

**Reasons for Women to Terminate a
Pregnancy:
a Qualitative Study**

by

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Submitted in partial fulfillment of the requirements for the degree

Magister Artium (Demography)

In the Faculty of Humanities
Department of Sociology
University of Pretoria

July 2005

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TABLE OF CONTENT

	Page number
CHAPTER 1: ORIENTATION AND BACKGROUND	
1.1. Introduction	1
1.2. Abortion Legislation	2
1.3. The International Arena	4
1.4. South African Liberalisation	6
1.5. South African Legislation	7
1.6. Rationale for the study and Problem Statement	8
1.7. Aim of the study	10
1.8. Delimitations of the study	10
1.9. Limitations of the study	10
1.10. Assumptions	11
1.11. Research Methodology	12
1.12. Summary	13
1.13. Chapter Layout	13
CHAPTER 2: LITERATURE REVIEW	
2.1. Introduction	15
2.2. Reasons for women choosing to terminate a pregnancy	15
2.2.1. Contraception	20
2.2.2. HIV/AIDS	21
2.3. Ethical Considerations	26
2.4. Feminist Framework	30
2.5. Historical Perspective	35

	Page number
2.6. Human rights and Reproductive rights	38
2.6.1. The World Population Conference, Bucharest, 1974	39
2.6.2. The International Conference on Population, Mexico City, 1984	39
2.6.3. The International Conference on Population and Development, Cairo, 1994	40
2.7. South African Population Policies	44
2.8. Abortion Legislation	48
2.8.1. World Situation	50
2.8.2. South African Legislation	57
2.9. Summary	65
 CHAPTER 3: RESEARCH METHODOLOGY	
3.1. Introduction	65
3.2. Aim of the Study	66
3.3. Research Design	66
3.4. The Population and Sampling	72
3.5. Data Collection	73
3.5.1. Access to respondents	73
3.5.2. Voluntary participation, anonymity and confidentiality	76
3.5.3. The Interview	77
3.6. Data Reduction and Analysis	78
3.6.1. Introduction	78
3.6.2. The transcribing of interviews	78
3.6.3. Conceptualisation of data	78
3.6.4. Coding of data	79
3.6.5. Analysing of data	79
3.7. Summary	80

	Page number
CHAPTER 4: RESEARCH FINDINGS	
4.1. Introduction	82
4.2. Identification of Sets of Reasons	83
4.3. Reasons for Women Terminating their Pregnancy	85
4.3.1. The relationship between age, employment status, financial concerns and personal circumstances	85
4.3.2. Relationships	87
4.3.3. Values	95
4.3.4. Alternate considerations	97
4.3.5. Guilt versus the Correct Decision	98
4.3.6. Counselling	100
4.3.7. Ideal family size	103
4.3.8. Contraceptive use	103
4.3.9. Sexual behaviour	106
4.3.10. Gestation Period	107
4.4. Summary	107
CHAPTER 5: DISCUSSION AND INTERPRETATION	
5.1. Introduction	112
5.2. Historical Evolution of Abortion Legislation	112
5.2.1. The International Arena	113
5.2.2. South African Liberalisation	115
5.3. The Aim of the Study	117
5.4. Research Methodology	117

	Page number
5.5. The Results	118
5.5.1. The linkages between age, employment status, financial concerns and personal circumstances	119
5.5.2. Interpersonal relationships and support networks	120
5.5.3. Personal values	121
5.5.4. Alternate considerations	122
5.5.5. Emotional responses: Guilt versus the Correct Decision	123
5.5.6. Advantages of pre-abortion and post-abortion counselling	123
5.5.7. Ideal family size and Current family considerations	124
5.5.8. Women's reproductive health	124
5.5.8.1. Contraceptive use	124
5.5.8.2. Sexual behaviour	125
5.5.8.3. Gestation period	126
5.6. General perceptions and Recommendations	126
5.6.1. Recommendations for further studies	129
	131

BIBLIOGRAPHY

APPENDIX

Appendix A:	Tables
	Table 1 - Status of Abortion in selected countries by Statutory Grounds for Abortion: mid-1978
	Table 2 - Grounds on which Abortion is permitted: 1999
	Table 3 - Liberal Abortion Laws per Country per Continent: 1999
Appendix B:	Research Findings - Diagram
Appendix C:	Interview Schedule
Appendix D:	Transcribed Interviews

ACKNOWLEDGEMENTS

A special thank you to the following people:

- Dr. M. de Waal, my study leader, for her support, leadership, availability and her determination to see the completion of this mini-dissertation.
- To Prof J.L. van Tonder and Me. M. Hough-Petersen for their input, feedback and suggestions.
- Dr. T.Crywagen and the staff at the Reproductive Choices Clinic for allowing me access to their facility, for their assistance in facilitating the interviews and their constant support in the research process.
- To my parents, for your lifelong example and constant belief in me. For all your love, support and pride that is evident in everything that I do and accomplish and for always being there for me.
- To my husband, James, for your constant motivation. Thank you for your love and assistance and for putting up the late nights working and the moods experienced while completing the document.

ABSTRACT

The right of women to exert a choice regarding their reproductive behaviour is a fundamental right within the context reproductive rights. Reproductive rights and health encompass the exertion of individual choice but also adequate, safe and accessible health care services. Within this framework, the right to abortion and the right to access to safe abortion services is an integral part of reproductive rights and health.

Reproductive rights and the right of women to choose the outcome of their reproductive behaviour, came to the foreground in terms of population policies and programmes that were concerned with rapid population growth. The widespread use of contraception and family planning programmes and the outcomes thereof, led to a focus on the rights of women in totality as well as the personal exertion of their choices.

It is important to investigate the reasons that lead women to make a decision to terminate a pregnancy. In terms of demographics, answers are provided in terms of statistical rankings and weightings but no focus is given to the personal situations, circumstances and experiences of women. This is crucial to be able to determine the reasons for women terminating a pregnancy as reasons and sets of reasons are intricately linked within primary and secondary relationships. No reason stands in isolation to another, and a holistic view of a woman's true and personal reality is required to understand why some women choose to terminate their pregnancy and other choose an alternate outcome.

OPSOMMING

Die reg van vrouens om 'n keuse aangaande hulle reprodktiewe gedrag uit te oefen, is 'n basiese en fundamentele mense-reg binne die konteks van reprodktiewe regte. Reprodktiewe regte en reprodktiewe gedrag sluit onder andere die be-oefening van individuele keuses in, asook die toegang tot veilige en gehalte gesondheidsdienste. Binne hierdie konteks is die reg tot aborsie 'n integrale deel van reprodktiewe regte en gesondheid.

Die opkoms van reprodktiewe regte moet gesien word binne die konteks van bevolkingsbeleide en programme wat gemoeid was met bevolkingsgroei. Die beginsel van die beleide en programme was gesinsbeplannings en die gebruik van kontrasepsie. Die uitkoms van die sterk beklemtoning hiervan, het gelei tot 'n fokus op vroue-regte in totaal, asook vrouens se regte om hulle eie keuses te maak en die keuses uit te oefen.

Dit is van kardinale belang om die redes wat vrouens lei om hulle swangerskap te beëindig te ondersoek. In terme van demografie, word die antwoorde hierop voorgelê deur middel van statistiek, maar geen fokus op vrouens se persoonlike situasies, omstandighede of ondervindings, word in aanmerking geneem nie.

Om vas te stel wat die redes is wat daar toe lei dat vrouens besluit om hulle swangerskap te beëindig, is dit noodsaaklik om die redes en stel redes in verhouding tot mekaar te sien. Geen enkele rede is verantwoordelik vir die besluit om 'n swangerskap te beëindig nie. Redes en stelle redes beïnvloed mekaar in terme van primêre en sekondêre invloede, en dit bepaal hoekom sekere vroue besluit om hulle swangerskap te beëindig, terwyl ander vrouens 'n alternatiewe uitkoms kies.

CHAPTER 1

ORIENTATION AND BACKGROUND

1.1. INTRODUCTION

Abortion or the termination of a pregnancy is seen within demographics as part of the fertility component of population growth and it is within this framework that a focus on the reproductive behaviour of women came into focus. Concerns regarding population growth became prominent in the international arena in the middle of the twentieth century with the Malthusian threat at the foreground. Nations became overtly concerned that the earth's resources could not sustain the current population growth experienced by nations. At the heart of population growth and a direct determinant to this, were the fertility rates of women.

When taking demographic transition into consideration, the aim of nations was to lower fertility levels to reach replacement levels. This was designed to be addressed through family planning programmes and reaching demographic targets set by nations and supported by the international community. Not central to this was the role of women and the influence of women on population growth and development. Population growth and fertility levels were viewed in terms of statistics to indicate the dire position of the earth's population position. Population growth is not only influenced by fertility, but various other developmental factors as well, that act as proximate or non-proximate determinants.

Central to reproduction is women as only women bear children and therefore influence fertility levels. This does not stand in isolation as a woman's position in society and her ability to influence reproductive behaviour in terms of decision making on the number of children she wants, when she wants, how far apart, and if she wants any children at all, was not part of the framework provided for women. Reproductive decision making was in the hands of policy makers as to what is deemed better for society (collective good) and not the individual.

As it became clearer that women are central to lowering fertility levels and therefore population growth, more rights were given to women to theoretically exert a personal choice. This was fleeting during the 1970's-1980's but became more prominent in the 1990's. This was true with the emergence of human rights and therefore reproductive rights afforded women. The voice of feminism also became louder which allowed a greater focus again on women and their personal decision making capability. Even though this emergence of women's rights was prominent within reproductive health and rights, and all that is encompassed within this, reproductive behaviour was discussed within a

demographical and statistical framework and not within the influences of women's experiences and personal choices. Reproductive and sexual rights do not only include the freedom of choice to exercise individual rights, but includes the provision of services provided. This includes access to family planning services, access to safe and legal abortion, access to safe maternal health care as well as safe and accessible health care services to all women, and access to the basic right of education.

When determining women's reproductive and sexual behaviour based on individual decision making, demographical profiling and statistics provide a basis of trends of current or predicted scenarios. Due to the fact that reproductive and sexual behaviour is personal to each women, especially where choosing to either use contraceptive methods to avert conception or when choosing to terminate an unwanted pregnancy, it was deemed important to do an investigation of women's personal stories and narratives and not focus on statistical analysis.

When taking the issue of abortion into consideration, demographics provide us with the numbers per demographic characteristic and profile as well as the most frequently stated reasons women give for terminating their pregnancy. These statistical reasons usually correlate to conditional allowances for women terminating their pregnancy or not terminating their pregnancy. It does not provide us with a true¹ reflection of reasons as to what influences women to terminate their pregnancy and whether it is a personal choice exercised or if it is forced.

To be able to investigate the reasons or sets of reasons that women have for deciding to terminate their pregnancy, and the relationship between these reasons, the study aimed for women to be able to tell their own stories in their own words, based on their own reality and personal experiences, situations and circumstances. Only by allowing this would we be able to get a true reflection of reasons that influence women into choosing to terminate their pregnancy or not.

1.2. ABORTION LEGISLATION

David (1974:3) states that as a means of fertility control, abortion is as old as humanity and probably occurs in all cultures as women have resorted to abortion to terminate

¹ When referring to a true reflection or true meaning within the text, the essence of truth is referred to in the context of a woman's personal perception and the meaning that she assigns to her own understanding of her reality. It is therefore "true" to her personal situation and circumstances and the meaning and understanding that she ascribes to her experience.

unwanted pregnancies regardless of moral or legal sanctions often at considerable physical or physiological risk and cost.

With populations becoming more concerned with population growth and thus with fertility levels, the realisation that women do not stand in isolation to development, increased awareness of human rights and women's rights and the strong voice of feminism, all contributed to placing abortion as a right to choose, on the map. This however did not occur overnight and not only must this emergence be viewed in terms of the historical evolution on the stance on abortion and abortion legislation, but it must also be viewed in terms of a change in focus in the international arena.

Historically abortion has been viewed as deviant and pathological behaviour, and therefore criminal, as it was largely concerned with the moral and religious values specific to a nation. Illegal abortions have been performed since recorded history but it was a practice that women were forced into either by exerting a personal choice to end a pregnancy or being forced by partners or society to end a pregnancy.

A shift in attitude toward abortion and abortion research were only experienced in the mid-sixties for Western countries. The restrictions of abortion, both morally and legally, only began approximately 200 years ago as the laws that were implemented were intended to curb the number of non-medical abortions which were present, and which resulted in high mortality and morbidity rates. Even with these restrictions in place, unlawful abortions still continued widely with much the same frequency and continued to present a leading cause of death among women, and a threat to the health of women who have non-medical abortions (David, 1974:19; Ferreira, 1985:5)

The liberalisation of abortion laws must be seen within the context of moving from illegal laws to restrictive, conditional or liberal laws. This affects the right of women to determine their own choice regarding their reproductive behaviour and their choice as to whether or not to terminate a pregnancy, free of recrimination and fear of reprisal. Even within conditional abortion legislation, women cannot freely determine their choice as they are still bound to certain conditions and their personal circumstances and situations are not taken into consideration. In countries where legal abortion is permitted, access to safe services is to be provided, and women have the right to choose to terminate their pregnancy or not. Terminology in terms of legislation differs from country to country. A significant indicator in terms of legislation is whether abortion is permitted on request from the women. Within certain liberal legislation, this exact wording may not be present but by including abortion on the grounds of socio-economic conditions and the impact thereof on

the women, it does allow women to consider their personal situation and the impact of continuing with the pregnancy on their lives.

According to Ferreira (1985:5), the rationale offered by many countries with more liberal abortion laws embraces the following arguments: 1) recourse to abortion (legal and illegal) may affect all women, regardless of their incomes, social backgrounds, religion, level of education and marital status. Socioeconomic conditions prompt some women to seek abortions. If a woman decides to terminate a pregnancy, she will use whatever means available, 2) to view abortion from solely a moral viewpoint is unwarranted. To do so, is to refuse to face the real social and health problems involved. Morality evolves with the transformation of society. It therefore remains a woman's right to have recourse to abortion if her own moral view allows it, and 3) to refuse a woman the possibility of having an abortion under proper medical and psychological care, is forcing her to seek an abortion under clandestine conditions, with consequent serious risk to her health and even her life.

The liberalisation of abortion legislation can only be viewed in terms of a change in the international arena regarding reproductive rights and therefore the right to safe and accessible abortion services and the choice whether to terminate a pregnancy or not.

1.3. THE INTERNATIONAL ARENA

From the 1940's up until the World Population Conference in Bucharest in 1974, population growth was seen as a threat to the earth's resources and the only recourse was to lower population numbers and fertility rates through applying family planning programmes and contraception. The goal was to reach set demographic targets regardless of personal choice as this was driven by governments and policy makers.

As the worth of family planning became more evident and the people reaped the rewards of smaller families and experienced socio-economic improvements, the need for improved provision of family planning services came to the foreground. Women had to some extent a choice as to whether or not to use contraception, depending on the gender position of women in a society.

Only in 1974, at the World Population Conference in Bucharest, was it realised that chasing demographic targets does not stand in isolation to development. Development could not be realised without the contribution of women to development and for the first time gender equality came into the picture.

Family planning and the provision thereof to be universally available within the context of non-discrimination was a milestone for women. Within the provision of safe and adequate family planning services to be available, the issue of abortion was raised and was given focus when the USA declared that it will retract funding from any agency that support abortion related services. This milestone was achieved at the 1984 International Conference of Population in Mexico City where the international community declared that population is interlinked with resources, environment and development. Women are central to the three overarching themes and the focus was on their contribution within these to the population issue.

The significant breakthrough however occurred at the International Conference on Population and Development (ICPD) in Cairo in 1994 which had a strong focus on women as reflected in its concern with gender inequality and with a definitive emphasis on the concept of reproductive health. The conference focused strongly on the human rights of women and the girl child, and states that they are an integral and indivisible part of human rights (IUSSP, 1995:26).

The ICPD program reflected a move away from the lowering of population numbers as a goal in itself and focused towards the goal of improving the quality of life by promoting human rights. The most prominent topic on government's and Non-governmental organisations (NGO's) political and developmental agenda's universally was: the protection and promotion of women's rights.

The IUSSP (1995:26) states that the Program of Action of the ICPD did not create any new international human rights, but that the emphasis on reproductive rights and reproductive health introduced a new perspective on human rights. The notion of reproductive health encountered, emphasised the need for equality of men and women in universal access to health care services and reproductive health care programs, including those related to reproductive health care, which includes family planning and sexual health. The relationship between family planning, contraception and abortion are intricately linked within the reproductive health framework. In addition to the promotion of gender equality and equity, is the ensuring of women to control their own fertility. Reproductive rights also include the right to make decisions concerning reproduction, free of discrimination, coercion and violence.

Of importance is the fact that reproductive and sexual health does not only refer to the freedom of choice to exercise individual rights, but also to the provision of health services. These include access to safe family planning services, access to safe and legal abortion

services; access to safe maternal health care as well as safe and accessible health care services to all women, access to information, and access to the basic right of education. Reproductive rights and reproductive health clearly encompasses abortion. The ICPD (Cohen, 1995:47) recognises safe abortion as an integral part of reproductive health programs and emphasises the following points: 1) abortion should never be promoted as a method of family planning, 2) the need for abortion should be eliminated, 3) all efforts should be made to deal with the health impact of unsafe abortions, and 4) in circumstances where abortion is not against the law, access to safe abortion services should be provided.

Nafis Sadik, former director of the United Nations, placed the whole abortion debate within medical terms and not population terms by advocating that abortion is not a form of contraception but rather a medical issue as countries where access to safe abortion is restricted by legislature, very high maternal mortality rates prevail. This sparked criticism from feminist groups as the issue was taken out of the women's rights context, but it led to a greater acceptance of the incorporation of the advocacy of safe and legal abortions (Cohen, 1995:78-79).

1.4. SOUTH AFRICAN LIBERALISATION

South African population policies never stood in isolation to the international arena as seen by the National Family Planning Programme that was implemented in 1974 and aimed at limiting population growth. This stood in direct correlation to the 1972 World Population Conference Charter developed in Bucharest in 1974. Contraception was provided free of charge at various designated clinics to achieve a lowering of population numbers as a goal. Unfortunately, due to South Africa's political situation, this was not accepted by the African population group which saw this as a method of curbing African population growth as a politically motivated incentive.

In 1984, the Population and Development Programme (PDP) aligned to the implementation of strong family planning programmes and chased demographic set targets as per the International Conference on Population in Mexico City.

The programme realised that family planning itself would not achieve the demographically set target of a total fertility rate of 2.1 by 2010 and included supportive interventions such as education, primary health care (including family planning), economic development, human resources development and housing.

In South Africa, a long awaited democratic political dispensation dawned to coincide with the ICPD of 1994. The White Paper for a Population Policy was developed in 1996, within the context of democratisation and within the framework of the new Constitution. In contrast to previous population policies, which focused on fertility reduction as a goal in itself to reach demographically set targets, the principles of the White Paper for a Population Policy provided the ethical context for a human rights approach aligned to the findings and charter of the ICPD of 1994. The Population Policy was based on the charter of the ICPD and the predominant view expressed was that of human and women's rights. It advanced gender equality and the empowerment of women and that *"all couples and individuals had the right to decide freely and responsibly the number and spacing of children, and to have information, education and the means to do so"*.

Out of the historical evolution in the international arena and the alignment thereto of South African Population Policies, the Choice of Termination of Pregnancy Act no. 92 of 1996 was passed in South Africa.

1.5. SOUTH AFRICAN LEGISLATION

The South African Choice of Termination of Pregnancy Act no. 92 of 1996 is a liberal abortion law. The Act determines the circumstances and conditions under which a pregnancy may be terminated, and thus repeals the conditional Abortion and Sterilisation Act no. 2 of 1975.

The new act is in direct relation to the international arena in terms of population development and policies and the role of women. The act therefore encompasses individual freedom of choice, as well as the advancement of women's rights as per the international ICPD and our South African White Paper for Population policy.

The Act was passed in parliament on 22 November 1996, but was only implemented on 1 February 1997. The South African Choice of Termination of Pregnancy Act no 92, does not encourage abortion, it simply makes abortion safe (Parliamentary Bulletin, 1996:2). According to the Choice of Termination of Pregnancy Act no. 92 of 1996, an abortion may be performed upon the request of a women during the first 12 weeks of the gestation period of her pregnancy, and from the 13th up to and including the 20th week of the gestation period if a medical practitioner consents to the termination and for socio-economic reasons.

Various reasons can influence the women in her decision to terminate her pregnancy and it is vital to investigate these reasons and sets of reasons and their intricate relationship. Studies prior to 1996 were focused on the impact and incidence of illegal abortions in terms of maternal mortality rates and morbidity rates. Again, this indicates alignment to the international arena in terms of placing abortion within a medical health/safety paradigm and advocating the safe access to abortion services.

1.6. RATIONALE FOR THE STUDY AND PROBLEM STATEMENT

Studies regarding abortion within a liberal framework commenced after the implementation of the Choice of Termination of Pregnancy Act no. 92 of 1996. Based on the fact that legalised abortion is a relatively new phenomenon in South Africa; information and data regarding women that choose to terminate their pregnancy is not widely accessible. Current statistics compiled from data received from state hospitals and abortion clinics is not unified or standardised as seen by discrepancies in the reporting from the Department of Health. The information provided is in terms of the number of abortions performed nationally and on provincial level, number of institutions providing abortion services, and a percentage profile of women that terminate their pregnancy.

The percentage profile is based on the demographical characteristics of women at private and state hospitals and clinics. The percentage profile is also extended to include the reasons for women terminating a pregnancy based on the demographical characteristics of women. Generalisations are based on these perceptions and do not advance the right of women to choose freely and fairly whether or not to end their pregnancy as it does not allow for their own reasoning and decision making. The most frequent stated reasons is taken in isolation and presented as the true reasons for women terminating a pregnancy. These reasons are not investigated in relation to each other or within a relationship where reasons are influential to making a decision to terminate a pregnancy.

This is not a true reflection of why women choose to terminate their pregnancy or choose not to. There exists an intricate relationship between reasons and sets of reasons. Numerous reasons exist for women wanting to terminate a pregnancy and it is crucial to explore the relationship between these reasons and the sets of reasons as no reason stands in isolation to another. An intricate web of relationships between reasons exists and those that are not primary are influenced by secondary reasons. The relationship is either a proximate cause for women deciding to terminate their pregnancy or non-proximate/ influential in the decision making process. Important as well is that reasons are personal to the situation or circumstances of women but the relationship between

HIV/AIDS, contraceptive use and abortion cannot be ignored. The proximate determinant to falling pregnant is the non-use or failure of contraception. One proximate determinant to contracting HIV/AIDS is the non-use or failure of condoms. The influence of this on the decision making process of women is part of the personal reasons for deciding to terminate a pregnancy but important when investigating the reproductive rights of women.

The reasons for choosing to terminate a pregnancy is personal and in relation to the current (and possible perceived future) of women and must look at the personal circumstances, situation and experiences of women that is their true reality. To be able to investigate the true reality of women in deciding to terminate their pregnancy, we must allow for women to narrate their personal stories by using their own words and the meanings that they ascribe to it. Only when we allow women to give a voice to their personal situation, can we get a true reflection of what reasons or sets of reasons motivate women to choose to end their pregnancy.

Some might argue that we already know why a woman obtains an abortion: she does not want the baby, and that we should look no further (Bankole, Singh & Haas, 1998:1). The immediate explanation that women often give for seeking induced abortion is that the pregnancy was unplanned or unwanted. A time lag exists between a woman knowing that she is pregnant and having the actual abortion and this indicates that the decision is more complex and is usually motivated by more than one reason. However, the complex social, economic and health circumstances that underlie such explanations have not yet fully been explored and can only be done if we give women the platform to tell their stories within this complex reality. By not allowing women their say, it denies the existence of various steps between the acknowledgement of a pregnancy and having an abortion.

Conditions that were either unknown or were less serious before conception may change, resulting that the pregnancy wanted at the time of conception is not wanted later on. The same holds true for women that were faced with an unwanted pregnancy. Conditions that were more serious at conception may change to make it conducive for women to continue with the pregnancy and therefore not to opt for a termination. Women that are faced with choosing to terminate their pregnancy may therefore choose to either do so, or may choose an alternative dependent on their personal situation.

To be able to identify the reasons or sets of reasons within their unique relationships and the impact on women's decision making, it is crucial to allow women to tell their own stories true to their own reality as to what motivated and influenced them to decide to terminate their pregnancy.

1.7. AIM OF THE STUDY

Not all unwanted pregnancies end in a pregnancy termination. The importance was to investigate why certain women choose to terminate an unwanted pregnancy while others choose not to. What are the factors that led to women to follow this specific course of action? What are the reasons that differentiate women terminating a pregnancy compared to women that choose not to?

International and national studies conducted as to the reasons for women terminating their pregnancy are based on statistics gathered to indicate a ranking in terms of the most frequent reported averages for the most common reasons cited. The studies do not however allow for women to give a voice to their personal situations, circumstances and experiences which led to their decision to terminate their pregnancy.

Thus the aim of the study was to investigate the reasons given by women for choosing to terminate a pregnancy over other alternatives to deal with an unwanted pregnancy.

1.8. DELIMITATIONS OF THE STUDY

The delimitations of the study is in terms of the participation of respondents: 1) the only variable under consideration was that women had already terminated their pregnancy, and 2) twelve willing respondents were interviewed based on voluntary participation.

1.9. LIMITATIONS OF THE STUDY

The limitations of the study can be seen in terms of the following:

- 1) A literature review on a controversial subject such as abortion can never be fully complete. Problems regarding the literature were found, as most literature on abortions in South Africa is completely out-dated, i.e. in the years prior to the Choice of Pregnancy Termination Act no. 92, 1996. Few studies have been completed about the reasons for women choosing an abortion since the status of abortion has been legalised;
- 2) Studies after the implementation of the act does not focus on the reasons women have for deciding to terminate their pregnancy, but rather on statistical profiles;
- 3) Most of the literature regarding legalised abortion is limited to countries where the status of abortion has been legalised for a number of years. This poses a problem as

the culture and factors contributing to women having abortions differ from the scenarios present in South Africa.

- 4) Data regarding abortion in South Africa is limited and contradictory to each other. Studies preceding the legalised status of abortion, focused mainly on the number of illegal abortion performed with varying statistics. Statistics provided by the Department of Health also contradict each other and no uniform method of data collection exists between state hospitals and abortion clinics.
- 5) Problems regarding the fundamental statistics of abortion were also experienced, as the Department of Health is reluctant to provide the information. The researcher had to make use of limited information gather from various forms of media.
- 6) Due to the sensitive nature of the topic, access to respondents was difficult. This resulted in the study being limited to one reproductive health care clinic, the Reproductive Choices Clinic in Midrand, Gauteng. The choice of the clinic was based on the fact that the clinic was the only clinic found to be providing post-abortion counselling. Other designated hospitals and clinics only provide counselling preceding the abortion. This meant that an interview had to be conducted with patients immediately following an abortion procedure. This was unacceptable to the researcher as it was viewed as unethical. The consequence of this is that some variables may be underrepresented in the study and some information may have been lost. This did not however impact on the study as the aim was not to generalise findings to the greater population.
- 7) Problems were also experienced with respondent's reluctance to be interviewed due to the sensitivity of the subject matter. Respondents either refused to be interviewed and those that willingly did, may have been reluctant to provide too much information.

1.10. ASSUMPTIONS

The assumptions made regarding this study was that the women that had an abortion at the Reproductive Choices Clinic had access to money as the cost of an abortion was R850.00. This led to an assumption that the respondents could be classified in terms of their socio-economic status as middle-class or financially free as they are able to afford the abortion at a private clinic and did not need to have the procedure performed at a government hospital. The assumption also holds true as accessibility to the clinic was between Pretoria and Johannesburg and not close to public transport routes.

No other assumptions were made as to the age, marital status, race or level of education of the respondents or the gestation period.

1.11. RESEARCH METHODOLOGY

To achieve the aims of the research, it was decided that a feminist framework would provide the basis for a qualitative study to be employed to explore the reasons that women have for terminating their pregnancy as well as to provide the platform for women to narrate their stories in terms of their personal situation, circumstances and experiences. Only by allowing women to give a voice to their personal situations, do we allow women to share their true reality and what is important to them. By employing a qualitative study, it provided the platform for women to relate their stories and not be grouped into categories with weightings attached to their answers or discussions.

Taking the above into consideration, the research study was formulated as an exploratory study to investigate the reasons that women have for deciding to terminate their pregnancies. Current studies found regarding the reasons that women decide to terminate their pregnancies is based on statistical analyses of averages and rankings. It was important to explore these reasons as narrated by women themselves without preconceived categories or classifications. It was important to provide a more open-minded and investigative platform to investigate the relationship between reasons and sets of reasons narrated by women.

A semi-structured interview was used during the interviews. The reasons for the semi-structured interviews were that certain questions regarding demographical factors were pre-populated as well as certain questions regarding the investigation as to the reasons for women deciding to terminate their pregnancy. This was used as a framework for the interview but allowed the researcher further scope for probing questions as to further explanations or clarifications were possible, and to understand the construct of the woman's reality. A semi-structured interview was conducted on a one-on-one basis with twelve women that had already terminated their pregnancy. This was conducted at the Reproductive Choices Clinic in Midrand during post-abortion counselling sessions.

Access to respondents was fraught with difficulty due to the sensitive nature of the topic under investigation. To gain access to respondents, a purposive sampling technique had to be employed. Access to the respondents would have been impossible without the assistance of the staff at the clinic. The clinic staff facilitated access to the respondents for the interviews to be conducted by explaining the reasons for the study in detail during the post-abortion counselling sessions. This allowed for twelve women to participate in the research and women that were willing to participate did so on a complete voluntary basis. Anonymity and confidentiality was guaranteed to each respondent.

Many women (24) refused to participate in the research although anonymity and confidentiality were guaranteed. This is ascribed to the sensitive nature of the research as well as the fact that many women fear identification within our judgmental society.

1.12. SUMMARY

The reasons or sets of reasons that influence women in their decision to terminate their pregnancy, is crucial for us to understand the relationship between reasons or sets of reasons and their influence on one another. Reasons for deciding to end a pregnancy do not stand in isolation to each other but form a web of interlinked relationships. By allowing women to decide the outcome of their pregnancy, is giving women the power to choose their future. This does not stand in isolation to women but external factors such as the gender position of women or the liberalised status of abortion legislation impacts the extent to which women can decide.

The power of decision making must be seen within the context of human and women's rights, and therefore reproductive rights. The emergence of these rights is in accordance with the evolution of international perception changes and legislative contexts of nations. Reproductive rights are also central to the population debate and issue and it is recognised that women do not stand in isolation to this. Population polices align to the change in the international arena, and South Africa is no exception. South African population policies aligned to the ICPD led to the creation of the Choice of Termination of Pregnancy Act no. 92, 1996 which is a liberal abortion law which allows women to decide whether or not to terminate their pregnancy.

The reasons for women choosing to end their pregnancy, is not isolated to women's personal situations and circumstances. Primary reasons may be intrinsically motivated but factors such as contraceptive use, abortion and HIV/AIDS cannot be seen outside of the relationship between reasons.

1.13. CHAPTER LAYOUT

In Chapter 1 the outline and rationale for the study was discussed as to the aims and objectives of the study. The limitations and delimitations of the study as well as the assumptions for the study were listed. This encompassed the clarification of the difficulties experienced in obtain detailed literature as to the why women decide to terminate their pregnancy. It also provided a framework for the study in terms of the historical evolution of abortion legislation aligned to the change in the international arena.

From this, the South African liberal legislative stance was placed within a population policy context. An overview of the theoretical framework and the research methodology was also provided.

In Chapter 2 a literature study is undertaken to clarify the international context or arena in which the abortion debate grew. A historical overview regarding the emergence of human rights, women's rights and ultimately reproductive rights placed within a demographic context and within a feminist theoretical perspective will also be discussed. Within this context the South African population policies that affect the South African population will be set out in detail and within that, the abortion context in our country. The legal aspects of the South African Termination of Pregnancy Act no. 92 of 1996 will be detailed and compared with our previous conditional Abortion and Sterilisation Act no. 2 of 1975. An overview regarding abortion legislation within the context of the international arena will be provided. In terms of liberal, conditional, restrictive or illegal legislation will be discussed in terms of comparing international countries as well as drawing a comparison with South Africa. The rationale for conducting the study within a feminist framework will be noted as this influenced the research methodology applicable to the study. Reasons as to why women choose to terminate a pregnancy will be provided based on international studies and ethical considerations as well as the impact of the relationship between maternal mortality, abortion, contraceptive use and HIV/AIDS on women deciding to terminate their pregnancy.

Chapter 3 involves the research methodology used for the study within a feminist framework. The rationale for the research design, data collection methods, data coding and analysis within this context as well as the sampling methodology will be provided. A detailed discussion of the research process is also provided as well as the ethical considerations during each phase of the interviews.

Chapter 4 provides the research findings as per the interviews conducted at the reproductive Choices Clinic in Midrand. The findings are classified per reasons or sets of reasons stated by the respondents who had their pregnancies terminated. The reasons and sets of reasons will be discussed as well as their intricate relationship with each other.

Chapter 5 will provide a discussion and interpretation of the study. Gaps in the research will be identified and discussed and singular recommendations will be made.

CHAPTER 2 LITERATURE REVIEW

2.1. INTRODUCTION

The literature review will encompass investigating reasons women have for deciding to terminate a pregnancy. The relationship between reasons and sets of reasons for choosing to end a pregnancy cannot be seen in isolation to the proximate cause of conception, i.e. the non-use or failure of contraception. As this is also one of the proximate causes for contracting HIV/AIDS, it is important to view the possible impact of this epidemic on women's decision to terminate their pregnancy.

When viewing the right of women to determine their own reproductive behaviour, the alignment and reasoning for a feminist theoretical framework will be provided. The reasons for women deciding to terminate their pregnancy are placed within women's rights and the right of the women to narrate their own personal stories, true to their reality. The ethical considerations regarding abortion will also be reviewed and feminism will also be placed within this context.

The literature will look at the historical shift in attitude and perceptions toward abortion and the emergence of this as a central theme to human and women's rights. Within this, reproductive rights and the importance of what this encompasses must be seen within a change in the international arena toward population concerns and the role of women. The international arena forms the basis on South African Population Policies and on which the Choice of Termination of Pregnancy Act is based. A comparison will also be done in terms of the abortion liberalisation internationally and nationally and comparisons between countries will be provided.

