

The broader environmental influences on decision-making that impact on sexual reproductive health for young women will also be explored. This study will therefore be drawing on the Social Ecology Model (Bronfenbrenner 1979) that incorporates the direct and indirect contributing factors which influence behaviour, and also uncovers how the individual is pressured to behave and think in a certain way. Brofenbrenner further argues that in order to understand human development, one must consider the entire ecological system in which growth occurs.

According to Bronfenbrenner these ecological systems range from the individual‘s immediate spheres of influence such as their families and schools to the wider society such as governmental institutions and the economy. McLeroy further explains social ecological model as an ~~e~~overaching framework, or set of theoretical principles, for understanding the interrelations among diverse personal and environmental factors in human health and illnesses” (McLeroy et al. 1988; Stokols 1996: 283)

The Social Ecology Model (SEM) holistically examines factors that influence the individual towards practicing a particular behaviour. In light of the main objective of my study, the SEM will create a platform to review the communities‘ existing Government programmes, and to try and assess where to do things differently in order to reduce the frequency of backstreet abortion cases. In this study, I will focus on young women aged between 18 and 24 from Amahlongwa and Amandawe. My objective is to establish their understanding of abortion, and to learn how the topic of abortion is talked about, or silenced, within the community.

This study is informed by situational analysis research on maternal and child health community dialogue findings (Gumede and Delate n.d.). The community dialogues indicate that few women use condoms as a prevention tool for unwanted pregnancy, opting instead for backstreet abortion in the event that they fall pregnant. The questions designed for this study will investigate how young women understand abortion, from where they get information about abortion, and how they talk about it in their community.

According to a Human Sciences Research Council (Shisana 2009) survey, there has been a decline in condom use for all age groups from 85.2% in 2008 to 65.7% in 2012 in South Africa.

However, 67.5% of young males between the ages of 15 and 24 report high rates of condom use during their last sexual encounter. This group also reports the highest number of multiple and concurrent sexual partners (Shisana 2009).

In the HSRC Shisana (2009) also reports that people in stable relationships do not use condoms consistently with their sexual partners. Citing Ku et al. (1994), condom use is likely to be highest at the beginning of relationships and to decline as the relationship continues. The report further states that for people who are with multiple sexual partners, condoms are mostly used with short term than with long term partners: (Rehle et al. 2006). Furthermore, Shisana (2009) in the HSRC report also confirms this finding by highlighting that some people use condoms only with their *makhwaphenis* (casual partners outside of a more formal relationship), not with their stable partners.

This inconsistent condom use amongst young people is confirmed by the community findings uncovered by DramAidE in 2011. Some community dialogue participants report that their sexual partners ~~–~~do not want them to use condoms because they do not feel comfortable, they prefer flesh to flesh" (Gumede and Delate, n.d.: n.p.). This sentiment comes out in most dialogues, and indicates that young women are willing to compromise their safety just to please their sexual partners, even if they know that they are not the only ones in that relationship. Multiple and concurrent partnership is one of the main contributors to young people opting for backstreet abortions (Odujinrin 1991). An anthropologist and researcher on gender equality Suzanne Leclerc- Madlala reports that young people get into transactional relationships whereby they trade sexual favours for gifts. Multiple and concurrent sexual partnership has also been identified as Southern Africa's key behavioural driver of HIV (Leclerc-Madlala 2002).

These community dialogues findings increased my interest in identifying the barriers that prevent women from protecting themselves from pregnancy, and ultimately why they choose backstreet abortion as an option. The DramAidE dialogues also exposed the power imbalance in relationships, whereby women are expected to be submissive to their male counterparts, and the impact of culture on sexual behaviour, which may result in young women feeling that they have no say over whether or not to use contraception when they have sex.

Ncube (2009) reports that young girls rely entirely on boys to use contraceptives and because of this, 50% of these sexually active girls are at both risk of falling pregnant and of HIV infection. Their

reliance on boys limits their negotiation power in terms of condom use in the relationship and also in their sexual reproductive rights practices. This issue is explored to some degree through my research.

Questions to be asked

Research question 1: How do young women talk about abortion?
Sub-questions:
Do young women ever talk about abortion?
When do these conversations happen?
How are these conversations initiated?
What do young women talk about during these conversations?
Do young women know the difference between legal abortions and backstreet abortions?

Research question 2: Where do young women get their information about abortion?
Sub-questions
Who do young women talk to about abortion?
Where have young women seen or heard information about abortion
What does their community say about abortion?
What do their parents say about abortion?
What do other young people in the community say about abortion?
Are young women exposed to any information about legal abortions at hospitals or clinics? How is it communicated?

Research question 3: How do young women make decisions about abortion?
Sub-questions:
Do most women have backstreet or legal abortions?
Do young women know about the dangers of backstreet abortions?
What makes young women choose backstreet abortion?
What makes young women choose legal and safe abortions?

Research Methods / Approach to Study

This research draws from a sample population of young women aged 18 to 24 who reside at Amahlongwa and Amandawe communities in the UGu district in KwaZulu Natal province. As a member of DramAidE, the researcher was already working with community members in the area on another public heath communication project. This enabled direct access to the group and a working relationship of trust had already been developed. The researcher employed a self-selecting sample, whereby a presentation was conducted in a community meeting, and participants were encouraged to volunteer for participation in the study.

An interpretative, qualitative research paradigm was used to collect and analyse data from this group. The question of how young women understand their choices about abortion was addressed through conducting focus group discussions. The aim was to establish their understanding of abortion and to ascertain the source of the information.

The focus group discussion, with eleven individuals, was facilitated in the participants' first language, which is *isiZulu.* This allowed participants to express themselves freely. Open-ended questions were asked, and a tape recorder was used to record the feedback and discussion in these sessions. The discussions were then transcribed. A thematic analysis based on the key themes explored by the research questions was used to analyse the gathered data.

Thesis Structure

Chapter One of this thesis provides a concise background for the study. It also introduces the study's objectives. It spells out the aims of the research and the questions that the study aims to answer.

Chapter Two is a review of literature about the topics that are relevant to this study. This literature includes previous and current reviews on backstreet abortion cases and its consequences, media reports, as well as information on the Choice on Termination of Pregnancy Act. Chapter Two also highlights the steps taken by the South African government to try to address the issues surrounding abortion in the country since 1996.

Chapter Three provides theoretical perspectives on the framework within which decision-making is influenced. The basic hypothesis of the research is that people make decisions and act in accordance with their subjective understanding of the situations in which they find themselves. The Social Ecology Model (Bronfenbrenner 1979) comprises four levels of influence on human decision-making processes. The micro -, meso -, exo-, and macro levels highlight the influence of culture, community, organisation and individual on decision-making and behaviour. This model allows for the integration of multiple levels and contexts to establish the bigger picture for the health consequences related to unsafe abortion (Oetzel et al. 2006).

Chapter Four discusses the strategies used to generate data for the study. It highlights the methods used in selecting the sample for the study.

Chapter Five provides the focus group interviews findings and examines the conversations linked to the decisions made by young women on backstreet abortion conversations.

Chapter Six discusses the findings from the focus group interviews in relation to the social ecology model. The findings highlight that sexual behavioural change can be achievable when the environment is conducive for people to take action to address their health and wellbeing.

Chapter Seven provides the conclusions from the findings. It also deals with interpretation and discussion of the key findings and recommendations.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides definitions of the terms ‗abortion' and ‗unsafe abortion', as well as some of the statistics for abortion worldwide, in South Africa, and in the UGu district. It will also examine literature around abortion trends, exploring why women choose to have abortions and why some opt for backstreet abortions when legal abortions are available. The literature on how young people talk about sex and abortion is briefly reviewed.

Talk about sex and abortion

Jewkes and Morrell (2012) report that communication about sexual matters between young people and their families is very limited, and teenage girls' predominant sources of information are peers, boyfriends and teachers. Lambert and Wood (2005) further elaborate that male partners often take advantage of this communication gap, as their female peers were not found to discuss intimate details of their sex lives with their partners. Opportunities for young women and teenage girls to formulate alternative constructions of love and sex are limited (Jewkes and Morrell 2012).

It is also noted that the social obstacle to explicitly talk about sex sometimes is caused by different levels of conservatism in societies. This then indirectly spreads the culture of silence around sex and sex education (Lambert and Wood 2005). Therefore these above notions highlight the importance of finding the piece of the puzzle that would assist in opening up conversations about sex with older generations in order to eradicate or minimize the backstreet abortion tendencies.

According to Ncube (2009) teenage pregnancy is common in South Africa and it has reached a threatening level as seeing that many teenagers fall pregnant at a very immature age. Therefore this reason on its own may perhaps indirectly contributes to the numbers of backstreet abortion cases in the country where sometimes young girls terminate pregnancy before parents find out. Lovelife (2007) further highlights that the majority of teenagers are sexual active and are directly or indirectly exposed to sexually transmitted infections as well as high temptations to choose abortion if unwanted pregnancy took place.

Young people may avoid discussing sex for fear that raising the topic of sexual engagement may lead to losing of face (embarrassment) or hurting others‘ feelings, or may damage their reputation by seeming inappropriately promiscuous. This reluctance to talk about sex makes safer sex difficult to plan (Marston and King 2006). These findings highlight the silence around these important issues, which suffer from a lack of opportunity for young people to share information about sex, pregnancy prevention and abortion, which in turn might promote backstreet abortion to young people who find themselves in desperate situations. Marston and King (2006) further highlight that young people‘s decisions about sexual health are shaped by a range of social and cultural factors, which explains why access to information alone is often insufficient to allow them to make healthy and informed decisions about sex, pregnancy prevention and termination of pregnancy.

Legal abortion and the right to choose

South African human rights legislation grants women control over their bodies and reproductive decisions (National Progressive Primary Health Care Network (NPPHCN) 1996). The Choice on Termination of Pregnancy Act (1996) recognises 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 (abortion), as well as sexuality education.

‗Abortion‘ is commonly defined as the termination of pregnancy by the removal or expulsion from the uterus of a fetus or embryo prior to viability. The term ‗abortion‘ most commonly refers to the induced abortion of a human pregnancy. An abortion can occur spontaneously, in which case it is usually called a miscarriage, or it can be purposely induced. Abortion, when induced in the developed world in accordance with local law, is among the safest procedures in medicine (DOH 1997).

In South Africa, any woman of any age can have an abortion simply by requesting one in a health centre with no reasons given if she is less than 13 weeks pregnant. A pregnant minor can be advised to consult her parents, guardian, family members or friends before the pregnancy is terminated (DOH: Act 92 of 1996, 1997). If the woman is between 13 and 20 weeks pregnant, she can have an abortion if her own physical or mental health is at stake, or if the baby carried

to term will have severe mental or physical abnormalities, or if she is pregnant because of incest or rape, or if she is of the personal opinion that her economic or social situation is sufficient reason for the termination of pregnancy. After the 20th week, termination of pregnancy is allowed only if the continuing pregnancy would endanger the woman‘s life or result in severe fetal malformation or a risk of fetal injury (DOH 1997; Althaus 2000).

According to South African law, a girl under the age of 18 requesting an abortion will be advised to consult her parents, but she can decide not to inform or consult them if she so chooses. A woman who is married or in a stable relationship will be advised to consult her partner, but again she can decide not to inform or consult him. If the woman is severely mentally ill, then the consent of a life-partner, parent or legal guardian is required.

When abortion was legalised in South Africa in 1996, it brought hope that women‘s pleas had been heard, and that they were being given a safe choice within their sexual reproductive rights regarding unwanted pregnancies. The Act was seen as a tangible expression of the government‘s commitment to allow women to attain their right to self-determination (Brooks 2008).

The South African Constitution does not explicitly mention abortion, but two sections of the Bill of Rights mentions reproductive rights. Section 12(2) (a) states that "Everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction". Section 27 states that "Everyone has the right to have access to health care services, including reproductive health care”. Furthermore, women‘s right to life, human dignity, freedom and security is enshrined in the Constitution.

In 1996, the percentage of South African pregnancies ending in abortion (excluding miscarriages) was 0.17%. This number increased to 2.8% in 1997, and later reached 11.5% in 2004 (Blaauw and Penn-Kekana 2010). In 2007, it was reported that the number of abortions, especially safe abortions, which are easy to track, had doubled. DOH statistics further show that abortions jumped from 32,679 in 2001 to 71,856 in 2006. It is currently estimated that 50% of all pregnancies in South Africa end in abortion, and more than 500,000 women have had the procedure done since the introduction of the new laws in 1997 (Adams 2007). In 2012, the South African Minister of Health reported that a total of 77,771 legal abortions were performed in South African in 2011 – a 31% increase from 2010, when a figure of 59,447 abortions was

recorded (Stevens 2012). These latest numbers exclude miscarriages as well as estimated backstreet abortion cases.

Despite the increase in legal abortion figures, there are still a number of barriers to the uptake of legal abortion services. A South African study conducted by Jewkes et al. (2005) into the lack of uptake of legal abortion services found that 54% of the women involved in the study indicated that they did not use legal abortion services because they did not know about the law. The study also suggests that poor service delivery in health facilities is a barrier to women accessing safe abortions. The majority of women involved in the study indicated that they experienced barriers to legal service use, some did not know where to access abortion services, and others feared rude staff or breaches of confidentiality (Jewkes et al. 2005).

A further study confirms that many women in South Africa are not aware of the Choice on Termination of Pregnancy Act that gives them more choice and control over their reproductive rights (Morroni et al. 2006). Those who know that abortion is legal lack the information and logistics around the Act itself to be able to achieve a positive outcome. Morroni et al. (2006) found that 32% of women surveyed did not know that abortion is legal. Among those who knew about legal abortion, few knew about the time restrictions involved (for example, that the abortion had to be completed in the first trimester).

Although the 1996 Act gives women in South Africa the right to choose whether or not to have a safe abortion, women still need to be empowered on such a sensitive and fundamental procedure that encourages them to take a stand with regards to their rights in sexual and reproductive decision-making.

Backstreet Abortion

‗Unsafe abortion', also known as ‗backstreet abortion', is the termination of unwanted pregnancy by persons lacking necessary skills, or in an environment lacking minimal medical standards, or both (Sedgh et al. 2007). ‗Unsafe abortion' may refer to an extremely dangerous life-threatening procedure that is self-induced in unhygienic conditions, or it may refer to a much safer abortion performed by a medical practitioner who does not provide appropriate post-abortion attention (Sedgh et al. 2007).

Shah and Ahman confirm the danger of women who opt for unsafe abortions entrusting their lives to people lacking the necessary qualifications and skills to perform induced abortions (Shah and Ahman 2007). Unsafe induced abortions do not meet officially prescribed circumstances and safeguards; they are aggravated by unhygienic conditions, dangerous interventions or incorrect administration of medication. It is every woman‘s right to choose whether and when to have a child. The problem of unprotected sex, unwanted pregnancy, sexually transmitted infections and unsafe abortions are inextricably linked (Brady 2003). Therefore, unsafe abortions might be preventable if dual contraceptive methods are encouraged and monitored (Berer 2000).

In the community dialogues that were conducted by DramAidE in 2011, women confessed to taking dangerous mixtures to get rid of the unwanted pregnancies. The study found that young women were using substances such as bleach, manganese, Stametta (a mixture of herbal concoctions), crystal potassium, and aspirin mixed with household substances such as Coca-Cola, Omo (washing powder) and pesticides in order to induce abortion (Gumede and Delate n.d.). The large number of women who risk death, injury, and the social or criminal consequences associated with unsafe abortion, demonstrates clearly how desperate they are to delay or avoid pregnancy.

A South African study shows that illegal abortion dates back to the 1940s, when physicians reported the impact of backstreet abortions on medical facilities, which had to provide services to women suffering from the resulting complications (Mokgethi 2009). Prior to 1996, there was no organised system to keep track of the numbers of actual cases of abortion. Practitioners performing abortions in that era would not keep records or disclose the practice because at that time abortion was illegal. This meant that all the procedures were done in covert venues and at a fast pace, to avoid practitioners being caught and losing their license to practice. Haddad & Nour (2009) argue that:

> ~~O~~btaining accurate data for abortion is challenging, and especially so for unsafe abortion. Two-thirds of nations do not have the capacity to collect data, and data collection varies from country to country in both quality and quantity. Because unsafe abortion is often done clandestinely by untrained individuals or by the pregnant women themselves, much of it goes undocumented: figures are therefore estimates” (Haddad & Nour 2009: n.p.).

A 2012 edition of *Drum* magazine published an investigation on backstreet abortion in Gauteng in which the journalist confronted a group of alleged doctors who practice backstreet abortion to needy women for a price (Makgalimele 2012). Makgalimele confirms how easy it is for an ordinary person to access these backstreet abortions. She pretended to seek abortion in two backstreet abortion centres. In both these centres she successfully met unqualified doctors. One sold her pills to insert into the vagina, and the other explained that she would insert a tube and afterwards the journalist could take her parcel meaning ―fetus" home. Makgalimele elaborates that the ‗doctor' even suggested that she could take the medication at home by herself as long as she stick to the instructions. All this was done without even asking for her name or any other personal information (Makgalimele 2012).

In Cape Town, a *Cape Argus* investigative report confirms that witchdoctors sell *mutis* (herbal concoctions) to women wanting to induce a miscarriage (Hammond 2003). These topical news reports confirm that backstreet abortions are still a problem in South Africa, 16 years after abortion was legalized.

The above scenario's confirms that one of the serious concerns around the backstreet abortion process is that most women are left to care for themselves after the procedure is over. There is no facility where women who have had a backstreet abortion can recuperate to ensure that the process does not jeopardize their life. One positive aspect of the medically-safe abortion is that there are post-abortion facilities to care for the patients who have gone through the process. A further study by Haddad and Nour (2009) highlights the fact that unsafe abortion still continues to proliferate even though Choice on Termination of Pregnancy (CTOP) is in existence. Gresh (2010) highlights that numbers of abortion cases are on the rise, with young people justifying opting for unsafe abortion with reasons such as sexual abuse, gender-based violence and rape.

Harries et al. (2009) highlights that health care provider's attitudes towards termination of pregnancy might influence women who seek safe abortion to distance themselves from health facilities. Harrison et al. (2000) highlights that in some instances health care workers at some hospitals refuse to provide abortions or refused to be trained to do so. The provision of Termination of Pregnancy services in South Africa is centred on health workers and their rights, rather than on women and their right to seek care.

These attitudes may hinder the implementation of the Choice on Termination of Pregnancy Act in the process. These judgmental attitudes might also unintentionally create an environment that is not conducive for young women who opt for abortion to frequent the health facilities. This might also reduce the likelihood of adequate post-abortion counselling which may cause many women to leave official health facilities after treatment for complications arising from unsafe abortions without thorough counseling on how to prevent future pregnancies, and without proper guidance on comprehensive contraception. This is highlighted by Harries et al. (2009) who reports that the dearth of abortion providers undermines the availability of safe, legal abortion and has serious implications for women's access to abortion services and health service planning. This might leave an accepted tendency for these women to practice unsafe abortion in their future if they experience an unwanted pregnancy crisis.