2.2. REASONS FOR WOMEN CHOOSING TO TERMINATE A PREGNANCY

According to a study conducted by Bankole et al (1998:2), the most common reason cited for having an abortion is that the pregnancy is unintended and unwanted. The labelling of a pregnancy being unintended and unwanted involves a myriad of social, demographical and health circumstances. These circumstances are in relation to each other and do not necessarily stand in isolation to each other where the pregnancy was either unintended or unwanted. According to Bankole et al (1998:2), in the USA and in some Eastern European countries, approximately one-half (1/2) to three-fifths (3/5) of all pregnancies were unintended, and a large proportion was resolved through abortion.

In less developed countries, the proportion of recent births that are unintended, exceeds 40% even in regions where large families were still wanted, and 10-20% of births are unplanned. According to the authors, the level of unintended pregnancies for less developed countries would be even higher if accurate abortion information were available as it is estimated that high proportions of these unintended pregnancies are resolved by abortion: 61% in Tanzania, 43% in Mexico and 63% in Chile (Bankole et al, 1998:2). Although unintendedness is the first level of explanation according to their study, for many women it covers a wide range of more specific underlying factors.

Bankole et al (1998:5) state that although it is acknowledged that all abortions result from unwanted pregnancies, it must be taken into consideration that numerous steps exist between acknowledging an unintended pregnancy and having an abortion as many women who are faced with an unintended pregnancy either do not seriously consider having an abortion or do not consider it at all. Life is fluid and conditions that was either unknown or less serious before conception may also change resulting in a pregnancy wanted at the time of conception, is no longer wanted later on. Of importance is the fact that not all women seeking to have an abortion will obtain one.

Findings from 32 studies in 27 countries were used by Bankole et al (1998:1) to examine the reasons that women give for having an abortion. Regional patterns in these reasons and the relationship between such reasons and women's social and demographic characteristics were examined. The data that they used came from a wide range of sources, including national representative surveys, official government statistics, community based studies and hospital – or clinic based research. Of importance is that the study did not draw comparisons between the current legislative aspects of countries in relation to the reasons cited or the percentages obtained. The study grouped together reasons from various sources and quantified these into the most frequently stated reasons found.

The study made use of various national studies carried out between 1967 and 1997 using various databases such as Popline, Medline, Population Indexes, and National Fertility Surveys, Official Government statistics on abortion and Sub-national Surveys on Women that included reasons for abortions, National Surveys of abortion patients as well as Sub-national hospital – or clinic based surveys of abortion patients (Bankole et al, 1998:2). The information used was information provided directly from respondents that already had a termination of pregnancy performed with a range of response alternatives as per the specific database enquiry either by making use of questionnaires, interviews or assembled by medical providers.

This again does not allow for a direct comparison as these methods of collection varied depending on the survey conducted. Reporting could also have been influenced by the legal status of abortion in certain countries and therefore women's willingness to report fully on their reasons for seeking to obtain an abortion. From the 32 published studies used, they differed in their grouping of reasons and therefore exact comparisons were not possible. The authors used similar worded reasons and used their own discretion to create nine broad and according to them comparable categories.

The study by Bankole, et al (1998:1) focused on the individual reasons given by woman and their demographical characteristics. The reasoning is still classified but the categories vary. The study also found that restrictions on responses prevents a better understanding of the reasons why women have abortions, especially when women have more than one reason or find it difficult to rank reasons in order of importance. Bankole et al, (1998:4) found that a mean of 3.7 reasons, with 63% reporting 3 – 5 reasons and 13% reporting 6 – 9 reasons. Only 7% of women in the study gave just one reason for obtaining an abortion.

The study by Bankole et al (1998:1) found numerous factors which will influence women in their decision to terminate their pregnancy and classified these as per the following themes: 1) socio-economic position, 2) relationship with partner, 3) age of the woman, 4) accessibility of abortion services: in countries where abortion is not legal, safe abortion services are scarce, 5) the pricing of abortion services result in poorer women risking their life and health to have unsafe abortions performed, 6) religious opposition, 7) values that oppose abortion, 8) community values that oppose abortion, and 9) partner's objections.

These values influenced women into making their decision to terminate their pregnancy or stood in proximate reasoning to the termination. The authors state that influencing factors such as religious opposition and values that oppose abortion were secondary to the main reasons cited but were important nevertheless.

The results from this study state that worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing. Of interest is that this is directly linked to a woman's demographic characteristics as with few exceptions, older women and married women cite limiting childbearing as their main reason for abortion. In Kazakhstan and Uzbekistan, more than one-third and approximately four-fifths of unwanted/unplanned pregnancies result in an abortion where women want to stop childbearing (Bankole et al,1998:1). It must be noted that in former Soviet states, contraceptives were not freely available and abortion was used as a form of contraception

with women having an average of 3 abortions during the lifetime. In contrast to this phenomenon, younger and unmarried women state postponement of childbearing as their main reason for abortion. The study found that 50% of women stated that birth-timing and family-size control as their most important reasons for terminating their pregnancy. In Bangladesh, India and Pakistan, one-half to two-thirds of women citing multiple reasons, cited postponing and stopping childbearing and in Czechoslovakia 49-67% of women cited the desire to postpone or stop childbearing as their most important reason. This can be ascribed to other factors in a woman's life that makes the timing of the pregnancy undesirable.

The second most common reason cited for terminating a pregnancy according to Bankole *et al.*, (1998:1), is socio-economic concerns – including the disruption of education or employment, lack of support from the father, desire to provide schooling for the existing children; and poverty, unemployment or inability to afford additional children.

In addition to these concerns, relationship problems with a husband or partner, and a woman's perception that she is too young, constitute other important categories of reasons. Economic reasons or a woman not being able to afford to properly care for a child was found to be second overall in importance. 30%-68% of women cited poverty contributing to their decision to terminate their pregnancy. Women that cited overall socio-economic reasons varied from 10%-86% depending on the country and survey in question.

Relationship problems were only indicated as a major reason in a relatively small portion of women, 4%-14% in the Czech Republic, Romania and the USA. In Australia, 19% and 16% in the Netherlands stated that problems with their husbands or partners were contributing factors. In the USA (51%) and Australia (29%), women mentioned that they did not want to be a single mother. Underlying this was the threat from partners to abandon the women if she gives birth, the partner or the women herself refusing to marry to legitimate the birth, that a break-up is imminent for reasons other than the pregnancy, that the pregnancy resulted from an extramarital relationship, that the partner mistreated the women because of the pregnancy or that the husband or partner simply does not want the child. The study found that sometimes women combine these reasons with not being able to afford the baby, which suggests the importance of having a partner who can offer both financial and emotional support.

Being young and unmarried were other reasons found. Being too young or fearing that parents or others would object to the pregnancy was found to be a common reason with

10%-37% of women gave this as their main reason, again depending on the survey and country. In Australia this was found to be true for 25% of women being too young while 15% did not want their parents or others to find out about the pregnancy.

Risk to maternal health was cited in 10%-38% of the cases. This includes risk to either the physical or mental health of the mother. This can be quite tricky as a true reason as this could either be true as identified by a medical practitioner or diagnosed by the woman herself. The other concern is that in many countries, this is one of the conditional allowances made for women to be able to terminate their pregnancy and thus supports the legislative allowance as well as the moral justification in terms of society.

Foetal defects or potential problems for the baby were rarely reported. This could stem from low actual incidence of birth defects, as women obtain an abortion before defects could be properly known or it is not generally detected in developing countries. These reasons may also have been grouped together with other reasons in some studies or been omitted all together. This was only cited as a reason in one-third of the countries with 11% in India and 5%-8% in South Korea, Taiwan and Thailand. In terms of these countries, it is assumed that sex selection plays an important role and is ascribed as a foetal defect.

Other reasons were less common with only 10% of women choosing this although this was an option across all the surveys and databanks used. These were unspecified and did not give attention to why women seek an abortion. It must be noted that this must not be seen as a uniformed meaning to all women as many may have selected this where sensitive issues such as rape or incest may be the cause of conception.

Important was the focus given to the use or non-use of contraception. The study found that women that wanted to postpone or stop childbearing were either not using contraception or were not using it correctly. This was especially true for sub-Saharan Africa. There were many reasons for women not using contraception including ambivalence about pregnancy, lack of knowledge regarding contraception, their own partner's opposition to family planning, poor access to contraceptive services, fear of side effects and woman's perception that she cannot become pregnant. The study by Bankole *et al* (1998:8) also state that methods used by women who want to avoid pregnancy do not necessarily provide complete protection and each method can fail even if used correctly.

The failure rate of the pill is 8%, the failure of condom is 15% and the more traditional methods such as abstinence and withdrawal are as high as 26% (Bankole *et al*, 1998:8). Many women also use less effective methods such as periodic abstinence, withdrawal and other traditional methods.

2.2.1. CONTRACEPTION

Even though the planning status of an abortion does not tell us the full reason why women choose abortion, understanding the prevalence of an unplanned pregnancy and its proximate cause – non-use of contraceptives or contraceptive failure – is essential for understanding the context within which women seek abortion. In this context, abortion can be viewed as a result of the non-use of contraceptives or contraceptive failure. The opposite is also true, that abortion can be used as a method of contraceptive use.

Although abortion is not advocated to be performed as part of contraceptive use, it cannot be denied that this is true in many areas of the world, especially in less developed countries (Mangnani, Rutenburg & McCann, 1996:36) where access to safe contraceptive methods is limited. Jacobson (1994:177) concurs that abortion is the most common form of contraceptive use worldwide. The incidence of abortion of a specific population is influenced by the availability of contraceptives to the woman, access to information regarding family planning, access to effective reproductive health services and the way in which woman can empower their sexual partners to use contraception. Improved methods of contraception may help prevent unplanned pregnancies including contraceptive education and education related to abstinence.

The UNFPA (1998: 5) estimate that if resources fall short, 97 million additional individuals and couples who would have chosen contraception will not be able to do so, totalling between 130 – 170 million people who are not able to use contraception for the period 1995 - 2000. In many less developed countries, the incidence of abortion is an important indicator of the availability, accessibility and use of contraceptive services. The contraceptive prevalence for married women in less developed countries was only 9% in 1965 and it had risen to 60% by 1997. It is estimated that in 1990, 300 million couples were using what they termed as unsatisfactory contraception while 100 million couples were not using any form of contraception although they did not want children (WHO, 1998:184). A lack of accessibility as reason for non-usage of contraceptives was reported to be 9% in Uganda, 12% in Kenya and 18% in Togo (WHO, 1998:185). In Russia, only 63% of women aged 24-49 used some form of contraceptive in 1992-1993, and this figure increased to 67% in 1994 (Entwisle & Kozyreva, 1997:16).

Jacobson (1994:178) states that in Poland, only 12% of the population that can produce children use reliable methods of contraception. The UNFPA (1998:5) states that with continued inadequate contraceptive usage, the number of unintended pregnancies will increase dramatically – by 130-230 million for the period 1995-2000 worldwide.

The South African Abortion Survey (De Jonge, 1999:2) states that the overarching reason for an unplanned pregnancy was found to be the ignorance regarding contraceptive methods and usage. In South Africa it is estimated that contraceptive use stands at 50% (WHO, 1998:196). The UNFPA (1997:x) state that contraceptive prevalence for South African married women in 1994 was estimated to be approximately 60%. The highest usage was found to be amongst Whites (81%) and lowest amongst Africans (55%), with huge discrepancies between the high usage in urban areas and the low usage in rural areas. This discrepancy can be attributed to various factors such as the availability of contraceptives, the choice of contraceptive methods and access to information and clinics.

In addition to the increased exposure to unwanted pregnancies due to non-use of contraceptives or contraceptive failure, another factor of grave concern is the increase of exposure to HIV/AIDS. The impact of HIV/AIDS on the decision making in the case of the woman or partner being HIV positive and/or the impact of this in terms of the support structure of a family impacted with HIV/AIDS is crucial to the women deciding to terminate their pregnancy.

2.2.2. HIV/AIDS

According to USAIDS (2003:1) 60 million people have lived with HIV/AIDS since the epidemic was identified more than 15 years ago, and 20 million have already died from the disease.

The figures indicated are staggering when taking into consideration that globally sub-Saharan Africa is the most severely impacted with an estimated 24 million people currently living with the disease (HSRC, 2002:1) compared to 26.6 million stated by USAIDS/WHO (2003:7) for the same region. These totals are estimated to be 30% of the globally infected people, and when taking into account that this region holds less than 2% of the world's population, it truly reflects itself as an epidemic. USAIDS/WHO (2003:7) state that an additional 3.2 million people became infected during this period with an estimated 2.3 million deaths for 2002 in the region. African women are also more prone to becoming infected, at least 1.2 times more likely than men.

This can be ascribed to the sexual activity of women starting at an early age and that young women tend to have sex with older partners (USAIDS/WHO: 2003:7). The authors also state that women are found to be 2.5 times as likely to become HIV-infected as their male counterparts and that this can be ascribed to the biological fact that HIV generally is more easily transmitted from men to women.

The following HIV/AIDS figures were reported by USAIDS/WHO (2003:2).

GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC
December 2003

DESCRIPTION	CATEGORY	NUMBERS
Number of people living with HIV/AIDS	Total	40 million (34 – 46 million)
	Adults	37 million (31-43 million)
	Children under 15 years	2.5. million (2.1-2.9 million)
People newly infected with HIV	Total	5 million (4.2-5.8 million)
	Adults	4.2 million (3.6-4.8 million)
	Children under 15 years	700 000 (590 000 – 810 000)
AIDS deaths	Total	3 million (2.5-3.5 million)
	Adults	2.5 million (2.1-2.9 million)
	Children under 15 years	500 000 (420 000-580 000)

As stated, HIV/AIDS, is more severe in sub-Saharan Africa with prevalence's varying cross the continent, ranging from less than 1% in Mauritania to 40% in Botswana and Swaziland. It is estimated that one in five pregnant women are infected in most countries within Southern Africa (USAIDS/WHO, 2003:7). A trend analysis of antenatal clinics in eight countries between 1997 – 2002 show HIV/AIDS levelling off at 40% in Gabarone, Botswana and Manzini, Swaziland; 20% in Lusaka, Zambia; 18% in Maputo, Mozambique; 16% in Blantyre, Malawi; 30% in Lesotho; 23% in Windhoek, Namibia; 25% in Harare, Zimbabwe; and exceeding 30% in Johannesburg, South Africa. USAIDS/WHO (2003:9) state that in Botswana, Lesotho, Namibia and Swaziland, the epidemic has assumed devastating proportions as seen by the percentages indicated and when taking into consideration that a decade ago, Botswana stood at 4% compared to the now 40%.

When comparing Southern Africa to Eastern and Central Africa a very different picture emerges. A decline in the prevalence of HIV infections is evident especially in Uganda where it stood at 8% in 2002 compared to 30% a decade earlier. The same is evident in Rwanda where it now stands at 13% compared to 35% in 1993.

USAIDS/WHO (2003:11) continues that in Addis Abba, among 15-24 year-old pregnant women, the prevalence has dropped to 11% from 24% in 1995. In Kenya, the prevalence among pregnant women is 10%. For these countries and their declining figures, human intervention in the form of education programmes and condom distribution proves that governments can make an impact if this is focused and targeted. It must however be noted that the prevalence of HIV/AIDS among pregnant women are much higher in urban areas compared to rural areas.

In South Africa, 2002 data show that the average rate of women attending antenatal clinics has remained at a constant high level from 1998-1999 ranging between 22%-23% and then increasing to 25% in 2000-2002 (USAIDS/WHO, 2003:9). The highest prevalence in South Africa is amongst young women between the ages of 15 – 24 years. The authors found that a slight decline in teenage prevalence (between ages 15-19) has been offset by consistent high levels among 20-24 year old pregnant women and rising levels among those aged 25-34. It is estimated that 25% of all pregnant women are now HIV positive. The epidemic varies within our country as 37% prevalence among antenatal clinic attendees in Kwa-Zulu Natal is three times higher than that recorded in the Western Cape, with a total of 5.3 million South Africans living with HIV at the end of 2002 (USAIDS/WHO, 2003:9). The authors state that South Africa is experiencing a relatively recent epidemic and when looking at current trends, deaths will continue to rise rapidly over the next five years.

The high rate of infection can be ascribed to behaviour and the risk that women and men expose themselves to. The following behavioural risks have been identified by the Nelson Mandela/HSRC Study of HIV/AIDS in 2002 (HSRC, 2002:78):

- Age of first sexual intercourse;
- Sexual experience and number of partners;
- Condom access and use;
- Socio-cultural practices; and
- Sexually transmitted diseases.

The behavioural risk factors described is crucial when the age of first sexual intercourse is taken into consideration. The average age in South Africa is 18 years which could lead to a number of sexual partners during a life time. It is also true that younger women tend to have sex with older men that have already had previous sexual partners.

The sexual experience and number of partners is crucial as this increases the risk of contracting HIV/AIDS. Various socio-cultural practices such as polygamy, dry sex, rites of

death of spouse for widows also impact on the transmission of the disease. Apart from sexual abstinence, condom use is the only other preventative method available. This relates back to knowledge regarding usage and correct usage which is only possible with education and access to condoms. Not only do condoms prevent the transmission of HIV/AIDS, it is one proximate contraceptive form that prevents conception which also prevents the transmission of HIV/AIDS to a child.

Another aspect regarding HIV/AIDS is knowledge, perception and attitudes:

- Knowledge regarding transmission and effects;
- Knowledge and prevention behaviour;
- Relationship between socio-demographic variables and HIV/AIDS knowledge;
- Attitudes and stigma toward people living with HIV/AIDS; and
- Access to information.

Knowledge regarding the transmission of HIV/AIDS is crucial especially when taking risk behaviour as well as perceptions and stereotypes into consideration. The effects of HIV/AIDS are not commonly known as people can live for a number of years without physical effects. To some, this translates that the person is not infected or sick at all until full-blown AIDS becomes evident. Knowledge regarding prevention behaviour in terms of sexual abstinence and condom usage is marred by other factors such correct usage, gender influence and “it wont happen to me”. The study also found that respondents that were younger, more educated, who live in urban areas, who are employed and who have higher household socio-economic status are more informed. The study also found that the White population group are the most informed followed by Indian, African and Coloured population groups. Access to information regarding the disease as well as the prevention thereof is crucial to combating this epidemic. It was found that the higher the level of education, the better the knowledge regarding prevention, infection, transmission and care.

Sadly, the perception and attitude toward people infected with HIV/AIDS, is negative and people tend to avoid infected or ill people. This is true where infected children are concerned as well as if the mother and/or father is infected. Due to this no support structure could possibly be in place which could result in a HIV positive mother deciding to terminate her pregnancy.

The Nelson Mandela/HSRC Study of HIV/AIDS in 2002 (HSRC, 2002:101) found that all race groups are affected by this epidemic. The differences in the rate of infection can be ascribed to social and behavioural determinants such as living in informal settlements,

access to information and education necessary for prevention, knowing people who have HIV/AIDS or who have died from AIDS, multiple partners as well as having a sexually transmitted disease. Not only does the prevalence differ among race groups but also among gender lines and age groups. Women are at a higher risk of contracting the disease as their reproductive systems make it easier for them to be infected where men are more effective at transmitting the disease due to semen being more infectious. Women are also more likely to have undetected sexually transmitted diseases and infections. Although biological differences can contribute to a higher prevalence among women, we also have to take gender inequality into consideration. This is true when taking the acceptance of multiple sexual partners for men into consideration, male control over contraceptive usage and the women's economic position which makes them and their families dependant on men. This relates back to women's reproductive health and their reproductive rights which is not a given in the South African context.

Of concern of the figures provided above by USAIDS and WHO, is the fact that these are numbers taken from antenatal clinics and are prevalent among pregnant women which are measurable. These do not include the numbers of women infected that are not pregnant, male infections and people that do not know that they are HIV positive. What is significant however is that with this high prevalence of infection amongst pregnant women, their HIV infection could be a primary factor in deciding whether or not to terminate their pregnancy. This could be seen regarding either their own HIV positive status, fear of infecting the child, concern regarding the future of the child as well as current available financial and support networks or the availability of future financial and support networks.

Unfortunately, studies regarding the relationship between abortion and HIV/AIDS have not been conducted and this phenomenon could increasingly impact on the reasons that women cite for terminating a pregnancy and abortion figures as such.

The reasons that women cite for terminating a pregnancy, can be placed within their demographic, social and economic contexts and behaviours. Within these contexts, contraceptive use and the prevalence of HIV/AIDS plays an important role as it either impacts demographic, social and economic contexts or is the result of specific demographic, economic or social behaviours. Although generally assumed by policy makers, the reason for a woman terminating her pregnancy, does not stand in isolation, but was found to be interchangeable within these three contexts. Of importance is the fact that these contexts and behaviours are directly linked to the status and value attached to women, and thus their right to decision making, the freedom to exert a personal choice and the right to adapt their behaviour to reflect the decision made.

If the woman is in a position to exercise these fundamental rights, her demographic, social and economic situation and position will be considerations as to terminate her pregnancy or not (UNFPA, 1998:24).

2.3. ETHICAL CONSIDERATIONS

Although abortion is commonly practised throughout most of the world and has been practised long before the beginning of recorded history, it is a subject that arouses passion and controversy (Population Policy Data Bank, 2004:iii). Abortion raises questions about human existence, such as when life begins and what is it that makes us human. It is also at the heart of such contentious issues as the right of the women to exercise control over their own bodies, the nature of the states duty to protect the unborn, the tensions between secular and religious views on human life and the individual and society, the rights of parents and spouses to be involved in the abortion decision, and the conflicting rights of the mother and foetus.

Abortion raises moral and ethical dilemmas in our private conscience, societal spheres and public policy. Since the beginning of Christianity the church has been concerned with the ethics of abortion. Within the doctrines of different religions and churches there still remains no consensus on this. This view is still strongly supported today, it being the basis of the continuing controversy and debate on abortion. Most of these dilemmas are attributed to religious, moral and philosophical awareness that will dictate whether the abortion stance of a nation will be liberal, conditional, restrictive or illegal. This in itself creates sub-categories of groups within a country as the constitutional law may represent one stance where there exist discrepancies within members of a nation, as members take slightly different positions regarding abortion which stems from their own belief systems.

Mappes and Zembaty (1997:1) concern themselves with the ethical (moral) acceptability of abortion. The authors state that discussions on the ethical acceptability of abortion take for granted an awareness of the various kinds of reasons that may be given for having an abortion as well as an acquaintance with the biological development of a human foetus.

Mappes and Zembaty (1997:1) indicate the following catalogue that is sufficient to indicate that there is a wide range of potential reasons for women terminating their pregnancy:

- If the foetus is allowed to develop normally and come to term, the woman will die;
- If the health of the woman, physically or mentally, will be severely endangered if the pregnancy is allowed to continue;
- If the pregnancy will produce a severely impaired child;

- The pregnancy is a result of rape or incest;
- If the pregnant woman is unmarried, and there will be the social stigma of illegitimacy;
- If having a child, or having another child, will be an unbearable financial burden; and
- If having a child will interfere with the happiness of a woman, the joint happiness of the parents, or even the joint happiness of a family unit that already includes children. This category includes endless possibilities, the woman may desire a professional career, and the relationship might be damaged by the intrusion of a child. Parents may have older children and not feel up to raising another child.

In terms of the moral and ethical deliberation of abortion, most is based on the conditional grounds for allowing abortion to occur. The financial implication of children are also considered and the happiness of a woman, be it in a relationship or not, is also taken into consideration. In terms of the last mentioned, the happiness of a woman encompasses many social and personal issues that the woman might be experiencing

The determinant for deciding when it is morally acceptable to terminate a pregnancy is dependant on *up to what point of foetal development, if any, and for what reasons, if any, is abortion ethically acceptable?* This relates back to the question when does personhood start. Mappes and Zembaty (1997:3) state that some hold that abortion is never ethically acceptable or only acceptable when necessary to save the life of the mother, thus a conservative viewpoint. Others that hold that abortion is always ethically acceptable - at any point of foetal development and for any of the standard reasons, is seen as holding a liberal viewpoint. While others view that abortion is acceptable up to a certain point of foetal development and/or hold that some reasons provide a sufficient justification for abortion whereas others do not, is deemed as the moderate view.

The basis of the moral-religious argument is based on: *When does life begin?* The question forms the premise of the theoretical debate on whether abortion is morally justifiable and acceptable, and is also dependant on at what stage the foetus is viewed as having a soul, thus being classified as being "alive". This implies that abortion is either viewed as "murder" and "killing", or not, depending on the answer provided to the above question. The conservative viewpoint states that the foetus has full moral status and entitled to the same degree of moral consideration as a fully developed human being (Mappes & Zembaty, 1997:3). By assigning full moral status to the foetus, it entails that the foetus has the right to life that must be taken as seriously as the right to life of any other human being.

In direct contrast to the conservative view, the liberal view holds that the foetus has no (significant) moral status and no rights, and therefore abortion is not morally objectionable. Mappes and Zembaty (1997:5) further state that moderates may argue partial moral status and therefore the foetus has limited rights and moral status. In terms of moderate viewpoints, some abortions are morally justifiable and some morally objectionable. Thus both the alleged justifying reasons are relevant factors in assessing the moral acceptability of abortion.

It is due to the varying answers relating to when does life begin that the premise underlying whether women should have a choice to terminate their pregnancy or not, lies. A social consensus does however exist that when human personhood (or life) begins, that person must be protected. The distinction is made on what are the necessary and sufficient conditions of personhood. It is based on the conflicting beliefs of when personhood starts, that leads to the opposing beliefs of whether a woman should terminate her pregnancy or not (Religioustolerance: 2001).

To people that oppose abortion, human personhood (or life) begins at the instant of conception and stipulate that all abortion should be prohibited (Bouchier-Hayes, 1998:1). The main argument advanced against abortion is that the foetus is an innocent person and that it is morally wrong to end the life of an innocent person (Hinman, 2001:10). Ferreira (1985:12) states that from the middle of the 20th century, the abortion debate developed into a clash between the interest of the individual and those of society. This brings into context the debate between the collective good of a society versus the individual good. These resulted in a clash of rights between the rights of the foetus and the rights of the mother, or the rights of society as such, and were argued that the rights of the foetus were subservient to those of the mother. Within this classification, many members however will allow for conditional abortion, e.g. when the life of the woman or foetus is threatened or in the case of rape and incest. This conditional view point allows for exceptional circumstances to be taken into consideration.

The principle of double effect (Hinman, 2001:19) indicates justification based on moral grounds where bad consequences are weighted against morally justifiable consequences. This indicates that although abortion may be viewed as morally wrong and personhood viewed as starting at conception, allowances for terminating a pregnancy are made under certain conditions. These conditions are however based on moral perceptions and the consequences of continuing with the pregnancy. These may be more negative such as the potential death of the mother or when the conception occurred on a negative premise such as rape or incest.

It is important to note the conditional stance of abortion legislation where conception occurred due to rape or incest, is also dependent on the position of women in a society and the legislative stance taken on rape and incest.

In the case of a more liberal stance on abortion, human personhood (or life) does not begin the instant of conception but begins later in gestation or only at birth (Bouchier-Hayes, 1998:1). Historically, the time at which a person has been said to come into existence varies. Muslims date personhood from fourteen days after conception, Aristotle and his followers dated ensoulment at forty days after conception for a male foetus and eighty days after conception for a female foetus (English, 1997:21). This allows for the moral justification that abortion does not end the life of an innocent person as the foetus is not viewed to have reached personhood at the time of the termination. Within this classification, the debate as to when personhood starts, also vary and members will only support the choice to terminate a pregnancy if this occurs prior to the foetus reaching personhood. The premise is that abortion is an informed decision made by a woman based on her individual circumstances and position.

As previously stated, discrepancies exist within viewpoints as to when personhood starts. Even though it may be seen as starting from conception, a liberal stance can still be taken based on the situations and circumstances of women and their right to choose to terminate their pregnancy. Carl Sagan reasoned that "*abortion is a civil rights matter....a decision that should be left up to an informed woman and her physician*" (Religioustolerance: 2001). It is safe to say that consensus regarding abortion will never be reached due to the fundamental question of when does life begin

Central to the subject of abortion is the highly controversial social issue of sexuality as it leads to the consideration of how the pregnancy came about and the ways that the pregnancy could have been prevented by using contraception. Abortion is not a method of family planning or so it is theoretically positioned. It could be used as such where access to contraception is not freely available and leaves no other discourse for women to follow.

Regardless of which stance is taken on abortion legislation, the objectives are the same: to reduce the number of abortions. The methods of achieving these objectives are different and they are based on divergent beliefs about when abortions are justifiable or not. The difference lies in whether abortion is opposed in totality, whether it is allowed under certain conditions or whether it is liberal.

2.4. FEMINIST FRAMEWORK

Feminist theory has been applied in the sociological, psychological, social, economic, moral and ethical studies but not prevalent as yet within a demographical framework. Demographics are concerned with the quantitative analysis of statistics to provide us with measurable data for generalisation and comparisons. In terms of investigating reasons women have for terminating their pregnancy, it was deemed important to view this within a feminist framework as it ultimately is the woman that is impacted by terminating a pregnancy as only the woman can ultimately decide whether or not to have an abortion. In no way is the impact of abortion on partners or spouses denied, or the fact that external factors such as the opinions and actions from others or society influence women or are primary reasons in deciding to terminate their pregnancy, but it is ultimately the women and her body that undergoes a termination of a pregnancy. Mary Daly (Daly, 1973:106) states that *“one hundred percent of the bishops who oppose the repeal of antiabortion laws are men and one hundred percent of the people who have abortions are women...to comprehend accurately, they (arguments against abortion) must be seen within the context of sexually hierarchical society”*.

Sherwin (1997:49) states that because the public debate surrounding abortion has been set up as a competition between the right of the women and the rights of the foetus, feminists have often felt forced to reject claims of foetal value in order to protect women's needs. She also states that on a feminist account, foetal development is examined in the context in which it occurs, within a woman's body, rather than in isolation. Foetuses develop in specific pregnancies that occur in the lives of particular women. Sherwin (1997:49) continue that they are not individuals housed in generic wombs or full persons at risk only because they are small and subject to the whims of women. Their very existence is defined and reflects foetal development within particular women's bodies; and therefore that relationship gives those women reason to be concerned about them and themselves.

Mappes and Zembaty (1997:7) state that the following set of beliefs are common amongst feminists: 1) traditional society is patriarchal, i.e. male-dominated, 2) the institutions of contemporary society continue to advantage men at the expense of women, and 3) traditional thought patterns typically express a male point of view and often submerge and distort the experience of women. Feminist theory is mainly a response to “male-stream” theory by challenging male centred perspectives. Warren (1997:10) argues that conventional theory is about men's lives and men's worlds and is in actual fact disregarding half of the human race, that is, women as their experiences are ignored and

rather focused on that of men. This in itself distorts the truth reflected in society as women are still marginalised. McKay (1999:341) states that contrary to the conventional science that prides itself in that it is value-free and therefore a neutral science. Feminist theory argues that the commitment of conventional sociology to “value neutrality” and its endeavour to being a value-free science tends to camouflage the male political bias within the discipline.

In contrast to this, a women centred perspective attempts to present a theoretical system of ideas and features from a women centred perspective. “*What about women?*” is the underlying theme. An argument to sustain this perspective is that women’s visibility is one indicator of their inequality (McKay, 1999:342). Blackmun (1997:33) state that feminist theory has attempted to explain how the social differences between women and men have arisen and to then describe the types of social change that that would lead to equality and freedom.

Due to the increasing emphasis placed on these concerns of feminist theory, it has contributed to a theory of universal importance and produced a switch in our understanding of the world. Mappes and Zembaty (1997:7) also state that a commitment to take seriously the experience of women is also a premise for feminist theory. Of importance is the experience of women involving insistence on the importance of relationships and the responsibility in which the relationships give rise. Therefore, feminists view human beings as interconnected and interdependent individuals and not in isolation and independent of each other.

Although feminism focuses on women being central to the theme, it inexplicitly attempts to alter social institutions and situations as women are present in most social situations. Where they are not present, it is not because they lack ability or interest but because there have been deliberate efforts to exclude them. Where women are present in social situations, women’s roles are very different from the popular conception of themes, e.g. as passive wives or mother (Ritzer, 1992:310). Although women are actively present in most social situations and their roles have been essential, they still have not been identical to those of men. In this regard their roles have been different, less privileged and subordinate to those of men. Their invisibility is only one indicator of this inequality.

Apart from the first question, feminism also needs to incorporate the question of “*Why is the situation as it is?*” seeking an explanatory answer. This allows for the classification not only of the general objective of the feminist theory, but the underlying studies and expanding literature on gender (Ritzer, 1992:318).

This leads to the classification of explanations based on theoretical classifications as possible explanation. Many feminist theories are linked and based on a central point of explanation. Marxist feminism is based on capitalism being the basis of women's difference, inequality and oppression. Radical feminism is based on patriarchy being the basis of women's difference, inequality and oppression.

Due to the various answers in terms of the above questions, it is important to differentiate this further into the existence of many feminisms. McKay (1999:342) further acknowledges that the term "women" does not imply sameness amongst all women as it is aware of the theoretical invisibility and inequalities affected by class, race, age, religion, ethnicity, global location, personal volition and affectional preferences. Moore (1993:11) concurs that feminism is divided into many factions so to speak and also cuts across different schools, e.g. Marxists feminism, Psychoanalytic feminism, Liberal feminism, etc, and that we should term feminism in terms of the existence of feminisms.

Therefore not a united feminist perspective but rather a multitude of feminist theoretical deviations although the following underpin all feminist theory (McKay, 1999:342). Ritzer (1992:308) states that: 1) the major objective of feminist investigation is the situation (or situations) and experiences of women in society. This is true as the study aims to understand the situations, circumstances and experiences of a woman's life and these influences on their decision to terminate their pregnancy. Reasons for deciding to terminate a pregnancy do not stand in isolation and is an intricate relationship between reasons and sets of reasons. The current situations and circumstances of women provide the framework for their decision making and outcomes are based on past and present experiences, 2) feminist theory treats women as central subjects in the investigation process by attempting to see the world from the distinctive vantage points of women in the social world. By allowing women to narrate their decision making process and the reasons that influenced their decision in their own words, allows us to see their reasoning from their own perspective and their own lives without generalisations. It is important to hear stories that are true to women and true to their lives, and 3) feminist theory is critical and activist on behalf of women, seeking to produce a better world for women.