Another South African newspaper, the *Sunday Sun,* published an article focused on the scourge of backstreet abortion. The article reads: "Deadly abortions: why women STILL choose backstreet doctors" (*Sunday Sun* 2012, 15 June: 5). It reveals that from 2008 to 2010 at least 186 women died in public hospitals because of bleeding, infections or miscarriages resulting from backstreet abortions. The article further notes that 42 of these women died as a direct result of being treated by fake abortion doctors. The *Sunday Sun* further warns that even those that survive unsafe abortions are not entirely lucky: complications from backstreet abortions include tearing of the cervix, severe damage to the genitals and abdomen and blood poisoning, as well as a very high risk of being permanently unable to have children (*Sunday Sun*, 15 June 2012: 5).

The above media stories, although often sensationalist in their angle on the problem, have been confirmed by other researchers. The study undertaken in Gauteng by Jewkes et al. (2005), for example, explains how one woman was treated and left to care for herself. She describes how she heard from people in the community of a general practitioner in Pretoria who did backstreet abortions. She went to him, and he inserted a needle into her that made her bleed. She complained that he sent her home and did not explain what she should do after she left the surgery.

The DramAidE situational analysis study that was conducted in rural areas of KwaZulu Natal, South Africa highlighted that the issue of backstreet abortion needs to be given serious attention, as women are willing to gamble with their lives just to get rid of unwanted

pregnancies. The fact that women opt for the trauma of the backstreet abortion procedures, and the potential consequence of permanently destroying the uterus, suggests that the dangers of backstreet abortions, when compared to the option of safe abortions, are not fully understood by young women.

From April 2011 to March 2012, the G.J. Crookes Hospital, which serves UGu district, with a special focus in Amahlongwa, reported 361 cases of termination of pregnancy. Many of these were cases of dealing with illegal and incomplete abortions, which had been performed mainly on girls under the age of 15 (personal correspondence, G.J. Crookes Hospital, 2012). This confirms that many young girls choose not to use contraception, and when they find themselves pregnant, opt for backstreet abortion. The other concern indicated by this statistic is that young girls engage in sexual activities at a very early age, contrary to accepted community norms.

Figure 1: G. J. Crookes Hospital Abortion Statistics for 2011 to 2012

	APR 2011	**MAY 2011**	**JUN 2011**	**JUL 2011**	**AUG 2011**	**SEPT 2011**	**OCT 2011**	**NOV 2011**	**DEC 2011**	**JAN 2012**	**FEB 2012**	**MAR 2012**
Abortion Incomplete expulsion	18	8	29	20	19	15	19	27	13	24	13	0
Abortion Legal	7	15	17	10	13	16	12	14	9	10	12	12
Abortion Septic	0	1	1	4	1	1	0	1	0	0	0	0

This above table, provided by the J.G. Crookes Hospital, demonstrates that young women still, in this era, are opting for backstreet abortion to get rid of unwanted pregnancies. The reasons for this may include a lack of information about the safe abortion option, or the fact that in some places hospitals are far from the communities; or perhaps it is the negative attitude of hospital nurses. However, women and their communities need to know that safe abortion option is freely available in government hospitals and some clinics. They should also be informed that other safe options are private doctors, as well as non-governmental organisations (NGOs) such as Marie Stopes, whose clinics charge a fee for safe abortion. More information about these safe options could prevent deaths and disabilities resulting from illegal abortions processes.

According to Rehle et al. (2006) HSRC survey, many young women who date older married men who are five years or more senior; if they fall pregnant they are often too shy or ashamed to carry the pregnancy to term, and instead opt for unsafe abortion so that their own families, as well as the families of the older married men, do not find out about the pregnancy. In addition to these socio-cultural factors that influence their decision-making, the Amahlongwa and Amandawe communities are in a rural setting where the only local hospital is staffed by local people, which might also prevent young women from opting for safe abortion, as they fear local gossip, or their parents finding out.

Perceptions about abortion and why women have abortions

Socio-cultural and traditional norms, inequitable gender relations, socio-economic inequalities, the dominance of patriarchal ideology in societal gender norms, and religious beliefs are all barriers that stop or delay women from accessing safe abortion (Orner et al. 2011).

According to WHO (1998), most women seeking abortion are either married or living in stable unions, and sometimes already have several children. Therefore, they seek abortion to limit the sizes of their families. This alludes to the difficulties that women may encounter when negotiating safe sexual practices with their partners.

The concept of controlling family size through using backstreet abortion needs great scrutiny. It may be of great concern to the country if such drastic measures are used as a substitute for contraceptives, particularly because a lack of use of barrier contraception methods, such as condoms, may also lead to an increase in the HIV infection.

Fidel Hadebe, spokesman for the National Department of Health, suggests that there is a drop in safe abortion figures ~~t~~hat these drops can be attributed to the booming illegal abortion business" (Mapumulo 2012: 1). Hadebe continues that: ~~A~~Act 92 of 1996 was intended as an avenue to allow women to use when there is a need. What we see today, where women seem to be using it as a form of contraception, is totally wrong" (Mapumulo 2012:1). This above notion is supported by Mapumulo (2012), who reports that young women are using abortion to replace contraceptives. Mapumulo argues further that abortion is seen as ~~t~~he new birth control". Gresh (2010) further highlights that voluntary family planning is the best protection against abortion, as well as a major contributor to saving women's lives and a human right.

Globally, backstreet abortion is like an epidemic that will take centuries to overcome, mostly because it is accompanied by stigma, privacy and discrimination. The example of countries like India, where safe abortion was legalized as early as the 1970s, shows that legalizing abortion does not necessarily mean a reduction in unsafe abortions (Haddad and Nour 2009).

Surprisingly, in countries where abortion is legal, unsafe abortion is of a similarly high rate as in countries where abortion is illegal (Shah et al. 2007). More than 70 countries have legalised abortion with the intention of reducing mortality in women and children, and of providing a safe route to abortion. There may be a number of reasons that young women choose backstreet abortions, even though abortion is legal in those countries.

In the South African context, these reasons may include access to clinics or other safe abortion centres, lack of access to information, and social and cultural beliefs about contraception. Abortion in South Africa is a sensitive subject, and women who are afraid of the stigma attached to it may opt for backstreet abortions. The process of backstreet abortion is promoted by secrecy and the fact that it is a taboo. In other countries, too, women who have issues around these above-mentioned beliefs will keep it hidden (Haddad and Nour 2009). The secrecy around abortion may prevent women from accessing safe abortion services.

The Medical University of South Africa (Medunsa) stipulates that whilst deaths from unsafe abortions have all but been wiped out since the new laws, backstreet abortions are still occurring. He suggests that the reasons for this are mainly long waiting times for abortions at state hospitals. However, other research suggests that negative attitudes and lack of access are the key issues that drive women to seek out unsafe abortions (Ncube 2009). The data from this study will add to this research, exploring how women communicate with regards to abortion issues, which may influence their decisions to undergo backstreet abortion instead of the safe legal option.

The stigma surrounding abortion and HIV and AIDS is another factor said to promote unsafe abortion for women in South Africa and other countries (Orner et al. 2011). Orner et al. (2011) suggest that women who are HIV-positive are still discriminated against, and this is exacerbated if they are seen to be pregnant. Hale and Vasquez (2011) support the above notion by reporting that a study that was done in India highlighted that 5 out of 7 HIV positive women were denied abortion and sterilization services in government hospitals because of their status. This

attitude alone may encourage women who are HIV-positive to practice unsafe abortion, to avoid stigma and hope for acceptance by the community.

Other factors that impact on women‘s decisions regarding illegal abortions include the social and cultural contexts in which they live. Most women who opt for backstreet abortions are unmarried, or do not know who the father of the baby is, and may therefore be labelled as ‗loose‘ by people around the community. Another factor is that, culturally, women are seen to be submissive to their sexual partners; so this may encourage the woman to opt for backstreet abortion because her boyfriend is either pushing her to abort, or has disappeared (Maforah, Wood and Jewkes, 1997).

The issues of culture, belief systems and ideas of morality are a key to understanding attitudes to abortion. Opinions about abortion among Zulu adolescents are divided (Varga 2002). Varga states that many surveyed adolescents see abortion as a sin, immoral (like murder), or socially irresponsible. In another South African study, it was found that female university students tend to disapprove of abortion, with almost 55% of those surveyed stating that they were against abortion (Patel and Myeni 2008). This disapproval was often due to conservative morals and religious beliefs. However, many interviewed young people commented that, regardless of its acceptability, abortion is a social reality and should be made safe and available (Varga 2002). Despite this attitude, it appears that legalizing abortion has not been enough, because backstreet abortion continues to escalate. However, advocates of legalized abortion argue that repealing laws that prohibit or restrict abortion prevents many women from dying or being harmed as a result of dangerous, illegal abortions (Gumede 2004).

A study on sex and the economy by Leclerc-Madlala (2002) highlights the economy as a factor for not practicing safe sex, which may have a direct impact on pregnancy rates and abortion. Young women use sexual intercourse as a transactional resource to be exchanged for anything ranging from basic needs such as food and shelter to high-end goods such as cellular phones, cars or holidays in exotic locations (Leclerc-Madlala 2002:10). This means that South African women take risks with unprotected sex for economic reasons. This unprotected sex may result in them choosing to have an abortion instead of opting for contraception to prevent the pregnancy. In many cases, these may be backstreet abortions.

Culturally, in South Africa, parents do not communicate to their children about sexual issues (Mkhwanazi 2010). This practice might limit access to accurate information for young women who end up ‗learning by doing', or getting inappropriate information from their peers. The other belief that might contribute to young women choosing backstreet abortion may be the fear that when she uses contraception her body ―will be wet" -meaning that she will have increased vaginal lubrication, a perception associated with promiscuous women (Gumede and Delate n.d.). Other studies report that most young people have a perception that women who use contraception are seen as promiscuous (Patel and Kooverjee 2009), which indirectly creates a high risk of women opting for backstreet abortion. These factors may force pregnant women to opt for backstreet abortion to avoid being labeled or being discriminated against by their social peers.

Previous studies highlight that secrecy, shame, fear of ridicule and taboos associated with abortion impact highly on the notion that these young girls who were somehow pushed to undergo abortion procedures were seen by the communities as having ‗infectious' behaviour that might badly influence other girls (Kumar et al. 2009). Kumar goes further, elaborating that religion also plays a major role in stigmatising abortion – whereby young women and men experience stigma and express feelings of regret that they have committed a sinful and immoral act based on their ideas of family and religion. These feelings lead them to keep their abortion a secret (Kumar et al. 2009).

The high rate of backstreet abortions may be linked to the above-mentioned religious reasons that encourage young women to hide pregnancies and, in the process, attempt backstreet abortions to eliminate the shame they have brought to themselves and their families. Backstreet abortion is also historically linked to oppression that did not allow women to make decisions with regard to their lives as well as their sexual reproductive health.

Safe abortion in South Africa can be done in public hospitals as well as some local clinics, where it is done for free as these places are registered. Most private doctors and Marie Stopes clinics (Marie Stopes is a sexual and reproductive health care charity which has 37 clinics in South Africa) also provide safe abortions at the price of R960. Marie Stopes also provides after-care information through booklets and videos; however, this information does not reach most women. In most South African city streets, pamphlets on backstreet abortion are visible on street poles, building walls, and through people handing them to pedestrians and drivers. On the

other hand, there is very limited publically visible information about safe abortions, and young women need to go directly to clinics to access such information.

Findings from the World Health Assembly (WHA) suggest that for abortion to have a positive impact on maternal mortality, health structures need to be improved (Ahman and Shah 2007). The WHA further argues that in underdeveloped countries, deaths and complications related to abortion will rise. This confirms that to legalize abortion without proper facilities, communication and education for the intended audience may have a negative effect on maternal and child mortality. In most countries that have legalized abortion, there is a common gap around the education and communication of abortion facts. Some women need to be both educated and empowered around matters that affect their bodies and their life-choices regarding reproduction. This therefore means sexual reproductive health information needs to be prioritized to empower women to take full responsibility for their sexual lives.

Women need to know and understand the abortion legislation in order for them to access the services. The distribution and communication of information concerning the legislation has to be clear and accessible to women of all socio-economic statuses. In countries where abortion is legal it does not translate to all abortions being safe or abortion services being accessible (Gumede 2004: 20).

“Talking about abortion”

Although there are many media reports about abortion, and sensationalised stories about the death and deformation caused by backstreet abortions, there is little literature on positive news or conversations about abortion. Moreover, even though women are expected to have sexual reproductive health rights to make decisions over their bodies but silence and patriarchy in the societies perpetuates the environment that is not conducive to support women in making the decisions on abortion. Talking about abortion is therefore viewed as immoral and disrespectful.

It is still a taboo in South Africa for young people to talk about sex with their parents, grandparents or educators even though this country has one of the highest rates of HIV in the world (Macleod 2010). This practice of silence about sex makes abortion a topic that is seldom talked about. According to Fried (1990), women hardly talk about abortion, and they cannot even admit to themselves that they have had an abortion. According to Macleod (2010),

abortion is and will continue to be a difficult-to-talk-about topic because it will remain controversial. She further argues that abortion is linked to politics, which makes it a difficult topic to be openly discussed.

There are different attitudes in people‘s responses to the Choice on Termination of Pregnancy Act. In KwaZulu-Natal there are lots of different views about Act 92 which make it difficult to implement fully. The topic of abortion is still shrouded with an air of secrecy and a sense of moralistic judgements from close-knit communities, peers and spouses despite it being a legal right in terms of a woman‘s reproductive health decisions (Harrison et al. 2000; Jewkes et al. 2005; Varkey 2000).

Another older study on teenage pregnancy by (Craig and Richter-Strydom 1983), establishes that abortion in young people evokes mixed reactions. The study discovered a different side: that most pregnant teenagers viewed abortion as an acceptable way of dealing with unplanned pregnancy. Singh (2006) also indicates that more young women present with complications that relate to incomplete induced abortion than older women, and they are at greater risk than adults. A different study that established a completely opposite view reports that some young people view abortion as sinful, immoral and illegal (Varga et al. 2002). Both these findings on whether young people are supportive of or against abortion highlight the chances that young people might use backstreet abortion as an option for unwanted or unplanned pregnancies.

Emphasis on mixed feelings about abortion is further confirmed in the study by Harrison et al. (2000). This highlights that termination of pregnancy is favoured by women, as well as nurses, only if the pregnancy is caused by incest or rape. Nurses are reported to look at their profession as to save lives, not remove them. This belief makes some nurses look at abortion as murdering or killing another human being, which they believe is against the nurses‘ professional code (Harrison et al. 2000).

The Harrison et al. (2000) study also establishes that some nurses feel that they do not have a problem if the termination of pregnancy is to help women after a failed botched abortion, because to them that is not murder, but helping the sick woman. This statement highlights that some nurses see abortion in the same bracket as murder. They go further to express their view that the stigma attached to abortion will not be attached to the nurses, but to the woman who attempted abortion. Therefore that idea of helping after a botched abortion is better to them, than undertaking the termination of pregnancy from the beginning. Their reasoning is based on

the grounds that they will be fulfilling their professional duty in saving lives (Harrison et al. 2000). The nurses‘ ideas of morality and the negative attitudes that go with it are seen as a barrier for young women who want to access the safe and legal termination of pregnancy in the same process turning to backstreet abortion as an alternative process.

Harrison et al. (2000) further notes that nurses feel that termination of pregnancy is an added responsibility when they are already overworked and, most of all, short-staffed. On top of that, the nurses feel that since abortion is part of the human rights principle, they also have a right to choose not to do abortions. Other nurses are so perturbed by the Choice on Termination of Pregnancy Act that they say they feel it has been imposed on them, and it favours young women‘s right to kill babies in order to continue enjoying sex.

Daily Maverick journalist Rebecca Davis (2013) highlights that the fact that women may seek illegal abortion because the reception they receive at public facilities is unfriendly and moralistic. She refers to Marie Stopes‘ reports that young South African women seek abortions from illegal providers because public sector nurses frequently castigate clients for being sexually active, for being irresponsible, or for choosing to terminate the pregnancy rather than give birth (Davis 2013). This might suggest that some of the people with different views about abortion are failing to highlight as well as personalise the risks that are brought about by backstreet abortions.

Additionally, Christineani Varkey (2000) reflects that attitudes of the general public and health care workers do not support women‘s right to choose, and that there is a general reluctance to allow minors to have an abortion without parental consent. Frances Althaus (2000) conducted a study focusing on the expansion of access to abortion services which establishes that almost half (48%) of the South African population consider abortion as morally wrong, while 41% say it is warranted in the cases of rape. Only 11% believe that abortion was a woman‘s right.

Furthermore, Mojapelo-Batka and Schoeman (2003) note that there is a lack of black women‘s voices and perceptions of legal termination of pregnancy. Moreover, Mhlanga (2003) indicates that ~~t~~he attitude of the patriarchal societies makes abortion a taboo and therefore, abortion has never become a topic in the agenda of many countries despite its impact on the health of women and children” (Mhlanga 2003:126). This knowledge is important, as it will help us to understand the challenges and barriers to abortion. The aim of this study is to expand on the voices of black women, which might help grow the body of literature on the topic of CTOP in South Africa, by investigating some of the conversations regarding CTOP. Harrison (2000)

argues that even though the Choice on Termination of Pregnancy Act has been received negatively by communities as well as some nurses, it could be accepted in its totality if it were strongly advocated to communities as well as professionals.

After research into abortion dynamics amongst adolescents in KZN, Christine Varga (2002) states that most women are able to balance moral, cultural and religious beliefs about early pregnancy and termination of pregnancy with the challenges of early motherhood (Varga 2002). They do seek termination of pregnancy but the stigma from the community, health care system and important decision makers in their lives prevents them from choosing the safe reproductive health options available to them (Jewkes et al. 2005). They opt for backstreet abortions rather than legal and safe abortions. According to (Jahn et al. 2009) the Social Ecology Model (SEM) is described as a classic of knowledge about real- world phenomena. Since Social Ecology Model can help us to understand how a person is influenced by where they live and those around them, and how this impacts on their ability to make decisions. For that reason, SEM might be a tool that is required to alter social and behavioural norms about pregnancy and termination of pregnancy, and to empower young women and their families to balance provision of optimal health care services with appropriate quality (Panday et al. 2009).

According to Noelle-Neumann (1974), spirals of silence within groups can restrict the open and honest discussion that is essential to organisational or community improvement. The fear and threat of isolation keeps people from being open and honest about their opinion. Therefore if abortion is viewed as morally wrong (Althaus 2000) by the majority in communities; the spirals of silence will filter to the minority, even if they feel positive about it. Spirals of silence will ultimately allow people to make decisions, to either speak up or not, but most probably to keep silent, to withhold their opinions, ideas and concerns (Milliken and Morrison 2003). Young people in the case of abortion in communities that practice spirals of silence may elect to keep quiet just to maintain cohesion and consensus with the community‘s practices.

The above studies and notions highlight that there is culture of silence around abortion, and this research aims to explore how young women talk about abortion and from where they get information about it within this culture of silence. The fact that abortion is linked with politics and religion may reinforce the spirals of silence around the topic. The Social Ecology Model applied below will allow the researcher to unpack the contributing factors to the discussion around

abortion (or lack thereof), as well as understanding the multiple levels of influences that inform decision making about abortion.

Other theories that will inform the analysis of the collected data include Social Learning Theory (Bandura 1986) and Spirals of Silence (Noelle-Neuman 1974). The application of Social Learning Theory will allow the researcher to understand how young women are influenced by their peers and others in their community, and the Spirals of Silence theory will help the researcher analyse the data collected about why women do not talk openly about abortion, and where the information that they do have about abortion comes from.

Research on the HIV epidemic in a 2011 review reports that traditionally in many parts of South Africa women have played a subordinate role in reproductive and sexual decision-making, and culturally-based gender norms have rendered women subservient to male partners (SANAC, 2011). Whilst Jewkes and Abraham (2005) highlight that in South Africa men believe they are more powerful than women and that men are expected to control women in their relationships.

Jewkes et al. (2012) Rural African populations in South Africa are largely patriarchal in structure. Young women have very few avenues available to them for social or economic advancement. Young women offer sexual favours to men as a means of obtaining wealth and social status. This skewed power-relation is one of the causes for the prevalence of HIV infections and gender-based violence affecting women. Jewkes et al. (2012) goes further to note that an unshakable concern in Sub-Saharan Africa is the unequal impact of HIV on younger women. Variances in young women‘s relationships and the problems of coerced and transactional sex mean that young women are unable to negotiate safe sex because of the way gender inequality plays out in the realm of intimacy (Jewkes et al. 2005).

These societal predispositions restrict women‘s capacity to demand monogamy from their partners, negotiate safer sex or require behaviour change from their partners (Gupta 2002; Meyer-Weitz et al. 2000). These societal norms may also have an effect on how women view protection from pregnancy and decisions about terminating a pregnancy.

Summary

I have noted through my research that there are limited studies on perceptions of abortion, which has encouraged me to focus my study on the perceptions that encourage young women

to opt for backstreet abortion, when Act 92 clearly states that young women are free to choose safe abortion without any specific reasons.

Whether abortion is taboo or not, the reality is that women will continue to seek out backstreet abortions for unplanned or unwanted pregnancies to rid themselves of the embarrassment of being pregnant. One needs to take into consideration that the issue of abortion may have many layers, some accompanied by respect for culture and religious beliefs, which perpetuate the situation where women seek out backstreet abortion practitioners. Women still need to be given more information on the fact that abortion is legal for the Act to have a positive impact in South Africa. Due to the HIV and AIDS scourge, women also need to be encouraged as well as to be informed about relying on dual protection, which includes condom-use as well as chemical contraception use, which will boost the prevention of unplanned or unwanted pregnancy.

Backstreet abortion is difficult to reduce, unless research around abortion is conducted to identify the reasons that perpetuate a situation where women choose backstreet abortion, and new communication is developed to address these reasons. This study will examine how communication about abortion happens in the UGu district of KZN, in an effort to understand how communication influences decision-making in this regard. The study will establish young women‘s understandings of abortion, and how the topic of abortion is talked about, or silenced, in the community, irrespective of the legality around it, and will make recommendations for future communication campaigns regarding abortion.

CHAPTER THREE: THEORETICAL FRAMEWORK

Introduction

This study on young women‘s conversations about abortion in KZN will use the Social Ecology Model (SEM) to understand how and why young women make sense of abortion. This model was originally informed by Systems Theory, created by Ludwich Von Bertalanffy in the 1950s (Von Bertalanffy 1950). Systems Theory uses an approach that tries to establish or understand the human being‘s spheres of influence that are responsible for their behaviour. Murray Bowen (1978), an American psychiatrist, used the extended family as a means to trace the emotional and psychological development of individuals. Interlinking concepts all relating to the development of the self is known as Bowen‘s theory‘. The theory was initially used in child development contexts but had later been adapted for use in other contexts. The social ecology model is an offshoot of the aforementioned theories that aim to understand what drives an individual‘s behaviour on a societal level. As local contexts create new challenges, public health communication theories are adapted to local circumstances. The public health and development field is constantly in a state of flux due to the need to keep up with global and societal demands (Tomaselli and Chasi 2011).

Systems Theory looks at the wider scope of self-regulating systems that are found in the nature, including the physiological system of our body in local and global ecosystems and in climate and in human learning processes (Stichweh et al. 2011). Systems theory highlights that each individual in a community is interlinked into several interdependent links and that a change enacted within in the components of an entity influence the entity as a whole. Communities are comprised of several inter-related institutions, the church, schools, law enforcement authorities, businesses, families etc. Major breakdown or structural changes to one institution may influence far-reaching effects within the community itself.

The Social Ecology Model is crucial in ensuring the understanding of human behaviour, because it establishes the effect that an individual‘s environment has a direct link on behavioural patterns. The model focuses on the relationship between organisms and their biological and physical environments. Odum et al further explained ecology as all functional processes that make the household habitable (Odum et al. 1971). There are many forces that shape behaviour and they must all be considered when working with people (Bronfenbrenner 1979: 16; Lewin 1951: 25).

Understanding what influences health decisions

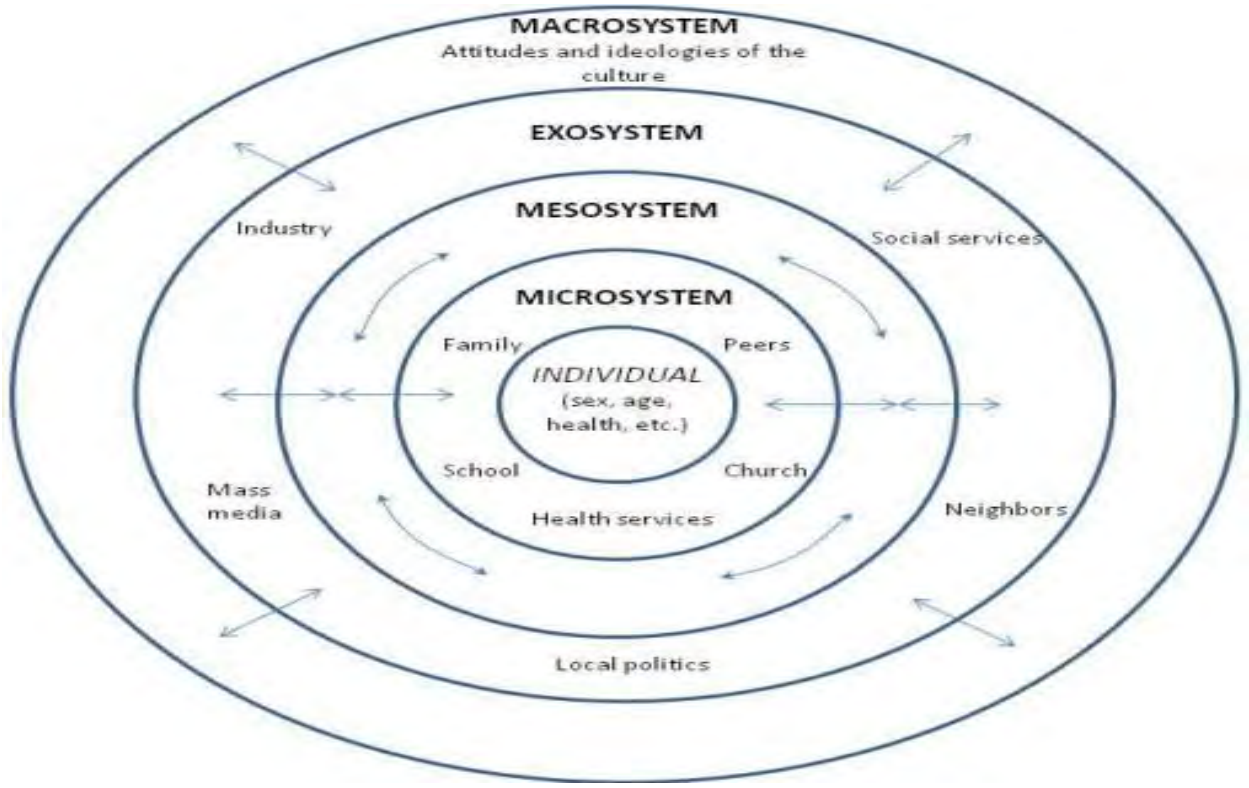
Whilst Systems Theory focuses on looking at the interrelatedness of the individual holistically, the Social Ecology Model focuses more on the individual in society, as it is the study of people in an environment and their inter-related influence on each other (Hawley 1950). Systems Theory is focuses on how the individual is moulded according to the norms of the family unit. According to Bowen (1978) in Systems Theory, members are expected to respond to each other in certain ways according to their role, which is determined by the manner in which they are related. He further explains that behaviour patterns of individual members of the family have an effect on the family unit.

The Social Ecology Model is a model that is all-inclusive for the understanding of human behaviour. It highlights that there are a variety of influences on human nature. It further emphasises that a human being is characterized by demographic characteristics such as sex, age and social economy, as well as psychographic characteristics such as personal knowledge, attitude and beliefs, but most of all by environmental factors (Bronfenbrenner 1979). All of these attributes contribute to how the individual makes decisions about their behaviour.

The Social Ecology Model (SEM) was used by Oetzel, Ting-Tooney and Rinderle (2006) who focused on communication, and identified SEM as the model that helps to establish the bigger picture to give insight into what influences individually-related decisions. In case of this study, the model will help highlight the influences that are linked to the decision-making that leads young women to consider backstreet abortions rather than the healthier decision to have a safe, legal abortion as provided at government hospitals.

Bronfenbrenner (1979) asserted that in order to understand human development, the entire ecological system in which growth occurs needs to be taken into account. The model looks at the individual in a holistic manner and attempts to ascertain how different external influences affect the social, psychological and emotional functioning of the individual. It should be noted that this model was initially created from Murray Bowen‘s (1978) theory that was created for use to predict children‘s behaviour after observing their behaviour with other individuals in the family itself and using those observations to gauge the child‘s interactions within the community.

Image 2: Urie Bronfenbrenner's Social Ecology Model



(Figure 2: Bronfenbrenner, 1979, copied from Wikimedia commons is *This work is licensed under the Creative Commons Attribution-ShareAlike 3.0 License.*)

Bronfenbrenner (1979) states that there are five levels of influence in the SEM, which are microsystems, mesosystems, exosystems, macrosystems, and chronosystems.

The microsystem

The microsystem is the level closest to the individual and contains the structures with which the person has direct contact. It comprises of the people and structures that the individual is in close contact with. It includes the immediate family, schools, religious organisations etc. The individual is influenced by these structures as well as exerts an influence on these structures. Family climate represents the bond young women may have with their parents, which may have a great deal of influence over their decisions, as young unmarried women may want to hide an unplanned pregnancy to avoid disappointing the parent. Albert Bandura, on the other hand, created the social learning theory that states that social behaviour is merely learned through

observing and imitating the actions of others. According to Bandura, these role models are an important source of behavioural change and learning new behaviour (Bandura 1986). As it is previously highlighted the microsystem as a sphere of influence is where young women are influenced by their family environment, which in this regard allows young women to look at the older women as their role models.

The mesosystem

Bronfenbrenner‘s concept of mesosytems refers to the relations between microsystems, or the connections between the individual‘s related contexts. This level examines, for example, the relationship of school experiences to church experiences, and family experiences to peer experiences. These might involve socio-economic factors (Dahlberg and Krug 2002). The mesosystem looks at the individual‘s intergration into society beyond the domestic sphere.

The exosystem

This system represents the larger formal or institutional structures that have an impact on the individual, but the individual often exerts very little if any, effect on the institutional structure. This could be viewed in terms of sometimes alienating manner that health care is provided, where bureaucracy supersedes the human connection in medical care –this affects the ways in which clinics are designed and managed, and how patients are processed and treated. The exosystem might include political influences, religion, what is promoted or communicated by mass media, as well the people with whom individual immediately interacts. In this system a person may not be actively involved but may still be influenced by the outcome of their applications (Bronfenbrenner 1979). The exosystem comprises of forces outside the individuals‘ immediate sphere of influence and interaction. It may pertain to government policies, trade union decisions, economic market decisions or other larger overarching institutional factors.

The macrosystem

Bronfenbrenner (1979) describes the macrosystem as the culture in which the individual lives in the community, where members of a cultural group share historical identity that in tied with their cultural values. This system unpacks the status of social networks in the community and how these impact on the health of an individual as well as their decision-making. The macrosystem in the context of this study of young women‘s conversation about abortion takes place in a semi-rural Zulu community where different kinds of influences, either urban or rural, cultural as well as

political are present. The research will examine the extent of these influences on participant‘s perceptions of abortion, and how they talk about it.

This may be explained by the theory of spirals of silence. The spiral of silence theory is reported to encourage fear of isolation for people who have transgressed society‘s rules, and then choose to keep quiet about unwelcomed ideas in the community. Therefore this indirectly perpetuates the culture of secrecy amongst people in the communities. Speaking up about problems or issues is not without risks but staying silent comes with its own set of potentially negative consequences for individuals (Milliken and Morrison 2003). Milliken and Morrison further argue that, not surprisingly, it appears that the decision to remain silent about issues or problems is fairly a common practice. Spirals of silence in this case operate at the level of macrosystems, where gender theory is linked, and this will be investigated in this research.

Gender theory highlights the fact that women are still influenced by patriarchy and gender stereotypes (Masinire 2013). Gender theory allows us to understand how issues of gender are seen and play out in the macrosystem. Gender roles play an important element in this study as the gender boundaries are never stable and complete; instead it is a contested order, subject to change (Potuchek 1992). Culturally, women are seen as child-bearers, therefore termination of pregnancy contradicts expected norms.

The macrosystematic concept of gender forms an over-arching means of socialisation for an individual. Both covert and overt guidelines and norms of behaviour are promoted by societal leaders and institutions to foster the acceptance of females that are submissive and meek in the face of patriarchal oppression. This imbalance of power in sexual politics is one of the factors that lead men to exploit women sexually, often leaving them with little economic or social recourse in the event of an unplanned pregnancy. Young vulnerable women then take drastic measures to abort the pregnancy (Connell 1987).

According to Charvet (1982) as well as McDowell and Pringel (1992) African women are socialised by highly patriarchal communities to be docile and subservient to the needs of males in the family and in the community. This entrenched imbalance of power-relations makes women vulnerable to exploitation from males to believe that they have ownership over the sexual availability of women. Women often feel intimidated and fearful about informing their

partners about unplanned pregnancies and indirectly contributes to the risk of undergoing an unsafe abortion than tell their partners (Khumalo & Garbus 2002).

The chronosystem

The chronosystem deals with the patterning of environmental events and transitions over a person‘s life-course, as well as their socio-historical circumstances (Bronfenbrenner 1979). In this system the young women can be forced or coerced by a situation over which she has no control. This situation might be poverty, which might influence intergenerational relationships; therefore if pregnancy took place the women might panic and choose backstreet[2] abortion as an alternative. In other instances where pregnancy is the result of rape or incest sometimes a woman cannot bring herself to carry the child full term due to the emotional and social trauma that will accompany such a task (Lathrop 1998). Elements within the chronosystem can be either external or internal, such as the history of failing relationships, or such as low self-esteem. Relationship dynamics are important as they occur within each system. Specifically, they have a powerful impact on how people respond to different situations.

Social learning theory

Bandura‘s (1986) Social Learning Theory highlights a few aspects that influences behavioural change which are attention, retention, reproductive and motivation. He further emphasizes that role-modelling and the need for acceptance might encourage young women to want to portray a false identity to their role models. In the context of this research, this may mean that young women keep secrets about unplanned or unwanted pregnancy, and this might influence the silence around abortion. This research will explore the level of influence of culture in this regard, to try and unpack the stereotypes around the influence of patriarchy in influencing young women on issues around sex and abortion. This study will also factor in the element of the lack of health resources, or poor service delivery in the communities, which might in turn have a direct influence on how young women reach dangerous health decisions in their communities.

The Social Ecology Model argues that a person is a co-dependant individual who is either influenced by the family, or community, or society, or the environment that s/he lives under – because a person isn‘t an island. Basically, the surroundings in the individual space have a direct impact on the decisions that will be made by that particular individual. In terms of

backstreet abortion these might be the underlying factors that influence the young women‘s decisions to opt for backstreet abortion, whereas legal abortion is available for free in public hospitals and clinics. The Social Ecology Model will assist the researcher in scrutinizing the different levels of influence which will in turn assist in identifying the contributing factors to young women‘s discussions and decisions about abortion.

Expanding on the Social Ecology Model

McLeroy et al. (1988) further describe the Social Ecology Model as delineating those multiple levels of influence that impact on an environment which has a direct impact on the individual behaviour and how the individual also impacts on the environment in which they live. McLeroy et al use ~~-in~~trapersonal factors” to relate to individual attitude, behaviours, knowledge and skills, which links to Bronfenbrenner‘s (1979) microsystems which looks at how the individual develops as an individual and establishes his or her own self-concept, self- identity, and how the environment influences the person.

McLeroy et al‘s ~~-in~~terpersonal factors” relate to processes such as social networks made of family, friends or colleagues that provide support, which is identical to Bronfenbrenner‘s mesosystem of the influences of family and peers, as well as age.

McLeroy et al (1988) further look at ~~-in~~stitutional factors”, which are similar to Bronfenbrenner‘s exosystems, as formal and informal organisations that may have rules, policies or prognostications that impact health behaviours. The resources that impact on the individual‘s life are also important, whether they are direct or indirect.

The ~~-c~~ommunity factors” identified by McLeroy are formal networks and norms among individuals, families, or groups or organisations. Whilst Bronfenbrenner (1979) studies macrosystems of how culture directly shapes an individual in a particular environment and how the environment is shaped by culture in a certain community.

The chronosystem highlights public policy such as laws or regulations that promote or inhibit certain health practices (Gregson et al. 2001). The chronosystem outlined by Bronfenbrenner (1980) looks at the actual environment, and whether it is conducive and supportive for

individuals that live in it; for example, which policies are in place, whether political or social, to assist in the well-being of those that live in a society.

The Social Ecology Model focuses on the influences exerted by external environmental stimuli on a human being. The primary principle is that people shape their environment and are shaped by it (Parker 2011). The result of these analyses on young women‘s practice of backstreet abortion and the fact that through these practices their lives are placed in high danger is highlighted. Bronfenbrenner (1980) further states that the principle of interconnectedness applies to the systems, as well as to the linkages between the systems, both in which the developing person participates and in which events occur that affect the person‘s immediate environment. SEM helps to identify the problems faced by individuals in the society by allowing for a holistic interpretation of their knowledge, attitudes and behaviour.