Only by allowing women to tell their personal stories, to try to understand their own reality and by listening and conceptualising their personal reality; and by giving women a platform on which to do so, can we provide a world true to women and true to the reality of women. It is important to provide a world true to women so that we can identify factors important to women self and not based on what men deem to be important to women.

Feminist theory provides a system of ideas about human life that features women as object and subject, doer and knower. This relates directly to the complexity of life and therefore again the importance of allowing women to tell their own stories true to their reality and perceptions. By imposing preconceived ideas and generalisation as to why women decide to terminate their pregnancy, we deny the truth as seen and understood by women from their personal reality.

Reasons for terminating a pregnancy can also be seen in terms of power relationships between women and their partners, significant others and society in general as well as the perceived consequences and reactions. By following a conservative viewpoint in which abortion is never justified, we project a power relationship from a societal viewpoint onto women in terms of dictating what is right and what is not, regardless of women's current reality. From this perspective it also places pressure on women in terms of either justifying their decision against a society that views abortion as immoral and wrong. This relays that women cannot openly and honestly discuss their reasons when deciding whether or not to terminate their pregnancy. It is also true from a gender perspective where women may not have full control over their reproductive health either: choosing to use contraceptive methods to stop conception if this is against specific religion or cultural values, or that they do not have control to decide whether or not to terminate their pregnancy.

Power relationships also influence women in sharing their reality for fear of recrimination and persecution which could be possible depending on societal norms, values and legislation. When not allowing women to narrate their personal stories, again a projection of what is correct behaviour and what is not is enforced, which limit a woman's power over her own world and reality. This then also limits women to exert their personal choice from an empowered position.

Aligning to the characteristic of webbed accounts (Ritzer, 1992:344), feminist theorists do not adhere to the concept of relativism by allowing one account to cancel out another through the process of prioritisation. When dealing with demography and statistics per se, weighting and prioritisations are key and is evident when investigating previous studies regarding reasons for women deciding to terminate their pregnancy. Again, the value of this is not denied but it does not reflect a true relationship between reasons by women. The relationship between reasons and sets of reasons is equally important in terms of a woman's reality. Not one reason stands in isolation to another unless this is true to a woman's personal situation or experience. Women's reality is linked through their experiences, situations and circumstances and reasons are related to each other in terms of primary or secondary concerns.

Although reasons and sets of reasons may be common across women's stories, it is not replicated verbatim as the concerns are relative to each woman's personal reality and cannot be generalised to be true for all women that decide to terminate their pregnancy. All accounts should hold equal weighting and the accounts are woven together by reporting all the respondents' versions of their experience and describing their situations from which they came, to create these versions or understandings.

Women find themselves caught up in agendas that shift and change in relation to others and the situations of others (Moore, 1993: 5). This is very true for women that decide to terminate their pregnancy as causal factors do not remain constant and as one situation in their lives change, so it affects the decision that they make. Many factors are unpredictable although some stay constant, but based on the constant, additional liquid factors come into play. For example, a woman that falls pregnant might have the constant situation of "I am too young" but liquid factors would include relationships with her parents, partner, religious and moral values, and personal aspirations. These factors are unpredictable and open to constant change. Her knowledge and understanding of these factors would inevitably guide her decision to terminate her pregnancy or not. This is substantiated by Ritzer (1992:349) as the model presents actors in their daily lives responsively located at the centre of a web of other's actions and who find themselves part of one or more situations by forces that they cannot predict or control. The factors that cannot be controlled can be numerous and again indicates the importance of allowing women to narrate their own stories as to what constants are not malleable and which reasons can be controlled to either make the decision to terminate a pregnancy or not.

The meaning that is ascribed to actions and behaviour is based within social situations and pre-defined definitions. Male dominant viewpoints and standards can trivialise women's viewpoints and render women's experiences insignificant or trivial. This is true when taking into consideration the historical viewpoint of abortion as being wrong and not taking the importance of women's reality into consideration. The personal circumstances and situations of women are fundamental in terms of their reproductive rights but also in terms of the importance that they attach to their experience. Women's reasons cannot be trivialised or ignored as this is fundamental in whether a pregnancy will be terminated or not. Of importance when women's stories are trivialised, each abortion is then seen in isolation where this is not necessary. By allowing a platform for women to narrate their personal stories, a bond can be created where women in similar situations can communicate. This may not be true as yet, but the platform should start to be created and by at least narrating their stories to the researcher, a first step has been taken. This could assist and lead to the creation of interactions between women to share and create

meanings that depict their life experiences which are true for women. Due to power relationships and perceptions, women fear sharing their experiences as it could be trivialised and judged according to pre-conceived ideas and historical perceptions.

Another factor than needs to be taken into consideration is that women are ascribed various roles which is often seen as less important than the roles of men. Within the context, women that choose to terminate their pregnancy can view their decision as a “failure” to conform to societal norms and thus inferior to what societal expectations of women as a mother and homemaker are.

The right of women to choose whether or not to terminate their pregnancy must be seen within the evolution of feminism and the voice of women emerging within an international context. Historically abortion was viewed in terms of what men deemed as appropriate and correct in terms of women’s behaviour and terminating a pregnancy was viewed and wrong and therefore illegal. Only through a strong emergence of human rights and therefore emphasis on women’s rights, did the historical perspective change regarding abortion. Again, this is not as simple as just the emergence of human rights, but the voice of women regarding their reproductive behaviour came to the foreground in terms of population concerns raised internationally and the role of women within this paved the way for women being able to decide whether they want to terminate a pregnancy or not.

2.5. HISTORICAL PERSPECTIVE

Historically abortion has been viewed as deviant and pathological behaviour as it was largely concerned with the moral and religious values of abortion (Ferreira, 1985:11). Although it is accepted that abortion is as old as civilisation itself, it is true for illegal abortions. A shift in attitude toward abortion and abortion research were only experienced in the mid-sixties for Western countries. The Population Reports (1973a) in Ferreira (1985:20) states that the year 1973 is taken as a starting point of significant abortion law liberalisation. Five of the most populous countries – China, India, the Soviet Union and the United States – already permitted legal abortion in early pregnancy. During 1973 and 1974 policies in Austria, Denmark and Tunisia were liberalised to permit abortion upon request during the first trimester of pregnancy. The new statute in 1973 in Korea permitted abortion if the pregnancy jeopardised the woman’s health. At the same time Guatemala and El Salvador permitted abortion to save the life of a woman. Abortion upon request was permitted in France in 1975, and in the same year abortion for economic indications become legal in West Germany.

Although abortion laws were still restrictive the historical liberalisation of these laws are quite significant and even more so the exceptions. The use of abortion as a method of contraception was already prominent and accepted in the former Soviet Union from the turn of the twentieth century. Abortion on request has been available in Russia under the decree of Stalin since 1920. Various satellite countries in Eastern Europe also legalised abortion from approximately 1920. All Scandinavian countries began to liberalise their abortion laws from 1938 (Ferreira 1985:20).

The visibility that abortion received during the sixties was two-fold: Firstly, the voice of feminism became very strong although feminism has existed since 1650. Only during this period did it gain enormous momentum in terms of publications and the emergence of different feminisms. Feminism upholds the idea of bodily self-determination and that reproductive consciousness is continuous and integrative, constantly affirming women's unity with nature (Humm, 1995:240). It also upholds the argument that because being women, they are most affected by reproduction and the choice should be theirs. And secondly, physicians became more aware of the complications that were associated with illegal abortions, a move from the collective-good toward individual-good, a decreased religious adherence and morality and a shift toward abortion being more legitimate and visible.

Since the 1940's, health care professionals began to voice concern at the prevalence of illegal abortion. This evidence, combined with social, demographic and medical developments, started the move to legitimating abortion. New medical advances in the development of safe, simple and inexpensive vacuum aspiration techniques challenged existing restrictive laws. In a study by Tietze and Murstein (1975) it was found that abortion done under medical supervision involved less risk than continuing a pregnancy to term. In addition the new techniques made early terminations of pregnancy available on an outpatient basis. Ferreira (1985:15) states that many laws originally enacted to promote reproduction or to protect women from unsafe practices were amended in the light of national recognition of the benefits derived from reduced population growth and from constantly improving medical technology. The liberalisation of abortion refers not necessarily to the legalisation of abortion laws but to the relaxation of the former more restrictive laws. The trend towards liberalisation of abortion laws began after the Second World War and gained vast momentum during the seventies (Ferreira, 1985:13).

Various societal trends in the sixties further contributed significantly to the growth of abortion reform, amongst these were the emergence of civil rights movements, feminism and the growing openness in regards to human sexuality.

Sarvis and Rodman (1973:44) cite the re-emergence of the women's movements, the first signs of interest in a consumer approach to health care delivery, and growing alarm over the rapid increasing world population amongst these trends. Of importance was the focus given to a greater appreciation of reproductive rights and women's rights to control her own body and privacy, and the emphasis on the importance of bearing children who are wanted and who can be properly cared for.

Feminism states that reproductive rights include the right to become a mother, the right to contraception and the right to an abortion. Humm (1995:241) states that control over the termination of pregnancy is central to the future of women as it is essentially a political struggle about a woman's right to self-determination. Abortion on demand is central to feminist theory and politics. It is the most visible sign of an "anti-women" healthcare system as it limits women's access to safe abortion services. Legal rights do not give women material rights (Humm, 1995:1). Ferreira (1985:14) states that these factors combined with an increasing recognition of demographic pressure and awareness of the demographic impact of abortion increased the change in attitudes and approaches towards abortion.

Although there was a change in the moral-religious ethics of society and a change in attitude toward abortion, it must be noted that this would not have been possible without the emergence of human rights. It is in this context that women's rights were given prominence and as such led to the legalisation of abortion laws. This was borne out of the fundamental principle of reproductive rights that emerged in the international arena. It must be noted that human rights are not limited to reproductive rights but encompass numerous factors (Ferreira 1985:14).

Holistically viewed, the emergence and acceptance of human rights changed the role of women in society and this has also contributed to a significant change in position that women hold in society. When viewing the change from the historical figure of wife and mother, liberalised women fulfil various roles and responsibilities, and this directly contributes to the fact that women have a choice regarding their reproduction and that this choice is different for each woman based within their personal context.

To understand the importance of the change in women's reproductive lives, it is important to understand the emergence of women's rights and the arena which contributed to the acceptance of women exerting an individual choice regarding the termination (or not) of their pregnancies.

2.6. HUMAN RIGHTS AND REPRODUCTIVE RIGHTS FRAMEWORK

Up until 1974, the international arena was fraught with contradiction regarding human rights and population growth. Regardless of the establishment of the Universal Declaration of Human Rights in 1948 by the United Nations, population growth was still viewed in terms of a threat (Homan, 1991:118). The 1948 Declaration underlined the principles of equality and non-discrimination and members that undersigned the declaration are bound by it to promote and to protect fundamental human rights. Homan (1991:120) states that the most significant responsibility placed on governments is the rights given to an individual to allow each individual to make their own decisions based on non-discrimination and equality.

The context of human rights is selective depending on each nation's moral, religious and philosophical values. Human rights are certainly not universal and nations are selective in their implementation of human rights, especially human rights regarding the freedom of individual choice. This is most prominent in the implementation of reproductive rights. In the 1968 Tehran conference regarding human rights, emphasis was placed on the inclusion of reproductive rights within the framework of human rights (UNESCO, 1997:326), and that the slogan of "*parents have the right to determine freely and responsibly the number and spacing of children and the right to adequate education and information*", was born.

From the 1940's up until the World Population Conference in 1974 in Bucharest, the international arena was underlined by the Malthusian threat: the earth's resources cannot sustain or contain the world's rapid population growth. The international focus was on rapid population growth, thus high fertility creating strong barriers to economic development.

The solution was lowering fertility rates through the implementation of family planning programmes and thus promoting the use of contraceptives to reach demographically set targets (Cohen, 1995:76). Many may argue that these view points significantly impede the evolution of human rights, but contrary to this, this created a greater freedom of choice regarding individual reproductive rights and thus human rights. Ironic in the approach of curbing fertility through government programmes, and the promotion of contraceptives to deal with the collective-good rather than the individual-good and freedom, it paved the way for women to exert their individual preference regarding their fertility and reproduction.

By governments focusing on the provision of contraceptives to curb population growth, contraceptive methods became more advanced and available to women and assisted them with making personal decision based on personal circumstances (UNESCO, 1997:326).

2.6.1. THE WORLD POPULATION CONFERENCE, BUCHAREST, 1974

The 1974 World Population Conference in Bucharest was characterised by a debate between the countries of the northern and southern hemisphere (Ashford, 1995:9). Northern governments advocated demographic targets and supported the idea that family planning programmes should be the primary means to control population growth. The premise of the argument was that rapid population growth created barriers to economic development. This was vehemently contradicted by the Group 77 (G77), a non-aligned association of southern countries, who stated that rapid population growth was not the cause of underdevelopment, but rather a result of the lack of development. The G77 argued that “*development was the best contraceptive*” and that equitable socio-economic development would lay aside demographic threats (Ashford, 1995:9).

The conference led to the establishment of the World Population Plan (WPPA), which according to Ashford (1995:7) and Sen (1994:4), was the first ever formal international document addressing population policies and programmes. The WPPA compromised between the need to control population growth and the need to regard population issues as one of many variables affecting development. Of importance was the inclusion of the equality of women and their potential contribution to development.

The reference to the equality of women was unfortunately only fleeting and the WPPA advised that government actions should be taken within the framework of development, but no responsibility was placed on governments to adhere to the framework provided (Ashford, 1995:13; Sen, 1994:6).

2.6.2. THE INTERNATIONAL CONFERENCE ON POPULATION, MEXICO CITY, 1984

A reversal of views held 10 years earlier occurred. Southern countries now also advocated family planning programmes to curb high birth rates and thus rapid population growth characterised the International Conference of Population in Mexico City.

The change was based on results achieved by family planning programmes in various countries to achieve demographic targets, none more famous than China's one-child policy, reversing their previous slogan of "*China's wealth is her people*" (Ashford, 1995:7).

Ashford (1995:7) states that the Mexico City Declaration focused on the promotion of the equality of women and their potential contribution to development. This had more impact than the WPPA as the declaration also argued that nations must make safe and accessible family planning services universally available in the context of non-discrimination. The declaration was the first to note the relationship between population, resources, environment and development, and also gave more prominent attention to the rights and equality of women by stating that this must be taken into consideration during all phases of development (Ashford, 1995:8).

The withdrawal in the support of the UNFPA and the IPPF from the United States of America (USA) shocked the international arena. The USA, under the Reagan administration stated that population was a neutral phenomenon and as such withdrew funding from all agencies assisting in abortion-related services (Ashford, 1995:8-9). Characteristic of the WPPA and the Mexico City Declaration is that very little focus was placed on human rights and by extent individual rights. Individual rights were subject to the general and social well being of the community. Once again the age old debate between the collective-good versus the individual-good. Despite this, the fact that emphasis was placed on the equal status of women, paved the way for future development.

2.6.3. THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, CAIRO, 1994

The International Conference on Population and Development (ICPD) held in Cairo in 1994, was the breakthrough in the international arena by not only moving away from the idea of the collective, but also by emphatically emphasising reproductive health in the context of human rights. Johnson (1994:451) states that the ICPD based its arguments on the 1993 Women's Health Coalition, which stated that "*women have the individual right and social responsibility to decide freely when/if and how many children they desire*". This conference also focused on the fundamental sexual and reproductive rights of women and emphasised that family members, religion, policy makers, ethnic groups or governments may not dominate these rights.

Since 1974, attention was given to the status of women and their potential contribution to development, but only in 1994, was this aspect embraced by the international arena. The strength of the ICPD lies in the fact that this was the first international document or policy to be consented to by all parties present, including the Holy See (The Vatican), although accepted with objections and reservations regarding language referring to unnatural methods of contraceptive use and abortion on demand.

The World Plan of Action was drawn up by 180 governments, 1200 non-governmental organizations (NGO's) and various private organisations of which feminist groups were the most prominent (Johnson, 1994:324). Another breakthrough was that for the first time NGO's gained recognition for their role in the development of policies and for their work at grass-root levels, by affording them official participation at the conference and official involvement in the drawing up of the World Plan of Action. This revoked their observer status that was afforded them previously. The criticism of the ICPD is that the World Plan of Action is not decreed to the nations that consented to it. No government is obliged to enforce the Plan of Action, thus resulting in each government retaining their sovereign rights. This stems from the fact that many countries view human rights to be a purely western phenomenon and that it disregards their religious, moral and philosophical values.

According to Johnson (1994:326), the theme decided on prior to the ICPD was defined as "*population, sustained economic growth and sustainable development*". The importance of the ICPD does not only lie in its focus on individual rights but on the various topics brought to the foreground.

The topics as laid out in Johnson (1994:326) and the IUSSP (1995:18) are as follows:

- Population growth;
- Policies and programmes;
- Population – development - environment;
- Population distribution;
- Women-population, and
- Family planning programmes, health and family well being.

Relevant to this report is the focus on sexual and reproductive health of women, strongly advocated by women's rights groups and feminist groups. Support in their plight came in the reversal of the USA's stand on population being a neutral phenomenon.

The USA also defied attempts made by the Vatican to restrict the inclusion of abortion on demand, by declaring, “*Access to safe, legal and voluntary abortion is the fundamental right of all women*” (Johnson, 1994:327).

Sen (1994:4) state that criticism of population problems was that the previous top-down approach was target driven and according to a “*single-minded goal of fertility limitation which at times induced ethical violations, ineffective programmes, programmes with little regard for the health of women and coercive policies violating women’s rights to reproductive freedom*”. Target driven population policies view women as entities, and as part of the collective, thus disregarding their individual decision making with regard their own reproductive behaviour. The move away from the individual rights being subordinate to the collective well being of the community, promoted individual decision-making. Lane (1994:1310) states that women have borne the brunt of unethical population policies and this not only disregards their individual rights but also violates their bodily integrity.

It must be noted that individual rights are accompanied by the responsibility on the part of the individual regarding their reproductive behaviour. The focus on individual rights does not advocate demographic targets and as such does not address the population issue in terms of numbers. A vacuum that exists regarding human rights is that it does not address biological and reproductive differences between the genders and is solely based on decision-making (Lane, 1994:1307).

Reproductive and sexual rights do not only include the freedom of choice to exercise individual rights, but includes the provision of services provided. This includes access to family planning services, access to safe and legal abortion, access to safe maternal health care as well as safe and accessible health care services to all women, and access to the basic right of education. This change in focus brought about in the international arena sparked violent attacks on many nations for their existing population policies, which are still target driven. Sen (1994:4) and Ashford (1995:7) state that the underlying principle in the conference was summarised as “*a broad range of voluntary family planning programmes and services integrated into a program of reproductive and sexual health care that would include access to safe and legal abortion, based on the women’s right to control her own fertility*”.

As concluded from the above, abortion on demand is an integral part of reproductive rights; and the provision of adequate abortion services, an integral part of reproductive health. Unfortunately for feminist groups, the abortion debate at the conference was placed in medical terms, and taken out of the context of women’s rights.

This argument was a rational one as it incorporated the premise that abortion is not a form of contraception, but rather a medical issue as in most countries where access to safe abortion is restricted by legislature, high maternal mortality rates prevail. This led to a greater acceptance of the incorporation of the advocacy of safe and legal abortions in the Plan of Action (Lane, 1994:1317).

The ICPD's Plan of Action is not binding to any government and all countries remain sovereign in their rights to determine their own population policies within the framework of the Plan of Action (Lane, 1994:1318). This allows governments to place their religious, ethical and cultural heritage in a superior position to individual and human rights. The Plan of Action recommendations take on the form and quality of international norms that exercise pressure on nations who do not conform to the framework provided.

Due to the fact that the Plan of Action is not international legislation, not binding all governments to the implementation thereof, it restricts the freedom of individual reproductive rights of certain women. When taking the historical emergence of the plight of individual freedom of women into account, it is significant to note that although a major breakthrough has occurred, it is sadly limited to specific nations. The population conferences contributed significantly to giving prominence to women's rights and reproductive rights, and have allowed women to exert a personal and individual choice regarding their reproductive behaviour. Due to the fact that abortion was accepted by many countries, liberalisation, and in some instances, legalisation of abortion laws followed. This has led to women being able to make a decision regarding abortion without fear of legal recourse and to consider their personal situations in their decision making.

Of importance is that South Africa did not stand in isolation during the emergence of human rights and reproductive rights in the international context. South Africa was very much part of the adherence to the international framework and this is evident in both the previous government legislation and our constitution. South African abortion laws has adhered to the guidelines stipulated in the international arena as is evident from the Abortion and Sterilisation Act no. 2 of 1975 which was viewed as liberal, though conditional. Our legislation regarding abortion has also followed the evolution process of becoming legal, and this is evident in our current Termination of Pregnancy Act no. 2 of 1996. It must be noted that this process must be viewed in terms of our own human rights and population policies that paved the way for the legalisation of abortion.

2.7. SOUTH AFRICAN POPULATION POLICIES

The National Family Planning Program, which was implemented in 1974, aimed at limiting the population growth rate. This was perceived to be a political move, to curb the population growth rate of the black population within the context of the white minority (UNHCF, 1997:24). Within the context of the program, static and mobile family planning clinics were established and contraceptive commodities were provided free of charge. The program however came under much pressure, both for its ideological focus and for the inadequacy of its services (UNHCF, 1997:24).

In the early 1980's, the decision was made by government to implement a policy aimed at explicitly lowering the national population growth rate. This was based on the grounds that the country's resources (especially water) could not sustain the prevailing high levels of population growth (PDP, 1984:2). The 1984 Population and Development Program (PDP) conformed to the international arena in that it was a target driven population policy by attempting to reduce population growth. The PDP strongly supported the Mexico City Declaration by aligning and accepting the Malthusian threat of population growth. Strong support was given to family planning services and the use of contraceptives to reach demographic set targets. The PDP set a demographic target of achieving a total fertility rate (TFR) of 2.1 by the year 2010 (PDP, 1984:7). In recognition of the fact that family planning by itself would not achieve this objective, the policy included interventions in other areas that impact fertility levels, namely: education, primary health care (including family planning), economic development, human resource development and housing (PDP, 1984:4).

The recognition of the broader dimensions of population growth marked a significant shift in government's attitudes to the population problem. However, the PDP was still viewed by some as a political plot by the apartheid government to target specific population groups to lower their population numbers in fear of strong opposition coming to the foreground. This fact is debatable when one takes into consideration the context of the international arena. Problems experienced with the PDP are that it centred only on the provision of contraceptives and did not involve various aspects of reproductive health, such as the provision of safe and accessible health care services.

Changes in the above attitudes towards population issues became discernable by the early 1990's as the African National Congress (ANC) and various NGO's got more involved in the population issue. This is indicated by their involvement in both the 1984 Mexico City, and the 1994 ICPD conferences (Ashford, 1995:9).

After the 1994 ICPD, a need arose to replace the PDP with a service that focuses on the provision of welfare services, aimed at improving the quality of life of the whole population rather than reaching demographic targets. A desperate need existed for a policy that focused on the socio-economic development of the country as a whole.

Since 1994, under a new democratic dispensation, a turn-around in the perception of and attitudes towards population issues has occurred. Recognition of the role of population in development is viewed as inseparable from democracy, development and basic human rights.

The development of the new national population policy commenced in June, 1994 when the African Government of National Unity initiated a review of the population policy adopted during the apartheid era as well as the functions of the population units at national and provincial levels (Population Policy for South Africa, 1998: vi).

The Green Paper for Public Discussion: Population Policy for South Africa was borne in April 1995 within the context of the ICPD and within the framework of a human rights approach. The Green paper was widely advertised and written submissions were requested from interested parties and the general public. Unfortunately, response rates were low and a total of only 749 submissions were received from academics, community groups, government departments, NGO's and the private sector (Population Policy for South Africa, 1998: vi). From these responses, proposals were formulated regarding the approach that the population policy should take to reflect the findings.

According to the Population Policy for South Africa (1998:vi), the predominant view expressed was that a new population policy for the country was necessary, and that the policy should:

- Form an integral part of national development strategies;
- Have as a major goal the provision of a broad range of social services to improve the quality of life of the entire population, instead of the achievement of demographic targets;
- Ensure the establishment of effective mechanisms for the collection, analysis and interpretation of demographic and related socio-economic data and their use in policy formulation, planning, programming, monitoring and evaluation processes in various sectors; and
- Lay the basis for the construction of interventions that should receive attention as part of the implementation of specific programs in sectoral departments.

The completed draft discussion was presented to the Minister of Welfare and Population in September 1996. The following month Cabinet approved that the document be gazetted and released for public comment as the first Draft White Paper for a Population Policy for South Africa (Population Policy for South Africa, 1998: vii). This was widely distributed and public comments on the contents were invited until the end of February 1997. The Cabinet Committee approved the final draft of the White Paper for Social and Administrative Affairs in August 1997 and public hearings were held in October 1997 to offer the public an opportunity to air their views on the policy.

The White paper was tabled in Parliament in April 1998 (Population Policy for South Africa, 1998:vii). The population policy described in the White paper is designed to provide a comprehensive and multi-sectoral framework. The approach is that population concerns are multi-faceted and inter-sectoral. The policy further conforms with the Bill of Rights contained in the Constitution of the Republic of South Africa and forms an integral part of the strategies to enhance the quality of life of the entire population. The program is also inclusive of South Africa's endorsement of the Program of Action of the ICPD and thus the strategy for development that focuses in the interdisciplinary relationship between population, development and the environment. We can clearly see that South Africa adhered to the international road paved by the ICPD, and adopted the principles of the Plan of Action.

According to the Population Policy for South Africa (1998:x), twenty-four strategies covering ten broad areas were identified namely:

- Coordination and capacity building for integrating population and development planning;
- Advocacy and population information, education and communication (IEC);
- Poverty reduction;
- Environmental sustainability;
- Health, mortality and fertility;
- Gender, women, youth and children;
- Education;
- Employment;
- Migration and urbanisation; and
- Data collection and research.

The guiding principles of the policy are based on the following (Population Policy for South Africa, 1998: 7):

- All South Africans are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights and the Bill of Rights of the Constitution of South Africa. Population policies must therefore respect human rights.
- The right to development is a universal, inalienable and integral part of fundamental human rights. The people are the country's most important and valuable resource as well as the central subject of development. The role of government in the development process is to facilitate people's ability to make informed choices, and to create an environment in which they can manage their lives.
- Population, sustained economic growth and sustainable development are closely interrelated. Population policy should therefore be an integral part of an integrated system of development policies and programs in a country. Its ultimate goal should be enhanced human development.
- A population policy is more comprehensive than a fertility policy and includes such consideration as fertility, mortality and migration as well as their economic, social, cultural and other determinants.
- Timely and reliable data and information are basic prerequisites for the design, monitoring and implementation of an appropriate population policy.
- *Advancing gender equality, equity and the empowerment of women, are fundamental prerequisites for sustainable human development, and thus constitute cornerstones of population and development programs.*
- *All couples and individuals have the right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so.*
- People have the right to move freely within the boundaries of their country. Refugees may seek asylum from persecution in countries other than their own.
- Poverty is one of the most formidable enemies of choice. Therefore, one of the most important objectives of a population policy is to contribute towards the eradication of poverty and all forms of social and economic exclusion of people.
- People have the right to be informed about all matters relating to their daily lives. Consequently, the South African public should have access to relevant information concerning government policies, and an appropriate understanding of this information and its implications for all facets of their lives. This includes information on population and development issues.
- The overall well being of children should be given the highest priority by government.

- Civil society should be involved in the design and implementation of population policies and programs.

It is ardently clear that the White Paper is based on human rights and the freedom of choice. It thus moved away from the focus of lowering population numbers and fertility rates as a goal in itself, but towards the improving of the quality of life for South African citizens in the post-apartheid era. The White Paper evolved from the very restricted and limiting PDP program by taking into account that fertility does not stand in isolation to development but that various other factors such as mortality and migration are also key factors in population trends. The White Paper also moved away from the top-down governmental policy implementation to a more middle ground approach by asking for public and expert opinions and advice from across South Africa. The population policy as set out above is a holistic policy taking numerous factors that affect population as a whole into consideration and resulting in a multi-faceted approach which corresponds to the international arena. Of importance to this paper, is the inclusion of human rights, gender equality and equity, and the freedom of choice of individuals and couples regarding their own reproductive behaviour.

The importance of these factors led to a revision of reproductive rights and especially abortion rights in South Africa that focused on population policies and abortion legislation corresponding to the World Plan of Action as stipulated by the international community. This ultimately led to South African women being able to assert their personal decisions regarding their reproductive behaviour free of fear of legal recourse and to make their decisions based on individual and personal circumstances.

It must be noted that this is true for certain nations including South Africa, but not binding to nations, as the World Plan of Action was not dictatorial and differences exist in international abortion legislation (Lane, 1994:1318).

2.8. ABORTION LEGISLATION

Abortion laws in countries are adapted to their own cultural and religious views, thus allowing different nations to all adopting different forms of abortion laws. Laws also differ to the degree in which they permit a woman to choose to have an abortion. Although there is no uniformity among international abortion laws, the official justification for the termination of a pregnancy is in virtually each case concerned with the physical, mental, social and economic well being of the woman. The World Health Organisation (1990:20) states that most abortion laws have one or more clauses pertaining to procedures for the

approval of application, medical certification for the necessity of and reasons for the abortion, prescriptions regarding the locale where, when and how an abortion may be carried out, prescription regarding the handling of emergency situations, and the reporting of legal statistics for statistical and other purposes. Abortion legislation is part of every nation's legislative channel, and due to the moral-religious debate, very emotive with various groups within a nation supporting this or not. Of importance is the fact that where abortion is liberal, it does not dictate that women have to exert this choice, but only makes the choice available to women (Bankole et al, 1998:2).

Abortion legislation and can be defined as per the following four categories:

STATUS	DESCRIPTION
Illegal	Abortion is prohibited with no exception.
Restrictive	Abortion is only permitted in life-threatening circumstances.
Conditional	Grounds for abortion include eugenic (genetic) factors, humanitarian factors (rape or incest) and broad health indications.
Liberal	Abortion is permitted "on request", this being the decision of the woman and her doctor, for social indications, where the doctor considers the relevance of social factors when evaluating the threat of a continued pregnancy to a woman's health

According to the Population Policy Data Bank (2004: iii), reporting on the worldwide legal status of abortion is fraught with practical difficulties: Legal materials for especially less developed regions are difficult to obtain. The legal infrastructure of some countries are not well developed, laws in force have not been collected or brought up to date and information regarding laws is not widely disseminated even within the country itself. Other social and economic problems consume scarce resources that could be used for the publication and consolidation of legal and court decisions. Wars, civil disturbances, dramatic changes in governments, changes in governmental policies and legal systems contribute to the problem. In some countries language is also a problem and complications also arise from the federal nature of certain countries. In certain situations, in individual sub-jurisdictions (states or provinces) different laws may exist within a country. Legal provisions governing abortion are also not always held within a central text as some could be held in the criminal code while a law on abortion could describe the circumstances under which abortion is allowed.

The majority of countries follow three major legal systems: civil law, common law and Islamic law, and based within these legal systems, abortion laws can be seen as illegal, restrictive, conditional or liberal.

Civil law which derives from Roman law and more recently of from the Napoleonic Code, is a system based on codified laws such as civil codes, penal codes, family codes and commercial codes (Population Policy Data Bank; 2004: v). These codes are designed to serve as a general guide for individual conduct, with the goal of projecting justice and morality in a society.

The emphasis is on social responsibility and the rights of people are viewed within a social context. According to the Population Policy Data Bank (2004: v) a branch of civil law is socialist law which is based on the codification of socialist principles and which allows little room for interpretation, except to conform to these principles. It emphasises the good of society as a whole and not the rights of individuals.

Common law has its origin in court determinations made by judges within lands governed by the English crown. Law is not viewed as a guide for conduct but rather a means of resolving disputes by individuals (Population Policy Data Bank: 2004: v). It emphasises individual rights more than the order and welfare of society. It is therefore more fluid and less static as judges are given greater leeway to interpret statutes.

Islamic law, also known as Shariah, is a religious law. It is inseparable from religion so that no distinction exists between the secular and the religion which is the case under civil and common law systems. Islamic law is based on the text of the Quran and the sunnah, the collection of acts and statements made by the prophet Mohammed which is considered the guide for human conduct (Population Policy Data Bank: 2004: v). These laws are fixed and unchanging.

Even though these are the three basic laws, in very few cases do countries only conform to only one of these models, but most legal systems contain elements of more than one model. Laws in many countries have been strongly influenced by local legal and cultural traditions. Despite the hybrid of laws, the legal systems can still be broadly classified under the three major systems. It is within these three systems that the liberalisation of abortion legislation lies and whether the legislation can be seen as illegal such as the case under Islamic law, restrictive, conditional or liberal under either common law or civil law.

2.8.1. WORLD SITUATION

In 1987, 22 million legal abortions were reported whilst between 4-9 million were not reported, totalling 26-31 million legal abortions alone in 1987 (Abortionfacts: 2001).

A report from the Alan Guttmacher Institute continues that in conjunction with the above legal abortions, 10-22 million “clandestine” abortions were performed, bringing the total worldwide figure to 36-53 million abortions in 1987. Jacobson (1994:177) states that in 1994, 50 million abortions are performed annually, of which 20 million were performed illegally. The UNFPA (1998:5) estimate that abortion figures could increase dramatically from 50 million extra abortions to more than 90 million over the period 1995-2000.

In terms of investigating the legislative stance regarding abortion in terms of restrictive, conditional and liberal abortion laws, the most commonly cited instances in which abortion is permitted include the following:

- a) Intervention to save the life of the woman (life grounds);
- b) Preservation of the physical health of the woman (narrow health grounds);
- c) Preservation of the mental health of the woman (broad health grounds);
- d) Termination of pregnancy resulting from rape or incest (juridical grounds);
- e) Suspicion of foetal impairment (foetal defect);
- f) Termination of pregnancy for economic or social reasons (social grounds); and
- g) On request.