It will therefore allow for different methods to be used to help understand what might be the leading cause for young women to opt for backstreet abortion. In particular, it is anticipated that the mesosystem will carry a great deal of influence, and this will be examined to try to identify how the individual reaches decisions about abortion and what other underlying factors in relation to the family, society, resources and physical and internal environmental factors have influence.

Other theorists who have built on the Social Ecology Model argue that social influence is the effect that others have on the individual, and the effect groups have on attitude and behaviour (Berkman and Kawachi 2000). Berkman‘s conceptualisation suggests that social influences are exerted through social context, social networks, and groups, which mainly operate on social norms. If sexual engagements are a norm amongst some peers, the whole group will engage in unhealthy behaviour with dire consequences, just because it is acceptable. To some extent, this research will use the theory to understand if this kind of peer-pressure is instrumental in the way that young women think and talk about abortion.

Support for the health decisions of young women is necessary, because, according to Germain and Gitterman (1995:8), the relationship between the environment and the person is reciprocal in that each influences the other over time through multiple exchanges. The statistics for backstreet abortion in the UGu district indicate that young women are in dire need of support and information about where to get appropriate assistance that will not jeopardise their lives.

There are insufficient support services available to pregnant adolescents in some areas, and by improving support and facilitating access to support services, it would be possible for adolescents to adjust better to the stress related to pregnancy (Furstenberg 1976). This confirms the fact that through information and increased accessibility to young women, backstreet abortion might become the last option, and young women would use the services of safe abortions and dual protection instead.

There are lots of contributing and underlying factors to the individuals‘ behaviour that is highlighted by SEM which therefore makes it difficult to pinpoint what then exactly have a direct influence. Theorists who critique SEM argue that ~~-b~~ecause social ecology model incorporates everything in it, it is then too complex because it tends to overlook important aspects of the situation” (Watts et al. 2009). Watts et al. (2009) critique Bronfenbrenner‘s SEM theory noting that it is too wide and complex to narrow it down to an environment‘s impact on the individual. Watts et al argue that it is more than environment but introspection and self-evaluation that might impact on the environment as well as societal influences.

The same critique (Watts et al. 2009) argues further that the environment has nothing to do with the influences on a person, but it is nativism that plays a major role in how a person turns out as an individual. Louw (2001; Killian, 2004) highlight the fact that it is pointless to choose one over the other. According to these theorists they both play a major role. McLeroy argues further that even though other health theories are important, they are secondary to environmental influences (McLeroy 1988). The research will allow the researcher to understand how SEM is a useful way to understand what young women are talking about regarding abortion decisions.

At the level of the family, the parent‘s opinions on pregnancy before marriage might push young unmarried women who fall pregnant to choose abortion before their pregnancy status is discovered by their parents. At the community level, a lack of reliable and confidential health resources in the community might result in young women who experience unwanted pregnancies opting for backstreet abortion. At the societal level, social norms may dictate that young unmarried women opt for abortions in order to hide unplanned pregnancies. Some of these factors will be explored in this research. Since the Social Ecology Model takes into consideration all factors relating to an individual, it will help the researcher to understand how young women talk about these factors and their relation to decisions about abortion.

CHAPTER FOUR: METHODOLOGY

Introduction

This research applies a qualitative methodology. The qualitative research approach was used as a way to go beneath the surface of the sensitive issues relating to abortion. "Qualitative research is studying things in their natural settings, attempting to make sense of, or interpret, phenomenon in terms of the meanings people bring to them" (Biggam 2008).

Sotirios Sarantakos (2005) suggests that "qualitative research often goes beyond identifying the subject meaning and explores the process of constructing social situations and everyday structures that guide and explain personal views and opinions". This made it a useful methodology for my study, to explore how young women construct meaning around the issue of abortion and to find the link between what people say about abortion and the thinking behind backstreet abortion cases. Qualitative research is useful because the participants have great insight into the research topic as far as the community is concerned. Participants also have experience at first hand of the community they live in. Qualitative research allows for questioning that uncovers what this experience is.

Outline of the research questions

To remind the reader, the three key questions are:
1: How do young women talk about abortion?
2: Where do young women get information about abortion?
3: How do young women make decisions about abortion?

Hypothesis

The hypothesis is that young women's conversations about abortion are influenced by the community that they live in, and by the different levels of social influence that are outlined by the social ecology model. These models are microsystem, mesosystem, exosystem, chronosystem and macrosystem.

Research method

It was decided to use focus group discussions (FGD) to gather data on the topic of conversations about abortion. Focus group discussions are ~~a~~ group of people brought together for the purpose of the study guided by the researcher and addressed as a group. It explains trends, and variances, reasons, causes, attitudes and opinions" (Sarantakos 2005).

In these focus groups the researcher also observed the conversations among participants in order to gauge the participants' thoughts and understanding about abortion. Two focus group discussions were conducted; one in October 2013 and one in March 2014. The first focus group was conducted in Amahlongwa and it was made up of six participants. The second focus group that consisted of five participants was conducted in the Amandawe area, which is a few kilometres away from Amahlongwa. Both of these areas fall under the uGu District in KwaZulu-Natal. The discussions aimed to understand the attitudes and opinions that young women hold about the topic of abortion, and how they talk about this topic.

Sampling and research population

Young women were recruited for this research because during the community dialogues that were facilitated by DramAidE in 2011 on the issues of maternal and child health, participants reported that backstreet abortion was a contributing factor to the morbidity and mortality of young women in the area. The feedback on young women's conversation when dealing with unplanned or unwanted pregnancies that lead to them doing backstreet abortion is informed by community dialogues that were conducted in communities around KZN. The findings will assist this community in understanding what conversations are these that make young women choose unsafe abortion.

The participants in the qualitative research were self-sampling: both groups of young women, six in the first group and five in the second group volunteered to be part of the focus group discussions. This method was chosen as the most effective way to reduce bias. It seems to be quick and it provides the most reliable results (Biggam 2008). Self-sampling is a good way to get accurate information and makes it easy to draw conclusions about the community. These young women were aged between 18 and 24 and live in the area. Three of the participants were

still studying and the rest had left school. One participant had a child already and another one was pregnant.

The first self-selected group was drawn from a larger group of people who were at the Amahlongwa community centre to attend a community *imbizo* (gathering) on community development. To gather the participants for the first focus group discussion, the researcher spoke to the ward councillor, who is the gate-keeper for the community *imbizo*. The ward councillor ensured that at the beginning of the community *imbizo*, when announcements were made, he introduced the researcher and explained why she was there; he further reminded the community about the findings of the community dialogue that had been conducted in 2011 on maternal and child health which the researcher was also part of. He asked for participants to volunteer for the research and further explained that the researcher wanted six young women between the ages of 18 and 24. He then asked people willing to be part of the research to raise their hands and after that to meet the researcher in his office at half past twelve to start the interviewing session.

This office was part of the community hall where the *imbizo* was taking place. Due to the fact that there were a large number of people attending this event, a sound system was used. The resultant noise from the sound system made it impossible for the discussions to take place in the office organised for the interviews because the sound would disturb the whole interview recording.

Therefore the interviews were held outside the hall, under difficult conditions because of the heat of the sun (without any shade) and some wind. This outdoor setting had further challenges because people were passing by and loudly asking participants (whom they know in the area as friends, sisters or daughters) what the gathering was about and why were they not invited. This disturbed the recording which had to be stopped in the middle of the interviews to minimize interferences for the recorder whilst the interviews were continuing. These interruptions might have indirectly affected the girls and added to the fact that abortion is not a topic that is openly discussed. So the girls might have withdrawn from fully opening up and to be honest and straightforward with their answers during the interview session.

The second self-selecting group volunteered after a request that was placed on a notice board at the local crèche centre. Local people who usually frequent the crèche saw the notice and

informed their friends, daughters, sisters and aunts. Those who were interested registered their names with the local community care-giver, who was the contact person. She further facilitated a suitable time and date for all interested parties to gather at the local crèche for the interviews. The office in the crèche was used for the interviews, so that they took place in an organised and quiet environment.

Informed consent

The researcher explained the research topic to the participants. She explained that they were not being forced to participate and they could withdraw from the research at any time if they felt uncomfortable or lost interest. They were then given consent forms to sign in isiZulu to ensure that they fully understood and gave the researcher their permission to record the interview. (See Appendix A for the informed consent form.) They also chose pseudonyms to ensure confidentiality, so that they would be able to say things that they might not feel free or comfortable to say otherwise. This was also done to ensure that they could distance themselves from the sensitivity of the topic, which helped because when they responded it was not attached to the real person‘s name.

During the focus group interviews the researcher spoke in isiZulu. This was intended to demonstrate the researcher‘s authenticity, which meant the participants were comfortable and understood everything, since isiZulu is their first language. This was also done to ensure that when participants responded they fully understood the question and were also able to say exactly what they meant.

Structure of the discussion

The focus group discussions were based on three broad research questions, with the aim of finding out what constituted the conversations that might encourage young women to opt for backstreet abortion. These questions mainly focused on what young women say about abortion, who they talk to about abortion, and whether they are aware of the distinction between legal and backstreet abortion. They also explore the societal factors that influence young women‘s decisions to have or not to have abortion. These questions had sub-questions tha were designed to encourage the participants‘ engagement with the topic. (See Appendix B for the discussion-guiding questions.)

These research questions were guided by the Social Ecology Model (SEM) (Bronfenbrenner 1979) which will be used to analyse data collected during this study. As discussed above, the SEM argues that in order to understand the human development the entire ecological system in which growth occurs needs to be taken into account. Factors noted through the SEM which have a direct impact on an individual‘s behaviour are peers, parents and community at large (Dahlberg and Krug 2002).

Interview recording and transcription

The discussions were recorded so that the data gathered was safely stored. This also ensured that when the transcription of the discussion was done the researcher could easily relate the voice to the pseudonym given by each participant. The researcher listened to the recordings several times when doing transcription to ensure that the data was heard correctly. This was also to ensure that each and every response was noted and transcribed accurately.

The transcriptions were translated from isiZulu to English by the researcher. The researcher listened numerous times to ensure that all the narrated information is interpreted correctly.

Data analysis

The data was manually coded into three themes, which focused on what is said by young women about abortion, where they get information, and how they make decisions about abortion. These three themes were informed by the three main research questions in order to ensure that the data collected was in line with the research topic and covered all the contributing factors to the decisions made by young women about abortion.

Limitations of the research

The limitations of the research were around the topic under discussion, the circumstances of the data collection, and the sizes of the focus group.

Abortion itself is seen as a private topic for this community, which then made it difficult for the participants to respond openly during the discussion. To include a pregnant participant also made it a bit uncomfortable for that particular participant in terms of responding to other

questions about pregnancy and young women. More time together with the researcher before the discussion may have allowed the group to open up more as they became more comfortable with each other and with the researcher. However, this was not possible on the days of data collection.

In the instance of the first focus group discussion, another shortcoming was to do interviews on the community information-gathering event date. This created lots of confusion for the participants, since the interviews started later when the initial venue plan was found not to be conducive for the recordings. This problem was avoided in the second focus group discussion, where a more conducive environment was found for the discussion.

The size of the focus group discussion was small which made it difficult for the researcher to generalize from the findings. Amahlongwa and Amandawe are just small areas in the KZN province and that makes it difficult to look at the findings in a broader sense. If time had allowed, it would have been wise to look at two different districts in KZN as well as to do data triangulation, which might have allowed for greater observations to be made by the researcher.

CHAPTER FIVE: DATA PRESENTATION AND DISCUSSION

Two focus group discussions were conducted for this study, first one in October 2013 and the second one in February 2014. There were eleven young women who volunteered to participate in the study. All the participants resided at Amahlongwa and Amandawe in the uGu district. They were all between the ages of 18 and 24. Three of the participants were high school learners and the rest were youth out of school. One of the students was pregnant, and some of the participants had already had children of their own.

The researcher explained the method of the research and what it was about. After explaining the participants were also reminded that their participation is voluntary, they were not forced, and they could withdraw anytime in the research if they felt uncomfortable or lost interest, they were given the informed consent forms to sign. The issue of confidentiality was discussed, and each participant chose a pseudonym, as follows: Pretty, Thando, Nokubonga, Sibahle, Zodwa, Zama, Londi, Sne, Ntombi, Thembeka and Nonhle.

From observation, the topic of the research – discussions about abortion – was not an easy topic for the focus group participants to talk freely about. The participants were slow and reluctant to start responding to the questions. From the discussion after the interviews, it was apparent that abortion is a very sensitive issue to talk about. After the interviews most participants indicated that it was just difficult to talk about it because of their cultural and family upbringing.

The discussion was guided by specific questions, and the presentation of the data is discussed below, under the heading of each question.

Do you ever talk about abortion? What do you say about abortion?

The participants were asked whether they ever openly talk about abortion, and what they say about the topic. This question was aimed at finding out if abortion is an open topic to communicate about in community and to also try to find out what is said with relation to abortion.

Participants started by showing uneasiness to respond to this question and a few of them whispered amongst themselves. One commented quietly that: –No, we don‘t talk about abortion

unless we see someone who has done it". Even after they were asked by the researcher to say it loud for the recorder there was a long pause until the researcher read the question a couple of times and paraphrased it. The researcher had to emphasize that responding to the questions does not mean that you had actually had an abortion. After that had been confirmed, participants started to feel a little bit more at ease, even though, from observation, they were still not very open. Societal and community practices were obviously having a direct influence on how discussion about the issue of abortion is controlled in these communities.

The participants from the second focus group behaved in a similar manner to those in the first group by showing uneasiness when the topic of the research was mentioned. They also added that ~~"p~~people around here do not talk about such a topic in public because it's a disgrace. I'm sure even young people who have done it, will not tell other people because they might be gossiped about it and be laughed at" (Nonhle, FGD, 2014).

Another participant explained that abortion is generally a topic that the community avoid in all public spaces; this was even communicated through their body language. ~~"I~~have never heard of such a topic in the community even when there are community gatherings; people do not talk about abortion because it is a shameful topic" (Londi, FGD, 2014). Communities frown upon open discussion about the topic of abortion, which creates the culture of silence that indirectly creates a vacuum of reliable information on the topic, for young people especially. This silence makes one wonder how and where the youth of this community access factual information around sexual reproductive health which could somehow address the problems associated with backstreet abortion cases in this community, which are happening even though the community shy away from admitting it.

Most of the participants said that they thought abortion was wrong, and therefore they did not talk about it openly within their families. In both focus group discussions, participants moved away from answering the question at hand and started talking about cases that they have seen. This suggests that although they say abortion is not discussed, it is clear that it does become the topic of conversation and speculation when somebody in the community is assumed to have had an abortion. It also endorses the fact that if young people view abortion as wrong and unacceptable by the community, it might indirectly promote and encourage young women to opt for backstreet abortion in cases of unplanned pregnancy. One could also argue that this view

promotes the culture of silence around safe or unsafe abortion in the cases of unwanted pregnancies and the stigma attached to them.

Rather than reflect on how abortion was discussed, the participants gave their own elucidations and assumptions about abortion:

> My mother does not even believe in abortion. So even if you get pregnant by mistake she will always encourage that you keep the baby. She will even volunteer herself to assist you in caring for the baby. She once highlighted that if one of us do abortion it will be as if you have murdered a person and that is a big sin in our community. Because maybe that child is the only child that GOD has given you and then you go and kill it, she doesn‘t approve of abortion at all (Ntombi, FGD, 2014).

One respondent commented that abortion was ‗life-threatening‘: ―I say that we must stop doing abortion because it is very dangerous, you might end up putting yourself at risk of dying in the process" (Pretty, FGD, 2013).

The participants in the second focus group interview also responded to the question by bringing up abortion cases that they have seen or heard of from the neighbourhoods. They highlighted that this community views abortion as an unpardonable act that is equal to murder.

> ―Our community is very silent about abortion; even women who have done it they will pretend that they have never heard of it. Except for one girl that I know who tried to do abortion, she paid R500 to actually do abortion in some pretentious so-called doctor in Durban. However, it failed because the medication that she was given by the so-called doctor did not work. Apparently it never materialized and she gave birth to the child who is still alive, has grown up now and is even attending school. That is the only person I have ever heard actually talking and confessing that she tried to do abortion in my whole life. Most people keep it to themselves because once they tell someone they know that they will be the laughing stock of the community. They are afraid that maybe when they walk by in the neighborhood people will start gossiping about their abortion attempt or practice saying ―look at that one that killed an innocent baby" (Nonhle, FGD, 2014).

The responses from both interviews highlight the notion that abortion is taking place in this community irrespective of whether it is openly talked about or not. Therefore, this hidden issue

amongst community members contributes to a high rate of hidden backstreet abortion cases that can lead to an increase in maternal morbidity and deaths. In retrospect, young people lack the skills to communicate about issues of abortion and sexual reproductive rights in the community. That is coupled with a lack of appropriate resources to deal with the problems of unwanted and or unplanned pregnancies.

Surprisingly, after the uneasiness that was demonstrated by participants in responding to the first question, later in the discussion there was a major change. The participants opened up about their own experience of observing or helping friends who had had backstreet abortions. Highlighting, further that these participants were aware of the dangers of backstreet abortion; they even associated it with having a negative impact on their future lives. One participant talked about the risk of future fertility after having an abortion:

> I say it is wrong to abort because of the risk involved in your life, much later after abortion when you get married and you want to have children you might be unable to as the aborted child will not allow or will prevent other children to survive since s/he did not, that might prevent you from having children when you want to and ready for. So I say it is not right to do abortion (Zodwa, FGD, 2013).

In the second focus group discussion, participants re-iterated what the first groups commented on that from their perspective and according to their knowledge, there is really not much difference between safe abortion and backstreet abortion. Both groups highlighted myths and stereotypes around abortion. They also voiced an opinion that abortion, irrespective of whether it is legal or illegal, is just a dangerous act. Both focus group discussion participants associated abortion with ‗murder‘:

―It is the same, abortion is just murder whether it is safe or not; it is just killing an innocent soul, that‘s it" (Thembeka, FGD, 2014).

It is clear that young women put a lot of thought into abortion even though it is not openly talked about. They even link abortion to their traditional beliefs that it might cause future difficulties to conceive, including being infertile or a damaged womb unable to conceive when they are ready to have children, or when they are married. These young women further reported that abortion can damage the womb which can create fertility complications later in life.

> Abortion is never discussed at all in this community, I'm sure that promotes or pushes young women to be discreet about such issues. All that we know or been told is that sometimes when you have done abortion later you will not have kids when you are married. It is not a good thing because it might damage the womb (Nonhle, FGD, 2014).

This cultural belief might also have a direct link to the secrecy around abortion, since no one wants to be gossiped about if they have fertility problems in the future when they are known the community to have had an abortion. The comment also reflects lack of accurate knowledge about the possibilities for women who have had legal abortion that it is actually safe, they can fall pregnant and have children in the future.

The participants from the first focus group felt that there was no need to talk about abortion if young women used protection consistently to avoid getting pregnant.

> We need to stop doing abortion since when you have sex without a condom or any protection you do that knowing very well that you might get pregnant. As a woman it is given that if if you are sexually active and you are not using protection you might have a baby and a baby is just a blessing it is not something you just take out when it suits you (Sibahle, FGD, 2013).

The religious belief of the community and young women, that a child is a blessing, simply highlights the notion that for them using contraceptives as prevention is not acceptable, since it might limit your blessings. In the second focus group this was also brought up by the majority of participants.

> My mother does not talk about abortion at all because she views it as a disgrace to the community. So the majority of our parents do not approve of abortion at all because they believe that a child is a blessing from God, so you cannot decide to kill such a blessing. She also doesn't encourage us to take contraceptives simply because she believes that pills and injections might kill the only child (Thembeka, FGD, 2014).

The above statement seems to contradict the previous reports that abortion cases are taking place in this community. If there are young women who strongly believe that a child is ~~a~~ gift from God", why then do they abort it? This might therefore suggest that they do not appreciate the ~~g~~ift". It might also indicate that sexual prevention measures are not taken seriously because they work against the beliefs of the community that a child is a blessing'. The rate of

pregnancies also suggests that having a child at an early age or out of wedlock is normal. This might have a direct link to why the subject of abortion is taboo.

Some of these participants‘ comments highlight that they were anti-abortion themselves because they looked at the unborn child as a relief from a dire situation. Their belief that the child might make a positive contribution to life made one participant comment that she was against abortion irrespective of it being legal or backstreet:

> My opinion is that abortion is not a good thing because sooner or later when you are a girl and you are sexual active you will get a child, maybe when it grows up it will do good things for you that you couldn‘t have powers to do them for yourself (Nokubonga, FGD, 2013).

Traditional beliefs play a major role in young people‘s decision-making processes; this makes it clear that a child is seen as a lucky charm to change the poor conditions of some families or parents. Young women will look at the opportunity to change the negative situation by having unsafe sex with the hope of conceiving in the process.

Some of the responses also gave an indication that religious beliefs play an important factor in opinions about abortion, and how young women would advise each other against abortion:

> No we don‘t talk about it but every now and then amongst us we advise each other about it, because sometimes we see a girl that was pregnant and after sometime she is not and then we suspect that she aborted the child. That‘s when we talk about it, advising each other not to abort because a child is a blessing (Zama; FGD, 2013).

The participants from the second interview supported the above statement as the contributing reason as to why people in the community do not talk openly about abortion.

> I have heard that a young woman got sick because of the concoctions she took when she was trying to abort, but it was late because the foetus had grown so much. They reported that after abortion you could see that the baby is a girl. She was even lucky that they both survived because her friends took her to hospital in time and she got help. The mother and the baby were both given oxygen, otherwise they were going to die. The other case was more or less the same but different, where the other mother attempted to do abortion alone at home and when there were complications there was no one to take

her to help her or take her to hospital. She was the only who survived the baby did not make it (Londi, FGD, 2014).

Despite this pervasive feeling, there was an indication in the group that there were times that abortion was ~~"u~~navoidable", but participants felt it was still not morally justifiable:

> Sometimes you do abortion just because you did not plan to get pregnant or you were raped or you are not well but still it is not right. Abortion is not okay but sometimes parents do advise their kids to go to doctors for abortion (Thando, FGD, 2013).

This also highlighted that there are sexual abuse cases taking place in the area and sometimes the perpetrators put pressure on young women who have been victimised to opt for abortion even if they do not believe in it. The contradiction in the report is that parents are silent about abortion; however this report suggests that when they are desperate they do advise their daughters to opt for abortion.

One participant talked about the fact that abortion is a sensitive topic. When they suspect that someone in the community has tried and had unsuccessful abortion attempt or had complications, this person becomes the laughing stock of the community.

> Yes we do talk about abortion. In my homestead, girls are always doing abortion and then we talk about it, advising each other not to do it because it is wrong. Sometimes we see you in the streets and you are now not what you used to be and people laugh at you as if you have gone crazy whilst you just had abortion. Then we advise each other using you as an example not to do abortion (Nokubonga, FGD, 2013).

The participants from the second focus group interview also reported that sometimes young people do gossip amongst themselves when they suspect that another young woman is pregnant or has had an abortion.

> Sometimes when you are young and sexual [sic] active pregnancy happens by mistake and then you abort before people find out. I know of young people who got pregnant by mistake and they aborted. Sometimes they share that with their close friends who after abortion will gossip behind their back about the friend who did abortion and then they laugh at you behind your back. Eventually your secret will end up known by everyone here at Amandawe. Even if the gossiping friend is the one who did abortion first and she

was the one who suggested that you do abortion but she will be the one gossiping about your case pretending to be innocent (Nonhle, FGD, 2014).

The other participant added to the above statement, indicating that actually abortion is sometimes talked or gossiped about:

> Most times we young people influence each other to experiment things. Because there is no guidance often young people end up getting pregnant. Friends will usually advise the unfortunate friend to do abortion as the first option before parents find out about the pregnancy (Londi, FGD, 2014).

It was very interesting to note that there was lots of contradiction between this statement and the beginning of the interviews, where participants reported that abortion is not an open topic for discussion in their communities. As the interview continued, participants reported that they sometimes do talk about abortion and parents sometimes advise young women to do abortions. The participants from the second focus group interview also highlighted that it‘s not talked about but it‘s also talked about‘. They further alluded to other contributing reasons for young women to choose backstreet abortion.

The above comments also highlighted other contradictions, in that some instances some do abort and yet they advise others not to. So this suggests that sometimes the community is divided, or has two sets of standards: if you have done it, it is okay, and if you haven‘t, you will be advised against it. Participants‘ comments helped to differentiate the ways in which abortion is talked about. Generally, it is not openly ―talked about‖; instead it is usually discussed through gossip or when the going gets tough.

> Yes we do gossip about it, especially when we see a pregnant girl and next time we see her and that the pregnancy is gone. We do sit down and talk about it – that she has aborted the pregnancy and she is thinking that we do not know (Sibahle, FGD, 2013).

This finding shows that gossiping behind the back of a pregnant young woman encourages backstreet abortion, even in the ones who are themselves gossipers to avoid to be gossiped about in the future. The participants‘ comments help shed the light on why some women opt for unsafe or back street abortion. Those who are suspected of having aborted are gossiped about. The consequence of this is that silence around the matter is inadvertently encouraged and unsafe abortion options are chosen. Even the gossipers are likely to choose this option because they already know what people will say.

What does your community say about abortion?

This question was designed to highlight the role of the community in talking about abortion in this area.

Participants were very eager to respond in order to emphasise that the community has a direct impact on the increase of cases of abortion. The researcher noted that all participants had something to say, which pointed to the community‘s influence on abortion.

One participant noted that the community has a big role to play in matters of sexual reproductive health for the public. There is a lack of open communication about abortion, but the culture of gossip can leave young unmarried women with indirect pressure to opt for backstreet abortion to avoid being gossiped about. Participants from the second group were very adamant in saying the community does not talk about abortion. They alluded further to the fact that it is seen as shameful and also that it is not acceptable to even be seen or heard talking about abortion. Young women from the focus group interviews reported that ―when community members especially adults suspect that you are linked or know about abortion they advise their children to stay away from you because you are labeled loose with no morals” (Ntombi, FGD, 2014).

Another participant commented that young people will pretend to be innocent to avoid being labelled negatively or stigmatized by the community. ―Sometimes young women feel that they are still young to fall pregnant. It‘s going to be a disgrace to the community and then they choose abortion to avoid being seen pregnant and most times its backstreet abortion. They do abortion secretly and ensuring that no one finds out” (Sne, FGD, 2014).

Other participants highlighted that there is not much said by community members in terms of abortion. However, they recognise that the gossip that surrounds this silence forces young women to opt for backstreet abortion in their time of need.

> The community do pressurize young people because if they suspect that you are pregnant, instead of advising the young pregnant woman they gossip about her. Yet there is nothing that they do to ensure that abortion does not take place in their communities. Our parents are even very shy to talk about sex with us young people and when young people ask questions about it they become angry (Sibahle, FGD, 2013).

Bronfenbrenner (1979) maintains that cultural norms of the community and society tend to have considerable influence on everyday interaction in terms of the individual‘s behaviour. Society indirectly sends messages that teenage pregnancy as well as abortion is unacceptable. This therefore makes it challenging for young people to divulge their status to their community when they are pregnant, and consequently they seek backstreet abortion as a preferred option. The fact that abortion is a secret and unaccepted by the community means young sexually-active women try by all means to avoid being talked or gossiped about. Abortion therefore becomes an easy solution to avoid any added stress.

Others elaborated on the perception that:

> The community is forcing young women to do abortion because when they see a young girl especially that attends school being pregnant they gossip and scold that girl saying ~~-w~~hy did you get pregnant, you like sleeping around with men?”. The girl realises that she did something wrong which then leads to the young girl having abortion (Pretty, FGD, 2013).

Unwanted and unplanned pregnancies leave young women with the shame of being pregnant at a young age, particularly for school- going girls, and this shame might encourage them to opt for abortion rather than being chastised. The comment about ~~-li~~ke sleeping with men” also suggests that there may be instances where these young girls are involved with ~~-s~~ugar daddies” (older men who give girls money or gifts in exchange for sexual favours), which may add to their shame.

The stigma that is linked to termination of pregnancy in such communities makes it difficult for young people to get good advice from older people, including parents and educators. The role of educators indirectly playing an influential role in the decision to have backstreet abortions was highlighted when participants suggested that the way educators try hard to discourage teenage pregnancy, and in the process they may inadvertently promote backstreet abortion.

One participant commented:

> Sometimes they scold and point at young pregnant women in front of other learners, saying that ~~-y~~ou are very young but you opened your legs to sleep with men and look at you, now you are pregnant”. The young woman feels embarrassed and ends up doing abortion (Zodwa, FGD, 2013).

The participant from the second focus group discussions added her comments that the community is very silent but they usually blame the young woman for negligence in prevention.

> The community does not take you as someone who behaves well if you do abortion. They gossip up your case and do not even trust that you will ever go through pregnancy full time in the future they see you pregnant because they think you are going to do abortion again. They also do not understand why you choose abortion in the first place because when you were engaging in unsafe sex you should have known that you might fall pregnant. Then when you fall pregnant you do abortion, therefore it is totally unacceptable (Thembeka, FGD, 2014).

It is clear from these comments that teenage pregnancy is frowned upon in the community, rather than discouraging pre-marital sex or unprotected sex. Instead of encouraging young women to use contraceptives to avoid getting pregnant; the participants felt that this community censure results in a higher rate of abortion.

What do your parents say about abortion?

The participants were asked whether abortion was ever discussed with parents, so that the researcher could understand the influence on young people‘s discussions about abortion from this source. In most responses the participants highlighted that parents, as part of the community, sometimes do pressurise young women to have an abortion. They commented that sometimes parents will see the pregnancy as an added responsibility, and advise their young pregnant daughter to have an abortion.

> The community says nothing but sometimes the mother advises that ~~“m~~my child you must do abortion because the living standards are not okay here at home”. On the other hand to cover the shame that will be brought by the pregnancy especially when the girl does not know who the father of the unborn child is, then the mother advises the girl to abort or gives the girl something to consume in order to have abortion (Nokubonga, FGD, 2013).

Participants from the second focus group interview reported cruelty in the way the community responds to abortion.

> The community will just laugh at you and gossip about your behaviour. Even if you did it once, but they will always quote that incidence that paints you as a bad person or they

> label you as a killer. They will even associate the abortion incidence with your family members as if they are the ones who told you to do abortion. They will not even console you but they will just laugh in your face. At the end your whole family will suffer because they will be ostracized by the community (Londi, FGD, 2014).

This above statement reinforces the core reasons that might prevent open conversations on unwanted pregnancies and abortion in these communities. Young women will be indirectly encouraged to keep silent by the length of gossiping in the community reciting the way young women who have previously had an abortion was treated.

There were many reasons highlighted as contributing factors in parents encouraging children to have an abortion, including economic reasons and not to bring shame to the family. This also contradicts the previous responses, when the baby was highlighted as a blessing, whilst in another response the pregnancy was seen as a chance or a lucky charm to better the poor condition of some homes or families.

> Some parents are the ones who force young women to do abortion in places where it‘s done because sometimes in other homes they might be struggling so when you get pregnant it‘s like you are adding or increasing the number of mouths to feed so this then pushes the parent to rather encourage the young woman to do abortion (Zama, FGD, 2013).

It is noted in other studies that the economic status has a direct link to abortion in situations of poverty. Families that are struggling financially are most times likely to take a chance to view abortion as an option. Nowadays caring for a baby is costly and when the family is struggling it looks at the unborn child as an addition to poverty.

The participants also felt that parents had high moral standards or high expectations for their children, and this might indirectly influence their children to have an abortion to avoid humiliation in the community and embarrassing their parents:

> Some parents are okay with young women doing abortion because sometimes they feel that the pregnant young woman brings shame to the family by getting pregnant, so they encourage young woman to do abortion. However, some parents are aware that no child will die of hunger so they just accept the shame brought to the family by the young woman (Sibahle, FGD, 2013).

One participant highlighted sexual violence and rape of a girl by a parent, and suggested that this was another reason that might encourage mothers to force her daughter to have an abortion:

When your father rapes you and when you mistakenly get pregnant you will be forced to do abortion because your mother will not believe that it‘s your father who abused you (Thando, FGD, 2013).

This also confirms the secrecy in the community not only about abortion issues, but also about rape and incest cases. In South Africa, rape and sexual coercion form one part of the broader problem of gender-based violence, which in turn is heavily influenced by a general culture of violence which pervades society. Research on domestic violence has found that a quarter of women have been beaten by an intimate partner. The problem of rape in South Africa has to be understood within the context of the very substantial gender power inequalities which pervade society. Rape like domestic violence, is both a manifestation of male dominance over women and an assertion of that position. In relationships of dependency, women find it very difficult to protect themselves from sexual exploitation and very often have to tolerate abuse (Asay et al., 2013).

In communities where patriarchy is prominent, women might in turn be paralysed from taking action or reacting to violent situations, even if these situations might endanger their children. Simply because they were raised to be subservient and reliant on men, this then prevents women from reporting these cases because their husbands might be thrown into jail and they will be left to suffer to make ends meet. They are frightened to choose the child over their man because to them it will be a challenge to survive without the support of a man. This then makes these women to turn a blind eye to the ills committed by the father. The shame that is associated with incest appears to indirectly make these young women choose abortion to shy away from the actual problem.

What do other young people say about abortion?

This question was aimed at uncovering what is being said by other young people about abortion, and at investigating how social networks may impact on discussions about abortion. It appears that the culture of secrecy as far as abortion is concerned sometimes creates tension and lots of gossip which spirals tension and fights in the area.

> Most young people gossip about you when they see that the other young woman is pregnant. They do not approach the pregnant woman but gossip about her in such a way that it causes tension between siblings and there will be fights amongst them. So that is wrong because they just gossip (Zama, FGD, 2013).

Despite recognising that gossip is harmful, all these participants also noted that they themselves participate in this kind of talk or gossip about other young women who have abortions.

Ncube (2009) highlights that sometimes young people engage in unsafe sex knowing the risks involved because they know that they can have abortion as an ~~-e~~scape route". This is acknowledged by one of the participants:

> I have heard that many young people do unsafe abortion because they feel that carrying pregnancy to full term will stop them enjoying life. Sometimes that particular young woman feels that choosing to do abortion is the only solution of dealing with the problem at hand. But I have never heard that from friends that I know, only hearsays from the community that sometimes other young girls do that. Even in my closest group of friends it is not an open topic we discuss but I would also not completely say they (friends) have never done abortion (Londi, FGD, 2014).

Another participant highlighted that there are lots of issues around the role of young people especially women in the abortion issue. The element of one night stands and multiple concurrent relationships was also highlighted when the participants noted that sometimes young pregnant woman might not know who the father of the child is.

> We young women we first sit and plan for the abortion with a friend, but after abortion we young people just gossip about the friend's pregnancy. Instead of advising they pressurise you. They will sometimes advise other young women to do abortion if the father is not known by the pregnant woman or if the father is unemployed, old or married (Thando, FGD, 2013).

This question of young people's communication on abortion seemed to be one that created tension in the group. They were uncomfortably quiet and showing unwillingness to respond to it. There might be lots of underlying reasons for this feeling since the above comment highlights lots of concerns in relation to the young people's sexual behaviour. The other reason might be that it was questioning their integrity, their secrecy and role around abortion, or it might be that they were afraid to acknowledge their involvement in this issue. The element and impressions of

their social networks exacerbates the negativity that might eventually promote abortion. After the focus group interview the researcher asked the participants about this. The participants did highlight the fact they were uncomfortable with responding to such a private topic, suggesting that even amongst their own peers there is secrecy on the topic.

Do you know the difference between legal abortion and backstreet abortion?

This question was designed to establish whether young women are aware of the distinction between legal and backstreet abortion.

It was noted at first that some participants looked confused and lost. This might have been fuelled by the fact that some participants never thought there was any difference in the first place. The participants did not differentiate between legal and backstreet abortions, but immediately said that abortion is dangerous. Their comments incidentally confirm that backstreet abortions are happening in the area, and that young women are aware that it is dangerous:

> Abortion is the same whether legal or backstreet, so for me I think abortion is abortion and it is not a right decision to do abortion. If you give birth to a fatherless child the government have support grants. So in the case of unplanned pregnancy nowadays there is really no need to abort because a baby is just a blessing so there is no need and once you are pregnant you need to just accept (Nokubonga, FGD, 2013).

This above comment suggests again a strong morality in terms of abortion in the community, coupled with a feeling that the economic arguments for abortion in cases of unintended pregnancies are not valid enough in the context of abortion because of availability of social grants for those young unemployed women with children.

One participant honestly confessed her ignorance of the difference between legal and backstreet abortion:

> I did not know that there was any difference, but what I know is that when you do abortion on your own without going to the clinic or hospital you can die or have a serious complication for the rest of your life that‘s all that I know (Sibahle, FGD, 2013).

Participants from the second focus group interview also showed little understanding of the difference between legal abortion and backstreet abortion. They all shook their heads and showed support for one participant‘s comment who bravely said ~~–~~It is the same abortion is just

killing whether it is safe or not it is just killing finish" (Thembeka, FGD, 2014). Another participant further agreed with the above statement that ~~"~~it is definitely the same whether safe or unsafe it is just killing" (Sne, FGD, 2014). These comments reflect a moral position rather than an understanding of the difference between the practiced procedures themselves.

It was a serious concern that in both of the groups, a total of only three participants understood that there was a difference between legal and backstreet abortion, because if they cannot make sense of the important differences between the two they will not know that legal abortions are associated with safety, as they are carried out under clean settings with proper equipment, supervision and management. Whereas this may not always be the case in the backstreet abortion since safety is not really a concern. This lack of knowledge amongst young women might encourage others to use dangerous methods to abort an unwanted pregnancy whilst jeopardising their own lives in the process.