To better understand the classification of abortion laws and to make a comparison between nations available, a common understanding of what is classified within each of these categories is important as per the Population Policy Data Bank (1997:vii):

a) Intervention to save the life of the woman

The performance of abortions is most commonly permitted on the grounds of saving the life of the pregnant woman. Although some countries provide detailed lists of what they consider life-threatening situations, in general, these situations are not specified but left to the judgement of the physician or physicians performing and/or approving the performance of the abortion. Almost all countries allow abortions to be performed to save the life of the pregnant woman either explicitly or under the general criminal law principle of necessity.

b) Preservation of the physical health of the woman

In the majority of countries, abortion is permitted when it is necessary to preserve the physical health of the pregnant woman. The term “physical health”, however, has been defined in a number of different ways. In some countries, the definition is narrow, often encompassing lists of conditions that are considered to fall under this category. In other countries, the term “physical health” is broadly defined, allowing much room for interpretation.

In a number of countries, the abortion law does not specify whether the term “health” encompasses both physical and mental health, but merely provides that an abortion is permitted when it averts a risk of injury to the pregnant woman’s health.

c) Preservation of the mental health of the woman

Many abortion laws specifically provide for the legal performance of abortions in cases involving a threat to the mental health of the pregnant woman. What constitutes a threat to “mental health,” however, varies significantly. In some countries, no definition exists, while in others, most of them Commonwealth countries, mental health is defined to include emotional distress caused to children of the marriage or emotional distress caused to the pregnant woman as a result of her environment.

d) Termination of a pregnancy resulting from rape or incest

Permitting abortions to be performed in cases of rape or incest is a common provision of the world's abortion laws. Even in countries with restrictive abortion legislation, such as the Latin American countries, abortion is often allowed on these grounds. This is not true for Islamic countries. Such justifications for the performance of abortions take several forms. Some countries specifically mention rape and incest in their legislation. Other countries refer to these as cases in which the pregnancy is the result of a “criminal offence”, with no specification to the nature of the offence. This phrasing of the law is somewhat broader, encompassing statutory rape (consensual sex with a minor) as well as forced rape and incest. Procedural requirements also vary. Some countries require the case to be brought to court or to be reported to the authorities before permission for an abortion can be granted, thus discouraging many women from seeking to obtain an abortion on these grounds.

e) Suspicion of foetal impairment

As is the case with the juridical grounds for abortion, abortions are often permitted on the grounds of foetal impairment in countries with restrictive abortion laws. Several countries specify the type and level of impairment necessary to justify this ground.

f) Termination of pregnancy for economic or social reasons

The phrasing of laws permitting abortion on socio-medical, social or economic grounds varies widely. Some specifically mention social or economic conditions while others only imply them. Most laws that permit abortions to be performed on social and economic grounds are interpreted quite liberally and, in practice, differ very little from laws that allow abortions on request.

g) Availability upon request - abortion permitted on all grounds

In countries that allow abortions to be performed on request, a pregnant woman seeking an abortion is not required to justify her desire to have an abortion under the law. She needs only to find a physician who is willing to perform the abortion. Even in countries where abortion is allowed on request, time limits are usually set for the performance of the abortion, often within the first trimester. After this stage of pregnancy, the woman must present a valid ground for the abortion to be permitted.

Within this context, comparisons in terms of the legal standing across countries can be made. The comparisons are made in terms of an evolution in the liberalisation of laws as per the international arena.

Ferreira (1985:21) states that by 1976, 60% of the world's population lived in countries where abortion during the first trimester of pregnancy was legal, either for social and economic reasons, or on request. Another 16% were residing in countries where abortion was permitted on extended medical grounds, for genetic indications, and/or for humanitarian reasons associated with rape or incest. Most of the countries that permit abortion under a broad range of conditions are located in Asia, Europe and North America. In most Latin American countries, abortion is either completely illegal or permitted only to protect the woman's life or health. At this time South Africa was viewed as a country with a more liberal stance under the Abortion and Sterilization Act no. 2 of 1975 as this act allowed for abortion on certain conditionals.

Table 1, as per Ferreira (1985:23) (see Appendix), indicates the legal status of abortion in 108 countries covering a total of 4001.2 million people for which information was available in 1978. The figures represent 96% of the world's population and categorises the status of abortion laws for 73 countries with population numbers exceeding 5 million in terms of Liberal-, Conditional-, Restrictive- and Illegal abortion legislation.

Countries with a liberal abortion legislation totalled 27, constituting 61% of the world population. These countries constituted mostly European countries, e.g. Austria, West Germany, Italy, France and the United Kingdom. Of interest is that Italy has a very strong religious and family basis as determined by the Roman Catholic Church and population growth has declined to below replacement level. Former Soviet states that were identified included the USSR, Bulgaria, Poland, Romania, Czechoslovakia, Hungary and Yugoslavia. It must be noted abortion in the former east block countries has been prevalent since the 1920's and was used as a form of contraception with 1 out of every 3 pregnancy ending with an abortion. Only Japan and the Peoples Republic of China represented Asia.

This can be ascribed to China's one child policy due to the high population density and growth. The Nordic countries included Denmark and Sweden, while only Zambia and Tunisia in Africa was deemed to have a liberal population policy as well as the USA representing the America's.

Countries with conditional abortion legislation totalled 36, representing 15% of the world's population. Africa and the America's were significantly represented in this category with countries in Africa being Cameroon, Ethiopia, Ghana, Kenya, Morocco, Uganda and South Africa. South American countries included Argentina, Brazil, Cuba, Chile, Ecuador, Mexico and Peru. This can be ascribed to the South American countries also having a very strong Roman Catholic basis and only allowing for abortion on certain conditions. Unlike the USA, Canada only adhered to conditional abortion laws in 1978. Asia also having a strong family and religious basis was represented by Nepal, The Republic of Korea and Thailand. Middle Eastern countries such as Syria and Turkey also allowed for conditional abortion even under very strong Muslim religious doctrines.

The majority of the world's population (2568.3 million people) lived in countries where abortion laws were liberal, but only constituted 27/108 countries, whereas the majority of the world's countries (36/108) adhered to conditional abortion laws but only included 614.1 million people.

A total of 30 countries, being the second highest after conditional abortion laws, constituted only 11% of the world's population is categorised as restrictive. African countries included in this category were Algeria, Ivory Coast, Malawi, Nigeria, Senegal and the Sudan. South American countries included Guatemala and Venezuela while Middle Eastern countries included Iraq, Pakistan and Sri Lanka. This corresponds more to the restrictive Muslim religious views on abortion. Of interest is that the only European countries that had restrictive abortion laws were The Netherlands and Spain.

Countries with illegal abortion laws, whereby abortion is prohibited with no exception, included Belgium, Burma, Colombia, Egypt, Indonesia, the Philippines, Portugal, Taiwan and Zaire. This category only constitutes 9% of the world's population and totalled a number of 15 countries.

It is clearly indicated that abortion laws are influenced by a nation's moral-religious ethics, but this does not solely determine whether these laws are liberal, conditional, very restrictive or illegal.

It is clear that countries that adhere to a strong religious base, whether it is the Roman Catholic or Muslim religion, are not just influenced by the religious argument of abortion. Legislative bodies also take numerous other factors into consideration and abortion laws are based on a holistic view of population dynamics while not disregarding the religious base. Although the legislative frameworks provided indicates the level to which abortions may be obtained, it is still a highly emotive issue within different sectors of a nation. It is ardently clear that the promotion of rights and reproductive rights in the international arena has made a significant impact on abortion legislation worldwide. A significant shift in the liberalisation has taken place when comparing the abortion legislation of 1978 with that of 1999.

Table 2 (see Appendix) indicates the grounds on which abortion is permitted in various countries. The ground for abortion as indicated includes to save a woman's life, to preserve physical health, to preserve mental health, rape or incest, foetal impairment, economic or social reasons and upon request. In terms of the figures indicated, abortion is viewed as legal when abortion services are provided upon request. Where this is not indicated, abortion is viewed on a conditional basis.

For the purpose of the study, countries which have liberal abortion laws are indicated as this represents the greatest shift in attitude when compared to the abortion legislation in 1978.

A total of 193 countries were included in the review. Out of a total of 193 countries, only 52 countries allowed abortions to be preformed upon request. This however is a significant change when taking into consideration that in 1978, only 20 countries had liberal abortion laws. 63 Countries cited that abortion is allowed on economic and social grounds, 76 countries allowed for abortion where foetal impairment was evident, only 83 countries allowed for abortion where rape or incest was involved, 120 allowed for abortion to preserve mental health, 122 allowed for abortion to preserve physical health and 189 allowed abortion to save the woman's life. It is clear that most countries still adhere to conditional abortion legislation when taking these factors into account. This in itself is also a significant change as only 4 countries still adhere to abortion laws that are illegal compared to 15 countries in 1978. It must be remembered that conditional abortion laws also differ from country to country depending on the conditions defined in the legislation, but it is still classified as conditional abortion laws (World Abortion Policies: 1999).

Abortion upon request is more evident in more developed countries (totalling 48 countries) as 31 countries allow for these compared to only 21 countries in less developed regions

(totalling 145 countries). Abortion based on economic or social grounds is allowed by 36 more developed countries compared to only 27 less developed countries. The majority of countries in both more developed and less developed regions allow abortions where the woman's life is at risk (World Abortion Policies: 1999).

Of interest is that where rape or incest is cited as a condition for abortion, 39 more developed countries allow for this whereas only 44 less developed countries. This can be ascribed to human rights and reproductive rights, as the position of women in less developed countries are usually inferior and tend to be less significant than those of men. Cultural and traditional views of women are more adhered to in less developed countries and in many countries rape is not deemed as a crime due to the gender position of women in society.

Table 3 (see Appendix) indicates countries that have liberal abortion laws. Since the Termination of Pregnancy Act no. 92 of 1996, South Africa is now the third African country with liberal abortion legislation. Tunisia has remained constant in their abortion legislation as it was already classified as liberal in 1978. In 1978 in Asia, only the Peoples Republic of China and Japan had liberal abortion legislation but compared to 1999, this has increased to 15 countries, including Mongolia, Cambodia, and Vietnam. The Democratic Peoples Republic of Korea and Syria has also evolved from conditional legislation to that of liberal legislation. Included under Asia is former East Block countries comprising of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan and Armenia, even though these countries comprise of a large Muslim religious base. In Europe, the number of countries has increase from 13 in 1978 to 39 in 1999 (World Abortion Policies: 1999). The greatest evolution is indicated by Belgium who moved from illegal abortion legislation in 1978 to that of liberal in 1999. The same can be said for The Netherlands who had a restrictive legislation in 1978, and who by 1999 has the world's most liberal abortion policy. Countries that adhered to liberal abortion legislation in 1978 did not regress to conditional, very restrictive or illegal abortion legislation. Countries that included the transition from conditional legislation to liberal abortion legislation included Australia, Canada, Cuba, Greece and Syria.

The majority of countries not indicated to have liberal abortion legislation, is still classified as conditional or very restrictive as only four countries still deem abortion illegal (World Abortion Policies:1999).

Although abortion legislation is classified as either being liberal, conditional, restrictive or illegal, the conditions for each also varies in the terms and conditions stipulated in their

abortion acts. As noted earlier, moral-religious factors influence the classification of abortion laws but do not determine them. Various factors involving human and population dynamics as depicted throughout the history of a nation, all contribute toward the compilation of legislation.

2.8.2. SOUTH AFRICAN LEGISLATION

The statistics regarding the number of abortions performed in South Africa vary although the details were obtained from the Department of Health. This leads to greater confusion as to the exact state of abortions in our country and can be ascribed to a poor collection of abortion data from the 269 (The Citizen, 5 June 2000:7), compared to 247 (The Citizen, 7 June 2000:5) hospitals and clinics that are designated to perform abortions. There are even discrepancies regarding the number of hospital and clinics that provide abortion services. What is apparent though in the results, is that the number of abortions is on the increase. This can be ascribed to an increase of women exerting their personal choice regarding their pregnancy in context of their personal position and circumstances, an increase in the need for abortion, a decrease in the stigma attached to illegitimate children, a better understanding of women that opt to terminate their pregnancy or a combination of these and other factors.

During the first 18 months (February 1997 – July 1998) 48 321 abortions were conducted and from 1997 – 2000, 160 000 were performed with 39 334 in 1998 (The Citizen, 7 June, 2000). This increased to 45 000 in 1999 and 51 132 in 2000 (Rapport, 24 June, 2003:4). It is estimated that to date approximately 350 000 abortions have been performed (Love Life, 26 March, 2004:18) with 50% of abortions having been performed in Gauteng followed by 13.5% in the Western Cape.

The perception that exists and that are expressed by members of society and in various studies is that women that terminate their pregnancy are unmarried, uneducated, irresponsible and promiscuous teenagers (The Citizen, 5 June, 2000: 7). Furthermore, the perception exists that these women are selfish, immoral and use abortion as a method of family planning with no remorse or emotion. These perceptions are stereotypical and not necessarily substantiated. It does not take the personal situations of women into consideration. The liberalisation of South Africa's abortion law is aimed at providing abortion services to all women, regardless of age, race, education levels, marital status or other characteristics.

The Choice of Termination of Pregnancy Act no. 92 of 1996 is classified as a liberal abortion law. The basis of the development of this act is within the context of the Program of Action of the ICPD and the White paper for a Population Policy.

The premise on which the act was passed is set out in the Choice of Termination of Pregnancy Act no. 92 of 1996 (Government Gazette. No 17602, 1996:2) and recognises the following:

- The values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the achievement of human rights and freedoms which underlie a democratic South Africa;
- That the Constitution protects the right of persons to make decisions concerning reproduction, and to security in and control over their bodies;
- 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 a safe pregnancy and childbirth;
- 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 include family planning and contraception, termination of a pregnancy, as well as sexuality education and counselling programs and services;
- 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 the termination of a pregnancy is not a form of contraception or population control; and
- Promoting reproductive rights and extending 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.

The following are circumstances in which and conditions under which pregnancy may be terminated (Government Gazette no. 17602, 1996:4):

- A pregnancy may be terminated –
 - Upon request of a woman during the first 12th weeks of the gestation period of her pregnancy;
 - 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 –

- The continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- There exists a substantial risk that the foetus would suffer from a severe or mental abnormality; or
- The pregnancy resulted from rape or incest; or
- The continued pregnancy would significantly affect the social or economic conditions of the woman; or
- After the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or registered midwife, is of the opinion that the continued pregnancy-
 - Would endanger the woman's life; or
 - Would result in a severe malformation of the foetus; or
 - Would pose a risk of injury to the foetus.
- The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1) (a), which may also be carried out by a registered midwife who has completed the required training.

From these conditions specified, the liberal stance can be credited to the fact that a termination may be performed *upon request* of the woman during the first 12 weeks of her gestation period and also the fact that from the 13th up to and including the 20th week of her gestation period “*if the continued pregnancy would significantly affect the social or economic circumstances of the woman*” (Government Gazette no. 1760, 1996:4).

Most conditional abortion laws are restricted by the medical situation of the woman and/or foetus, but this mentioned loop-hole leaves a large room for abortions to be carried out up to and including the 20th week of the woman's gestation period. This fact has come under severe attack from various fields as this “allows” women to resort to abortion at a late stage in the pregnancy. It must be noted that no designated institution or healthcare worker may be forced to perform an abortion, and may exercise the right not to perform one free of coercion and force. Abortion practitioners limit themselves to abortions that are within the 12 week gestation period with very few institutions performing abortions on patients who have exceeded this gestation period.

Of interest in the act, is the specification that the State shall promote the provision of non-mandatory and non-directive counselling, before and after the pregnancy. This however is not compulsory and very few of the designated institutions provide post-abortion counselling. De Jonge (1999:2) states “*results indicated that levels of emotional distress in the short term after a TOP are much lower than before a TOP and as a result most*

women do not want post-abortion counselling". This statement will be revisited during the findings and recommendations of the study.

Another insert in the act is that "*no consent other than that of the pregnant woman shall be required for the termination of a pregnancy*" (Government Gazette no 17602, 1996:6). This includes a pregnancy in the case of a minor. Assumptions exists that a minor does not have the insight to make a rational choice regarding her pregnancy termination. The act clearly states that "*In the case of a 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 the minor chooses not to consult them*" (Government Gazette no 17602, 1996:4). The reason for allowing a minor to terminate her pregnancy without consent is that the decision should be made free of coercion, discrimination and fear.

The following are the circumstances in which and conditions under which a pregnancy may be terminated where a woman cannot make a rational decision herself (Government Gazette no 17602, 1996:6):

- 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 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.
- 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 or injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the foetus 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 foetus; or

(iii) would pose a risk of injury to the foetus,

they may consent to the termination of pregnancy of such a woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be:

Provided that the termination of pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

The South African Termination of Pregnancy Act is a very liberal abortion act aligned to the democratic dispensation of our constitution. The act does not encourage abortion as many may argue, but was passed to align to the international arena and to promote human and reproductive rights. South African abortion legislation had moved from a conditional to a liberal policy and this is evident when comparing our current termination of Pregnancy Act no. 92 of 1996 with the conditional Abortion and Sterilisation Act no. 2 of 1975.

This act only allowed abortion under clearly stipulated and defined conditions and variance from this was upheld as a breach of legislation, thus illegal. This however did not stop illegal abortions from being performed which negatively influenced maternal mortality. Under the new governments, a revision of this act followed, not just to align to the international arena but also because of the significant number of illegal abortions being performed as well as the high incidence of maternal mortality and morbidity due to the high number of illegal abortions. The maternal mortality and morbidity rate of unsafe abortions are extremely high in Africa and including South Africa as the continent of Africa was estimated to have the second highest recorded deaths due to unsafe abortions, 23 000 per annum (Pathways to Health Magazine, 1998:24).

The National Incomplete Abortion Reference Group (Department of Health, 1997:435) found that a large number of women that reported to state hospitals nationally did so as

result of incomplete illegal abortions. The group found that 8% of these abortions were definitely unsafe and that 39% were as a result of attempted abortions in the second trimester of a woman's pregnancy. According to their research, it was found that in 1994, 425 women died as a result of unsafe abortions.

Pathways to Health (1998:26) states that in a 1994 study, it was estimated that 44 686 women in South Africa had been admitted to hospitals with complications due to incomplete abortions and agree with the National Incomplete Abortion Reference Group (Department of Health, 1997:435) that 425 women died every year as a result of incomplete abortions.

In 1995 alone, it is estimated that approximately 4 000 legal abortions were performed. Unfortunately, the number of illegal abortions can only be determined by the admittance of women to hospitals due to the effect of unsafe abortions. Taking these figures into consideration, the need for the protection of women deciding to have an abortion, is significant. This scenario led to the formulation of a liberal abortion law by replacing the conditional Abortion and Sterilisation Act no. 2 of 1975 (Government Gazette no. 4608, 1975:2).

Under the Abortion and Sterilization Act no. 2 of 1975, abortion was only allowed under certain terms and conditions, such as the health/life of the mother/child, if pregnancy resulted from rape or if a pregnancy resulted from incest. For the purposes of this report, only the sections pertaining to abortion will be set forth as per The Government Gazette no. 4608 (1975:2):

No person shall procure an abortion otherwise than in accordance with the provisions of the Act.

- Abortion may only be procured by a medical practitioner only, and then only-
 - Where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy so endangers the life of the woman concerned or so constitutes a serious threat to her physical health and abortion is necessary to ensure the life or physical health of the woman;
 - Where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy creates danger of permanent

damage to the woman's mental health and an abortion is necessary to ensure the mental health of the woman;

- Where there exists a serious risk that the child to be born will suffer from physical or mental defects of such a nature that he will be irreparably seriously handicapped, and two other medical practitioners have certified in writing that, in their opinion, there exists, on scientific grounds, such a risk; or
- Where the fetus is alleged to have been conceived in consequence of unlawful carnal intercourse, and two other medical practitioners have certified in writing –
 - aa. In the case of alleged rape or incest, after such interrogation of the woman concerned as they or any of them may have considered necessary, that in their opinion the pregnancy is due to the alleged rape or incest, as the case may be; or
 - ab. In the case of alleged unlawful carnal intercourse where the woman concerned is an idiot or imbecile.
- A medical practitioner who has issued a certificate referred to in subsection (1) shall in no way participate or assist with the abortion in question, and such a certificate, or such certificates issued for the same purpose, shall not be valid if issued by members of the same partnership or by persons in the employ of the same employer,
- The provisions of paragraph (a) shall not apply to the performance by any person of his functions in the service of the state.
- At least one of the two medical practitioners referred in subsection (1)-
 - Shall have practiced as a medical practitioner for four years or more since the date of his registration as a medical practitioner;
 - Shall be a psychiatrist employed by the state, if the abortion is to be procured by virtue of the provisions of subsection (1) (b);
 - Shall be the district surgeon concerned where the fetus is alleged to have been conceived in consequence of rape or incest.

It is evident from the Abortion and Sterilisation Act no. 2 of 1975 that certain conditions and requirements had to be met before consent was given to a woman to have an abortion. Not only did the woman have to meet these requirements, but it had to be determined by a medical practitioner, a psychiatrist or the district surgeon. The conditions under which an abortion was permitted was where the pregnancy endangered the life of a woman or posed a serious threat to her physical health, where the pregnancy constituted a serious threat to the woman's mental health and where there exists a serious risk that the child will suffer from a severe physical or mental defect to then be considered seriously handicapped, and where the pregnancy could be contributed to rape or incest.

In all the posed conditions, two medical practitioners had to certify in writing that this was valid grounds for the termination of a pregnancy.

The Act of 1975 also made provision for the termination of a pregnancy where it was found that the pregnant woman was of limited intellect or mentally handicapped. The legislation, although conditional, was very strictly imposed and any deviance from the stipulated guidelines for both the pregnant woman and the medical practitioner could result in a criminal offence. In terms of establishing alleged rape or incest cases, the time period required for investigations could exceed the safety period for the woman of having an abortion. Many of these conditions were intricately linked to other legislative acts such as determining when a woman's mental capacity could be defined as being that of an "idiot or imbecile". These factors led to frustration as women could not exert their personal choice regarding their reproductive behaviour and led to a high incidence of illegal and back street abortions. Resorting to back street or illegal abortions were the only choice many women could exert in terminating their pregnancy as they did not have ground for abortion offered by legislation, but their reasons for terminating their pregnancies were sufficient to resort to abortions performed in clandestine conditions and by unskilled providers. Many conditional abortion laws cater for the social and economic conditions of the pregnant woman as reason for terminating a pregnancy. This was however not the case with the Abortion and Sterilisation Act no. 2 of 1975.

When compared to the Termination of Pregnancy Act no. 92 of 1996, the age of a woman was not specified. The conditions stipulated were regardless of age whereas the current abortion law caters for pregnant minors. Many may argue that you cannot give freedom of choice to a minor; although it does align to the human and reproductive rights given to women. In the case of minors, reasons for terminating a pregnancy also vary but the most common reasons cited for terminating a pregnancy is age, completing schooling and a lack of support infrastructure. In many cases, the pregnancy was either forced and the woman is left without the support of the partner, thus placing pressure on the extended family for financial support. Another significant difference is that in the Abortion and Sterilisation Act no. 2 of 1975, abortion was allowed on the grounds of a woman's mental incapacity, whereas as this is not even noted in the new legislation.

When comparing the conditional abortion law of 1975 and our current liberal law of 1996, it is evident that a transition has occurred corresponding to international trends.

Under our new constitution, abortion legislation was aligned to human rights and reproductive rights as set out in the World Plan of Action of 1994 and also was introduced

as a medical concern. This paved the way for women to exert their personal choice regarding their reproductive behaviour in so far their cultural, religious, moral and philosophical values will allow them. Although individual rights are based on non-discrimination and equality, cultural values will dictate the actions of women when placed in the context of a patriarchal society.

2.9. SUMMARY

Within the context of reproductive behaviour, access to safe abortion services is crucial, but does not necessitate women to make use of them. This remains a personal choice and is based on the current emotional, economical and social circumstances that the woman is faced with. The choice to terminate a pregnancy is based on a rational decision making process and is dependent of the circumstances that the woman is facing. Most decisions are based on the woman's economical, social and demographical circumstances, but this classification deprives the woman of her individual reasoning and decision making as reasons are intricately linked and combined.

The investigation of reasons free from classification and ranking is imperative for us to gain an understanding of the reasons and sets of reasons that women have for terminating their pregnancy. Only by allowing women to narrate their own stories, do we get a true reflection of their reality and what is important to them.

By investigating the historical evolution of abortion legislation and the emergence of the rights of women to exert a choice regarding their reproductive behaviour, it has to be seen within the change in the international arena regarding women's rights and their positioning in terms of population. Within this context, abortion legislation is imperative to whether or not a woman can decide to terminate her pregnancy free of fear from legal recourse. Illegal, restrictive and conditional abortion laws does not stop women from obtaining an abortion if she decided, it just makes it unsafe as women then turn to illegal or back street abortions.

CHAPTER 3 RESEARCH METHODOLOGY

3.1. INTRODUCTION

The research methodology is crucial in establishing whether the aims of a study can be met and therefore adding value in the area of research. By not identifying a methodology that will support the aims of a study, the entire research project could potentially be lost.

The research methodology followed for this study will identify why a qualitative approach was followed rather than a quantitative approach especially when seen within a feminist research framework. Alongside this, the nature of the study as an exploratory study will be explained to again support the use of a qualitative approach. Problems experienced with the population, sampling and the rationale for using a non-purposive sampling technique will also be discussed. The data collection in terms of access to respondents, voluntary participation, anonymity and confidentiality within the interview process will be discussed. Finally, the details regarding the reduction and analysis of data will be provided in terms of the transcribing of the interviews, the conceptualisation of data, the coding of data as well as the analysing of data which led to the research findings.

3.2. AIM OF THE STUDY

The aim of the study was to investigate the reasons given by women for choosing to terminate a pregnancy over other alternatives to deal with an unwanted pregnancy.

The study aims to come to a better understanding of the relationship between reasons and sets of reasons that ultimately influence women in their decision making process as to whether or not to terminate their unwanted pregnancy.

3.3. RESEARCH DESIGN

Groenewald (1988:68) defines a research design typology by differentiating between five basic research designs, namely, the case study, the historical study, the experiment, the typological study and the survey. From these five broad bands, numerous new research designs were born, namely qualitative research, quantitative research, content analysis and comparative research. Groenewald (1988:68) states that the terms qualitative and quantitative research methods within this typology, encompasses the previously mentioned types of research.

Researchers today have the opportunity to choice from a multitude of research designs but the most encapsulating terms used is that of qualitative and quantitative research, which in turn is encapsulated and supported by theoretical approaches and methods of data collection and analysis.

Although contemporary social researchers have tried to close the gap that persists between the use of qualitative and quantitative research methodologies for social research, the differentiation continues to exist. According to Neuman (1997:327), although differences exist, the similarities must also be taken into consideration. The aim of both research methodologies is to ultimately seek the truth to a specific problem and a common ground should be found in the combined utilisation of qualitative and quantitative methodologies as both methodologies share basic principles of science but each has its strengths and limitations dependant on the topic or issue at hand. Although a combined utilisation is not denied, it was not deemed appropriate for the purposes of this study.

International statistical research regarding the reasons that women give to terminate their pregnancy, is based on quantitative analysis of the single reasons and factors that influence this decision. This provides a framework for investigation but because it only focuses on the most frequently cited averages, it does not provide us with a true narrative from a woman's personal experience. The statistics do not show a relationship between reasons and does not indicate sets of reasons but focuses on the ranking of reasons in terms of the most frequently mentioned or recorded. This was seen to be a limitation for the aim of this study, and therefore a qualitative approach was decided on.

A qualitative research methodology was therefore chosen as it indeed does construct social reality and cultural meaning; it focuses on the interactive processes and events and values, not only between the researcher and the respondent, but also within the situation specific reality for the respondent. It was important to provide a platform for women to narrate their personal experiences and situations as to what reasons influenced them to make their decision. Qualitative research also provided a situationally constrained environment as only twelve interviews were conducted. The analysis of the data is based in thematic analysis and the researcher does not stand in isolation to the respondent or the theme under investigation.

The focus of this research was therefore based on qualitative methods of data collection due to:

- the nature of the study,
- the sensitive nature or topic of the study,

- access to respondents,
- understanding the respondents own frame of reference while conducting the research, and
- allowing the respondent to “tell her own personal story” as to why she opted to terminate her pregnancy and did not seek out other alternatives.

The term qualitative research is used as an umbrella term to refer to various research strategies that share a common denominator. The data that is collected is rich in the description of people, places and conversations that is not fully explored or encapsulated by statistics as per the use of qualitative data collection. According to Bogdan and Bilken (1996:2) research questions are not framed operationalising variables but rather formulated to investigating topics in all their complexity and in context. As previously stated, the aim of the research was to allow women to narrate their own personal stories and the data collected is viewed in terms of relationships between reasons and sets of reasons without placing a numerical or quantitative value to their personal circumstances. This reduces women to a number and does not allow for the full integration of possible reasons which could lead to data being lost.

Qualitative data collection does not approach the research with structured specific questions to answer or hypothesis to test, but rather try to understand certain behaviour from the subjects own frame of reference while external causes are of secondary importance (Bogdan and Bilken, 1996:2). By allowing women to tell their own stories, it allowed for women to provide their own interpretation to classified themes or reasons as these differ in terms of perceptions and where a person stands in relation to a certain theme. Data is therefore collected through the sustained contact with people in their personal settings and their personal experience of a specific action or setting and the meaning that they ascribe to this. We can only come to understand the decisions made by women to terminate their pregnancies, if a “voice” is given to their personal situations and circumstances that allowed for them to exercise their decision making rights. The study did not want to test a specific hypothesis but rather investigate their personal settings and experiences which ultimately led to their decision to terminate their pregnancy. Qualitative research allows for this study to be more open to using a range of evidence and to discover new issues that might not fall within the framework that has been cited for women to undergo an abortion.

Due to the nature of this research, the focus was on the use of a qualitative approach but this in no way undermines the use and contribution of quantitative research. To understand the aim of the study, a more open and creative approach was needed,

therefore the use of qualitative research, but the study did make use of nominal and ordinal questions to obtain demographical data which would lead to our understanding of the demographical characteristics of women that terminated their pregnancy. This was incorporated when looking at the demographic profile of respondents as well as certain determinants for contraceptive use as well as reasons for terminating a pregnancy.

Of importance is the fact that up until the 1980's, research was predominantly quantitative in nature due to the adherence to a positivistic research framework as depicted by Neuman (1994:63): "*Positivism sees social science as an organised method for combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity*". This stands in contrast to the qualitative methodology which uses inductive logic and does not aim at proving or disproving a set hypothesis with empirical and objective data as the aim is not to always generalise the findings.

During the 1980's, two additional approaches or theoretical frameworks came to the foreground, namely Feminist research and Post-modern research. Both feminist research and Post-modern research further developed into different research fields within the each specific research approach.

Feminist research forms the basis of this investigation. The basis on which this research project was conducted was that of a woman's right to exert her choice regarding her reproductive behaviour and ultimately, her choice regarding her pregnancy aligned to women's and human rights. Because women can exert a choice regarding their reproductive behaviour it does not mean that all women will choose to terminate an unwanted pregnancy. This can however only be investigated if we give women a platform for voicing their reasons that led them to decide to terminate their pregnancy.

Feminist research is conducted by researchers who hold a feminist self-identity and consciously use a feminist perspective (Neuman,1997:80). Feminist methodology attempts to give a "voice" to women as women express themselves differently than men. This can be ascribed again to our personal understanding and experience of our social reality. It is important for women to relay their stories by placing it within their own personal terms of reference and social reality which is shaped by their experiences and understanding. The research is also based on an awareness that the subjective experience differs from an Interpretative or Positivist perspective which is based on a male orientation of being objective, logical, task orientated, and instrumental (Neuman, 1997:80).

The Feminist orientation upholds that the social world is a web of interconnected human relations, and tends to emphasise the subjective, empathetic, process orientated and inclusive side of social life (Neuman,1997:80). Bogdan and Bilken (1996:27) state that gender is the central topic; not only within the research, but also within the reality that women ascribe to themselves. Neuman (1997:80) states that the generalisations of research of the experience of men are generalised to all people and ignores gender as a fundamental social division while using male points of reference. Bogdan and Bilken (1996:27) align to this but add that feminism affects the content of the research as the researcher studies how the respondents make sense of the way gender constructs their world as women. This allows for the interpretations of women to take center stage and allows for their personal interpretation of their reality, thus their “voice” to be heard, especially regarding the factors in their lives that led women to decide to terminate their pregnancy.

Based within in this context, an exploratory research design was followed. According to Neuman (1997:19), exploratory research is aimed at exploring a new topic or issue of which there is little information. The goal is to formulate a premise of understanding for the formulation of more precise questions for a more systematic and extensive future research. The aim of this research was to be used as a premise for a more detailed study on women that terminate their pregnancy at a later stage when more details are known regarding their decision making and their reasons or sets of reasons, and the linked relationship between these. As previously stated, quantitative analysis of reasons have been conducted but did not investigate the relationship between reasons but rather isolated reasons in terms of ranking or frequency. Exploratory research does not aim at providing definitive answers but rather addresses the “What?” (Neuman;1997:21). This directly corresponds to the theme of the research as to what are the reasons or causes for women to terminate their pregnancy? What are the underlying factors that influence their decision?

Neuman (1997:20) establishes the goals of exploratory research as follows:

- to become familiar with the basic facts, people and concerns involved;
- to develop a well-grounded mental picture of what is occurring;
- to generate many ideas and develop tentative theories and conjectures;
- to determine the feasibility of doing additional research;
- formulate questions and refine issues for more systematic enquiry; and
- to develop techniques and a sense of direction for future research.

When taking the above into consideration it is clear that this was the best option to follow for the study as we first needed to establish a relationship with respondents in terms of the sensitive nature of the study. Because current studies are quantitative in nature, it was deemed crucial to let women tell their own stories from their own personal viewpoint to establish whether relationships between reasons and sets of reasons exist or whether these stand in isolation to each other. This allowed for a profile of respondents to be established as well as constant new themes or reasons to be established with each interview. Due to the findings (to be discussed in detail in Chapter 4), it was possible to make certain recommendations for further research and further studies.

Neuman (1997:19) continues that exploratory research is difficult to conduct as there are few guidelines to follow as the steps are not well defined and the research may change direction during the research process. This was found to be true for the research study. Although each respondent told their personal story, many similarities came to the foreground but which also differed in terms of importance. Respondents were questioned further to add additional explanations or definitions to specific statements which changed the direction of the interview and which led to further themes being uncovered. Due to the nature of the study, exploratory research also allowed for a more open-minded, flexible and investigative stance that allows for the exploration as to the relationship between reasons and sets of reasons that influence women decide to undergo an abortion.