The participants from the second focus group suggested that marketing for backstreet abortion might be misleading young women into thinking it is a safe and legal process.

> Others choose backstreet abortion not knowing that it is not legal because when they give you, these flyers in the street they are written that its safe abortion done by a particular doctor for a specific amount. So this sounds safe and legal, it is really confusing and so when they see that it is a doctor who is going to do abortion to them they than think it is safe. So therefore you do not tell yourself that it is illegal and not safe. You feel at ease most often that at least it's a professional person who is handling my problem. Sometimes young women are scared of the shameful act of abortion so they choose to hide it from parents and community members. In most of these backstreet abortion places they do not care to ask you any reasons why you want to do abortion in the first, second or third place. No matter how many times you go back there they just take your money and give you pills that is it. Sometimes after taking this medication you get sick and then therefore you are forced to disclose that you did abortion (Londi, FGD, 2014).

Where participants did know the difference, cultural traditions around death and burial seemed to impact on their understanding of what was ~~"~~right" or ~~"~~wrong" about abortion.

> The difference is that in places like Durban or in well-developed places there is information on the street that says in one hour or two hours you can be done with

> abortion. Whilst in public hospitals they do not market CTOP that it is safely monitored under a professional doctor‘s supervision and when the foetus comes out they ensure that it‘s buried whilst in backstreet abortion they just throw it in the dustbin, it is never given a decent burial (Zama, FGD, 2013).

This suggests that the strong cultural beliefs in the community may have an enormous impact on decision-making about abortion. However the contradiction is that the proliferation of back street abortions suggests that these cultural and religious beliefs about a ~~-d~~decent burial" are not sufficient to encourage young people to opt for a safe, or legal, abortion or it might be lack of knowledge with regards to CTOP.

There was also a distinction made about the after-care provided with a safe and legal abortion:

> If you do backstreet abortion at home you can get sick without help, also you do not have the cleaning process equipments or the know how of profuse bleeding, whilst in the hospital they take care of you and when there are complications you can go back to hospital and they assist you (Sibahle, FGD, 2013).

This recognition of safe after-care is supposed to be a vital piece of knowledge to prevent young women from being at risk after a botched back-street abortion.

Most people do not know that safe abortion in hospitals is free and most participants reported that this information is not visible especially for young people in their community. Some people do not even know that CTOP is safe and freely available because abortion in many communities is seen as a shameful thing. Therefore, this gap of information makes people think that the posters that they see on street corners advertising the quickest way to have an abortion is the right one, not knowing that actually it is not safe.

Have you seen or heard any information about backstreet abortion?

This question was designed to establish out whether information on backstreet abortion is available to young people. Participants‘ responses focused on what they heard in their neighbourhood about backstreet abortion:

> In our neighbourhood a young woman who fell pregnant and did not know that she was pregnant with twins did backstreet abortion. In the process only one twin was aborted the other one was left inside the womb and she than had serious complications, when she was taken to hospital she lied that she miscarried because the baby was growing in

> the wrong tube. But when at hospital they kept on asking lots of questions she was than forced to tell the truth and then confessed that she did backstreet abortion and one child came out dead and the other was left inside the womb (Nokubonga, FGD, 2013).

This detailed but rather confused story suggests that this case was the topic of neighbourhood gossip, and that despite the participants saying that abortion is not discussed in detail, there are clearly gossip cases where it is.

Since the participants suggested that abortion was mostly discussed in the realm of gossip, one participant confirmed this:

> I did hear that one girl from my neighbourhood went to her neighbour‘s house to ask for pills and took those them, she lied when she was asked why does she want pills, she said that she wants to clean the womb. She didn‘t disclose that she was actually pregnant and after taking those pills she aborted the baby. When she was asked she lied saying she was not pregnant she was just having urinary problems whilst she knew that she was pregnant (Nokubonga, FGD, 2013).

This comment shows how easy it is for young women to get medications and concoctions that they use for illegal abortion instead of just going to the hospital and accessing legal abortion.

Another participant spoke of a personal experience of helping a friend through an abortion ordeal:

> I personally saw my friend doing abortion; when she was at the toilet she aborted; there was a protuberance from her vagina when she was sitting on the toilet seat and she couldn‘t stand up that‘s when she called me that I must rush to her place because she needs my help. When I got there she then first lied that she has a miscarriage forgetting that a day before she told me that she wanted to do abortion. When I reminded her she admitted that ―did abortion yesterday, I drank jeyes fluid”. Then I told her mother who approached her and she confessed. The mother later took her to the doctor but it was too late, the foetus was already out (Thando, FGD, 2013).

This comment suggests that when there is a health risk or a health emergency associated with abortion, young women do recognise the need to talk to a parent or other adult and get advice or help from them, but only after they have attempted to hide the process by undertaking unsafe abortion.

Who do young people talk to about abortion?

This question was meant to establish at what social level conversations about abortion happen.

Participants highlighted that young people talk amongst themselves about abortion, but that this is without proper guidance. They noted that sometimes they encourage others to have an abortion because they prioritise fun, dating and partying first when weighing the options about whether or not to continue with a pregnancy. "They encourage one another to abort because having a baby will be a burden; they will not enjoy life since the baby will take up most of their time. So they just encourage one another to do abortion" (Zodwa, FGD, 2013).

They also commented on the fact that while some young women discussed the option with their friends, there are others who make decisions about abortion on their own, maybe trying to avoid being the topic of gossip amongst their peers: "Some young women talk with their friends and some take those decisions all by themselves secretly" (Sibahle, FGD, 2013).

There may be a number of reasons for this secrecy, and it serves to increase the culture of silence and taboo around abortion that some women are willing to take such drastic steps or dangerous things all by themselves.

Other participants said that young women sometimes involve their parents when deciding what to do about an unwanted pregnancy: "Some talk to friends whilst some discuss that with their parents and end up doing abortions" (Nokubonga, FGD, 2013).

Even though some young women have abortions, it is apparent that very few do inform their parents about the issue.

Participants also agreed that there were some young women who talked about abortion with their boyfriends, but they did not comment on this in depth.

After clarifying that abortion was indeed spoken about at different social levels and in different groups, the participants were asked about sources of information on both legal and backstreet abortion.

Have you seen or heard information about legal abortion in hospitals or clinics?

This question was designed to find out whether Choice on Termination of Pregnancy or legal abortion is publicised and how young women access information about it.

Participants seemed to take their time answering this question, and after repeating the question the researcher ended up trying to find out whether they visit local clinics and hospitals, and whether they had seen any information there. The researcher had to rephrase the question a couple of times before they responded, and even when they did respond they were hesitant. This silence may be indicative of the fact that young women either have not been to clincs or hospitals where abortion is offered, do not know about CTOP or do not want to be seen by their peers to have accessed these services.

After some prompting, one participant acknowledged that there is some information about abortion in the public health facilities: ~~I~~can say I have seen it in J.G. Crookes that there is legal abortion, there are posters that tell you that there is a doctor that will assist you in doing abortion" (Nokubonga, FGD, 2013).

The fact that only one participant mentioned that there was information on legal abortion in the only local hospital explained the part of their reluctance to respond. This might indicate that the mobile clinics which frequent the community do not have the focus on information of safe legal abortion or that young people are ignorant. So therefore if you have never been to the hospital, you would not know about CTOP, and the fact that it is a free, safe and legal option.

This participant did note that information on legal abortion was at a local hospital, but the fact the she hesitated before responding shows that they are not confident about what they have noted.

Another participant's response highlighted that even if the information on legal abortion is available in public health facilities, it is not clearly unpacked: ~~I~~'ve seen it but I'm not sure that they really do abortion" (Zama, FGD, 2013). This suggests a certain amount of distrust in the provision of care offered by government health services.

Health institutions need to put rigorous effort into marketing information on CTOP clearly and visibly because this above comment indicates that even after reading about abortion, since it is a sensitive topic, people might be afraid to ask for clarity. This leaves them unsure, and they will not access help even if it is freely there for them to use.

The other participant, after a long silence, commented that some people hadn‘t accessed the information: ―I haven‘t seen any information when I‘m in hospitals‖ (Thando, FGD, 2013).

This highlights the lack of visibility of CTOP information for clients and targeted audience.

Another participant noted: ―I have never seen it but I have heard that there are places in hospitals where they do abortions. I have never seen it only heard through hearsays‖ (Sibahle, FGD, 2013).

Participants from the second focus group discussion seemed to struggle with the same notion of a lack of information on the Choice on Termination of Pregnancy Act at their local health facilities.

> Sometimes you see someone pregnant and later there is nothing and people in the community will suspect that she did abortion. Sometimes other young women will lie and say they got miscarriage but this thing is really dangerous it makes these women seriously sick and sometimes they even die. The other person I know died after doing abortion where she drank poisonous concoctions. Sometimes it is because they are guilty that they killed someone and now they don‘t feel free knowing that they are murderers and they might never be accepted by the very same community they live in (Sne, FGD, 2014).

This comment shows that information on termination of pregnancy is very scarce or not visible in local health facilities, yet according to Act 96 it is supposed to be available in hospitals and local clinics. This lack of information on TOP creates a barrier for clients in terms of accessing it.

Have you seen or heard information about backstreet abortion?

This question was meant to discover whether information on backstreet abortion is accessible to these young women as they represent the target audience. The participants were very eager to share, and it was clear that they all had something to say, either about information they had seen or heard, or – more – on known cases of abortion.

> I have actually seen the girl from my neighbourhood who tried to abort and failed. She got sick for a long time and she lost lots of weight and ended admitting to attempting abortion. I have also seen information in the newspapers and street poles; even when you in town eMzinto people will be giving you pamphlets about traditional healers who

> can give you *izimbiza* [traditional medicines] that they can do quick abortion (Nokubonga, FGD, 2013).

Most participants confirmed that they had seen backstreet abortion advertised widely and were willing to share where they had seen or heard about backstreet abortion: ~~I~~have seen posters in the street corners in town that in certain building, floor so-and-so there are doctors who help those who want to do abortion" (Zama, FGD, 2013).

The participants from the second focus group re-iterated statements that were made in the first focus group discussion.

> These few years I have been studying in Mzinto. There are people there who just distribute pamphlets and they do not tell you what it is about and sometimes you just take without reading it. When you are at home alone you realize that it is actually about abortion information. Maybe you are with a friend and you both see that the pamphlet is about abortion. Sometimes when by mistake you fall pregnant and you become desperate you then recall that information on abortion that you have mistakenly read about in the papers. Then you sometimes go to the places like Durban or other big cities that were mentioned to take care of this pregnancy. What is interesting is that in these pamphlets they say it is safe and that this abortion is done by doctor so-and-so. Sometimes other young women will choose to go to the traditional healers and get *imbiza* [traditional mixtures] to quietly get rid of the unknown pregnancy (Londi, FGD, 2014).

The spiral of silence around issues of abortion is clear, as the topic was recognised as a major source of secrecy, and the reason that these young women choose a more easily accessible and better-advertised backstreet abortion services as their only option to hide pregnancy.

> Peers sometimes share such information on backstreet abortion with their close friends. For example if you tell your friend that you are in a dilemma and you don't know what to do. The friend will sometimes share her own experience that when she was in the same problem she did this and that to eliminate the pregnancy and ensuring you that you will be okay. This continues to you as well; if someone in the circle of friends has the same problem in the future you then share and advice from your own experience (Nonhle, FGD, 2014).

The above comments demonstrate one reason why there are so many backstreet abortion cases: this concept is highly marketed, it is there in people‘s faces, which makes it easier to opt for it in desperation.

Complications from backstreet abortion were the highlight of this strand of conversation, which was surprising since participants were so shy in the beginning to talk about abortion. This clearly confirms normality in the culture of gossip that is hidden behind abortion and that abortion cases and complications are difficult to keep in the dark because the reality of their existence is in front of everyone.

> Yes I have seen it from the girl at school who did abortion and later had a problem that every time when she goes to the toilet she will be in excruciating pain as she couldn‘t walk straight, she told us that she had abortion and ended up with this problem (Sibahle, FGD, 2013).

Everyone seemed to have something to share about the consequences of having backstreet abortion. This sudden interest in opening up might have been the fact that most participants were sharing first-hand information of what they had seen, not heard: ―have seen it. The girl at school who did abortion ended up wearing pampers because she bled profusely non-stop after abortion and the panty alone with normal pads was not helping” (Zodwa, FGD, 2013).

These accounts may be the result of local gossip that is shared amongst young women in the community, and this might suggest that they become cautionary tales for girls about the dangers of abortion.

The different versions of what is written about abortion, and the different concoctions that are written about in the newspapers, were also shared amongst participants: ―have read about it in the newspapers that if you take a certain *imbiza* [traditional mixture] it will help you to do abortion quickly” (Zodwa, FGD, 2013).

Participants from the second focus group also lamented to the fact that information on backstreet abortion is always visible, compared to safe abortion.

> I have also never seen it in clinics but I have seen it in town like Durban or Mzinto where they give you flyers that tells you where to do it. The thing is that these flyers do not tell you that it‘s illegal these flyers are saying safe abortion by Dr so- and -so. When you get

there they do not ask anything they just give you pills and you pay that‘s it (Sne, FGD, 2014).

The participants also had a sense that backstreet abortion is highly marketed as an easy process that is convenient for desperate young women: ―I have seen it in the newspapers that you can do abortion in a minute and it is done” (Sibahle, FGD, 2013).

Participants showed a greater understanding of the dangers involved in backstreet abortion cases, particularly where the young woman doing abortion take drastic steps:

―It‘s risky because sometimes if you drink Jik [bleach] or the concoctions and then you might end up dying and your inside will have a problem, or you might end up having cancer” (Nokubonga, FGD, 2013).

This was one of the fascinating parts of the research: that these young women are fully aware of the dangers relating to consuming these concoctions, and their potential negative and long-lasting effects.

> The participants recognised the risks to both the mother and the unborn child in the process: ―If you do abortion you are just putting your life at risk because when you do abortion the child might not die but you might end up being the one dying or with irrevisible and serious complications” (Zodwa, FGD, 2013).

Another participant reiterated this concern about the unborn child: ―I say it‘s risky because what if when you try to abort you fail and then you end up giving birth to a disabled child, you will not know whether if you didn‘t do abortion the child was going to be okay” (Sibahle, FGD, 2013).

The participants from the second focus group confirmed that even though abortion is not talked about, it does happen through gossips and such cases are well known.

> I have heard or seen it happening at my neighbour, and in a hospital whereby one young woman was sick after taking home made concoctions. She ended up having abortion and it was a grown foetus, you could see that it was a baby boy. She was even lucky that they both survived because they took her to hospital in time and she got help where both the baby and the mother were put on oxygen otherwise she was going to die. In another similar incidence where abortion was done at home this time the mother was not taken to hospital so the baby did not make it but the mother was lucky to survive. The

sad part is that she is always sick and bleeding heavily since the abortion (Londi, FGD, 2014).

The difference in knowledge amongst the participants about legal and backstreet abortion suggests that information on backstreet abortion is much more widely available and CTOP is less known so that means there is still a lot of information that need to be cascaded into communities. It was also noted that botched back street abortions provide a rich source of gossip in the communities. Abortion as the topic of gossip indirectly encourages young women to look beyond the possible, visibly-known consequences of having disabled children, or death, and to choose to take a risk with their lives and the lives of their unborn babies.

Who can you talk to about abortion?

The participants were asked whether they themselves would have anybody to talk to about abortion if they experienced an unwanted pregnancy. There were different responses to this question. Most participants preferred to share their secret topic with their peers. This was a huge concern for the researcher that even though in the previous responces the dangers linked to abortion were strongly highlighted, but not one person from the participants made a choice to stand against unsafe abortion. But most were showing that they might do it if the need presented itself. This might be because the silence about abortion has normalised abortion in cases of unwanted or unplanned pregnancies.

One participant commented that she would be honest and tell my close friend about the problem: ⊣can tell my friend and will inform her that something happened and I have decided to abort and then it is up to her to support me or not" (Zodwa, FGD, 2013). Another participant felt that same way: ⊣can ask my friend to sit down, and explain that because of this pregnancy problem I have decided to do abortion" (Zama, FGD, 2013).

This reliance on peers suggests that young women may feel more comfortable with the opinions and support of others of their own age. However, as it is apparent that these young women do not have adequate information about legal and safe abortion, this reliance on peers for advice or support may result in them opting for the unsafe abortions options that are more widely known and easily accessible.

Another participant mentioned that she would share it with a sister: ⊣can talk to my sister because I cannot tell my mother since we hardly talk about such issues" (Thando, FGD, 2013).

Only one candidate thought of involving her parent in this discussion:

> I can talk to my mother, she is the one I can talk to when I have a problem she always assist me so I will tell her because if I have an abortion and experience some problems she will be the first one affected by it (Sibahle, FGD, 2013).

The rarity of this opinion is perhaps typical of the community in which the participants live, where parents are seldom involved in discussions with their children with regards to sexual reproductive decision-making or family planning. It highlights the need to bridge the communication gap between older and younger women. Also to open communication about such issues, as advice from peers may not always be the best advice.

Only one participant thought of involving the sexual partner: "I can talk to the guy who made me pregnant; if we are both not financially stable for a baby I will do abortion" (Nokubonga, FGD, 2013). The fact that only one participant suggested this may point to another important element of patriarchy that is linked to lack of open communication about such issues amongst sexual partners, which could mean that abortion is seen as a topic that is not suitable for discussion with men.

One participant from the second focus group reported that gossiping is another cause that indirectly promotes the culture of secrecy as far as abortion issues are concerned.

> I will not tell anyone because even if you tell a friend they will end up gossiping about you. Therefore it will be better for me to keep that incidence to myself because even if in the future I can't fall pregnant it will not be linked to what I did when I was young (Londi, FGD, 2014).

What causes young woman to choose to have an abortion?

This question was designed to try to identify the contributing factors to abortion. Participants highlighted lots of reasons for young women choosing to have abortions. The issue of rape and sexual violence was noted as the direct cause of some abortion cases: "Young people may be pregnant because of rape or they have slept with a step-father and when pregnant they might decide then to do backstreet abortion" (Nokubonga, FGD, 2013).

This is also a confirmation of known information about sexual violence cases taking place in this community, and the lack of open communication about abortion creates silence not only about abortion cases but also about incidents of rape and incest. Although the respondents did not

indicate which abortion method they would opt for under these circumstances, given earlier references to backstreet abortion methods being easily accessible, one could conclude that backstreet abortions also perpetuate silence in cases of incest and sexual violence. The culprits of both rape and incest seem to be left to wander freely to attack ather innocent victims, and make one wonder of how far they have gone with this behaviour.

Casual unprotected sex was another suggested cause: "Maybe it's when people who like to go to clubs and they engage in one-night stands, so when they get pregnant then they decide to do abortion" (Thando, FGD, 2013).