Various methods of data collection exist within the context of qualitative research e.g. observation, participant – observation, structured interviews, semi-structured interviews, un-structured interviews, in-depth interviews, focus groups, historical research and comparative studies. Each of these methods of data collection has their merits and greatly depends on the nature of the topic under investigation. Due to the fact that the research was focused on a qualitative approach based within a feminist theoretical base, and being exploratory by nature, a semi-structured interview was chosen for data collection.

A semi-structured interview was conducted on a one-on-one basis with 12 consenting respondents to obtain the required information during the period February-November 2000. The reason for using a semi-structured interview was due to the fact that some questions had to be pre-populated to structure the interview to obtain the desired information while at the same time not curbing the information that respondents give. It had to be open-ended for the women to elaborate and explain their decision to have an abortion in their own words and understanding of their situation and experiences.

It also allowed the researcher to probe further into specific statements that were made to gain a clearer and better understanding of their circumstances, situations and their rationale to decide to end their pregnancy.

The respondents also led the interview dependant on their responses. The order of the questions differed and was sometimes addressed within another set of reasons. Respondents also directed the interview in terms of what they deemed more important as well as how these reasons interlinked with one another.

Respondents would not have partaken in the research if a trusting relationship was not established and if the researcher did not display understanding and listening skills. This was crucial for women to narrate their stories but also to narrate their stories as truthfully and honestly as possible. This was also established by the interviewer being emotionally engaged with the respondent and allowing respondents to express themselves in ways that they were most comfortable using their own terms of expression, language and terms of reference.

3.4. THE POPULATION AND SAMPLING

A population or universe refers to the large pool of cases which the researcher desires to investigate and to draw conclusions. This however is an abstract concept as one can never truly determine all the elements within a large population (Neuman, 1997:203). To define a population, a researcher specifies the unit being sampled by defining their specific characteristics that is being studied. The only characteristic taken into consideration for this study was that the women had to have terminated their pregnancy. When considering the population which is being investigated, i.e. that of women that have terminated their pregnancy, it is clear that this is an impossibility to measure. This is due to the fact that no registry exists from which we could possibly obtain names and then draw our sample.

Sampling refers to the elements within the population or unit of analysis within the population that reflects the required characteristics of the population that is researched. The aim is to then generalise the findings of the results to the entire population. The aim of this research was to not to make deductions of the reasons that influence women to terminate their pregnancy and also not to generalise to the entire population as has been the case with previous studies. The aim was to identify reasons and sets of reasons and their relationship with, and between each other, that is true to the sample respondents under investigation.

Because of the difficulty in establishing the population, it is therefore impossible to draw a random sample from the population to identify our sample respondents. The starting point to identify respondents was to operationalise our sample, therefore creating a sampling frame. The sampling frame in this research was identified as hospitals or clinics within the Pretoria region that provided abortion services and more importantly, abortion counselling services. Only within this frame, would the researcher have access to women that have terminated their pregnancy. Initially three service providers were identified, Kalafong Hospital, Marie Stopes Clinic and the Reproductive Choices Clinic. The Reproductive Choices Clinic was identified as the ideal based on the fact that abortions were performed on a daily basis, the fact that the researcher was allowed access to the facility and to respondents, the support and assistance from the clinic staff as well as ethical research considerations.

To draw the target sample from the sample framework, a non-probability purposive sampling technique had to be used. Purposive sampling is not based on probability which again underpins the use of qualitative research for the study. The rationale for using purposive sampling is that the units of analysis are difficult-to-reach and is a specialised population. The researcher had to depend on the availability and the consent of respondents to be able to interview them. Once this was obtained, it allowed the researcher to have a more in-depth investigation of the women's stories to gain a better understanding of the women and their circumstances, without affecting the validity of the research. It was also impossible to identify women upfront to include in the interviews as it was only by willing consent and voluntary participation that interviews were conducted once respondents were informed of the aim of the study. Respondents either consented or declined to partake in the research. At the end, twelve semi-structured interviews were conducted with women that had decided to terminate their pregnancy and also had followed through with their decision, as the only variable under investigation was the fact that a woman had terminated her pregnancy.

3.5. DATA COLLECTION

3.5.1. ACCESS TO RESPONDENTS

After the sample framework of abortion clinics/hospitals were identified, telephonic arrangements for access to the facilities and respondents were arranged with the person in charge of each of the facilities. An appointment was made to brief the person in charge of the aims of the study and what information the researcher needed to gather. This in turn led to a tour of the facilities as well as an investigation of the process and methods followed for women to terminate their pregnancy.

This information allowed the researcher to establish the process that women follow when opting for an abortion, from the first appointment, pre-abortion counselling, homecare advice and procedures, the actual abortion and the post-abortion counselling. It was also allowed that the researcher be present when an actual termination was performed.

The nature of the study, being very sensitive, and the fact that respondents participation was voluntary, led to the problem of when an interview with the respondents could be done. On ethical grounds, it was not deemed appropriate during the pre-abortion counselling sessions, as this focused on obtaining demographical and medical information. It was also feared that the interview might influence the decision made by the woman during a very emotional period. Due to the fact that a time period exists between the first appointment and pre-abortion counselling session, and the actual date of the termination, women still had the opportunity to change their minds based on a change of personal circumstances. The researcher did not want to influence this in any possible way during the interview process. The second contact with the women was the day that the actual termination occurred, i.e. the day that the abortion was performed. Again, due to ethical considerations, this was deemed inappropriate as this is the most emotional phase during this process. Most women went through emotional grieving once the procedure was completed and this did not allow for voluntary participation and could have negatively influenced the data. The only option was then to interview the women during the post-abortion counselling sessions. Although the grieving process for many was still in progress, the intense, highly emotive stage had passed.

Once this had been established, it led to another ethical dilemma for the researcher. During the process it was discovered that both Kalafong Hospital and the Marie Stopes Clinic did not in actual fact offer post-abortion counselling. During a significant period of time spent at each of these institutions, the researcher deemed it unethical to continue the research at these facilities.

Not only was post-abortion counselling not offered, but the women were not treated with the sensitivity and understanding that is deemed necessary. At Kalafong Hospital, abortions were only performed 14 days after the initial contact due to a back-log of requests. A minimum of 20 women were then taken through the procedure that lasted approximately 10 minutes using the manual vacuum technique. A local anaesthetic is administered but due to the time constraints that the medical staff experience, the abortion procedure was started immediately, thus not allowing the anaesthetic to take effect. This led to the women experiencing both intense physical as well as emotional pain. In no way is the researcher denying the competency of the medical staff, but rather the process of

the abortions performed. Again, this is due to various factors that contribute to this process. At Kalafong Hospital, only one medical doctor and three nursing staff are involved with abortions. Other medical staff at the hospital cannot be forced to participate and to perform abortions as per the Termination of Pregnancy Act no. 92 of 1996. The second reason is due to the volumes of abortions requested and performed proportionate to the number of staff performing this service.

At the Marie Stopes Clinic, it was also found that post-abortion counselling is not offered. Although the volumes are less than at Kalafong Hospital the clinic scrapped the post-abortion counselling sessions based on previous research that indicated that this was not necessary. This curbed access to the respondents as described above. Although involvement and participation from the higher structures at the clinic was excellent, this was not found to be the case at the clinic itself with the medical staff.

The Reproductive Choices Clinic in Midrand, Gauteng, allowed full access of the facilities to the researcher with full co-operation and participation of the staff members. Full post-abortion counselling sessions were offered which then assisted the researcher to gain access to respondents. During observation of the interaction between the staff and the women, it was found that the women were treated with sensitivity and understanding and were not judged by the medical staff. This paved the way for a more stable setting in which the interviews could take place. In contrast to Kalafong Hospital and the Marie Stopes Clinic, the pre-abortion and post-abortion counselling sessions were conducted by a trained and qualified counsellor and not a medical practitioner. The researcher also fully explained the aims of the research and the details surrounding the gathering of data to the staff at the clinic. The semi-structured interview was shared with them as well. A relationship of complete trust and co-operation was established between the researcher and the staff at the clinic. The staff at the clinic also shared their experiences and information gathered during counselling sessions which also provided a better understanding of their dealings with various aspects of terminations.

Due to the full participation and co-operation of the medical staff at the clinic, access to respondents was gained via the post-abortion counselling sessions. During the counselling sessions, the counsellor briefed potential respondents regarding the aim of the research and obtained permission from each individual to become part of the sample. The respondent and the researcher were introduced to each other and a more detailed explanation was given to potential respondents regarding the aim and the interview process, as well as anonymity and confidentiality was agreed upon.

Participation was based on a willing and voluntary basis and many women opted not be part of the research. During February - November 2000 twelve interviews were conducted at the Reproductive Choices Clinic.

3.5.2. VOLUNTARY PARTICIPATION, ANONYMITY AND CONFIDENTIALITY

Participation in the research was completely voluntary and no woman was coerced into being part of the sample. After a detailed explanation as to the aims and objectives to the study during the post-abortion counselling sessions, women were given the choice as of whether or not to participate in the interview.

Their voluntary participation and informed consent of the interview were based on the informed consent statement as set out by Neuman (1997:450):

- A description of the purpose and procedure of the research was verbally discussed with each potential respondent,
- A statement of the risk or discomfort associated with the participation. This was limited to respondents feeling uncomfortable regarding the nature of the study or possibly embarrassed about sharing their personal experience with another person,
- All respondents were guaranteed anonymity and confidentiality of records so that no respondent could be identified once the findings were reported,
- The identification of the researcher and of where the information for the questions of the research was found, i.e. the literature review that formed the basis of the study, and
- All respondents were informed that participation is voluntary and can be terminated at any time should they wish to do so.

Of crucial importance is the fact that participation must be voluntary based on an informed decision regarding the information required for the research. Many women refused to participate for various reasons but twelve voluntary participants were interviewed. Voluntary participation was based on ethical considerations toward the respondents as these women are placed in a highly emotive, stressful, and for some, and embarrassing situation. Ethics considered, the interview should by no means aggravate these conditions and be uncomfortable for the person in question.

Anonymity means that the subject remains anonymous or nameless which, due to the nature of the study played a crucial part in obtaining the participation of the respondents.

For reporting the research results, names were changed to alphabetical letters to protect the anonymity of the respondents.

Due to the problems experienced in identifying respondents and their voluntary participation, they will not be identifiable as their identities will not be known to readers. Furthermore, the information gathered, will not link specific individuals to specific responses or stories, thus upholding confidentiality.

3.5.3. THE INTERVIEW

A semi-structured interview was conducted with twelve voluntary respondents. According to Groenewald (1988:44), the aim of the interview is a conversation to collect information. The structured nature of the interview was that specific questions were pre-prepared as to obtain the desired and specific answers required for the study. Also, demographical information regarding the age of the respondent, marital/relationship status, level of education, live children, were also structured. The majority of the information was gathered by probing the details of the responses offered by the respondents to the pre-determined questions. This also allowed the researcher to change direction regarding questions by following-up certain answers to gain a more in-depth understanding or explanation. The interview took the shape of an open and unstructured interview regarding the respondents' narration of their decision to terminate their pregnancy. This was the only way to establish all the reasons that influenced their decision and to gain a better understanding of the relationship between reasons as well as an understanding of their own perceptions of their personal circumstances.

No time frame was established for the interviews upfront as it depended on the woman's narration and which reasons influenced her decision. The majority of the interviews were conducted for approximately 60 minutes although some were significantly shorter and other extended this timeframe.

The interviews were conducted at the Reproductive Choice Clinic in Midrand, Gauteng, in a comfortable lounge and not in an office set-up. This allowed the respondents to be more relaxed and not influenced by medical equipment which could trigger a negative emotion. The respondent and the researcher were seated around a coffee table on the same level so as not to enforce a power imbalance.

The interviews were taped by the researcher with the full consent of the respondent. During the interview, field notes were also taken where applicable, from an observation

perspective of the researcher. Only one respondent refused the use of a tape-recorder and here the researcher had to rely solely on the use of field notes.

This could be ascribed to the respondent's fear of being identified later on, regardless of the assurance of anonymity and confidentiality. It must be noted that this could have impacted on some information being lost during the transcribing of the data.

3.6. DATA REDUCTION AND ANALYSIS

3.6.1. INTRODUCTION

Data analysis is the process of systematically searching and arranging the interview transcripts and field notes to increase the researchers understanding of them to enable to report your discovery to others (Bogdan and Bilken, 1996:155). Most often, the analytical task, interpreting and making sense of the collected information, appears monumental and impossible. Therefore the first step to start in the analysing process is to start with data reduction. Data reduction refers to the process where collected data is reduced to interpretative proportions for the purpose of analysis. Once analysed, the findings can then be presented in a scientific report for the scrutiny of a specific audience that is only interested in a specific phenomenon, as well as for the scrutiny of the reliability of the data (Baily, 1987:332; and Groenewald, 1988:77)

3.6.2. THE TRANSCRIBING OF INTERVIEWS

As already stated, the interviews were recorded on tape in conjunction with taking field notes. The first step in the process of data reduction was to have the interviews transcribed by a professional transcriber into a word document. Once this process was complete, the field notes taken during the interviews as well as the demographical data, were integrated to present a true reflection of the interview.

3.6.3. CONCEPTUALISATION OF THE DATA

The researcher started analysing the data by organising the data into categories on the basis of reasons or sets of reasons identified as themes as well as similarities that were evident. New reasons and the relationship between these reasons were developed and also included for investigation. The themes that become evident were linked to each other in terms of importance and frequency in a single interview and across interviews. As the researcher continued reading the data, new themes and their relationships to each other and within each other were formed, and continuous critical questions were applied to categorising and coding the data.

3.6.4. CODING OF THE DATA

The coding of data occurred by organising the data into conceptual categories and themes were created to use in the analysis. The process is led by the research question which in turn leads to new questions (Neuman,1997:421). Compared to quantitative research, where coding is a clerical task, qualitative coding is an integral part of data analysis. Neuman (1997: 422) states that during this process the researcher is then freed from the details of raw data while encouraging a higher level of thinking regarding the conceptual data. Data coding has a dual purpose, mechanical data reduction and analytical categorisation of data. This is achieved by ordering the data and during this process allows the researcher to retrieve the relevant parts.

3.6.5. ANALYSING OF DATA

According to Neuman (1997:426) the analysis of data means a search for patterns in data. Once a pattern was identified, it was then interpreted in terms of the setting in which it occurred. It thus involves the examining, sorting, categorising, evaluating, comparing and contemplating the coded data as well as constantly reviewing the raw and recorded data.

The analysing of data already started during the coding process. Each interview with the supporting field notes were read in detail. During this first phase, specific focus was placed on the research themes that were identified. The initial reasons were colour coded with coloured highlighters to differentiate between each identified reason. The second phase consisted of a continuous re-reading and evaluation of the identified reasons to establish the correctness of the identified themes, but more importantly to identify new reasons and the relationship between reasons, and to ensure that no data is lost. Of importance is the fact that although a semi-structured interview was conducted, themes were not limited to a specific question but are present throughout the entire transcription as respondent were free to tell their personal story regarding their decision to undergo an abortion and certain reasons were re-visited throughout the interview.

After the initial data reduction, an integration of the data occurred. This process identified the common themes or reasons that were present within, and throughout the different interviews and thus an integration or grouping of these reasons could be done. Although a comparison between women was not the aim of the study, certain similarities came to the foreground which made a limited comparison possible.

The nature of the study as well as the research methodology do not allow for a comprehensive comparison but do allow us greater insight into the relationship between reasons and sets of reasons that influence women's decision regarding whether or not to terminate their pregnancy.

3.7. SUMMARY

The research methodology followed for purposes of this study was fully supportive of the aim of the research project. To achieve the aim of investigating the reasons given by women for choosing to terminate a pregnancy over other alternatives to deal with an unwanted pregnancy, it was decided that a qualitative approach would be the most appropriate. In conjunction with supporting the aim, it was also found that current literature was conducted on a quantitative basis which in turn did not support the aim of the project.

To investigate the reasons that women have for deciding to terminate their pregnancy, a qualitative design was followed to allow for the women to narrate their personal stories framed by their personal experiences and circumstances. Placed within this framework, this was supported by the goals and outcomes of a feminist research methodology which supported the aims by upholding that the world is a web of interconnected human relations. It further allows for interpretations of women to take centre stage and allows for women's personal interpretation of their reality.

Although studies relating to the topic have been conducted as seen in the literature review, the statistical ranking of averages used to indicate primary reasons did not support what was being investigated. No reference was found that allowed women to narrate their own stories and indicate what their personal reasons for terminating a pregnancy was. By assuming that the most frequent stated statistical reason is the most important, does not do justice to women and their voice. A need existed to investigate the reasons given, but more importantly, to investigate potential sets of reasons and the relationship between and within these sets of reasons as well. To be able to investigate these relationships, an exploratory design was followed by making use of a semi-structured interview schedule.

By making use of certain pre-populated questions, it allowed for standardised demographical data to be collected but did not hamper the story-telling process. By allowing respondents to steer the interview, the interview followed the stories in terms of importance to the women as well as to why it was important to them, thus indicating the relationships between reasons.

It was also more interactive and women could relate their experiences and perceptions in more detail as they were not curbed by closed-ended questions. It also allowed for the researcher to delve deeper into certain statements and to clarify the respondent's interpretation of certain themes and concepts.

Although sampling was problematic due to the unavailability of an identifiable population as well as the sensitive nature of the subject, twelve respondents voluntarily engaged in the interviews. The findings from the study are important in terms of reasons not standing in isolation but within a definite relationship, and within sets of reasons, also between different sets of reasons, as well as their influence on each other to lead to a woman deciding to rather terminate her pregnancy rather than to follow an alternate course of action.

CHAPTER 4 RESEARCH FINDINGS

4.1. INTRODUCTION

Any decision to be made requires information to be interpreted and evaluated. It is based largely on an awareness that a non-desired state exists and that a decision needs to be made to attain a desired state. Making a decision is a perceptual issue (Louw: 1995:82). The complexity of making a decision lies in that a decision is made as a reaction to a perceived problem. There exists a discrepancy between a current state and a perceived desired state which requires careful consideration of alternate courses of action. Choices are then made among these alternate courses as to which would be the correct choice to meet the perceived desired state or to eliminate the non-desired state (Meyer, 2003:3).

The importance of a woman's current situation that is relevant to choosing to terminate her pregnancy is crucial when identifying alternatives and the strengths and weaknesses of each alternative are evaluated. This links with the woman's perception of the outcome of choosing a specific course of action and whether this would be the desired state she requires.

The decision made to terminate a pregnancy is not a decision that is taken lightly and is made after careful and serious deliberation of alternatives and the desired outcome of each. Women that are faced with an unwanted pregnancy will not necessarily opt to have the pregnancy terminated but will consider other alternatives. The consideration here is what is relevant to making the decision. The woman's interests, values and personal situation is taken into consideration and weighed-up against each other in order to give them correct priority in the decision making.

Although ultimately the choice to terminate a pregnancy lies with the woman, decisions are not made in isolation to other people and their perceptions of abortion. Consideration of the impact on other people's desired state also comes into play. Women can also be influenced in their decision to terminate their pregnancy by other people such as their partners or could be influenced not to tell other people about their decision due to perceptions. Women that do decide to have their pregnancy terminated must have the right to exert their choice free of coercion and fear of reprisal from partners or significant others.

When identifying and considering various alternatives and their desired outcomes, the personal situations and circumstances of women as well as their values are taken into

consideration. Once these situations and circumstances have been evaluated, the reasons and sets of reasons for women deciding to terminate their pregnancy becomes evident. It is important to note that no single reason stands in isolation in women's account of reasons for terminating their pregnancy. An intricate web of links between reasons exists to form the basis of a woman exerting her choice to terminate her pregnancy.

This chapter will discuss the theme identification process in detail. The themes identified are the reasons and the sets of reasons that led women to make their decision to terminate their pregnancy. It will also discuss the webbed relationship between these sets of reasons identified in detail and the impact of these on the decision made to terminate a pregnancy. Similarities in terms of the webbed relationships between reasons are identified and discussed as well as the importance of reasons in relation to respondents' current personal situations.

4.2. IDENTIFICATION OF SETS OF REASONS

The identification of reasons and sets of reasons started with structuring the demographical data collected in the semi-structured interviews with the transcribed interviews and field notes, to provide a unified base of information per respondent. This was deemed important so that all information pertaining to each respondent was integrated and presented as a whole so that data was not lost. The demographical data, the transcribed interviews and the inclusion of the field notes all support each other in providing a true reflection of the data collected and the personal position of the women interviewed.

After this integration, each respondent's data was read and re-read numerous times so as to gain a full understanding of each respondent and their specific situation and circumstances. This process also allowed for the researcher to start identifying concepts that were both similar and re-occurring across respondents or that stood in complete isolation and were very personal to a specific respondent. This initial analysis also allowed the researcher to form a basic profile of the respondents in terms of similar reasons identified.

Because the researcher now had a better understanding of the identified preliminary concepts and a basic profile of the women, the process of data coding started. It must be mentioned at this point, that some preconceived themes were already present, not only from the constant reviewing of the raw data, but also from themes identified in the

literature study. This resulted in preliminary bias as the researcher initially tried to group themes together to conform to findings as per the literature review.

The coding of data started with the using of coloured highlighters to note the preliminary sets of reasons per each respondent. For instance, where age was identified, the theme was searched for in each respondent's interview and highlighted. This was a cumbersome task as certain themes were similar across respondents and also were repeated within a single respondent's interview. As this process continued, the researcher realised that although certain reasons correspond to studies presented in the literature review, the sets of reasons that were identified in the coding process could not necessarily be grouped according to other studies. They were unique in their relationship and were also linked to other sets of reasons. Many of the reasons did not stand in isolation but a series of webbed relationships were identified. It was found that data would be lost if the researcher continued to align the identified themes as per the literature review.

This led to restarting the coding process with an open mind and evaluating each possible theme found in the raw data. Colour coding using highlighters were used again but codes within colours were also used to group together the relationships between sets of reasons which did not stand in isolation to each other but, formed an influential reasoning process with varying importance ascribed to the themes within this sequence. This also allowed for a more in-depth search of patterns across respondents as well as within each interview. The themes identified continuously within a respondents interview also assisted with the sequencing and ordering the importance of reasons as the researcher could identify how many times this was repeated and in relation to what other reasons it was given.

It was also found that the relationship of certain themes that were similar across various respondents only differed in terms of the relationship of one dissimilar reason that broke the now identified pattern. This led to re-grouping and new codes being formed to enable the inclusion of the particular pattern. In relation to this, a deviance of reasons within a certain themes was also found to be present, which led to sub-categories being formulated within specific themes.

Certain identified reasons stood in complete isolation to any other and this were found to be unique and easy to code. These reasons indicated the intense personal circumstances of the respondents and was grouped together in a relationship with other themes in terms of personal concerns where applicable. Much of the demographical data collected also stood in relative isolation.

It must be noted that a continuous review of the raw data occurred with every reason identified. Along with this continuous re-evaluation, and as new sets of reasons came to the foreground, a reorganisation of reasons took place per set of reasons or to the order of the relationship between these. The order of the relationship between sets of reasons is important as this indicates the intricate link within a set of reasons as well as within the webbed relationship between the different sets of reasons.

4.3. REASONS FOR WOMEN TERMINATING THEIR PREGNANCIES

4.3.1. THE RELATIONSHIP BETWEEN AGE, EMPLOYMENT STATUS, FINANCIAL CONCERNS AND PERSONAL CIRCUMSTANCES

The average age of respondents was 25 years and varied from age 20 – 40. Age was found to be the most frequently mentioned reason identified across respondents and repeated within their interviews. On the continuum of age being the main reason for deciding to terminate a pregnancy, two distinct sub-themes were identified:

- a. being too old, and
- b. being too young

The respondent that cited that being too old is the main reason for her terminating her pregnancy stated that “*Ek is te oud vir hierdie tipe goed*”. This indicates that the decision to terminate her pregnancy, is to stop childbearing. This is supported not only by her age, but also the ages of her two live children.

The same theme was identified throughout the interview as she also substantiated this claim by further stating: “*Hel, ek is 40 jaar oud en my jongste kind is 17 jaar oud. Hoe sou ek weer kans sien vir ‘n baba? O nee, ek sien net nie weer kans daarvoor nie*” and “*My oudste kind, my meisiekind is 20 en my seun 17. Kan jy dink wat sal gebeur het as ek nou, op my ouderdom, nog ‘n kind moet grootmaak?*”.

It must also be noted that although age was the most frequently mentioned reason, by repeatedly stating and referring back to the ages of her current children, consideration for her live children also played an important part in her decision to have terminated her pregnancy.

Being too young to have children was the most common reason cited and was applicable across respondents and re-emphasised throughout interviews. Age could not be seen in isolation but rather within a relationship with other reasons, therefore within a set of

reasons. Although age was the most frequently mentioned reason, the order within the relationship changed per respondent and her personal circumstances.

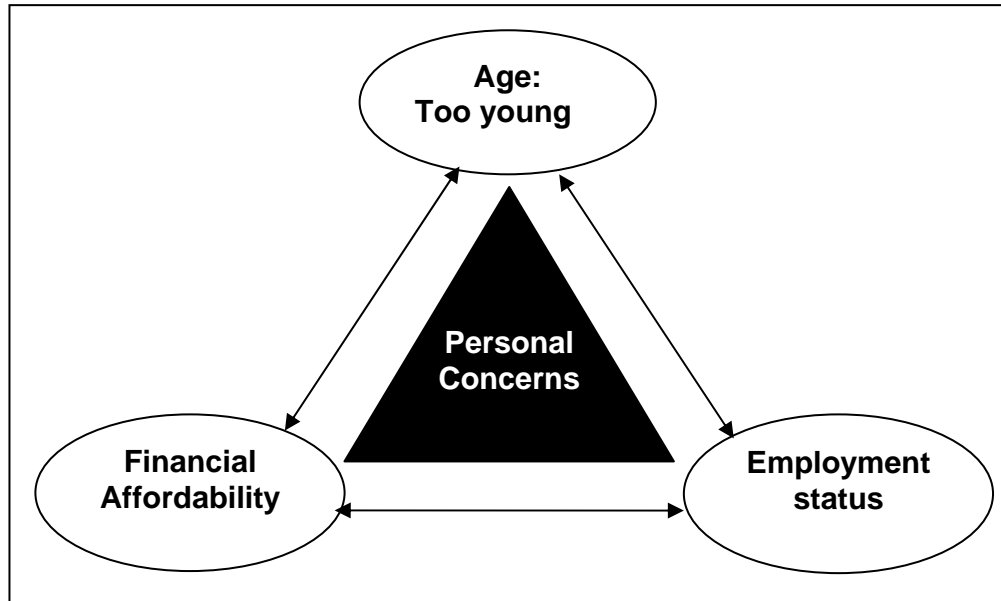
“I am too young...we are too young”. The respondent includes that the age of the father of the foetus is also too young according to their definition of what age is deemed appropriate to have children.

“I am way too young to be raising a child”. Age identified as a reason to raising a child is supported with specific mention of being too young. This indicates a perception of the requirements of raising a child and the respondent clearly felt that her age would not allow her to meet these requirements. The same holds true for another respondent as she states that she is aware that some women enter motherhood at even younger ages, but according to where she is on a personal continuum regarding age, she is also too young to meet the requirements of motherhood. *“I am 20. That is too young. I know that there have been younger mothers but I just couldn’t face having a child now. I am studying and my boyfriend is studying”*. The relationship between age, the requirements for motherhood becomes ordered in terms of importance as she includes the fact that she is a student and so is the father of the foetus.

The theme of either the mother and/or the father still studying (their current employment status) was found to be a recurring reason and can be seen as part of a prominent relationship correlated to age and financial concerns and personal circumstances or perceptions. The relationships are related to each other as follows:

- between either age and current employment status;
- between age, current employment status and financial concerns;
- between current employment status and financial concerns; or
- the above relationships supported and substantiated by a personal concern.

The relationship can be depicted as follows:



The current employment status was significant in terms of women being unemployed but currently studying at a tertiary institution. Due to the fact that they are currently students, it correlates directly with their being “too young” and also being unemployed and therefore citing financial concerns. *“We are way too young and still students, how will we pay for a baby?”* The statement clearly indicates that both the mother and father are not in a position to financially afford to have a child. It is also clear that the initial concern is the actual cost of having a baby but not taking the future cost of raising a child into account. This in itself indicates a short-term view regarding the financial impact of having children.

“Both of us are studying. We don’t work, where would we get the money from? Our lives are ahead of us. We would probably have to quit varsity and get jobs. What kind of job would we get?” The same relationship is evident but concerns for the future also come into play as the respondent considered the result of not only the financial impact of raising a child but also the impact on their current lifestyle as she took into consideration that the possibility of ending their studies exists and that the job market is not open to people that do not have a tertiary qualification.

“I also think I am too young and would like to concentrate on my career”. Age cited as the primary reason for choosing to terminate a pregnancy is supported by a view of disrupting the future lifestyle of the respondent pertaining to her career in advertising. It can be seen that a disruption of ideals/dreams and goals also plays a significant part in choosing to terminate a pregnancy when balanced with a longer term view in terms of the impact of having a child at that particular moment in time.

"I am studying and my boyfriend is studying. We don't work. We aren't responsible enough". Both the parents are studying and currently unemployed, again emphasising unemployment and in relation to this financial concerns. A personal aspect of not being responsible enough also contributed to the decision to terminate the pregnancy. This relates back to consideration for their current personal position on a continuum of what is perceived to be the correct characteristics for parents, i.e. a perception that parents should be responsible individuals to have a child.

Again both age and the fact that the respondent is currently studying at a tertiary institution are two reasons given for her decision but the order has been changed to indicate that her personal relationship with the father of the foetus outweighs the fact that she is still a student. *"Too young. I have only been with this guy for 6 months and don't know if we'll get married. I am still getting to know him. I am in my third year at RAU..."*. The respondent took the fact that her relationship was of a relatively short duration as well as the fact that she is still getting to know him into consideration. Her response also indicates her perception that parents with children should be married and that the traditional "order" of events should be followed, i.e. marriage first and then children.

"I am too young and I am studying.....and I don't have a mother that could help me". In this situation, age and current employment was ordered first and second respectively, but the personal situation of this respondent supported the decision. The personal situation of this respondent was the primary reason to her decision to terminate her pregnancy as *"I don't have anyone that I can rely on to help or support me...I don't have a mother that could help me, my mother died when I was very young, she committed suicide. What if I am like her? What will happen to my child if that happens to me?"* The main reason for her decision was the fact that she doubted her ability to be a mother *"I don't know if I would be a good mother"* due to her tragic past experience where her mother committed suicide and she found her mother's body. Her fear is that she might follow the same pattern and what would then happen to her child.

Where age was not considered a primary consideration, financial status linked to employment most definitely was where the personal circumstances in terms of the relationship with the father of the foetus was of utmost importance. *"I never worked while we were married and how am I going to support a baby? I have to find work to be able to support myself let alone a child.....He won't pay maintenance or help me...."*. Financial concerns were not limited to just having a baby or supporting a child but were also a valid concern for the respondent herself as she is unemployed and does not earn an income.

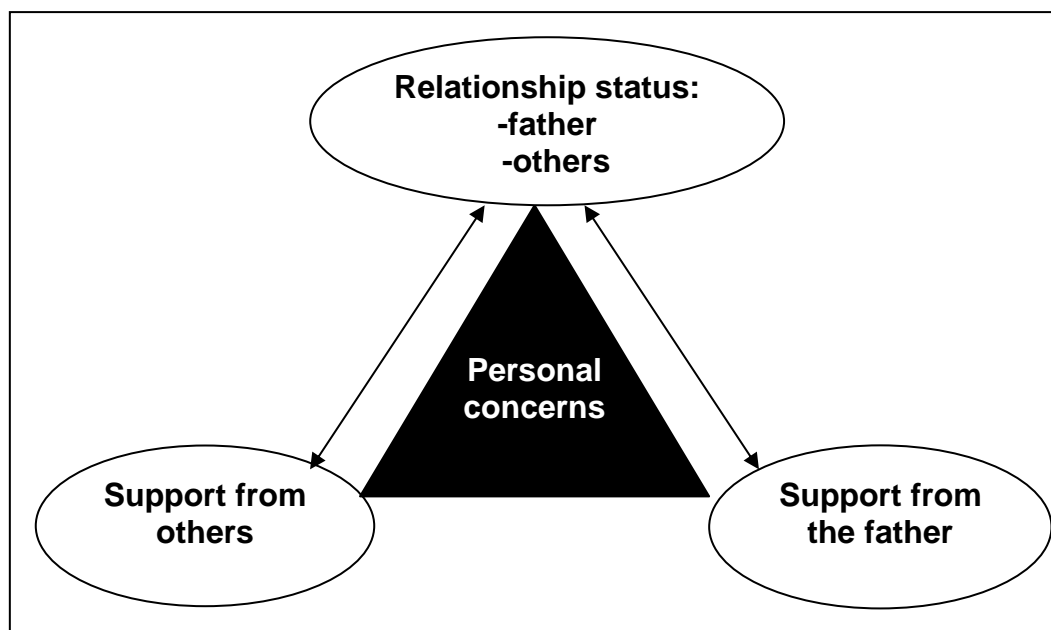
She was also concerned that she does not have an employment history as she never worked whilst married and now has to enter the job market.

She also believed that she would not receive financial support from the father which placed an almost double financial burden on her. This again indicates the circular relationship identified.

4.3.2. RELATIONSHIPS

Another set of reasons that was identified was the relationship status with the father of the foetus, the relationship status with significant others, support received from the father as well as the support received from significant others. Although this was identified as a strong theme or even a primary theme in terms of relationships, other secondary reasons to the specific relationship can also be viewed as personal circumstances or concerns as each relationship is a personal and private in experience.

The relationship can be depicted as follows:



Data analysed from the semi-structured interviews found that the profile of the respondents did not conform to the national stereotyping of being promiscuous as most of the respondents were in a relationship of longer than three months. This is significant where the duration of the relationship was cited as a reason for choosing to terminate a pregnancy.

“I have only been with this guy for 6 months and don’t know if we’ll get married.” The significance of this is that although the respondent was in a relationship of six months, this was not deemed long enough for the respondent and her partner to bring a child into this world or to get married. This again indicates the personal experience and views of respondents as the duration of a relationship differs for each individual as to the stability and long term prospects of the relationship.

The most significant finding in this regard was that marriage would be assumed to be the most stable relationship and be secondary to other reasons playing a primary or dominant role. In the case of married respondents, the relationship with the husband was identified as the primary reasons for choosing to terminate the pregnancy.

One married respondent indicated that she and her husband were separated after five years of marriage and she did not know that she was pregnant when she moved out. When she told him that she was pregnant he responded by *“.....telling me that I was a slut and that the baby wasn’t his. Like I would sleep around? I married him when I was 20.I thought that maybe the baby would sort things out, but he doesn’t believe it is his”*.

The respondent feels “forced” into having her pregnancy terminated as she is now without a partner, unemployed, not financially able to afford the baby by herself, and her husband does not earn enough to provide her with enough maintenance support: *“I cannot see how I can cope with a divorce and a child”*. This also clearly indicates the choice to deal with problems in a systematic way and deal with the first problem at hand without exasperating a personal situation with the inclusion of having a child.

The relationship also got abusive when she told her husband that she was pregnant *“...what a scene. The practically threw me out”* which indicates the mistreatment and abuse of women that was also classified as an independent reason. It is also evident that no support was received from the father in terms of both the pregnancy as well as the decision to terminate the pregnancy. From the above it is clear the personal experience and circumstances of this respondent’s relationship carries more importance in terms of her decision to terminate her pregnancy and can be seen as her primary reason.

Another married respondent had been trying to fall pregnant for two years. She was ecstatic when she found out that she was pregnant after six years of marriage but unfortunately: *“When I was two months pregnant I found out that he was having an affair. Can you believe it, here I am preparing for the most important thing in our lives and he has been having an affair for almost three years.”* The overarching reason for this respondent for terminating her pregnancy was the fact that her husband was having an

affair and she did not know if her marriage would survive. This was her first concern and priority as *“How can I have a child if I don’t know even know if we are going to get divorced or what is going to happen. I don’t know if we are going to make it. I don’t know what to do”*. In this case the respondent’s sole reason for choosing to terminate her pregnancy was the fact that her personal relationship with her husband was not stable. The greatest influence was not the fact that he was having an extra marital affair but the fact that she did not know if the relationship would survive and what the future outcome would be. The respondent was also very angry as the future that she has foreseen and planned was disrupted and did not conform to expectation. It was also clear that the decision was not an easy decision on two levels, firstly, being the fact that she wanted to initially have a child, and secondly, that she is still hesitant regarding her future relationship with her husband.

Although the respondent based her decision on the relationship status with her husband, she was also not supported in her decision to terminate her pregnancy as *“He did not want me to have an abortion but I am trying to cope with the fact that he has been having an affair. ...He wants me to keep the child”*.

In terms of receiving support from the father to terminate the pregnancy, it was found that although not all the women were supported in terms of the decision made because their partners wanted to have children; they were supported in terms of having the pregnancy terminated. This is evident as *“He says he supports my decision, but I don’t think so, he is very kind and loves me very much. I think that is why he tries to be supportive, but I can see that he is not happy”*.

“Ja, soortvan. Hy dink ook dit is die beste ding om te doen...hy is maar hartseer, want hy will graag kinders hê”.

“He didn’t want me to have the abortion....He wants a big family and was very happy when I told him I was pregnant”.

“No, he wants me to keep the child and is against abortion. So am I, but I just don’t know how to cope”.

“Hy is ‘n ou-jong kêrel en wil kinders hê, die eerste keer toe ek vir hom daarvan sê, to sê hy hy sal my dagvaar as ek daarmee voortgaan. Nou maak hy net of hy niks weet nie”.

It is clear from the above statements that the partners did not want the respondents to terminate their pregnancy as they wanted children or had values that oppose abortion. Although the fathers were not supportive of the decision to terminate the pregnancy, this was secondary to other identified reasons as the respondents did terminate their pregnancies which indicate that this does not carry as much importance in terms the decision making process. It must be noted that in the case of these respondents the partners were informed of the decision and discussion regarding the decision took place.

In certain situations, partners were not informed of the decision to have the pregnancy terminated. This links directly with the relationship status and the personal influences within the relationship. *“No, I didn’t tell him I was pregnant”*.

“I didn’t want him to know. I was scared he would want to keep the baby....I am too scared to keep the baby”. This was aligned to the primary reason² indicated by the respondent in terms of her personal experience of her mothers suicide and fear that she would have to continue with her pregnancy against her will and be forced to face her greatest fear, that of being a mother and having a child.

Of interest is the fact that the respondents that conceived as a result of a one-night-stand and that were not in a stable long-term relationship with the father of the foetus, did tell the fathers they intended to terminate their pregnancies. *“He is aware of it but both of us feel that it is the right thing to do.....we are not a couple and don’t love each other or anything like that”*. The relationship status with the father is a secondary consideration in this relationship as they are not in a stable relationship. This reason supported the primary reason³, the relationship between age, employment status and financial concerns which impacted on the decision made to terminate the pregnancy.

“Hy dink ook dit is die beste.....die ou wil ook nie moeilikheid hê nie (met die verloofde)”. The primary reason for this respondent choosing to terminate her pregnancy was her relationship status with her fiancé (significant others) and not so much the relationship status with the father of the foetus. The respondent was having relationship problems with her fiancé and the father of her current live child. They had temporarily separated and she had a one-night with her fiancé’s friend. It cannot be denied that the relationship status with the father of the foetus was important in terms of them being friends and not being in

² The differentiation between primary and secondary reasons is done within the context of the reasons stated by the respondents. This allows for reasons in terms of their importance and value that each woman assigns to her personal situation and circumstances that led to her decision to terminate her pregnancy.

a stable relationship, but this was a secondary consideration. Her primary reason for her decision falls within the personal concerns category as she and her fiancé has reconciled and that her current live child is the child of her fiancé. She feels very strongly about reconciliation and her concern is for her current son *“Ek moet aan my seuntjie dink. Kan jy dink hoe die ander hom sal terg as sy boetie of sussie nie dieselfde pa het nie. My verloofde is baie goed vir ons en ek is baie lief vir hom. Ons het net deur ‘n moeilike stadium gegaan. Dit moes nooit gebeur het nie”*. The respondent also indicates that she wants more children but that the father must be the same father as her live son.

The relationship cycle can also be viewed in terms of a stable relationship with joint decision making, which indicates that the status of the relationship, and the support received, acted as a motivating reason for terminating the pregnancy. This is true when looking at equality within a relationship and makes it easier to exercise the decision, as both parties are in agreement with the decision and mutual support is given. This impacts significantly on the relationship identified between guilt and the “have I made the right decision” theme identified by closing the gap of the two extreme points on the continuum. *“Yes, he actually brought me for the abortion and even came in with me during the abortion..... We made the decision together and although we both want children, now is not the right time, no, bad planning. We first thought we could keep the baby but we really, really discussed it and we both decided that we couldn’t.....We made the decision together and he did not force me.”*

The relationship with significant others and the support received or support to possibly be received from others, play a significant role in the decision making process. This affects whether a support structure exists outside of the relationship with the father of the foetus. Not only is the stability, strength and the support structure crucial, but also the considerations of the impact of a pregnancy on significant others. This relationship is important in the decision making process but it was classified as a secondary set of reasons.

Respondents that did not tell significant others in their lives about the pregnancy or the abortion, based this decision on perceived responses or perceptions of what the reaction would be. *“I would also not be able to face my parents. Maybe I am wrong, maybe they would have supported us”*. The perceived impact of the pregnancy and choosing to keep the child was definitely not a consideration in the decision making. It was also supported by the “fear” of being able to tell her parents that she was pregnant. Also significant was the fact that the respondent did not know what the reaction would have been but assumed

it would have been negative. This relates directly with the strength, support and openness within the relationship between her parents and herself.

“Ek is seker hulle sou my ondersteun, maar nog steeds, dis nie ‘n maklike ding nie. Ek kom uit ‘n familie van 7 kinders en ons leef baie naby mekaar. ...Ek wou juis nie ‘n groot familie gehad het nie, ek het gesien hoe my pa-hulle partykeer sukkel”. Significant for this respondent was that she perceived that her family would have supported her but the impact of past personal experience played a greater influence. She comes from a large family and financial concerns played a primary influence.

“I know they would support me and help me but I have to sort out my marriage first”. This respondent's primary reason was the relationship status with her husband. The support structures that would have been offered to her was not a consideration in her decision, as it carried less weight than her personal concerns regarding her marriage.

Respondents that did tell significant others about the pregnancy and their choice to terminate their pregnancy, was influenced not by finding support to keep the child, but was looking for support in terms of the decision to terminate the pregnancy. This was found not to be a primary consideration in the decision making but played more of an emotional supportive role than an actual influence.

“I told my mom....she is not happy and said that she would help me....My mom's also working and trying to do the best that she can. She is a single mom and I cannot place even more on her. My brother is still in school; and my sister at Technikon. She cannot support me and the baby now as well. No, it just wouldn't be fair to her”. The respondents concern was not for herself but more for her family and the impact that having a child could have on the lives of her significant others. Her primary consideration was financial concerns, but mostly for her family and secondary for herself. This indicates that women that terminate their pregnancy do not conform to the stereotype of being “selfish and only thinking of themselves”.

My dad had to raise my sister and myself, by himself. It was very difficult for him. He did his best and we are all very close”. The concern identified here was again for her significant others, i.e. her father and her sister. She took into consideration what the impact of her pregnancy could have on the relationship between the three of them even though they have a close relationship, again indicating consideration for others and selflessness.

Interlinked with informing significant others and the relationship status with significant others, is the perceptions and value codes not only of significant other but of society regarding both illegitimate children as well as abortion. This carried more importance in terms of telling significant others than the values that oppose abortion held by the father of the foetus.

4.3.3. VALUES

Values can be classified in terms of the following value themes identified:

- a. Moral values of respondents and/or partners;
- b. Religious values of respondents and/or partners;
- c. Moral values of society/community;
- d. Religious values of society/community;
- e. Cultural values; and
- f. Traditional values.

The differentiation between moral and religious values is done as people that hold moral values are not necessarily religious, although the value itself may be the exact same. Of interest is the fact that societal values played a more significant role than the personal values of the respondents and/or their partners. The values that are present also directly link with whether the respondent told significant others that she was pregnant or that she had her pregnancy terminated.

“My family, no way. A good Afrikaans girl from a good Afrikaans family?.....Just the two of us know. I couldn’t face my parents or his either. They don’t even know that we are living together so can you think what would have happened, they would kill me”. This respondent’s primary influence was not based on values or perceptions, but on the relationship between age, employment status and financial concerns. However, values played a secondary role. It is interesting to note that she did not tell significant others due to the perceptions of her specific culture and the cultural position of her family within society based on both moral and religious values that oppose illegitimate children as well as abortion.

The findings also indicate that family perceptions are closely interlinked with societal perceptions *“Can you imagine the scandal of all the ooms and tannies if this should come out”.* Of interest is that although the “scandal” of an abortion weighs heavily, the perception of an illegitimate child carries more weight in the decision making process *“(the scandal being the pregnancy or that you had an abortion?)....well, mostly the pregnancy”.*

Important is cultural values that not only oppose illegitimate children and abortion but also cultural values regarding tradition. *“We are a big family and very traditional (Hindi). If they knew that I was dating a black and we were living together and I was pregnant they would die”.*

Race was identified as a theme for influencing the decision made but played a lesser role. It can be classified under cultural values in terms what is acceptable or not for the family and cultural society.

“Hulle (family) sal my verkwalik dat ek swanger is by ‘n ander man. My verloofde is baie goed vir my en ons kind.” Moral or religious values were not a consideration for this respondent but what was significant, was family values that would oppose sexual behaviour, i.e. carrying another man’s child.

Due to the fact that many women (and their partners), that have values that oppose abortion do not decide to opt for a termination of pregnancy but consider other alternatives. It is not possible to draw a comparison regarding the proportion of women that consider other sets of reasons as more important or consequential than their values.

Although the following statements indicate both moral and religious values that oppose abortion, this did not outweigh the most prominent reasons cited for the termination of a pregnancy as might be assumed. *“We are really very religious and my parents would die. They would see it as murder and I just don’t have the energy to try to explain. They would really be disappointed in me and would make me keep the baby”.* Not only is the perception of reaction prominent but also the perception of a change in the current personal relationship between herself and her parents. *“I would also not be able to face my parents”.*

“...(He) is against abortion. So am I, but I just didn’t know how to cope....I was 11 weeks pregnant and if I decided to have an abortion later on, it wouldn’t be possible.” Significant was that not only values were taken into consideration but that the gestation period and other primary sets of reasons were more important in the decision making.

“I am an only child and have a wonderful mom and dad. We really get on well, but this would kill them.....they believe abortion is wrong and would never understand”. Although the respondent had a strong and open relationship with significant others, values outweighed the relationship status in terms of informing them of the pregnancy and the decision to terminate it.

"I just didn't think abortion is right, you know, killing the foetus, but because I am so young and I had to make a decision".

"Hulle (familie) is groot Christene en glo dat jy nie 'n aborsie mag hê nie. Ek sal hulle nooit vertel nie".

The above statements clearly indicate that both moral and/or religious values is important in terms of telling significant others that they are pregnant or terminating their pregnancy. The impact of values is not as significant as would be assumed in the decision making process, as all the respondents did terminate their pregnancies regardless of values. It is however significant in the relationship between feeling guilt regarding the decision and whether or not they had made the correct decision. *"I am very religious and so is he. You probably think that that is strange, being religious and having an abortion. It really wasn't easy as I do see it as life, from conception, but I had to make a choice...I will have to live with what I have done, but I believe that God will, hopefully forgive me".* Very strong religious values are identified but again it is secondary to the most important identified sets of reasons for the respondent.

Sadly, it is also true for the respondent that wanted to have a child. Due to family and societies perceptions of women that terminate their pregnancies, she could not tell them that she had an abortion but rather *"I told everyone that I had a miscarriage. I had to lie. I couldn't tell them I killed my own child. They wouldn't understand. Abortion is wrong, but I didn't know what else to do".*

4.3.4. ALTERNATE CONSIDERATIONS

Alternate considerations were found to play an influencing role in a woman's decision to terminate her pregnancy. This did not stand in isolation to primary reasons that affected their decision as these ordered as more important. However, if alternate considerations were an option to the respondents, the pregnancy may not have been terminated.

It was found that the respondents that were married initially wanted to continue with the pregnancy. *"If we could have worked out our marriage and he would go for counselling".* However, as their situation changed, so did their alternatives. As previously discussed, the primary consideration for these respondents choosing to terminate their pregnancy, was there current relationship with their spouses.

Other respondents that considered continuing with their pregnancy was influenced by the fact that their partners wanted children and did not support their decision to terminate their pregnancy. *“I only thought about it because he wants children”.*

“Ja, maar wat van my seun en verloofde?”

Although the respondents did initially consider keeping the child as an alternative, other reasons outweighed the initial response to keep the child. This however did not change their decision when the other primary sets of reasons that led to their decision were considered more important. This again indicates and supports that no single reason contributes to the decision making process and that reasons that may have been conducive to keeping a child change as the pregnancy continues. As the respondents situation changes and the other identified sets of reasons began to play an increasing role, the alternative of keeping the child decreases. It can also be seen in conjunction with the support and relationship with partners and significant others when viewed within the webbed relationship.

Once the decision had been made that keeping the baby is not an alternative, adoption could be assumed to be a choice. Interestingly, not one respondent even considered carrying the child to term and then giving the child up for adoption which dispels this as a viable option. *“Ek sal nooit die kind vir nege maande kan dra en dit weg gee nie....Ek is te lief vir kinders. Daar is nie genoeg mense wat kinders aanneem nie, sê nou die kind sit vir die res van sy lewe in ‘n kinderhuis, ek sal dit nooit kon doen nie. Ek sou altyd wonder en dit sal heeltemal te erg wees”.*

“I think that it is more cruel. To live your life wondering what happened to your child. Is he happy, even alive? Not a chance. How do you explain to your child that you were not ready to have him?” The impact of future feelings are prominent but more important is the emotional consideration for the child knowing that her/his mother was not ready to be a mother as the primary reason would possibly not be explainable. This can be ascribed to the emotional condition of always wondering what would happen to the child compared to the finality of ending the pregnancy.

4.3.5. GUILT VERSUS THE RIGHT DECISION

The emotional state of women are crucial in the decision making process. It however does not stand in isolation with the values that were represented previously when weighted against the more primary tangible and rational reasons identified by the women.

Of importance is the perceived importance of less tangible values against the more tangible reasons. This relationship places the woman on a continuum of what is more important. The decision to terminate a pregnancy is about the current situation pitted against the “what would be” or “could be” future perceived outcome.

This relationship is evident when considering whether the respondents felt that they had made the correct decision. *“Al het jy besluit om dit (abortion) te doen, is dit nog steeds moeilik want jy kan nie help om daaroor te wonder nie, was dit ‘n seuntjie of dogtertjie, het dit seergekry. Ek sal nooit weer kinders hê nie, en ek kan nie help om daaroor te wonder nie, maar ek is nie jammer oor die besluit wat ek gemaak het nie, ‘n mens wonder maar.....Ek glo ek het die regte keuse gemaak, dit was nie maklik nie”*. It is clear that the “what could have been” factor was present as the respondent considered the gender of the child. She also considered whether the baby had suffered during the abortion self. She will also not have any more children and therefore the consideration of whether an abortion will impact on her future fertility was not a consideration as she ultimately wanted to stop childbearing. Although this was evident her primary reasons outweighed all these considerations and she was confident that she had made the correct decision.

“It is hard knowing at times that you had a baby inside you, growing, but I think that I made the right choice. I sometimes wonder what the baby would have looked like. But, I’ll never know”. The consideration was for what the baby would have looked like and the guilt of never knowing is present. But again, when viewed against primary reasons the decision was correct at the time of making it.

In situations where the postponement of a child was the consideration, emotions was present as future children were wanted, but the primary considerations again outweighed the want of a future desire for children. *“Dit was nie lekker nie en ek wil nog kinders hê. Maar ek moes dink aan my seun en my verloofde. Ja, dit was die regte besluit maar ek is nog hartseer”*.

“What else could I do? It is not easy because I want to have kids but what else could I do? I hope that one day I will be able to have kids.....I just hope that I can have kids again. I will never forgive myself if I can’t have kids, one day”. The emotional consideration is the fact that she wants to have future children and the guilt is more prominent not for the current child but for possible impact of potential future children. It was felt that the decision was the correct decision but the “what would be” factor in terms of having future children is evident.

“Yes, I don’t see what else I could have done. I do want children but not now”.

“In a sense yes (feel guilty about the abortion), it was not nice. It is not physically painful but I am very scared that the baby felt pain. I don’t like to think about that. I just hope that it didn’t feel anything. I feel very scared that it was painful for the baby.

The guilt felt is not only about the decision made to terminate the pregnancy but for the pain possibly endured by the foetus.

A respondent indicated that she was worried about the phase of development of the foetus and wondered whether it could have been classified as a person. This indicates a level of ignorance on the part of the respondent especially seeing as she has one live child. *“Ek probeer maar net dink dat dit nog nie ‘n mens was nie. Hulle sou seker nie ‘n aborsie gedoen het as dit al soos ‘n mens gelyk het nie. Sou hulle? Nee, ek dink nie hulle sou as dit al handjies en voetjies gehad het nie”.*

Respondents that did not initially want to terminate their pregnancies, felt that they were “forced” to make the decision to do so. Ultimately it was their own decision but the status of their marital situation pushed them in this direction whilst they did not even consider a termination during the initial phase of their pregnancy.

“I didn’t have any other choice. I am sorry and angry that I had to have an abortion, but I didn’t have a choice. I want children but not alone in this world”. The emotions involved are more complex due to feeling “forced” to terminate the pregnancy as well as the fact that she wanted children but her situation had changed drastically from initially finding out she was pregnant to making the decision to terminate the pregnancy. Another consideration was the fact that she did not want to raise a child alone in this world.

“I don’t know. Everyday I wonder if it was the right choice. I don’t feel that I had a choice, but killing your baby, that is something else. I don’t know, I don’t know. I will always wonder. What if I can never have children again. I don’t know what I would do then”. Due to the fact that circumstances changed drastically from when she found out that she was pregnant and evolved to having a termination performed, the feelings of this respondent are more guilt ridden. She continues to doubt whether she has made the correct decision as well as whether she can have children again. She does however feel that she “did not have a choice” in the decision that she made, but still wonders whether it was the right choice.

4.3.6. COUNSELLING

The following relationships regarding pre-abortion and post-abortion counselling were identified:

- a. relationship status with significant others;
- b. support provided by partners or significant others;
- c. guilt versus the right decision made; and
- d. values

The impact of correct and supportive counselling played an influencing role in the decision making process. It is not seen as a primary or secondary reason, but does shape the situation in which the decision is made and makes the setting for women more conducive to making their decision. It also provides a support network especially where this was not present within terms of the relationship with partners or with significant others. It also links with the values detailed previously, as well as the perceptions and stereotypes labelled to women who choose to terminate their pregnancy.

Pre-abortion counselling is more directed at setting the scene conducive to making the decision as the facts regarding a termination are explained. Fear is more prominent during this phase of the process as the facts are now balanced against primary and secondary considerations.

"I came to find out about the abortion but wasn't sure if I was going have it. They told me everything about it.....they sent me away again to really think things over but nothing had changed".

"They make sure that you are sure about your decision. I think that it is very important because it is not an easy decision. I think some women aren't sure and then they regret that they had an abortion". This indicates that the pre-abortion counselling also determines whether woman have considered all the contributing reasons in making the decision to terminate the pregnancy. It can again be related back to the guilt versus the right decision syndrome.

"...I wanted the baby and now couldn't, they were very understanding". Support was provided in the counselling sessions not just for making the decision but also supported the personal circumstances of women.

Post-abortion counselling is linked with “feeling better” about the decision made and the abortion process. *“Ek was vreeslik bang voor die tyd, maar as jy na die tyd weer inkom en hulle kyk of alles reg is en gesels met jou, dan voel jy sommer beter”*. Before the termination, fear outranks other considerations but after the termination the considerations are for physical well-being and feeling better about the choice exercised.

Counselling is also linked to the personal support received as it provides a support structure to women as they are seeking understanding for their decision. In many cases this is also the only support that they received, as they did not receive support from partners or significant others. *“I was more scared before the time and on the day that I had the abortion, but they were nice and kind. I came for the check-up today and they really help you. You know, someone to talk to about how you are feeling. Someone that understands”*.

“...I came back here and they supported me. They listened to me”.

“It is scary after the abortion and my boyfriend was very upset. It helped me to handle him”. In terms of this respondent it was interesting to note that the counselling was not just limited to assist her with her decision made but stretched to include support to her partner. This was important as partners that opposed the termination also need to be supported especially where partners wanted to keep the child.

“They helped me cope with that and try to make peace with my decision...It was nice to know that someone cared about how you are doing after having an abortion. I know it is their job but it does make you feel better”. This is related the feelings of guilt versus the correct decision made as the respondent felt support was needed to make peace with their decision. It is also linked to the support structures provided after the termination as the respondent indicated that someone cared how she was after the abortion.

It was also found that the support provided by counselling services, provided a support base for whether guilt outweighed the reasoning that led to the decision to terminate the pregnancy. *“It makes you feel less guilty about your decision”*.

“Yes, especially because I felt I was doing something very wrong. Morally you know. They helped me cope with that and try to make peace with my decision”. Although the respondents felt that the correct decision was made at the time of making the decision, the values of respondents weighed heavily on their feelings of guilt and the counselling provided a support structure in which these emotions could be discussed with others that

did not judge their decision or condemn them in terms of the stereotypes labelled to women that choose to terminate their pregnancy.

4.3.7. IDEAL FAMILY SIZE

The stopping or postponement of childbearing is directly linked to the ideal family size indicated by respondents. The respondent that already had two live children indicated that she had reached her ideal family size and this was one of her considerations for terminating her pregnancy.

The average number of future children wanted was two and respondents indicated that they were concerned about falling pregnant in the future as this would impede their future expectation or perception of their life. Although the number of children wanted did not impact on their decision to terminate their pregnancy, it does impact on their feelings of guilt versus the right decision made.

4.3.8. CONTRACEPTIVE USE

A direct correlation exists between a women conceiving and the non-use of contraceptive methods or the failure of contraceptive methods to curb, postpone or to stop childbearing. Contraception does not play a direct role in the decision making of having a pregnancy terminated but is the proximate cause for women falling pregnant and must be investigated as a recurring theme. The common premise is the fact that women would not have had to make a decision to terminate a pregnancy if they had either used contraceptive methods or the contraceptive method they were using did not fail.

By taking this into account, contraceptive use can be viewed in terms of the following themes:

- a. the failure of contraceptive methods used;
- b. the non-use of contraceptive methods;
- c. access to contraceptive services;
- d. lack of knowledge regarding contraceptive methods;
- e. ignorance regarding consequences of non-use of contraception; and
- f. response to finding out that they were pregnant.

The most common form of contraception used was the condom, the pill and the injection.

Respondents that were using one of the contraceptive methods indicated, cited failure of the contraceptive method as a reason for falling pregnant. *“We used a condom but it broke”*.

“The condom broke. Maybe there was something wrong it”.

“I was scared after the condom broke, but didn’t worry too much”. This statement indicates that knowledge regarding the consequences of a condom breaking was present as the respondent was scared of falling pregnant, but did not pay much attention to the fact. It can be surmised that the initial fear disappeared and the “it won’t happen to me” syndrome kicked in.

When respondents were asked why they thought the specific contraceptive method failed, the response was that they did not know: *“No idea, absolutely no idea”*.

“I was on the pill, but don’t know what happened. I have been taking the pill since I got married”.

A respondent that indicated that she was using the contraceptive pill, stated that she had forgotten to take the pill *“I am using the pill but forgot to take it...I am a bit of a scatter brain and my boyfriend always joked that I would get pregnant because I forgot to take the pill”*. This cannot be classified as using contraception. Only when the correct and prescribed usage of the contraceptive method is applied, can it be ascribed to contraceptive failure. This in itself indicates either a lack of knowledge regarding the correct usage or ignorance regarding the impact of the consequences of incorrect usage. This is supported by the statement that she was aware that she could fall pregnant if she did not take the pill, but did not take this “threat” seriously, which also relates to the “it won’t happen to me” syndrome.

The same argument is true for the respondent that stated that the method failed as she was taking antibiotics: *“I was taking antibiotics but didn’t really think it would make a difference”*. This again supports the prevalence of ignorance of the consequences, and lack of knowledge regarding when the contraceptive pill becomes ineffective.

“Die ergste was dat ek op die inspuiting was. Vandat my seun gebore is. Hy is al 17 jaar oud. Gewoonlik sê hulle mos die inspuiting steriliseer jou”. This could be attributed to a lack of knowledge regarding the specific contraceptive method, as well as the fact that this respondent also viewed her age as a reason of not being able to have children.

Ironically the profession of this respondent was that of a nurse and it would be assumed that she would have a better knowledge and understanding of contraceptive methods as well as applying it. This indicates that knowledge and the practice of correct usage should never be assumed for what we stereotype certain characteristics to hold.

The following statement from a respondent also indicates the lack of knowledge regarding contraception as well as the lack of knowledge of the fertility cycle of a woman. It can also be contributed to ignorance on the part of the women and the “it won’t happen to me” syndrome “.....we always use a condom. Well, not always, but I was sure that it was a safe stage”.

“I didn’t think it would happen (fall pregnant). I am usually careful and monitor my cycle.....but I was off”. These statements also indicate that less formal and therefore more traditional (although more unsafe) methods of contraception are also used such as fertility cycle monitoring. Due to the lack of knowledge and ignorance displayed it is evident that this was done half-heartedly as falling pregnant would not happen to them.

Of interest in the findings is the fact that none of the respondents indicated that they used an IUD or a female condom. This could be attributed to the fact that the IUD required medical insurance and is quite costly, where the female condom is not as widely marketed as the condom, pill or injection, and is quite cumbersome to use.

Certain respondents stated that they did not use contraception. One reason was that the respondent wanted to conceive and therefore did not use contraception. It does not indicate lack of knowledge or ignorance but the exertion of her personal choice in falling pregnant. *“I wanted to fall pregnant..... I have been wanting to fall pregnant for the past two years”.* Unfortunately for the respondent, circumstances that was conducive to her wanting to and to her falling pregnant changed, which led to her deciding to terminate her pregnancy.

The only other true admittance of blatant non-use of contraception identified was with the two respondents that conceived from a one-night stand and that were not involved in a stable relationship. In both these cases, alcohol played a significant part and was a primary reason in not using contraception. : *“...ons was dronk en dit het net gebeur”.*

“It just happened. We were at a party and had a bit much too drink and then we had sex”.

It was not indicated that respondents did not have access to contraceptive methods or services, and therefore this was not a contributing reason to not using contraception to prevent an unwanted pregnancy.

The lack of knowledge and ignorance regarding failure or non-use of contraception can be seen in terms of the respondents reactions to when they found out that they were pregnant. This indicates clearly that they did not want to fall pregnant in the first place which was the initial step to considering terminating the unwanted pregnancy. *“Goeie vader, dit was ‘n baie groot skok. Ek kon my ore nie glo nie. Ek dink ek het dit eers geignoreer en gedink dit is ‘n groot fout”.*

“I was frightened.....petrified”.

“We both cried when I told him I was pregnant. It was a great shock to us and we couldn’t believe it”.

“Oh my God. That was all I thought. Oh my God”.

“Shock...horror. I couldn’t believe it. This could not be happening to me”.

“I couldn’t believe it. All I thought was that I don’t need this right now. Things are bad enough as it is. I don’t need this now”.

These clearly indicates that respondents did not wanted to fall pregnant, but also illustrates the “it won’t happen to me” syndrome as the pregnancy could have been prevented by either using contraception or using contraception correctly.

Only one respondent was happy about being pregnant as she had been trying to fall pregnant. *“I was so happy. It was wonderful news. I was really happy”.* Circumstances had changed and her primary reasons outweighed her wanting to continue with the pregnancy. In this case the non-use of contraception was aimed at conceiving.

4.3.9. SEXUAL BEHAVIOUR

The sexual lifestyle of the respondents can be classified into the following sub-themes:

- a. treatment for sexually transmitted diseases, especially HIV/AIDS;
- b. number of previous sexual partners;
- c. current live children; and

d. previous abortions.

None of the respondents indicated that they had ever been treated for a sexually transmitted disease. The most significant impact of a sexual transmitted disease would have been HIV/AIDS. This was never cited as a reason for choosing to terminate a pregnancy in any of the interviews conducted. The impact of HIV/AIDS in relation to a women choosing to terminate her pregnancy was not a primary or secondary reason and had no impact on the decision making process of the respondents. If the impact of HIV/AIDS or any other sexual transmitted disease were present, the number of sexual partners may have had a secondary impact. Demographical data collected indicate that the father of the foetus was the first sexual partner for most of the respondents.

The number of live children of respondents played a primary role in terms of the women deciding to terminate their pregnancy. *“Ek moet aan my seuntjie dink. Kan jy dink hoe die ander hom sal terg as sy boetie of sussie nie dieselfde pa het nie?* The respondent was concerned about her current son and the perceptions and behaviour of society towards him if she continued with her pregnancy that was not fathered by the father of her live son.

Consideration for live children is clearly also indicated by another respondent that repeatedly took the age of her current live children into consideration. *“My oudste kind, my meisiekind is 20 en my seun 17. Kan jy dink wat sou gebeur het as ek nou, op my ouderdom, nog ‘n kind moes grootmaak?* Although the primary concern in this case was her age, the constant repetition of her current children’s ages indicated that this definitely played an important role in her decision.

No previous abortions were identified or recorded. This was the first time that any of the respondents had a pregnancy terminated and this was not found to be an influencing reason in the decision making process.

4.3.10. GESTATION PERIOD

The gestation period was found to be a consideration in the decision to terminate a pregnancy with regards to the following respondent as *“I was 11 weeks pregnant and if I decided to have an abortion later on, it wouldn’t be possible”*. The gestation period did indeed influence her decision as she could not have waited longer to decide whether certain reasons that were primary in her decision would change to make keeping the baby an option. Because she was considering the option, the “cut-off” timeframe in terms of legislation was primary in having her pregnancy terminated.

4.4. SUMMARY

The reasons that influence women to decide whether or not to terminate their pregnancy must be viewed in terms of linked relationships between primary and secondary reasons or themes. These reasons do not stand in isolation to each other but form a relationship in terms of importance ascribed to each reason and set of reasons based on the continuum of a woman's personal and private circumstances.

Various themes and sub-themes were identified that all support and interlink with each other to form the basis of the decision. The relationships are also linked through a thread between the themes, as well as in terms of importance.

The proximate determinant in terms of falling pregnant is the non-use or failure of contraception. It does not relate directly to choosing to terminate a pregnancy but plays an important role in whether the woman wanted to fall pregnant or not. It was found that both the non-use and failure of contraception was significant but even more so the knowledge regarding the correct usage of contraception and ignorance regarding the consequences of non-use or incorrect usage. It was found that the "it won't happen to me" syndrome was dominant especially when viewing the feelings when women found out that they were pregnant.

It must be noted that although the relationships are detailed as primary between age, employment status and financial concerns as well as primary between the relationship status and support of the partner, and the relationship and support of significant others, either set of reasons are viewed as primary or secondary depending on what is more important to the woman. Where a woman's primary considerations are her age, employment status and financial concerns, the relationship with her partner could also be a primary consideration and therefore supports the personal concerns allocated in each webbed relationship. Another primary consideration could be the gestation period. Each woman's primary and secondary considerations vary although a pattern of importance and commonality was established.

A primary relationship was found to be between the age of the woman and partner, employment status and financial concerns. The respondents stated that their age, either being too young or being too old was significant in their decision making. This again relates directly to the employment status as the respondents that stated that they were too young were still studying at a tertiary and were students. Again, linked to this was the fact that because they were students, they did not have an income and financial concerns

regarding the raising of a child was an important consideration. The importance of these reasons within the relationship varied between respondents and is dependent on the personal situations and concerns of the women.

Another relationship was found to be between current unemployment and financial concerns as maintenance would also not be available to raise a child and this indicates the importance of relationship concerns.