Participants from the second interview corroborated with this suggestion:

> Sometimes other young women will fall pregnant through one-night stands. In other cases maybe she does not even like the person who made her pregnant and then she will choose abortion as an alternative than have a baby with someone she doesn't like. Others fall pregnant for just a person she met once and she doesn't even know him, so she will choose abortion to hide that shame (Thembeka, FGD, 2014).

Lack of trust amongst these partners, as well as casual relationships, was noted as a further contributing factor to young women making the decision to have an abortion: "Some young women abort because the person who got her pregnant is not accepting that it is his baby and they think it's better to do abortion" (Pretty, FGD, 2013).

This above statement also indirectly highlights the ignorance of young people in terms of personal information on sexual reproductive rights, as well as other legal options in terms of the suspected father running away from his responsibilities.

The high rate of orphans and vulnerable children leads to these young women and pregnant girls with not much choice rather than abortion. The loss of own biological parents leaving with no family support plays an important role in motivating the young girls or womens' decision to have an abortion.

> Sometimes young women who do abortion might be having problems at home. It might she is staying with an aunt because her parents passed away and she is scared that if she is known to be pregnant they might throw her out and be left without a place to sleep, so for her it's better to do abortion (Zodwa, FGD, 2013).

The second group‘s participants concurred to the first group‘s comments:

> Sometimes young people choose abortion maybe because you are an orphan and still very young so when you get pregnant you have no one to take care of yourself and no money to care for the baby. On the other hand maybe you are unemployed with no means to take care of the baby. You can therefore come to a decision to do abortion (Thembeka, FGD, 2014).

Throughout the discussion on this topic, the issues of poverty or poor living conditions were identified as one of the causes of young people choosing abortion.

> Sometimes other women come to a decision because they date older men [sugar daddies] known to be married and when these young women get pregnant the older men usually disappear. Then the girls are left all by themselves to deal with the pregnancy; in that way they therefore decide that it is better to do abortion. Sometimes even these young women‘s background is just bad and then they see that they cannot afford to have another mouth to feed and they choose abortion (Nonhle, FGD, 2014).

To confirm the above conclusion the second focus group participants commented on the fact that transactional relationships [sugar-daddy] are sometimes the cause for abortion from young women. ~~S~~Sometimes you abort due to the fact that the person that impregnated you is old and married; if he is rather financially not okay or from a poor background and conditions are not conducive for pregnancy, the woman will decide to abort” (Zama, FGD, 2013).

This was echoed by another participant, who suggested that young women do not know how to cope on their own if they do not have a supportive and financially stable partner: ~~I~~It is when the person who made you pregnant is not financially stable then the young woman doesn‘t know what she will do with the child and then she can therefore decide to do abortion” (Sibahle, FGD, 2013).

> Having strict parents was also seen as a contributing element to young people choosing to abort when they become pregnant outside wedlock. ~~O~~Others do abortion because in their homes they have been told that if you get pregnant you must leave because you cannot have a kid when you are not married therefore they end choosing to do abortion” (Sibahle, FGD, 2013).

The participant from the second group also highlighted a common factor that perpetuates abortion in this community. –Sometimes young women feel that they are still young to fall pregnant. It‘s going to be a disgrace to the community and then they choose abortion to avoid being seen pregnant. Most of the times they do abortion secretly ensuring that no one finds out” (Sne, FGD, 2014).

Furthermore another participant added that:

> There are whole lots of reasons, when you are a child and still at school it is a disgrace to your parents for you to fall pregnant. Sometimes when it happens therefore you might decide to do abortion to avoid bringing shame to the family. Our priest in church is always preaching us about abstinence so when you get pregnant what do you do? At times you might get a bursary therefore when you get pregnant you then decide to do abortion because the pregnancy will end up jeopardising your future. Some young women are scared that if they carry the pregnancies into full term their dreams will be shattered then parents will be disappointed. Other young women choose abortion because peers usually make fun of you when you get pregnant outside marriage. The other reason is that when you get pregnant it puts too much stress into your relationship with the father of your child; that makes abortion an easier choice than to have a fatherless child. Sometimes the decision to abort comes from all that (Ntombi, FGD, 2014).

Most parents in these semi-rural communities do not have a close relationship with their children. Sometimes they also become overburdened with youth behavioural practices and challenges and then they feel embarrassed to talk about sex and sexuality with young people and become defensive or stringent to avoid the interaction.

Strict parental guidance without thorough or accurate information might lead to desperation around young people becoming frantic that if they engage in sex and mistakenly get pregnant they might be forced to be homeless or to fend for themselves. This indirectly pushes young women to opt for abortion when found to be pregnant to avoid the repercussion from parent‘s anger (Londi, FGD, 2014).

What causes young people to do backstreet abortion when legal abortion is free?

This question was designed to find the reasons why young women opt for backstreet abortion. The participants highlighted a number of reasons, including secrecy, family shame, ignorance and hospital CTOP procedures:

> They are scared of telling their parents and sometimes they are scared to go to hospitals because in hospitals there are lots of procedures, they start by testing you for HIV and what if you are already HIV-positive? Then now you have accumulated lots of stress or it‘s not just pregnancy now it might HIV as well. If you are pregnant, you will have to stop having a good time in clubs and that‘s why they opt for abortion and keep it a secret (Nokubonga, FGD, 2013).

It is interesting that participants distanced the HIV element from this topic and it was being brought up very late in the discussions. The other concern is that sexually transmitted infection was not raised up at all in these responses; whilst it is also highly dangerous. The most fascinating part is that having unsafe sex is not a concern when it happens, but the consequences are seen to be the barrier to young women opting for termination of pregnancy as a safe precautionary measure. When legal termination of pregnancy was put in place, one of the reasons was to reduce maternal deaths and morbidity. However HIV infections seem to be the cause of the increment of maternal deaths just because respondents seem not to be willing to know their HIV status and or to use dual protection.

The issue of privacy as well as stigma was also highlighted, and the participants explained that in hospitals the area designated for choice on termination of pregnancy is isolated from the general daily activities. This on its own creates a barrier and limelight.

The other young people are afraid that they will be seen on the CTOP side by a family member or by her mother‘s friend who will in turn tell the young woman‘s mother that I saw your child sitting in the abortion area so she was there to abort *(*Zodwa, FGD, 2013).

The second focus group participants reiterated the same feeling, that gossip and the stigma attached to abortion have an impact on the decision-making regarding safe or backstreet abortion.

> Some choose backstreet abortion because maybe their family members and local people are working at the clinic so you cannot be seen on the CTOP section. The only

> way where no one will know of what you did, is to do backstreet abortion. Here in the clinics they know you and these nurses will come back and tell your family that you were in the clinic to do abortion. Sometimes people that know you in the community will share with others that you were in the clinic sitting on the termination of pregnancy side. Then everyone in the community will know that you were there for abortion (Thembeka, FGD, 2014).

In addition to this fear of the family finding out, the participants thought that young women were also afraid of the judgemental attitudes of nurses about teenage pregnancy and having unprotected sex:

> Others do backstreet abortion because they are shy that they have to tell nurses in clinic or hospitals that they are there to do abortion. Do you know how rude some of these nurses are, they just shout at you. That on its own makes you shy and scared that at the hospital they will ask you ~~"~~why are you doing abortion, why were you doing sex in the first place, didn't you know that there is protection?" (Sibahle, FGD, 2013).

Another participant reinforced this perception, commenting: ~~"~~The reason they choose backstreet abortion is because they know that they are young and they are scared that in hospitals they will be scolded for being pregnant when they are too young" (Zama, FGD, 2013).

Summary

These interview processes were mostly uncomfortable for participants, as has been mentioned previously. This would suggest that abortion is not a topic that is commonly talked about by the youth in rural areas like Amahlongwa and Amandawe, which might also be a challenge for most provinces in South Africa. The stigma attached to abortion indirectly perpetuates a fear of being judged, both by one's peers and others in the community.

The fear of these judgmental attitudes may encourage women to try and avoid being gossiped by the community members, and so prefer to stay silent on the topic or pretend to be innocent and pure. This fear of being stigmatised and the stigma attached to the word "abortion" made it difficult for the researcher to get detailed responses to some of the questions. Most often she needed to re-read and keep on rephrasing the questions and always remind the participants

that responding did not mean that they themselves had had an abortion. The findings from this discussion will be discussed in relation to the theory outlined earlier in the following chapter.

CHAPTER SIX: APPLYING THE SOCIAL ECOLOGY MODEL FRAMEWORK

This chapter aims to further explore the research findings discussed in the previous chapter using the social ecology model as a framework to better understand how young women conversate about abortion in their community. The SEM looks at the involvement and the influence of the community as a whole in the health practices. This theory highlights that the community spheres have a direct influence in the behaviour of an individual or a group. It therefore looks at these spheres in isolation in order to explain the conditions of the people who reside in the community (Bronfenbrenner (1979).

The issue of abortion in this area seems to be surrounded by lots of reasons that perpetuate backstreet abortion including societal or traditional beliefs which render the matter a taboo or a topic of shame or disrespect. The literature review on contributing factors in backstreet abortion in chapter Two also relates to the data analyses or findings of this study. In Chapter Two different reasons such as culture of silence around abortion, transactional sex, patriarchy, as well as unwanted pregnancies amongst other causes are reported as some of the reasons young women choose backstreet abortion.

The data collected during the focus group discussion reflects a culture of silence on the topic of abortion, and this indirectly promotes the practice of abortion that is not legal. In order to hide the shame of falling pregnant at a young age, and or being unmarried, young women opt for backstreet abortion which will not be known about in the community. The culture of silence about abortion practice promotes young woman to do things secretly, by taking herbal dangerous concoctions only known by her. Through such practices, young women usually find themselves in serious situations where they are faced with the irreversible side effects of the concoctions they have consumed, or with death.

Christine Varga (2002) points out that in South Africa, opinions of abortion among Zulu adolescents are divided. She states that many surveyed adolescents see abortion as a sin; immoral, like murder; or socially irresponsible. This notion is reflected in the findings, when participants report that they feel safe or unsafe abortion needs to stop because there are forms of protection when one is having sex and that ~~a~~ baby is a blessing" (Sibahle, FGD, 2013). There are two key beliefs or options expressed in this statement. One is the religious belief that

a child is a ‗blessing", and the other relates to the morality of sex before marriage, which in this case has been adapted to become censure about having sex without a condom.

The religious beliefs linked to the issue of child-bearing and abortion in this community also have a negative impact on increasing the number of backstreet abortions. The community looks at giving birth as a blessing and believes that the child is ‗a gift from God". This leads to an overall feeling in the community that abortion is wrong. It has been noted in the findings that this attitude provides young women who are faced with unwanted and unplanned pregnancies with fewer choices to deal with the situation that they have unintentionally got themselves into.

This religious belief on its own creates an environment that is not conducive for abortion options, whether legal or backstreet. The fact that this belief promotes secrecy around abortion practices leaves young women with no platform to discuss other options with adults or health practitioners, and they opt for backstreet abortion which is only known secretly by the person who has attempted or has successfully done it.

Additionally, religious belief that sex before marriage is a sin lays the foundation for the idea amongst some young women that if they are sexually active they must hide it; and when they do conceive through their sexual practices, they have no other choice but to have an backstreet abortion, in order to avoid being the subject of gossip in the community, and to avoid the shame that pregnancy might bring to the family.

However, if legal abortions information in the clinics or hospitals are more visible as well as part of the whole sexual reproductive health services it might increase the number of women accessing it. The challenge is that at the moment in most health institutions CTOP section is separate from other services, which make its more likely that a young woman using these services will be found out, be seen by people they know, or being recognised by local nurses; so they are more likely to choose the secretive option of backstreet abortion. The fear of being noticed by people they know and the fear of being reported is linked to prevalent notions of abortion as immoral, which on the other hand promotes backstreet abortion, to avoid being judged by the community.

In the literature review, Haddad and Nour (2009) highlight the other risks that are linked to abortion cases. This is confirmed by participants, who recite a number of stories about the dangerous side-effects of backstreet abortions on young women from their own neighbourhoods. Despite this talk about these risks and dangers, these ‗cautionary tales' do not

appear to reduce the likelihood of young women opting for backstreet abortions, nor increase the uptake of legal abortion. This may be an area where further research is needed to investigate how these stories have or lack influence on a community.

These arguments suggest that there are strong social factors that were also identified to have impact on young women‘s choices about abortion. Another factor that the research raises is that of the visibility of information about abortion. The visibility of backstreet abortion versus lack of legal and relatively safe termination of pregnancy information makes one see backstreet abortion as an accessible choice as opposed to legal abortion, information about which seems to have been concealed from the targeted audience. People from rural areas have very limited access to information, therefore having backstreet abortion information advertised in their faces normalises the practice in these communities. The biggest concern about these adverts is that this information doesn‘t have all the correct facts about the possible side-effects. It therefore leaves the young women with a vacuum to fill from own experience.

Microsystems

In this system there is a direct link between the individual and the family, which creates trust and dependency. In this case this refers to the young women and their links with their parents, siblings, friends, peers, church and schools. According to Brofenbrenner (1979) most of the person‘s behaviour is learned in microsystems because it consists of bi-directional influence. He goes further to highlight that the bi-directional relationship is the foundation for a person‘s cognitive and emotional growth. In this instance, if the belief within these spheres of influence is that abortion is a taboo, the end result will be secrecy around the topic. The community tendencies around abortion are linked to the parents‘ role: being silent about the topic of abortion with their children.

The silence means that parents are inactive and do not support their daughters, even in cases of sexual violence and incest. It was noted from interviews that parents will keep quiet, but once pregnancy has occurred, mothers will advise their daughters to have a backstreet abortion. Irrespective of the fact that in the process young women will be putting their lives at risk or be in danger of living with the catastrophic consequences of backstreet abortion.

The gossiping tendencies amongst women in the community – including both adults and peers – promote abortion for young women, to avoid becoming the centre of that gossip. Young women end up opting for backstreet abortion as it is seen as more private, whether done at

home through concoctions or consulting one of those doctors whose adverts through pamphlets are in the street poles all over the place. In this whole cycle of secrecy, young women are faced with serious consequences to their own lives and their sexual and reproductive health choices.

Peers seem to be the only support structure for most young women faced with the option of abortion. This research highlights that most young women who have had backstreet abortions in the area had informed their friends prior to the actual abortion process. In cases where it had gone wrong, friends were the ones who would explain the condition of a sick friend, or inform the family.

However, peers were also seen as the foundation of gossip in the community when it became known that abortion had been attempted or had been done. This behaviour therefore indirectly promotes the culture of secrecy. In a community where there are spirals of silence on the topic of abortion, young women faced with unplanned or unwanted pregnancies are left with limited platforms to openly communicate about abortion.

Mesosystem

This system refers to the relations between microsystems, or the connections between the individual‘s related contexts. This level examines, for example, the relationship of school experiences to church experiences and family experiences to peer experiences. It might be affected by the level of income, education and age (Dahlberg and Krug, 2002). In the context of the culture of silence around abortion in these areas, parents are found to be less open about communicating sex, sex education and abortion issues in their families. This is similar to the thinking behind Noelle-Neumann (1974), in which fear of disapproval by peers and parents may influence negative perceptions about abortion, which is directly linked to the ‗spiral of silence‘ theory. Without support from parents and friends, young women are faced with dealing with the hard decision to abort on their own.

There is a contradiction in this silence, though, since it is noted that parents in this situation (of having a pregnant daughter) are also found to promote abortion to avoid the shame that is brought to the family by the unintended pregnancy. The findings reveal that some parents will advise their pregnant daughters to consume concoctions that will help terminate the pregnancy, or will advise their daughters to go to places that will help with a quick abortion. This means that they also overlook the dangers in which they are putting their children. Participants note that

sometimes parents are supportive of abortion, in order to ~~–~~avoid shame that is brought by pregnancy" (Sibahle, FGD, 2013); they therefore encourage young women to have abortions.

Chronosystem

The chronosystem documents the trends of environmental events and transitions during a person's lifetime and establishes it effects on the individual. (Bronfenbrenner 1979). The Choice on Termination of Pregnancy Act was put in place many years ago in order to reduce cases of maternal and child mortality and morbidity in the country. However, cases of backstreet abortion are still escalating, due to the fact that abortion is still not an acceptable topic to be easily discussed in communities. The practical procedure of applying for CTOP and the waiting period in between becomes a challenge for young women's patience and indirectly push them to seek unsafe abortion because it is supposedly quick and easily accessible. Therefore, legal abortion might be acceptable and practical on paper, but for women there still seem to be barriers to accessing it freely and quickly.

The research participants highlighted that the fact that termination of pregnancy sections are separated from the normal health sections in health facilities, makes it difficult for women who do not want to be seen in that section because of the stigma attached to it and the local gossip that is linked to abortion irrespective of whether it is legal abortion or backstreet abortion. Young people are afraid that they will be seen by a family member, member of the community or by their parent's friend, who will in turn tell the young woman's mother or father that she saw the girl at the clinic in the ~~=~~CTOP abortion section'.

Another element in question is the fact that when the policies were designed, the issue of parental consent for CTOP was left in the hands of the person themselves, whereas the HIV counselling and testing policy is strict on parental consent or involvement.

Exosystem

A person may not be actively involved in this system, but still feel the impact of the outcome of its applications (Bronfenbrenner, 1979). The research data suggests that schools in the area play an important role in terms of health messages to young people. The negative attitude of educators and their involvement in health awareness programmes indirectly drives young women to opt for backstreet abortion when found to be pregnant at a young age, to avoid being embarrassed or becoming the laughing stock of the school community. Research participants noted that a teacher will sometimes reprimand a young pregnant woman by pointing at them in

front of other educators and learners or peers – and the young woman ends up having an abortion.

Macrosystem

At this level, we see the influence of the culture on the individual lives, where members of a cultural group share a common identity, heritage and values. This system includes the status of social networks in the community, and how these impact on the health of an individual and their decision-making. Cultural factors, as well as religion, were highlighted in the research data as they interpret abortion whether safe or unsafe as a process of killing an innocent child, which is a sin according to the bible. This, therefore indirectly promote the culture of backstreet abortion for young women.

The cultures of silence, as well as gossip, around abortion in the area were seen as somehow forcing young women to opt for backstreet abortion. Through the findings, the attitude of the community is seen as the force behind the cases of abortion in the area simply because it promotes the culture of silence around the topic of abortion. This culture of silence promotes the tendency to gossip about the assumed cases of abortion. The participants noted that young women in the community gossip and scold girls who were pregnant and they believe that this leads to these girls choosing to have an abortion.

CHAPTER SEVEN: CONCLUSION

Conclusion

The focus group discussions highlight the culture of secrecy around abortion in the Amahlongwa and Amandawe communities. Abortion, whether legal or illegal in this community, is not an open topic that is easily talked about. Usually, conversations about abortion in this area are sources of embarrassment to young women who have been found to be pregnant before marriage. This is caused partly by the fact that this community associates pregnancy with marriage. The secrecy around abortion was found to perpetuate and embolden the culture of gossip in the community, which puts young women under a lot of pressure to hide their abortion, which leads to dangerous outcomes.