These personal circumstances are primary when reviewing the relationships between partners and significant others. This in turn relates back to the support received by partners and significant others. Although respondents were in relatively stable relationships apart from two, their personal perceptions of what is deemed a stable relationship, also came into play. The relationship with partners and significant others also influenced women to either choose to tell them about the pregnancy and the abortion.

This relationship basis must be viewed in terms of a relationship between age, current employment status and financial concerns as well as values, and can be identified as primary compared to secondary when making the decision to terminate a pregnancy. Again, this is dependent on the importance ascribed to these sets of reasons that in turn is dependent on what is more important in a woman's life at that current point. The making of the decision is also closely linked with the support received or the perceived support received by the respondents. Although many respondents did tell their partners, they did not receive support for the decision made but did receive support for the termination. Support was also important in terms of values.

A relationship was found between values and the relationship status, and the support between partners and significant others. Moral and religious values played an influencing effect only in so far telling partners and significant others about the pregnancy and the abortion and was not primary in deciding whether to terminate a pregnancy. Cultural and traditional values also affected this relationship and were found to play a stronger role than moral or religious values. Even though values featured to a great extent, this was a secondary concern to terminating the pregnancy as all respondents interviewed, had already terminated their pregnancy.

Values were interlinked to feelings of guilt when measured against whether the decision was the correct decision or not. The feelings of guilt are linked to moral and religious values but the more tangible reasons weighed more than the values.

In terms of cultural and traditional values, these were not evident in terms of feelings of guilt. It must be noted that although strong feelings of guilt were present, the respondents felt that their decision was the correct decision.

Values and the relationship between guilt versus the correct decision are also linked in terms of alternate considerations. Certain respondents initially considered keeping the child but their personal situations or circumstances did not allow for this option. Circumstances that may have been conducive to this being an option changed when primary reasons were evaluated. The reaction of respondents indicated that in most of the situations, the pregnancy was unwanted from conception. Due to emotions, moral and religious values were less important as no respondent considered carrying the baby to term and then giving it up for adoption.

Counselling and the importance thereof, are important as a conduit to the decision making. It sets the setting for women to discuss their emotions, options and decision especially when related to the relationship status and support from partners and significant others. It allows them to give a voice to their decision when weighing values against tangible reasons. Counselling is also crucial when a perceived understanding of their situation is needed, and someone listening occurs in a non-judgemental setting.

Sexual behaviour can be viewed in terms of the diagnosis and treatment for sexually transmitted diseases, the number of sexual partners, number of live children and number of previous abortions. No respondent indicated that they have been treated for sexually transmitted diseases and none cited HIV/AIDS as a reason for choosing to terminate a pregnancy. This could be ascribed to the fact that the current father of the foetus was the first sexual partner in the majority of the cases.

Consideration for current live children was a primary consideration for two respondents. Ideal family size was found to be a primary consideration in one situation where the respondent had already reached her ideal family size of two children and the primary reason was to stop childbearing. This is not an isolated reason but relates to a range of other primary considerations such as age and financial concerns. Where the father of the foetus was not the same father as the current live child, this was found to be a primary consideration in the decision making process.

In only one case did the gestation period play a primary role in the decision making process. Where the women was still weighing her options, her gestation period forced to make the decision quickly, maybe even pre-maturely, as she was already eleven weeks

pregnant and would not be able to consider a termination of pregnancy after twelve weeks.

Gestation period, ideal family size and sexual behaviour were primary considerations for certain respondents. It was not re-occurring across respondents but was no less important or valuable in terms of the specific women's situations.

Primary reasons are identified per women in terms of her ordering identified reasons and sets of reasons in term of importance. Although reasons were recurring across respondents, the order may differ depending on the importance she ascribes to her specific situation or personal circumstances. The aim of the research was not to draw comparisons to other studies. It is important not to isolate reasons as there exists a definite webbed relationship between reasons and between sets of reasons and we cannot remove the personal experience and situations of women from their decision making and following through with their decision to terminate their pregnancy.

CHAPTER 5

DISCUSSION AND INTERPRETATION

5.1. INTRODUCTION

The value of the research findings must be viewed in terms of the evolution of abortion from a moral-ethical debate to a woman's right to decide freely and fairly to terminate her pregnancy or not to terminate her pregnancy.

When placing the research findings in context, we must firstly place abortion within a historical perspective and the evolution of international abortion legislation. This evolution must be seen within the changing international context regarding reproductive rights and the rights of women which have become a prominent developmental and human rights issue. A focus on the liberalisation of South African abortion legislation within South African population policies is also needed to provide the premise from which the respondents were legally "allowed" to terminate their pregnancy. The aim of the study provided the basis for the research methodology which in turn leads us to the interpretation of the reasons and sets of reasons and their linked relationships identified in the study. Based on the findings, general perceptions will be discussed and recommendations made to policy makers. Recommendations for further research and studies will also be discussed.

5.2. HISTORICAL EVOLUTION OF ABORTION LEGISLATION

Historically abortion has been viewed in terms of moral and religious values specific to a nation or to a society. These values formed the basis of abortion being viewed as deviant and pathological but did not eradicate the presence of illegal abortions being performed. The evolution of abortion legislation started two hundred years ago, moving from the deviant and pathological perceptions to a more liberal or acceptable stance.

This is true for the more western countries where a shift in attitude toward abortion started in the mid-sixties. This attitude encompassed a more lenient and acceptable stance and moved away from abortion being viewed as pathological and deviant. Certain nations, especially Eastern European countries had however permitted abortion since the turn of the twentieth century. The prominence of abortion during the nineteen-sixties was due to the voice of feminism becoming stronger and gaining momentum as well as the fact that physicians became more aware of the complications associated with illegal abortions.

The most significant historical change in terms of abortion liberalisation was in 1973 when the five most populous nations, namely China, India, the Soviet Union and the United States permitted legal abortions in the early phases of pregnancy³. This led to a ripple effect as other nations, e.g. Denmark, Austria and Tunisia also liberalised their abortion legislation to permit legal abortions within the first trimester of a pregnancy based on certain conditions, therefore still placing certain restrictions on women asserting their own opinion and choice, but evolving from an illegal stance on abortion.

Underlying the values and a nation's stance on abortion is the moral-religious debate of when does life begin. When viewed in terms of the historical and current legislative context, this provides the framework for abortion laws as to whether they are:

- Illegal - abortion is prohibited with no exception.
- Very restrictive – abortion is only permitted in life-threatening circumstances.
- Conditional – grounds for abortion include genetic factors, humanitarian factors such as rape or incest, and broad health indications.
- Liberal – abortion is granted upon request of the women.

The progression towards liberalisation is seen in terms of what is acceptable to a nation in terms of their values as to when is abortion legal. The legal status of abortion is important as this determines whether or not a legal course of action can be taken against a woman for having a pregnancy terminated. The outcome of this shift is that abortion moved away from being a criminal activity to an activity justified on human grounds. This refers not just to the legalisation of abortion laws but also to the relaxation of illegal and more restrictive laws as fundamental changes in the international arena became more evident. The evolution of abortion legislation must therefore be viewed within the historical development of population concerns, family planning and the strong emergence of human and women's rights.

5.2.1. THE INTERNATIONAL ARENA

From the 1940's up until the World Population Conference in 1974 in Bucharest, the international arena was underlined by the Malthusian threat: the earth's resources cannot sustain or contain the worlds rapid population growth.

³The USA, under the Reagan administration tried to change this stance at the International Conference of Population in Mexico (1984) by withdrawing funding to agencies assisting in abortion-related services. A turnaround in terms of this policy was evident at the 1994 ICPD conference where support to agencies re-instated. However, in March 2005, a debate regarding the Bush administration stance on abortion is in the headlines again by wanting to withdraw any support to abortion-related services. This was however resolved as it was accepted that this is not a new right as such, but is placed within the current reproductive rights sphere.

The solution was lowering population numbers and fertility rates through the introduction of family planning programmes and the use of contraception to reach set demographic targets.

As the curbing of population growth gained momentum and support, the concept of family planning became more acceptable to nations and societies. As the advantages of family planning became clear, the desired family size tended to decrease and this in turn led to an increase in the requirements for the provision of family planning services.

Through the emergence of family planning services, the rights of women regarding their own reproductive behaviour came to the foreground as this was the first time women were allocated some control over their reproductive behaviour in terms of exerting a choice as to using contraception or not. Although this choice could theoretically be made, the provision of contraception and access to contraception was urgently required for women to make the choice to use contraception so as to be able to curb population growth.

At the World Population Conference in Bucharest (1974), the importance of including women in terms of their contribution to development was noted as well as the notion of equality. However, this was brief and the focus of population issues were still based on a framework of development as opposed to individual rights. It was important though as this was the first time even mention was made of equality and women contributing to development.

Only during the International Conference of Population in Mexico City (1984), did the international community declare that apart from population being interlinked with resources, environment and development, nations must make safe and accessible family planning services universally available in the context of non-discrimination. The focus was still on contraceptive distribution, but the theme of abortion in terms of non-discrimination and equality could not be removed especially when the USA revoked funding from agencies assisting in abortion-related services. Within this context, the USA in essence created a greater awareness of the need for adequate abortion-related services and a new focus was given to abortion as a basic human right.

The International Conference on Population and Development (ICPD) in Cairo (1994) was the breakthrough in the international sphere by emphasising reproductive rights in terms of human rights as “*women have the individual right and social responsibility to decide freely when/if and how many children they desire*”, and that family members, religion, policy makers, ethnic groups or governments may not dominate these rights of women.

Reproductive and sexual rights include the freedom of choice regarding reproductive behaviour but also include the provision of reproductive services provided. This in turn includes access to family planning services, access to safe and legal abortion, access to safe maternal health care as well as safe and accessible health care services to all women, and the basic right of education. Reproductive rights encompass more than just the right to choose to terminate a pregnancy, but also the right not to make the decision to terminate a pregnancy. The right to the provision of education, access to family planning services and health care services, allows for women to exert a choice to prevent conception by choosing to use effective contraceptive methods and to have knowledge regarding the correct usage thereof. It must be clearly noted that in no way was the advocating of abortion as part of reproductive rights meant to be promoted as a method of family planning, but rather as an alternate course of action dependant on a woman's choice and decision.

The right of women to exercise their own choice regarding their reproductive behaviour could not have been possible without the emergence of human rights, and in turn women's rights. The above definitions therefore include that abortion on demand is an integral part of reproductive rights, and safe abortion services, an integral part of reproductive health. Although these were the findings and sentiment of the ICPD, no nation is forced to comply with these regulations as religious, moral and cultural codes still outweigh these principles.

5.2.2. SOUTH AFRICAN LIBERALISATION

In accordance with the international abortion liberalisation, the evolution in South Africa from the Abortion and Sterilisation Act no. 2 of 1975, to the Termination of Pregnancy Act no. 92 of 1996, clearly indicates that South African abortion legislation evolved from a conditional law in 1975 to a liberal law in 1996.

The evolution of South Africa's abortion liberalisation stands in direct correlation to the international shift in the acceptance of the reproductive rights of women and the liberalisation on the stance on abortion. This acceptance aligns to the change in the South African population policies as seen in the shift from the Population and Development Programme (PDP) that chased set demographic targets, to the Green Paper and White Paper for Social and Administrative Affairs.

The approach of this is that population concerns are multi-faceted between population, development and the environment.

The population policies conform to the Bill of Rights contained in the Constitution of the Republic of South Africa and is part of the strategy to enhance the quality of life of the entire population. Included is the embracing of the concept of equality, the empowerment of women and important to women that *“all couples and individuals have the right to decide freely and responsibly the number and spacing of their children, and to have information, education and the means to do so”*.

The Termination of Pregnancy Act no. 92 of 1996 allows for South African women to fully exert their choice to terminate their pregnancy or not. Abortion is provided on request during the first 12 weeks of the gestation period. Termination can also occur from the 13th and up to and including the 20th week of the gestation period under conditional circumstances as well as *“if the continued pregnancy would significantly affect the social or economic conditions of a woman”*.

Although the implementation of a liberal abortion law is based on the stance taken by the international community, the right to education regarding reproductive behaviour and its consequences, is vital when contraception is taken into consideration as contraception is a proximate determinant to whether a woman falls pregnant or not. Linked to this is the right of a woman to choose to terminate her pregnancy as well as the right to safe and accessible services. Where access to this is not provided, illegal abortions or self-inflicted abortions are performed, which could lead to severe complications or even death.

In South Africa, concern regarding the maternal mortality and morbidity rates of unsafe abortions was reviewed in accordance with the international arena and the ICPD. These rates were extremely high in South Africa as it is estimated that in 1994 alone, 44 686 women were admitted to hospital due to complications from unsafe abortions. Due to these high rates of illegal and unsafe abortions, questions were raised as to the provision of safe abortion services as the conditional status of the Abortion and Sterilisation Act no. 2 of 1975, did not stop women having their pregnancies terminated when this was the decision that they made. This indicated a desperate need as women's situations or personal circumstances outweighed the legal status of abortion laws and did not impact the course of action taken once the decision had been made by women to have their pregnancy terminated.

The implementation of the Termination of Pregnancy Act no. 92 of 1996 now allowed women to exert their choice as to whether or not they want to terminate their unwanted pregnancy without fear of legal reprisal and consequences. Government medical facilities as well as private clinics perform abortions within the specified framework.

Although this is within the legislative framework of South Africa, the provision of abortion services is still fraught with problems as medical staff cannot be forced to perform abortions if this is against their moral or religious values. Societal perceptions of women that do terminate their pregnancies as well as those medical staff members that assist with terminations, are also negative and can influence the treatment of women and staff. Statistics regarding abortion in South Africa is also not consistent and varies depending on the source. Information is not readily available from the Department of Health and therefore it is difficult to get a true or complete view in terms of the status of abortion in South Africa.

As women make decisions to terminate an unwanted pregnancy or choose not to terminate the pregnancy, a study as to the reasons for a woman deciding to terminate a pregnancy was deemed appropriate.

5.3. THE AIM OF THE STUDY

Not all unwanted pregnancies end in a pregnancy termination. The importance was to investigate why certain women choose to terminate an unwanted pregnancy while others choose not to. What are the factors that led to women to follow this specific course of action?

International and national studies conducted as to the reasons for women terminating their pregnancy are based on statistics gathered to indicate a ranking in terms of the most frequent reported averages for the most common reasons cited. The studies do not however allow for women to give a voice to their personal situations, circumstances and experiences which led to their decision to terminate their pregnancy.

Thus the aim of the study was to investigate the reasons given by women for choosing to terminate a pregnancy over other alternatives to deal with an unwanted pregnancy. This is true as the study aims to understand the situations, circumstances and experiences of a woman's life and these influences on their decision to terminate their pregnancy.

5.4. RESEARCH METHODOLOGY

To achieve the aims of the research, it was decided that a qualitative study was to be employed to explore the reasons that women have for terminating the pregnancy as well as to provide the platform for women to narrate their stories in terms of their personal situation and circumstances.

When taking the above into consideration, the research study was formulated as an exploratory study to investigate the reasons that women have for deciding to terminate their pregnancy.

Due to the fact that current literature regarding the reasons that women decide to terminate their pregnancy, is based on statistical analyses of averages and rankings, it was important to explore these reasons as narrated by women themselves. It was important to provide a more open-minded and investigative platform to give a voice to their stories.

A semi-structured interview was conducted on a one-on-one basis with twelve women that had already terminated their pregnancy. This was conducted at the Reproductive Choices Clinic in Midrand during post-abortion counselling sessions. The reasons for the semi-structured interviews were that certain questions regarding demographical factors were pre-populated. Certain questions regarding the investigation as to the reasons for women deciding to terminate their pregnancy were also used as a framework for the interview. The advantage of this methodology was that probing questions as to further explanations or clarifications were possible.

Access to respondents was fraught with difficulty due to the sensitive nature of the topic under investigation. Access to the respondents would have been impossible without the assistance of the staff at the Reproductive Choices Clinic. Respondents were interviewed during the post-abortion counselling sessions provided by the clinic. The staff at the clinic facilitated access to the respondents for the interviews to be conducted. Participation in the research process was completely voluntary and anonymity and confidentiality was guaranteed.

5.5. RESULTS

Findings from the study can be viewed in terms of the diagrammatical representation as presented in Appendix B. This indicates the reasons and sets of reasons that women have for deciding to terminate their pregnancy. The webbed relationship⁴ between the reasons is indicated by the arrows. This indicates that no reason stands in isolation to each another. There exists an intricate link between reasons as these forms a set of reasons which in turn links to other sets of reasons.

⁴ Webbed relationships refer to the interlinked and related relationship between reasons and sets of reasons. The term is used to depict that no reason was found to stand in isolation, but they are intricately linked and related to each other.

The reasons that influence women to decide to terminate their pregnancy can be summarised as follows:

5.5.1. THE LINKAGES BETWEEN AGE, EMPLOYMENT STATUS, FINANCIAL CONCERNS AND PERSONAL CIRCUMSTANCES

A definite relationship exists between age, employment status, financial concerns and personal circumstances and can be linked as follows:

- Between either age and current employment status;
- Between age, current employment status and financial concerns;
- Between current financial concerns; and
- The above relationships supported and influenced by personal circumstances

Age was the most frequently mentioned reason for women deciding to terminate their pregnancy. Two sub-themes identified were that the respondents felt that they were either too old or too young to have children. Age being a reason is also relative as it aligns to a women's perception of what constitutes too old or too young to raise a child. The age of the father of the foetus as being too young also impacted on the respondents as they felt that they (partners) were too young to have a baby and raise a child.

Being too young however does not stand in isolation and is linked to the current employment status of the women. The respondents that indicated being too young as a reason, also indicated that they are currently still studying at a tertiary institution, and are students. Again, the employment status of the father also came into play as the father of the foetus was also a student.

This in turn led to financial concerns regarding having a baby and raising a child due to their current employment status and being unable to afford having a child. Due to the respondents and their partners being students, they are currently not employed and therefore they do not earn a salary to be able to support a child.

Of importance is that it was also found that an interruption of their current life style (being a student) was also a consideration in the decision making. Respondents stated that even if they disrupt their current studies to find immediate employment to have a child, they would not be able to afford raising a child as the employment they would be able to get would not be worthwhile without a tertiary education.

Personal circumstances underlie the decision made to terminate the pregnancy. Within the sets of reasons discussed in Chapter 4, personal circumstances within this relationship could include the relationship status with the father, the relationship status with significant others, etc. These circumstances are either primary or secondary influencing reasons that impact on women deciding to terminate their pregnancy.

5.5.2. INTERPERSONAL RELATIONSHIPS AND SUPPORT NETWORKS

In terms of relationships identified, the following sub-themes were identified:

- The relationship status with the father of the foetus;
- The relationship status with significant others;
- The support received from the father of the foetus;
- The support received from significant others; and
- The above supported and influenced by personal circumstances.

The length of the relationship with the father of the foetus was found to be relative to the personal perception of women as to what is deemed as long enough and a stable relationship. Respondents also indicated that the length of the relationship does not implicate that the respondent and partners will be married and therefore impacted on their decision. Respondents indicated that in terms of sequence, marriage should be first then followed by having a baby.

The relationship with the father of foetus also impacted on whether or not respondents told the father of the foetus that they were pregnant or that they were deciding to terminate their pregnancy. It was significant that most of the respondents informed their partners of their pregnancy and the fact that they decided to terminate their pregnancy. In a minority of cases, the decision was a mutual decision.

It was found that the fathers that were informed of the pregnancy and the decision, did not want the woman to terminate the pregnancy as they wanted children. Although they did not want the pregnancy terminated and did not support the decision to have the pregnancy terminated, they did support the woman in terms of the course of action followed.

Interesting was the fact that married respondents were involved in the unstable and volatile relationships. These personal factors were the primary reasons for these respondents in terms of the current relationship status with their partners and not knowing

what the future status with their partners would be. Physical abuse from the partner also impacted on the decision made.

The length of the relationship did not stop respondents that fell pregnant from a one-night-stand to tell the father of the foetus of the pregnancy or the decision to terminate the pregnancy. They were supported in their decision but again, their personal circumstances determined their choice to terminate their pregnancy.

The relationship status with significant others also influenced women's decision to terminate their pregnancy. Of interest is the fact that this relationship was indicative of the concerns that women had regarding the impact of their pregnancy on significant others and their perceptions thereof. The impact of their experience in terms of their relationship with significant others also played an influencing role. This relates back to their past experiences within the relationship with significant others.

This relationship also influenced whether women told significant others about the pregnancy and the decision to terminate the pregnancy. It was found that the perceived reaction and perceptions of significant others influenced women in not telling them about the pregnancy and therefore not telling them about the decision to have the pregnancy terminated.

5.5.3. PERSONAL VALUES

Values were identified in terms of the following:

- Moral values of respondents and/or partners;
- Religious values of respondents and/or partners;
- Moral values of society/community;
- Religious values of society/community;
- Cultural values; and
- Traditional values

A differentiation between moral and religious values is done on the basis that not all people that hold moral values are necessarily religious, although the values may be the same. These values directly link with whether respondents told significant others in their lives.

It was found that the values, be it moral or religious, influenced whether respondents told significant others about their pregnancy.

The fear of reprisal and disappointment in terms of the values held by significant others were very strong and exerted an influence on making the decision to terminate their pregnancy.

This links to the values held by families and societies in terms of what they deem virtuous and acceptable. In terms of this, cultural and traditional values also are important. This was found to be true for the perceptions of illegitimate children as well as perceptions and stereotypes of women terminating a pregnancy. This must again be viewed in terms of moral and religious values. Cultural values had an influence on making the decision to terminate the pregnancy where race was identified as a theme.

An important finding was that although many respondents indicated that their own, as well as their partners moral and religious values opposed abortion, this did not stop the respondents from terminating their pregnancy when they took their personal circumstances and other more tangible reasons into account. This is supported by the fact that although these values oppose abortion, it did not stop women from terminating their pregnancy. Due to the fact that all the women that were interviewed had already terminated their pregnancy, it is not possible to establish a comparison between the reasons as to why women decided to terminate their pregnancy compared to why women decided not to.

These values influenced respondents as to whether they feel guilt or whether they see their decision as the correct decision. It also impacts on the value of counselling provided to the women.

5.5.4. ALTERNATE CONSIDERATIONS

Some of the respondents indicated that they initially considered having the baby and raising the child, but due to a change in circumstances that were initially conducive to do this, decided to terminate the pregnancy. One respondent wanted to fall pregnant and have a child while others took the fact that the father of the foetus wanted children into consideration. Again, due to a change in circumstances, and then considering other primary reasons, decided to terminate the pregnancy. Once the decision was made that keeping the child was not an option, the decision to terminate the pregnancy was made.

No respondent indicated that adoption was considered as an alternative to terminating the pregnancy. This was influenced by the values of respondents in terms of not being able to explain to a child that they were not ready to have children or to wonder about the child for

the rest of their lives. In turn, this influences the feelings of guilt versus the right decision made on a different level to feelings of guilt regarding the termination itself.

5.5.5. EMOTIONAL RESPONSES: GUILT VERSUS THE RIGHT DECISION

The emotional state of women is important in making the decision to terminate their pregnancy as well as dealing with the consequences of their decision. The values of women affect whether their feelings of guilt outweigh their perception of whether they made the correct decision.

The respondents indicated that they do have feelings of guilt and wonder about whether it was a boy or girl, did it suffer, did it feel pain and what it would have looked like.

Although the respondents indicated feelings of guilt regarding their course of action in terminating their pregnancy, they felt that they made the right decision when taking their reasons and considerations into account. Their personal reasons and sets of reasons are more important and more heavily weighted than their values.

It was indicated that the consequence of the termination in terms of infertility was considered and this “what would be” factor is of grave concern. Respondents also indicated that they hope they would receive forgiveness for making this decision but again, that it was the correct decision at the time of making it.

5.5.6. ADVANTAGES OF PRE-ABORTION AND POST-ABORTION COUNSELLING

The following relationships in terms of counselling were identified:

- Relationship status with significant others;
- Support received by partners or significant others;
- Guilt versus the right decision made; and
- Values.

Counselling played a supportive role in creating a platform for making the decision to terminate a pregnancy. This was found to be true where women were not able to tell significant others of their pregnancy and the decision to terminate their pregnancy. Pre-abortion counselling provided a premise for women to be able to discuss their

circumstances and situations free of perceived reprisal for their decision. It provides them with a support network that was otherwise not present.

Counselling also assisted women in feeling less guilty regarding their decision as again, they could discuss their decision and the consequences without recrimination and fear of being judged and stereotyped. The values of women in terms of the turmoil of considering the reasons for deciding to terminate a pregnancy were not seen to be selfish and immoral as they were defying their moral and religious values.

Counselling also supported woman in terms of extended support to the father of the foetus where he did not support the decision to terminate the pregnancy and wanted children.

It was found that both pre- and post-abortion counselling services were of great importance although for two different reasons. Pre-abortion counselling provided the platform for discussion and fact finding whereas post-abortion provided a confirmation of whether the right decision was made, whether they are physically unharmed and that the procedure was successful.

5.5.7. IDEAL FAMILY SIZE / CURRENT FAMILY CONSIDERATIONS

Ideal family size was found to be a social reason for deciding to terminate a pregnancy. In terms of women citing this to be a primary reason, it was found to be out of consideration for the current family unit and not due to financial concerns. Where respondents felt that they were too old, a primary reason for deciding to terminate the pregnancy was to stop childbearing as the ideal family size of two live children was already reached.

Where respondents indicated that they were too young, the ideal family size was indicated to be two children, but the primary reason was to postpone childbearing. The sets of reasons that were primary, was more important than having a child at the current point in their life. Financial concerns were an important consideration as part of postponing childbearing in terms of the linkages between age, employment status and financial concerns. Because of the future ideal family size that was indicated to be two children, this did impact the feelings of guilt versus the right decision.

5.5.8. WOMEN'S REPRODUCTIVE HEALTH

5.5.8.1. CONTRACEPTIVE USE

Although contraceptive use does not impact on making the decision to terminate a pregnancy, it is the proximate determinant to whether a woman will fall pregnant or not. The importance of this is that the decision to terminate a pregnancy would not have had to been made if women used contraceptive methods and used them correctly. Conception of an unwanted pregnancy can be seen in terms of the non-use and failure of contraception or the incorrect use thereof.

The following reasons for conception were identified:

- Failure of contraceptive methods used;
- Non-use of contraceptives;
- Access to contraceptive services;
- Lack of knowledge regarding contraceptive methods; and
- Ignorance regarding consequences of non-use of contraception.

The most common cited contraceptive methods used was the condom, the pill, the injection and more traditional methods such as the rhythm technique. Failure of contraception was the most frequently mentioned reason for falling pregnant with condoms that broke, the pill being ineffective and miscalculating their monthly cycle in terms of the rhythm technique.

Findings were that the actual failure of contraception as the reason for conception was limited. Where respondents initially indicated this to be the determinant of falling pregnant, it was found that lack of knowledge regarding the correct usage of contraception methods was the actual reason cause. It was found that the "it won't happen to me" syndrome was very prominent.

Ignorance regarding the consequences of incorrect use and non-use was also prominent when taking the lack of knowledge into consideration. Again, the "it won't happen to me" factor was obvious especially when taking the response of the respondents when finding out that they were pregnant into account. The response was overwhelmingly that this was an unwanted pregnancy.

5.5.8.2. SEXUAL BEHAVIOUR

Sexual lifestyle can be classified as follows:

- Treatment for sexually transmitted diseases;
- Number of previous sexual partners;
- Current live children; and
- Previous abortions.

The sexual behaviour of the respondents was important as no respondent indicated that they had ever been treated for a sexually transmitted disease. This was significant where HIV/AIDS could have been a primary reason for deciding to terminate a pregnancy.

This could link directly with the number of sexual partners of the respondents as a secondary reason. The demographical data collected indicates that for many of the women, the father of the foetus was the first sexual partner.

No previous abortions were indicated so there was not a relationship established in terms of using a termination of pregnancy as a family planning method.

A relationship between personal circumstances and current live children was present in terms of taking the current live children into account by evaluating the impact of carrying the pregnancy to term, on the current live children. This was found to be a primary consideration in making the decision to terminate the pregnancy.

5.5.8.3. GESTATION PERIOD

The gestation period was found to be a primary reason for deciding to terminate a pregnancy only in so far the time period of obtaining a termination is within the legislative framework. Respondents whose gestation period was close to or reaching twelve weeks had to act and make a decision to either terminate their pregnancy or not.

5.6. GENERAL PERCEPTIONS AND RECOMMENDATIONS

It is clear from the research findings that we cannot group or investigate reasons that women have for deciding to terminate a pregnancy in isolation to each other. A definite relationship exists between reasons which form a set of reasons and then between the sets of reasons as well.

By just viewing these reasons in isolation and only in terms of statistics, we do a disservice to women as we do not allow them to narrate their personal stories in making their decision. By viewing women in terms of just statistics, we also deny them identity which is a principle of feminism and women's rights.

The value of statistics lie in presenting the most common cited reasons and the number of terminations performed for certain nations, countries or continents. When taking these statistics into consideration, it provides an invaluable profiling framework from which to work as well as assessing the status of abortions in terms of increases and decreases in the number of abortions performed or even the projected number of abortions when continuing along certain developmental paths.

It is however crucial that we allow women to voice their reasons and to then investigate the linked relationships between reasons and sets of reasons. If we do not investigate these relationships between reasons we cannot accurately present profiles and target demographic characteristics or profiles in terms of supportive action, policies and corrective action. The relationship between these reasons and the sets of reasons provide a framework from which policy makers can identify neglected areas such as access to contraception and education regarding the correct usage of contraceptive methods.

Also, we would not be able to target specific demographic characteristics and determinants to try to prevent the termination of a pregnancy. Although making the decision to terminate a pregnancy is a fundamental human right and reproductive right of women to make the choice, it is clear from the research that this is not a decision without emotional and even physical consequences.

The respondents indicated that "what would have been" if their personal situations and circumstances were different. This leaves women with an emotional feeling of guilt even though the decision that they made was seen as correct and the only choice at the time of making it. Safe and accessible abortion services and the right to choose is the right of every woman but is a decision that is not without incredible insight and surety especially when moral and religious values are present.

When placing the choice of terminating a pregnancy into the international context according to the ICPD and women's rights conventions, the right to choose and to decide to terminate a pregnancy is a right that must be available to all women. Alongside the right to choose, it must be supported by access to safe abortion services. Women viewed their termination more in terms of the service provided than the actual right to do so but by

making the decision and following through with the decision, they exercised their right to choose in terms of what “is better for me” at that specific point in their lives.

The research proves that the decision is not an easy one and that the decision process requires the placing of reasons in terms of importance that will impact on the current position of the women. Although all the respondents felt the decision was the correct decision at the time of making the decision, and following through with the decision, the feeling of guilt are evident. Also, it is evident that the respondents question their decision after-the-fact because of feeling of guilt or remorse. Abortion should not be placed within the terms of contraception and every effort should be made to decrease the prevalence of abortion.

Based on this and the previously discussed findings, the following recommendations can be made:

1. Every effort must be made to make family planning accessible to all women in terms of accessibility to various contraceptive methods. The education of women regarding the failure rate of contraception and the correct usage thereof is crucial to address the level of ignorance and lack of knowledge regarding this.
2. Combined contraceptive methods should be promoted to counteract the failure rate of chosen contraceptive methods. Alternate forms of contraception should also be promoted such as the IUD and female condom. This would only be possible once the level of knowledge regarding contraception has been addressed for women to take ownership of using contraception and using it correctly.
3. Due to the fact that being too young, current employment status and financial concerns were the most frequent set of reasons stated, policy makers need to target young adults that are currently still studying at a tertiary institution. An education campaign regarding contraception needs to be highlighted as well as that “it could happen to you”.
4. Improved counselling services need to be provided nationally as the study proves that effective counselling is crucial to assist the woman in her decision but more importantly to deal with her decision to terminate her pregnancy. This means that skilled counsellors need to be employed at all institutions that provide abortion services. Alternatives to terminating a pregnancy should also be presented and assistance provided to women to investigate alternatives such as adoption.

5. National social services need to be revisited in terms of adoption services. Currently the number of children in orphanages far outweighs the requests for adoption. The fact that funding to institutions is largely based on public support also creates a perception that these institutions are less than adequate. Requirements for people wanting to adopt must also be revisited to make this a viable alternative for women that are facing an unwanted pregnancy.
6. Post-abortion counselling needs to be implemented at abortion service institutions which is currently not the case at the governmental and certain private clinics. The value of this lies in assisting women to deal with their decision and to provide a portal for communication.

Many women do not have a support network and this provides the support that they require. Post-abortion counselling does not just end at the woman self, but encompasses assistance to the partner as well.

It helps women to also deal with the impact of the abortion on themselves, their partner and the relationship. It also ensures “peace-of-mind” that physically everything is fine.

7. Although medical staff cannot be forced to partake in abortion services due to their own opposing values, medical staff involved in the needs provision of abortion services, should be orientated and educated to provide the support required by women that terminate their pregnancy and receive the necessary guidance or training that would better enable them to render abortion services without creating personal value conflict. The findings clearly prove that the support provided and the perceptions of medical staff weigh heavily on women dealing with their decision.

5.6.1. RECOMMENDATION FOR FURTHER STUDIES

The subject of abortion is very wide and can be viewed from so many different fields that the possibilities are endless for further investigation. Abortion can be viewed from demographical, sociological, physiological, anthropological and medical fields, just to name a few.

The theme of abortion also encompasses many facets that need to be taken into account. The aim of this research project was to identify the reasons that women have for terminating their pregnancy. Because the research was exploratory in nature and wanted to allow for women to narrate their own stories, certain elements that could add immense

value to understanding the process of deciding to terminate a pregnancy was not included as these reasons were not narrated. Other reasons were identified but a stronger focus could be given to investigate their individual impact.

The following are recommendations for further research:

1. The impact of HIV/AIDS on the decision to terminate a pregnancy.
2. The impact of rape on the decision to terminate a pregnancy.
3. The impact of abusive relationships on the decision to terminate a pregnancy.
4. The impact of the father's position in terms of influencing the decision to terminate a pregnancy.
5. Follow up studies with women that have terminated their pregnancy to establish whether the woman and the father of the aborted foetus are still involved in a relationship.
6. Follow up studies with women that have terminated their pregnancy to establish whether they still regard their decision as the correct decision at the time of terminating their pregnancy.
7. Follow up studies with women that have terminated their pregnancy to establish whether they have closure and acceptance of making the decision to terminate their pregnancy.