Religion also plays an important role in matters of abortion, since in this community pregnancy is associated with blessings. The community looks at abortion, irrespective of whether it is legal or backstreet, as forbidden, because the child is a ~~b~~lessing" and a chance to do good things for the parents that they are unable to do themselves. The emphasis on religion leads to the belief that abortion is a self-curse, because later in adult life, when women want to have children, they may be prevented by the child that was aborted. The belief is that the aborted baby was not given a chance to live so its spirit is unsettled.

Abortion appears to conflict strongly with tradition and culture, and people still believe that it is taboo to talk openly about abortion. This conflict makes parents, even if they know their off-spring are sexually active, keep quiet about the issues not only of contraceptives and dual protection as part of family planning, but also abortion itself. This silence not only jeopardizes the lives of young women seeking safe abortion, but also puts them at risk of other social ills, including sexually-transmitted infection, and HIV/AIDS. The silence propels some parents who find out that these young women are pregnant to encourage them to take concoctions that will help eliminate the pregnancy, without going to a public health institution that offers legal abortion which is considered safer.

Incest and sexual violence also contribute to young women having abortions in this community. Cases of incest were reported as another reason for these young women, often prompted by their mothers, to resort to backstreet abortion instead of reporting such unacceptable and immoral behaviour to the police. In the case of incest or rape, the mothers themselves were

reported to be the ones trying to hide the shame brought about by the pregnancy of the daughter, which would become the source of community gossip. They therefore encourage their daughters into backstreet abortion as a means of covering up incest or taboo.

The element of fun and wanting to have your ~~o~~wn time", without the responsibility brought by a child, was reported as another causal factor in the reported high rate of abortion in the area. Young women sometimes reportedly choose to have an abortion when they were pregnant and saw the potential responsibility of caring for the baby as less desirable than going out to parties. With these ideas in mind, young people rely on their peers as pillars of strength, and they talk with other people of the same age, advising and supporting each other to have backstreet abortions.

Stigma attached to abortion in health institutions was highlighted as another contributing factor in the high rate of back-street abortion in the area. Young women are shy to use the spaces created for termination of pregnancy or legal abortion in hospitals. It was reported that the legal abortion section in hospitals is separated from other health activities. This surrounds the area to perform CTOP with negative stigma which will lead to being sources of gossip in the community – if someone who they know them sees them, they might report it to their parents or gossip about it in the community.

Access to information was also investigated, and it was noted that information on backstreet abortion is easily accessible. Participants reported that they had seen a lot of information about backstreet abortion in the street poles or vendors in urban areas. They showed a clear understanding of the content of posters or pamphlets that market backstreet abortion. These marketing pamphlets and posters emphasize that backstreet abortion as a convenient solution, since it a quick and ‗safe' procedure. Some of these posters and pamphlets advertise traditional healers with traditional medicines, claiming that they can easily help make the pregnancy disappear. Young women felt that this process was easier than opting for a legal abortion, which they did not have clear and factual information of.

Most respondents confirmed and concurred that abortion is not a topic that is easily or openly discussed in the community. This may be an indication of the spirals of silence around abortion in this area whereby young people, who can be viewed as the minority, tread carefully as far as abortion is concerned, with fear of becoming isolated or ostracized if they are seen to know too much about it. This fear of isolation indirectly normalises the situation of opting for backstreet abortion, and confirms the topic of abortion as one ripe for gossiping.

Respondents highlighted in their comments that they felt that abortion, whether legal or backstreet was morally ~~-w~~rong".

The traditional beliefs which make abortion a taboo in the community also succeed in ensuring that young people are silent and secretive where the issue of abortion is concerned. This may indirectly fuel cases of backstreet abortion in the area, since young people faced with dilemmas of unwanted or unplanned pregnancies do not have a supportive environment in which to make informed decisions of how to deal with the issues of unwanted pregnancy and abortion at hand.

The participants commented on the fact that sometimes young women choose backstreet abortion simply because they fear the procedure that is associated with legal abortion, including the different tests that are conducted in hospitals and clinics. It was interesting that young people are still scared of their parents more than STIs and unwanted pregnancies. They are also scared of knowing their HIV status, yet they do not appear to fear the main mode of HIV transmission – unsafe sex, or its other consequences of unplanned or unwanted pregnancy. Young people are seen as privileged, with sexual reproductive health information and rights, but they still engage in unsafe sex and resort to other measures that might harm their lives.

Termination of pregnancy through the legal system is seen by the Government to be a good option for unplanned and unwanted pregnancies, but traditional as well as religious beliefs seem to create a barrier for young women accessing these services. These hindrances promote the culture of denial; as it was noted in the focus group discussions that the sense of justifying the illegal abortion practice makes it normal and easy to opt for the backstreet abortion route. The silence around such behaviour promotes a culture of acceptance, and encourages young people to consciously engage in unsafe sex, knowing well the negative consequences and how to avoid them.

The participants also revealed that information around legal abortion is still largely inaccessible to young women. This system, or Act 96, needs to be reinvented – or perhaps the DOH needs to strategise around communication to help women to use the service. Alternatively, they need to put thorough measures in place for women to know about the CTOP and be willing to use it without any negative hindrances. Additionally, information on CTOP still needs to be better marketed to make it accessible as a safe option. Putting together or uniting all sexual reproductive health services with CTOP sections in public institutions will also reduce stigma and discrimination around abortion.

Poverty and unemployment play a major role in the negative attitudes or risky behaviour of young people. The young women reported that these issues contribute to the cases of abortion in the community. An unwanted pregnancy creates desperation in families when their living conditions are not conducive to the extension of a sick family member already suffering and depending on another family member. Therefore it encourages young people to justify or opt for abortion to avoid the dire situation of an added family member.

Dual protection seems to be of less importance to young women, who are still engaging in sex without protection. There will be fewer occurrences of abortions of any type if young people practice safer sex options. As soon as young people adhere to the fundamentals of dual protection, abortion – especially unsafe abortion – will be minimised, and perhaps the strengthening of legal abortion could improve. In the event of partying and one-night stands, HIV and other sexually transmitted infections (STIs) could be prevented, as well as backstreet abortions.

Far more proactive measures to reduce the incidence of unintended pregnancy and unsafe abortion need to be put in place in South Africa. Programmes on dual protection are crucial towards reducing cases of unwanted and unplanned pregnancies that might be the leading cause of unsafe abortion cases. Programmes that communicate about safe- abortion- care could encourage young women to access these legal services rather than dangerous back-street abortions.

Moreover, the empowerment of women socially, economically and politically is very crucial in this stage. This process needs to be aligned with programmes that will look at changing men‘s attitudes as well as behavior and also empowerment of community members at large through community dialogues, workshops, media using health programs like *Zazi* and *Brothers for Life.* Traditional as well as local leaders need to take ownership of information programs to ensure all communications gaps are covered.

This research also raises a number of issues that could be addressed by national health policy and services, as well as organisations working in the field of sexual and reproductive health. Different levels in the community are directly influencing each other, so the recommendations noted below support elements of the Social Ecology Model.

Chronosystem: the public policy, laws and regulations of society

Most policies need to be designed taking into account the needs of the community people as well as the health benefits of that particular community. In the case of abortion, the Department of Health must ensure that policies are designed in a way that services in all health facilities are youth-user- friendly and must be available in all health ‗one-stop shops', whereby information on services is easily accessible and available. The Department of Health policies around Act 96 must be reviewed to ensure that information on termination of pregnancy is marketed properly and is easily accessible for the targeted audience. The sections or wards designed for the termination of pregnancy in hospitals and clinics should not be separated from all other activities, because it attaches a stigma to young women to be seen in the termination of pregnancy sections.

The Department of Health needs to increase the number of hospitals and local clinics in all Provinces that will provide CTOP to those women that needs services. This will require that human resources that specialises in CTOP as part of dual protection are increased as well and that they are well trained and encouraged to prioritize and render good services.

Support groups for pregnant young women in all health institutions need to be coordinated. Education or personal empowerment programs for health issues on the termination of pregnancy needs to be reviewed, as it is a subject that touches on strongly-held beliefs and religion in these communities. Workshops and information on preventing pregnancy and dual protection (using both condoms and other contraceptives) need to be integrated into all activities in the health centres, schools and higher education and learning institutions.

Issues of age and parental consent for accessing health services and abortion need to be explored to create a platform for parents to engage with information on sexuality. Lastly, most emphasis needs to be placed on family-planning and a turnaround structure needs to be designed. This structure must ensure that dual protection is made freely available to schools as well as empower home- based- care- givers to be able to monitor the uptake, since prevention is better than abortion.

Microsystems: the individual's attitude, behaviours, knowledge and skills

Information on sexual reproductive health needs to be freely available in the local health institutions for young people; this will assist them in making informed decisions. It was noted in the findings that peer, face-to-face sharing of information plays a huge role in this community. This therefore suggests that young people need to associate themselves with youth-development as well as health peer-education programmes that will assist them with relevant and accurate information, which will improve their self-worth and give them life skills to help sharpen their decision-making and self-efficacy.

Dual protection is seen as a comprehensive method for helping reduce deaths caused by backstreet abortion complications, HIV and STIs, therefore drastic measures need to be put in place. To deal with abortion, the communities need to encourage young people and older women and men to be devoted and consistent users of dual protection. They must also ensure that services linked to contraceptives are adolescent and youth user-friendly and well-marketed, and also invest in open communication about their promotion using all channels of communication. Contraceptives are seen as predictors of reduction in abortion; other researchers have argued that in countries where contraceptive use is high, cases of abortion are low. Since it was noted from findings that young women prefer to talk to their peers about issues of sex and abortion it is recommended that younger people, nurses as well as care-givers, need to be trained in all prevention measures as well as contraceptive dispensation.

Mesosystems: the interpersonal level and the influence of family and peers

The focus groups highlighted that lines of communication between parents and young people needed to be more open, so that they could talk freely about sensitive issues. Parents need self-empowerment programmes that will help them to confidently open up topics of sexual reproductive health with their children, since they sit between the community and the individual. This will not only help reduce the incidence of CTOP, both legal and illegal, but might also have a positive impact on the reduction of unwanted teenage pregnancies and STIs.

In many communities sexuality is not discussed. Communities speak in parables when it comes to words linked to sexuality. Parents become shy to talk to their kids and expect educators to play the role vice-versa. Parents in the communities need to be comfortable talking about ~~–~~sex" and ~~–~~intercourse" with their children in order to create a safe space for children to open up to

their parents about the challenges they face as young people. Until these silent tendencies are scrapped from the system the youth will bear the brunt of society‘s ignorance.

Macrosystem: community factors and formal networks and norms among individuals, families, groups or organisations

Community members need to move away from the culture of silence since it is likely to create confusion around problematic issues in the community at large.

It is recommended that information on public health, including adding more human resources, must be available at all community gatherings for availability as well as user-friendliness, in order to create a new norm.

Religious sectors must buy in to the sexual reproductive health communication and service delivery programmes so that they are easily accepted by communities which are strongly invested in religious beliefs.

It is also recommended that contraceptives, specifically free condoms, should be placed and distributed in social settings for easy accessibility, for example taverns, schools, churches, war-rooms (a community gathering where stakeholders meet and plan for community developments), shops and community halls; along with young people who are trained in counseling on contraceptive methods and dispensation. This might actually personalise the safety issues and develop young people‘s inclination of CTOP over backstreet abortion.

Exosystem: the institutional factors and formal or informal organisations, rules and expectations that impact on health behaviours

The involvement of different social structures in prevention programmes for youth engagement will assist in forming structured as well as consistent factual information. This will also assist in reducing negative attitudes in people working with the youth in communities. Educators, care-givers as well as nurses, need to help the community eradicate the stigma attached to abortion and also take ownership of health awareness programmes and be non-judgmental when communicating with young people about sensitive issues.

Local municipalities need to put strict advertising laws in place and take drastic action to remove pamphlets and posters placed on street poles and walls that promote backstreet abortion.

The DOH needs to strongly market the safe abortion (CTOP) process for the attention of young women who experience unplanned pregnancies.

It is also recommended that future researchers undertake research in different geographical areas of KZN in order to be able to compare findings. It will then be easy to summarise findings on a broader scale.

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APPENDICES

APPENDIX A: CONSENT FORM FOR RESEARCH STUDY

Name of Researcher: Ms T. Manana-207529235

Supervisor: Dr Emma Durden: 031-2601803

Institution: University of KwaZulu Natal, CCMS

Title of Project: *Ukukhishwa kwezisu* - „*Taking out the stomach'*: Young women's conversations about abortion in KZN.

Dear Participant

I, Thenjiwe Manana, am doing a study on ukukhishwa kwezisu - ‗Taking out stomach': young women's conversations about abortion in KwaZulu Natal.

This study explores how young people talk about abortion. The purpose of the study is to understand where information comes from and how this information influences young women's decisions about abortion. The study is for research purposes only. Our discussion will be recorded, but we will not use real names for this discussion. Real names will not be used in the research reports, to protect your privacy. Being part of this study is voluntary, and you can choose to withdraw at any time if you wish to.

Thank, you for your time and participation,

Thenjiwe Manana.

Dear Researcher

I ……have been informed about the nature, purpose, and procedures for the study.

I have also received, read and understood written information about the study. I understand everything that has been explained to me and I consent to take part in the study.

All my questions have been answered in a satisfactory manner.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I agree to take part in the above research study and I confirm that I understand the information that was explained to me on this date …… For the above study.

Participant:

……

Signature

Witness:

ZULU LANGUAGE CONSENT FORM FOR RESEARCH STUDY

Name of Researcher: Ms T. Manana

Supervisor: Ms Emma Durden: 082 673 6662

Institution: University of KwaZulu Natal, CCMS

Title of Project: *Ukukhishwa kwezisu* - „*Taking out the stomach'*: Young women's conversations about abortion in KZN.

Mina Thenjiwe Manana ngenza ucwaningo olungokukhishwa kwezisu. Lolucwaningo lufuna ukuthola ukuthi abantu abasha baxoxa bathini ngokuhushulwa kwezisu. Inhloso ngqangi yalolucwaningo ukuzama ukuqonda ukuthi ulwazi luphumaphi kanti lunomthelela muni ekutheni abantu besifazane abasha bathathe izinqumo ngokuhushulwa kwezisu.

Lolucwaningo lungolwenhlolovo kuphela. Izigxoxo zethu zizoqoshwa, kodwa asizukusebenzisa amagama ethu angempela kulezingxoxo. Amagama ethu futhi awezusetshenziswa kulombiko,ukuze sivikeleke. Ukuba yingxenye yalolucwaningo kuba ukuzinikela, futhi unganquma ukungabi ingxenye yalolucwaningo noma inini uma sengifisa ukuphuma.

Ngiyabonga, ukuzinikela nokuxhasa kwenu,

Thenjiwe Manana.

Mcwaningi

Mina ……Ngazisiwe ngomsuka, ngendlela , nenhloso yalolucwaningo.

Ngiyitholile futhi ngafunda ngaqondisisa umbhalo walo lucwaningo. Ngiyaqondisisa yonke into engichazelwe yona fithi ngiyavuma ukba yingxenye yalolucwaningo.

Yonke imibuzo yami iphendulekile ngendlela enelisayo. Ngiyaqondisisa futhi ukuthi ukuzibandakanya kwami kungokuvolontiya kwami futhi ngingayeka ngokukhululeka noma inini ngaphandle kokunika incazelo.

Mina ngiyavuma ukuba yingxenye yalolucwaningo futhi ngiyaqonda lonke ulwazi engichazelwe lona ngalolusuku ……..

Participant:

……

Signature

Witness: …….

APPENDIX B: RESEARCH QUESTIONNAIRE

Research question 1: How do young women talk about abortion?

Sub-questions:

Do young women ever talk about abortion?

When do these conversations happen?

How are these conversations initiated?

What do young women talk about during these conversations?

Do young women know the difference between legal abortions and backstreet abortions?

Research question 2: Where do young women get their information about abortion?

Sub-questions

Who do young women talk to about abortion?

Where have young women seen or heard information about abortion

What does their community say about abortion?

What do their parents say about abortion?

What do other young people in the community say about abortion?

Are young women exposed to any information about legal abortions at hospitals or clinics? How is it communicated?

Research question 3: How do young women make decisions about abortion?

Sub-questions:

Do most women have backstreet or legal abortions?

Do young women know about the dangers of backstreet abortions?

What makes young women choose backstreet abortion?

What makes young women choose backstreet abortion over legal and safe abortions?

IMIBUZO YOCWANINGO NGESIZULU

Imibuzo yocwaningo 1: Baxoxa bathini abantu besifazane abasebasha ngokuhushulwa kwezisu?

Sub-questions:
Bathini abantu besifazane abasebasha ngokuhushulwa kwezisu?

Abantu besifazane abasebasha bayahlukanisa yini phakathi kokuhushula okusemthethweni nokwenziwa emakhoneni?

Imibuzo yocwaningo 2: Abantu besifazane abasebasha balutholaphi ulwazi ngokuhushulwa kwezisu?

Sub-questions

Abantu besifazane abasebasha bakhuluma nobani ngokuhushulwa kwezisu?

Abantu besifazane abasebasha balubona noma baluzwa kuphi lolulwazi lokuhushulwa kwezisu?

Uthini umphakathi walaba bantu besifazane abasebasha ngokuhushulwa kwezisu?

Bathini abazali balabantu besifazane abasebasha ngokuhushulwa kwezisu?

Bathini abanye abantu abasebasha emphakathini ngokuhushulwa kwezisu?

Ngabe abantu besifazane abasha bayalubona yini obala ulwazi ngokuhushulwa kwezisu okusemthethweni ezibhedlela noma emitholampilo? Lolulwazi lukhulunywa kanjani?

Imibuzo yocwaningo 3: Basithatha kanjani isinqumo sokuhushula izisu abantu besifazane?
Sub-questions:
Ngabe abantu abasebasha besifazane bayazihoshula yini izisu ngokusemthethweni noma okungekho emthethweni?

Ngabe abantu besifazane abasebasha bayazi yini ngezingozi zokuhushulwa izisu okungekho emthethweni?

Yini eyenza abantu besifazane bakhethe ukuhushulwa kwezisu okungekho emthethweni kube kukhona okusemthethweni?

APPENDIX C: COPY OF ACT 92

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;
(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) "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;

(xi) "Woman" means any female person of any age. (xi)

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 (])(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) 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 counseling, 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 confer-red 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 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.

SCHEDULE

No. and year of law	Short title	Extent of repeal

Act No. 2 of 1975	Abortion and Sterilization Act, 1975	In so far as it relates to abortion

APPENDIX D: MAP OF UGU DISTRICT

Map of Ugu District 2013 showing Umdoni Municipality and Amahlongwa

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