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APPENDIX A

Table 1 - Status of Abortion in selected countries by Statutory Grounds for Abortion: mid-1978

Table 2 - Grounds on which Abortion is permitted: 1999

Table 3 - Liberal Abortion Laws per Country per Continent: 1999

TABLE 1
STATUS OF ABORTION IN SELECTED COUNTRIES BY STATUTORY GROUNDS FOR ABORTION
MID – 1978

	Liberal	Conditional	Very restrictive	Illegal
Total population covered (millions)	2568.3	614.1	49.6	369.2
Total number of countries represented	27	36	30	15
Percentage of world population	61%	15%	11%	9%
Major Countries	Austria Bulgaria Czechoslovakia Denmark France West Germany Hungary India Italy Japan Peoples Republic of China Poland Romania Sweden Tunisia United kingdom USA USSR Yugoslavia Zambia	Argentina Australia Brazil Cameroon Canada Chile Cuba Ethiopia Ghana Greece Kenya Mexico Morocco Republic of Korea Zimbabwe South Africa Switzerland Syria Thailand Turkey Uganda	Algeria Bangladesh Guatemala Iraq Ivory Coast Madagascar Malawi Malaysia The Netherlands Nigeria Pakistan Senegal Spain Sri Lanka Sudan Upper Volta Venezuela	Belgium Burma Colombia Dominican Republic Egypt Indonesia Philippines Portugal Taiwan Zaire

Source: Population: Briefing papers on issues of national and international importance in the population filed prepared by the Population Crisis Committee, World Abortion Trends 9, 1979: 2 (in Ferreira, 1985:23).

TABLE 2
GROUND ON WHICH ABORTION IS PERMITTED
1999

	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Total countries	193	193	193	193	193	193	193
Permitted	189	122	120	83	76	63	52
Not permitted	4	71	73	110	17	130	141
More developed regions	48	48	48	48	48	48	48
Permitted	46	42	41	39	39	36	31
Not permitted	2	6	7	9	9	12	17
Less developed regions	145	145	145	145	145	145	145
Permitted	143	80	79	44	39	27	21
Not permitted	2	65	66	101	108	118	124

Source: World Abortion Policies 1999. United Nations, Population Division, Department of Economic Affairs.

TABLE 3

LIBERAL ABORTION LAWS PER COUNTRY PER CONTINENT

1999

Country	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
AFRICA							
Tunisia	✓	✓	✓	✓	✓	✓	✓
South Africa	✓	✓	✓	✓	✓	✓	✓
ASIA							
China	✓	✓	✓	✓	✓	✓	✓
Dem Peoples Reb. of Korea	✓	✓	✓	✓	✓	✓	✓
Cambodia	✓	✓	✓	✓	✓	✓	✓
Vietnam	✓	✓	✓	✓	✓	✓	✓
Kazakhstan	✓	✓	✓	✓	✓	✓	✓
Kyrgyzstan	✓	✓	✓	✓	✓	✓	✓

Country	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Tajikistan	✓	✓	✓	✓	✓	✓	✓
Turkmenistan	✓	✓	✓	✓	✓	✓	✓
Uzbekistan	✓	✓	✓	✓	✓	✓	✓
Armenia	✓	✓	✓	✓	✓	✓	✓
Azerbaijan	✓	✓	✓	✓	✓	✓	✓
Bahrain	✓	✓	✓	✓	✓	✓	✓
Georgia	✓	✓	✓	✓	✓	✓	✓
Syria	✓	✓	✓	✓	✓	✓	✓
EASTERN EUROPE							
Bulgaria	✓	✓	✓	✓	✓	✓	✓
Czech Republic	✓	✓	✓	✓	✓	✓	✓
Hungary	✓	✓	✓	✓	✓	✓	✓
Romania	✓	✓	✓	✓	✓	✓	✓

Country	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Russian Federation	✓	✓	✓	✓	✓	✓	✓
Slovakia	✓	✓	✓	✓	✓	✓	✓
Ukraine	✓	✓	✓	✓	✓	✓	✓
NORTHERN EUROPE							
Denmark	✓	✓	✓	✓	✓	✓	✓
Estonia	✓	✓	✓	✓	✓	✓	✓
Latvia	✓	✓	✓	✓	✓	✓	✓
Lithuania	✓	✓	✓	✓	✓	✓	✓
Norway	✓	✓	✓	✓	✓	✓	✓
Sweden	✓	✓	✓	✓	✓	✓	✓
SOUTHERN EUROPE							
Albania	✓	✓	✓	✓	✓	✓	✓
Bosnia	✓	✓	✓	✓	✓	✓	✓
Croatia	✓	✓	✓	✓	✓	✓	✓

Country	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Greece	✓	✓	✓	✓	✓	✓	✓
Italy	✓	✓	✓	✓	✓	✓	✓
Slovenia	✓	✓	✓	✓	✓	✓	✓
Macedonia	✓	✓	✓	✓	✓	✓	✓
Yugoslavia	✓	✓	✓	✓	✓	✓	✓
WESTERN EUROPE							
Austria	✓	✓	✓	✓	✓	✓	✓
Belgium	✓	✓	✓	✓	✓	✓	✓
France	✓	✓	✓	✓	✓	✓	✓
Germany	✓	✓	✓	✓	✓	✓	✓
Luxembourg	✓	✓	✓	✓	✓	✓	✓
Netherlands	✓	✓	✓	✓	✓	✓	✓
AMERICA'S							
Cuba	✓	✓	✓	✓	✓	✓	✓
Guyana	✓	✓	✓	✓	✓	✓	✓
U.S.A.	✓	✓	✓	✓	✓	✓	✓

Country	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Canada	✓	✓	✓	✓	✓	✓	✓
OCEANIA							
Australia	✓	✓	✓	✓	✓	✓	✓

Source: World Abortion Policies 1999. United Nations, Population Division, Department of Economic Affairs.

APPENDIX B

RESEARCH FINDINGS

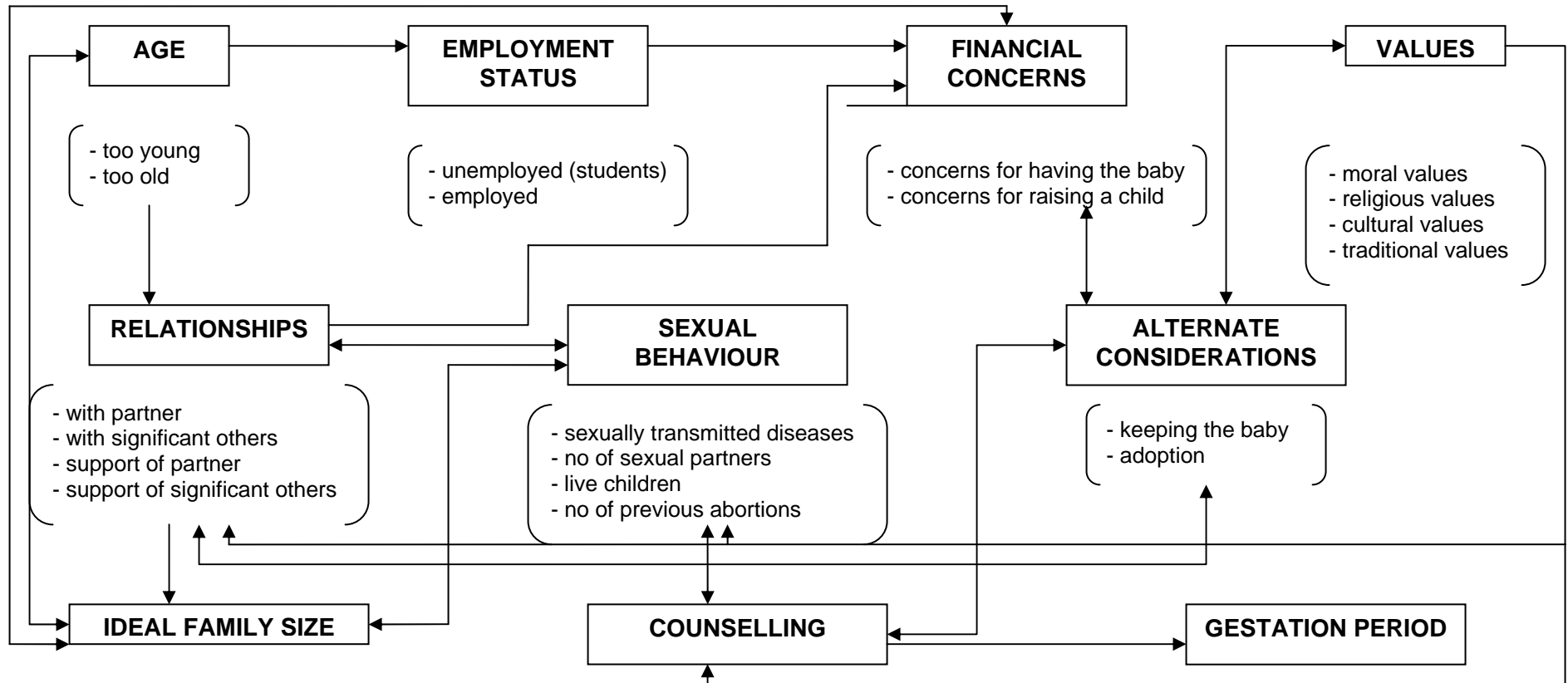
The following diagram indicates the relationship between reasons and sets of reasons for women choosing to terminate their pregnancy.

PROXIMATE DETERMINANT OF FALLING PREGNANT

CONTRACEPTION

- contraceptive failure
- non-use
- lack of knowledge regarding correct usage
- ignorance regarding consequence

PRIMARY AND SECONDARY REASONS



SUPPORTING PREMISE

PERSONAL CONCERNS OR CIRCUMSTANCES

GUILT VERSUS THE CORECT DECISION

APPENDIX C

INTERVIEW SCHEDULE

1. Demographical and Biographical Information
2. Questions

INTERVIEW SCHEDULE

DEMOGRAPHICAL and BIOGRAPHICAL INFORMATION

1. Age _____

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
--------------------	---------------------	----------------------	---	------------------------------------

4. Employment status

Scholar	Student	Unemployed	Employed
---------	---------	------------	----------

5. Age at first sexual intercourse _____

5.1. How many sexual partners have you had? _____

5.2. Have you ever been treated for venereal disease?

Yes	No
-----	----

5.3. If yes, for which disease? _____

6. Relationship status with the father of the foetus

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
-----------------	--------------------	--------------------	-----------------	---------	-----------	----------	---------

7. Were you using contraception?

Yes	No
-----	----

7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
--------	---------------	-----	-----------	------	-------

7.2. If Other, which method?

7.3. Why do you think it failed?

7.4. How far pregnant were you?

8. Have you been pregnant before?

Yes	No
-----	----

8.1. If yes, how many times?

8.2. If yes, how many miscarriages?

8.3. If yes, how many abortions?

8.4. If yes, how many live births?

8.5. If live births, how many children are still alive?

9. Do you want to still have children?

Yes	No
-----	----

9.1. If yes, how many?

QUESTIONS

- Tell me about your relationship with the father of the foetus?
- Did you tell him that you were pregnant?
- Is he aware that you have terminated your pregnancy?
- Did you discuss terminating the pregnancy with him?
- Did you receive any support from him?
- Did you tell your family or friends about the pregnancy?
- Did you tell your family or friends about terminating the pregnancy?
- Tell me about your family?
- Did you use contraception?
- How did you find out you were pregnant?
- How did you feel when you found out you were pregnant?
- Why did you decide to have an abortion?
- Did you ever consider raising the child?
- Did you consider adoption?
- Did you attempt to have the abortion done at a different facility?
- How did you experience the service provided at the clinic?
- Do you feel that the counselling session helped you deal with the abortion?
- Do you feel that the post-abortion counselling was of value?

APPENDIX D

TRANSCRIBED INTERVIEWS

The interviews presented here are verbatim transcriptions of the interviews conducted with the respondents without any interpretation or ordering in terms of their reasons or circumstances.

RESPONDENT A

1. Age 40

2. Race

African	Coloured	Asian	White
---------	----------	-------	--------------

3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
--------------------	---------------------	----------------------	---	---

4. Employment status

Scholar	Student	Unemployed	Employed
---------	---------	------------	-----------------

5. Age at first sexual intercourse 19

5.1. How many sexual partners have you had? 2

5.2. Have you ever been treated for venereal disease?

Yes	No
-----	-----------

5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
--------------------	-----------------------	-------------------------------	--------------------	---------	-----------	----------	---------

7. Were you using contraception?

Yes	No
-----	-----------

7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
--------	---------------	-----	-----------	------	-------

7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

N/A

7.4. How far pregnant were you?

8 weeks

8. Have you been pregnant before?

Yes	No
------------	----

8.1. If yes, how many times?

2

8.2. If yes, how many miscarriages?

0

8.3. If yes, how many abortions?

0

8.4. If yes, how many live births?

2

8.5. If live births, how many children are still alive?

2

9. Do you want to still have children?

Yes	No
-----	-----------

9.1. If yes, how many?

N/A

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FETUS?

Ag, ons is eintlik in 'n vaste verhouding. Ek ken hom nou omtrent 'n jaar, maar ek is nie bereid om ooit weer te trou nie. O nee, dit sal ek nie weer doen nie, nee, nooit weer nie. Ek was vir 15 jaar getroud. Dit was baie emosioneel toe ons geskei is en ek sal myself nooit weer daar deur sit nie. O nee, ek sien nie weer kans vir 'n man se nonsense nie (laughs). Nie weer nie, nie ek nie.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Ek het vir hom gesê ek gaan gaan vir 'n aborsie, maar ek dink nie dit het by hom geregistreer dat ek dit wel gaan doen. Hy weet nie eers ek het dit klaar gedoen nie (laughs). Kan jy dit glo, hy het nog niks weer daarvoor uitgevra nie. Dit is nou al twee weke terug, en hy het nog niks eers gevra nie.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

Nee, nie eintlik nie. Eintlik niks nie. Hy was 'n blerrie volstruis. Wil net niks weet daarvan nie. Ek het net vir hom daarvan vertel, maar nou ja (pulls a face), hy was die enigste een vir wie ek vertel het. Hy is 'n ou-jong kerel en wil kinders he, die eerste keer toe ek vir hom daarvan vertel, toe se hy sal my dagvaar as ek daarmee voortgaan. Nou, maak hy net of hy niks weet nie.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

Nee, nooit nie. (Pause). Ek dink dit is beter dat niemand anders dit weet nie. Net hy en ek. Ek verkies dit so, dat niemand anders weet date ek verwagting was nie. As my familie dit weet sou hulle gesê het ek moet die kind hou en groot maak. Hulle sou my definitief bygestaan het, maar ek het nie kans gesien om 'n baba nou weer groot te maak nie. (Laugh). Hel, ek is 40 jaar oud en my jongste kind is 17 jaar oud. Hoe sou ek nou weer kans sien vir 'n baba?. O nee, ek sien net nie daarvoor kans nie. No Way.

Q: TELL ME ABOUT YOUR FAMILY?

My oudste kind, my meisiekind is 20 jaar oud en my seun is 17. Kan jy dink wat sou gebeur het as ek nou, op my ouderdom, nog 'n kind moet grootmaak.? En ek preek vir hulle oor "contraception" en daar raak ek op 40 swanger. Ek is seker hulle sou my ondersteun het, maar nog steeds, dit is nie 'n maklike ding nie. Ek kom uit 'n familie van 7 kinders en ons leef baie naby aan mekaar. My pa is 4 jaar terug oorlede. Ek wou juis nie so groot familie gehad het nie, ek het gesien hoe my pa hulle partykeer sukkel. Ja nee, ek sien nie kans dat my ma of enigiemand anders deur dit moet gaan nie. Ek sien vir myself ook nie kans vir weer 'n kind nie. Nie op my ouderdom nie.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

(Laughs). Die ergste is at ek op die inspuiting was. Vandat my seun gebore is. Hy is al 17 jaar oud. Gewoonlik se hulle mos die inspuiting steriliseer jou. Ek is seker maar 'n vrugbare vrou. Ek het gedink dit sou nie met my gebeur nie....kyk net. Famous last words (laughs). En om te dink ek is 'n verpleegster (laughs). Dit is net nog erger, maar almal maak seker maak foute. Ek moes van beter geweet het, maar nou ja, ek was stupid.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

Ek het begin bekommerd raak toe ek my 2de "period" nie gekry het nie. Ek is baie gesteld op my periods. Toe kry ek infeksie en gaan toe dokter toe. Toe doen sy toetse op my. Toe se sy vir my date ek swanger is.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

Goeie vader, dit was 'n baie groot skok. Ek kon nie my ore glo nie. Ek dink ek het dit eers geignoreer en gedink dit is 'n groot fout. Die infeksie het dalk die toetse beïnvloed. Toe doen ek weer 'n toets, sommer by die apteek gekoop. En wragties, dit was toe ook positief.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

Ek het twee kinders, 20 en 17 en ek is 40 jaar oud. Ek is ook 'n enkel ouer en sien nie kans om nog 'n kind groot te maak nie. Nie in die omstandighede nie. Dit is net te veel. Ek verpleeg, en, nee, ek sien net nie kans vir dit nie. O nee, ek sien glad nie kans vir dit nie. Kan jy indink om weer elke paar uur te moet optaan vir bottels en voeding. Wat doen ek as ek nagskof moet werk? Ek kan nie verwag dat my kinders of ma na die kind moet kyk nie. Dit is nie reg nie. En ek sien nog minder kans om weer met 'n man se nonsense opgeskeep te sit. Nee, dit sal nie gebeur nie.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

Net vir 'n oomblik. (Pause), maar toe begin ek aan al die goed dink en ek sien net glad nie kans daarvoor nie.

Q: DID YOU CONSIDER ADOPTION?

Nee, dit sal vir my nog erger wees as die aborsie. Ek sal nooit die kind vir nege maande kan dra en dit dan weg gee nie. Ek twyfel of ek dit sou kon doen. Ek is te lief vir kinders. Ek dink ook nie daar is genoeg mense wat kinders aan neem nie en nee, se nou die kind sit vir die res van sy lewe in 'n kinderhuis ,ek sal dit nooit kon doen nie. Ek sou altyd wonder en dit sal heeltemal te erg wees.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

Ja, ek was by Dr X in Kempton park en sy het my verwys na Dr Y toe verwys wat vir my aborsie sou doen. Hy sou vir my 'n guns doen om dit gratis te doen. Niemand doen my ooit 'n guns nie. Toe kom een van die susters daar en sy vertel my van hierdie kliniek en gee vir my die telefoonnommer van die kliniek. Toe bel ek sommer dieselfde dag, en maak 'n afspraak. Ek wou vroeër inkom maar daar was nie kans nie. Dit was vol bespreek. Ek moes toe drie dae wag en toe kom ek in.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

Hulle is wonderlik. Baie vriendelik en behulpsaam, hulle gee aandag aan jou. Behandel jou soos 'n mens. Nie net iemand wat hier inkom oor 'n aborsie en jou weer laat loop nie. Hulle het my baie bygestaan. Ek het nie gevoel soos 'n krimineel nie. Ja nee, hulle was regtig oulik.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

Ja, definitief. Ek was vreeslik bang maar toe ek by hierdie plek inkom, en sien hoe oulik die mense is, toe voel ek sommer beter. Die sessie het êêook net bevestig dat ek die regte besluit maak. Moenie my verkeerd verstaan nie, hulle luister na jou en "judge" jou nie. Jy word nie soos 'n krimineel behandel nie. Ja, ek dink het help baie.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Beslis, 'n mens is meer bang voor die tyd maar as jy na die tyd weer kom, en hulle kyk of alles reg is en gesels met jou, dan voel jy sommer baie beter. Al het jy besluit om dit te doen, is dit nog steeds moeilik want jy kan nie help om te wonder daarvoor nie, was dit 'n seuntjie of 'n dogterjie, het dit seer gekry. Kyk, ek sal nooit weer kinders hê nie, en ek kan nie help om te wonder nie (pause), maar ek is nie jammer oor die besluit wat ek gemaak het nie. 'n Mens wonder maar.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Ja, ja, ek dink so. Eerder nou as wat dit later was. Ek glo ek het die regte keuse gemaak, dit was nie maklik nie maar ja, ek dink dit was reg. Ek is 'n sterk vrou, gee nie somaar op nie.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

Ek gaan myself sommer steriliseer. Ek het klaar 'n afspraak gemaak, sommer hier en dit gaan ek aan die einde van maand doen. Ek gaan nooit weer hier deur gaan nie. Nee, ek is te oud vir hierdie tipe goed.

RESPONDENT B

1. Age 22

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 20

5.1. How many sexual partners have you had? 1

5.2. Have you ever been treated for venereal disease?

Yes	No
-----	-----------

5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
--------------------	-----------------------	-----------------------	----------------------------	---------	-----------	----------	---------

7. Were you using contraception?

Yes	No
------------	----

7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
---------------	---------------	-----	-----------	------	-------

7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

Don't know

7.4. How far pregnant were you?

7 weeks

8. Have you been pregnant before?

Yes	No
-----	-----------

8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
------------	----

9.1. If yes, how many?

2

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We met at varsity and have been living together for almost two years. He is my first serious boyfriend and person I ever had sex with. He is very kind and supportive although both of us are sad that this happened now. If it could have waited until we were finished studying or married then it would have been OK. We are way too young and still students, how will we pay for a baby?

Q: HOW OLD IS HE?

The same as me, 22.

Q: WHAT ARE YOU STUDYING?

I am studying psychology and he is doing engineering, wants to build roads and bridges (laughs) ...he enjoys it.

Q IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Yes, he actually brought me for the abortion and even came in with me during the abortion. He brought me here today for my check- up and is in the waiting room. We made the decision together and although we both want children, now is just not the right time, no, bad planning. We first thought that we could keep the baby but we really, really discussed it and we both decided that we couldn't. It just wouldn't work.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

Oh yes, we both cried when told him that I was pregnant. It was a great shock to us and we couldn't believe. We made the decision together and he did not force me.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

My family...no way. A good Afrikaans girl from a good Afrikaans family. Kan jy dink wat sou gebeur? No, just the two of us know. I couldn't face my parents or his either. They don't even know we are living together so can you think what would have happened, they would kill me. (Long pause). No, they would kill me.

Q: TELL ME ABOUT YOUR FAMILY?

Good Afrikaans family from the farm (laughs). I make them seem horrible, but they are not. We are 3 children, 2 brothers and me. We are very close but the little baby having a baby would not be accepted, you know what I mean. They really would kill me, it just doesn't

happen in our community. When I left for varsity, they still joked to say don't have a "jool baba", and don't be fooled by boys and city life. This isn't a "jool baba" but I just don't think they would understand. (Crying) I would disappoint them.

Q: WHERE DOES YOUR FAMILY LIVE?

In the Free State. Small town although they are farmers. Vader, can you imagine the scandal of all the "ooms en tannies" if this should come out.

Q: THE SCANDAL BEING THAT YOU WERE PREGNANT OR THAT YOU HAD AN ABORTION?

Both, well mostly the pregnancy because no one will know that I had an abortion, right, you promised (questions researcher and becomes tense).

Yes, I promised that our conversation would be confidential and that you will remain anonymous..

Q: YOU STATED THAT YOU USED A CONDOM. WHY DO YOU THINK IT FAILED?

No idea, absolutely no idea. But I can promise you, I am going to use a loop, pill, condom...whatever else there is available. I cannot go through this again...no way. I still want lost of kids, a big family, this was just bad luck.

Q: HOW MANY CHILDREN WOULD YOU LIKE TO HAVE?

At least four, two boys and two girls.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

My periods are always regular and when I was late, I started worrying. I bought a home pregnancy test. I can't remember the name...um...oh well, and there was the coloured line. Man, I was so frightened; I didn't know what to do.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

I was frightened, petrified. I did not expect this. We always used a condom. Well, not always, but I was sure it was at a safe stage.

Q: WHEN DID YOU TELL YOUR BOYFRIEND THAT YOU WERE PREGNANT?

The same day. He came home and I told him. He was very shocked. He went to the chemist to get another test just to make sure.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

I am too young. We are too young. Both of us are studying. We don't work, where would we get money from? Our lives are still ahead of us. We would probably have to quit varsity and get jobs. What kind of jobs would we get? No, it just was bad luck. There were too many things. I also would not be able to face my parents. Maybe I am wrong, maybe they would have supported us but, no, it wasn't right. It was the only option.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

Yes, as I said, I would like kids, lots of them, but it wasn't the right time. We couldn't have kids now...no...no.

Q: DID YOU CONSIDER ADOPTION?

Not a chance.

Q: WHY NOT?

I think that it is more cruel. To live your life wondering what happened to your child. Is he happy, even alive. No not a chance. How do you explain to a child that you were not ready to have him? No, I couldn't do that.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

No, I heard other people talk about this clinic and came here to see what it was like before I made an appointment.

Q: WHY DID YOU DECIDE ON THIS CLINIC?

They were friendly and professional. They did not look at me as a murder. They were very nice.

Q: DO YOU FEEL THAT THE COUNSELLING SESSIONS HELPED YOU DEAL WITH THE ABORTION?

Definitely. They explain everything so nicely and you don't feel so bad or guilty. You have someone else to talk to about it. Yes, it makes a big difference.

Q: DO YOU FEEL GUILTY ABOUT YOUR DECISION?

Um, in some ways. It is a life, but I try not to think about that. I was the only thing I could do, at this stage. Yes, I didn't have a choice.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

I was more scared before the time and on the day that I had the abortion, but they were very nice, kind. I came for the check up today and they really help you. You know, someone to talk to about how you are feeling. Someone that understands.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Yes, what else could I do? It is not easy because I want to have kids but ...what else could I do? I hope that one day I will be able to have kids because I've heard people say that an abortion can make you, what's the word, infertile. I just hope that I can have kids again. I will never forgive myself if I can't have kids...one day.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

I will use everything and anything after this experience or will stop having sex (laughs).

RESPONDENT C

1. Age 20

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
---------	----------------	------------	----------

5. Age at first sexual intercourse 19

5.1. How many sexual partners have you had? 2

5.2. Have you ever been treated for venereal disease?

Yes	No
-----	-----------

5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
------------------------	--------------------	--------------------	-----------------	---------	-----------	----------	---------

7. Were you using contraception?

Yes	No
-----	-----------

7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
--------	---------------	-----	-----------	------	-------

7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

N/A

7.4. How far pregnant were you?

7 weeks

8. Have you been pregnant before?

Yes	No
-----	-----------

8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

2

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We have been friends for a very long time, a couple of years and um, we had a one night stand, and well, I fell pregnant.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Yes.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

Well, yes and no. He is aware of it but both of us feel that this is the right thing to do. We are not in a relationship and this happened once, so it won't happen again. We are not a couple and don't love each other or anything like that.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

No.

Q: WHY DID YOU TELL ANYONE ELSE?

I just didn't.

Q: TELL ME ABOUT YOUR FAMILY?

Well, I do not come from some trailer park as you might think. My parents are both professionals and I am studying accountancy. So, don't think that that I fell pregnant because I am stupid or come from a bad family or area. It was just something that happened.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

It just happened. We were at a party and had a bit much too drink and then we had sex.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

Missed my period and did a home pregnancy test.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

I wasn't happy, not at all. But what can you do? It was there and well, I decided to abort it.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

I didn't want a child. I am way too young to be raising a child.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

No

Q: DID YOU CONSIDER ADOPTION?

No

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

I went to a private hospital but they referred me here.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

At first I thought that was Carte Blanche or some show. It was not at all what I expected. I expected a real clinic, you know, a hospital place. But hey were very nice and friendly, not at all what I expected.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

I suppose so, don't really know. I already decided to have the abortion and well, it didn't really make a difference to me.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Ag, as I said, I already made up my mind, so it was more for the check up than anything else.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Yes. Definitely.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

Yes.

Q: WHICH METHOD?

Will see.

RESPONDENT D

1. Age 20

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 20

5.1. How many sexual partners have you had? 1

5.2. Have you ever been treated for venereal disease?

Yes	No
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5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
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7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

Don't know

7.4. How far pregnant were you?

6 weeks

8. Have you been pregnant before?

Yes	No
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8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

0

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

2

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We have been dating for about eight months. We met at varsity and ja, we have been together for eight months.

Q IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Yes. He wasn't too happy about it. I wasn't too happy either. But, we didn't really have a choice.

Q: WHY WERE YOU NOT HAPPY ABOUT HAVING AN ABORTION?

Well, I am very religious and so is he. You probably think that that is strange.....being religious and having an abortion but we are way too young to have children. It really wasn't easy as I do see it as a life.....from conception.....but I had to make a choice.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

Yes. Definitely. We weren't happy about it but we really did not see that we could do anything else. Not in our situation.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

My sister knows and she stands behind me. She brought me for the abortion as he was writing an exam; otherwise he would have brought me. She has been very sweet and promised not to tell anyone else.

Q: WHY DON'T YOU WANT TO TELL ANYONE ELSE?

We really are very religious and my parents would die. They would see it as murder and wrong and I just don't have the energy to try to explain. They would really be disappointed in me and would make me keep the baby. I just couldn't do that right now. I am 20 years old. I will have to live with what I have done, but I believe that God will, hopefully forgive me.

Q: TELL ME ABOUT YOUR FAMILY?

I live with my mom and dad and my sister.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

Yes, we used a condom but I don't know what happened.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

I wasn't feeling very well and went to a doctor. He did a blood test and told me.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

Oh my God. That was all that I thought. Oh my God.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

I am 20. That is too young. I know that there have been younger mothers but I just couldn't face having a child now. I am studying and my boyfriend is studying. We don't work. We aren't responsible enough. My parents would probably have to raise the baby while I tried to finish studying.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

No...not really. I just didn't think abortion is right...you know....killing a foetus...a baby. But because I am so young andI had to make a decision and well, for me the only answer was to have an abortion.

Q: DID YOU CONSIDER ADOPTION?

No.

Q: WHY NOT?

Just don't think that is fair on the child.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

I first went to the Marie Stopes clinic in Johannesburg but I didn't like it.

Q: WHY NOT?

Yuk....it was horrible. They didn't even smile or anything. All these girls and women were waiting there, and it felt like a mortuary. Nope, didn't like it...I was very uncomfortable.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

Wow, what a difference. Friendly, kind, helpful. I kept on thinking that I am killing a baby but they did not make me feel like that at all. I was very comfortable. They even had a recovery room and offered tea or coffee. Couldn't believe that this was an abortion clinic.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

Yes. Especially because I felt I was doing something very wrong. Morally you know. They helped me cope with that and try to make peace with my decision.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Yes. It was nice to know that someone cared how you are doing after having an abortion. I now it is their job but it does make you feel better. It really does.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Yes. It is hard at times knowing that you had a baby inside you. Growing...but I think that I made the right choice. I sometimes wonder what the baby would have looked like. But...I'll never know.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

Definitely, I already started with the pill. I warned my boyfriend that he will still use condoms as well. Not taking anymore chances.

RESPONDENT E

1. Age 25

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (<i>Matric</i>)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 20

5.1. How many sexual partners have you had? 1

5.2. Have you ever been treated for venereal disease?

Yes	No
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5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
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7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

Don't know

7.4. How far pregnant were you?

8 weeks

8. Have you been pregnant before?

Yes	No
-----	-----------

8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

Don't know

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We have been married for five years and we are separated. I didn't know I was pregnant before I left him.

Q: DO YOU THINK YOU WOULD SALVAGE YOUR MARRIAGE?

No, I don't think so. He is a real bastard and I am not interested to sort things out with him, not now, not anymore. I told him I was pregnant and he told me I was a slut and that the baby wasn't his. Like I would sleep around? I married him when I was 20. We were together since I was 18. I thought that maybe the baby would sort things out and that he would be happy, but he doesn't believe it is his.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

I told him that I would do but I don't think he believed me. What am I meant to do? I never worked while we were married and how am I going to support a baby? He won't pay maintenance or help me, he thinks it is somebody else's child. So what am I suppose to do?

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

I told my mom and she is very sad that I had an abortion. She is not happy and said that she would help me, but I am going through such and emotional time that I cannot see how I can cope with a divorce and a child. It is just too much. I have to find work to be able to support myself, let alone a child. My mom's also working and trying to do the best that she can. She is a single mom and I cannot place even more on her. My brother is still in school and my sister is studying at Technicon. She cannot support me and a baby now as well. No, it just wouldn't be fair to her.

Q: DID YOU NOT USE ANY METHOD OF CONTRACEPTION?

I was on the pill, but don't know what happened. I have been taking the pill since I got married.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

I did a home pregnancy test. When it came out that yes, I was pregnant, I went to my GP. He did a blood test and confirmed the results.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

I couldn't believe it. All I thought of was that I don't need this right now. Things are bad enough as it is...I don't need this now. After I calmed down, I thought maybe we could work things out and he would be happy. I went to him and told him, and what a scene. He practically threw me out. But, as I told you, he doesn't believe it is his child.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

I cannot see what else I could do. He doesn't want anything to do with the baby, he doesn't believe it is his. Who will support me? I have no money. Even if we get a divorce, he doesn't earn that much...it won't be enough for me and a baby. I don't have a job....I don't have anything. I'm living with my mom and brother and I cannot expect her to help me. She has enough in her life, also problems. I also don't believe that children should have a single parent. That's not fair either. I had to have an abortion.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

Yes, if we could have worked out our marriage and he would go for counselling.

Q: DID YOU CONSIDER ADOPTION?

No.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

No. My GP referred me to this clinic after I completed cracked. I just couldn't cope with the thought of going through a pregnancy as well. He was very nice and said that this clinic was very nice. They would help me. They don't force you to have the abortion and they let you decide for yourself. This was good for me as I first wanted to see if I couldn't patch up my marriage, maybe it would be OK.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

Brilliant. They really were very nice. I came to find out about the abortion but wasn't sure if I was going to have it. They told me everything about it. I told them that I first want to see if he would change his mind and they were very nice about it. When the big scene happened I came back here and they supported me. They listened to me. I was here for more than an hour and they didn't mind. They sent me away again to really think things over but nothing had changed. So I made the appointment and had the abortion.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Yes. I think it did make a difference. I am so angry at the whole thing. I had to have an abortion because of him. They referred me to a psychologist for counselling. It was bad enough that I am 25 and going to be divorced but he also made me have no option but to have an abortion.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

I dint have any other choice. I am sorry and angry that I had to have an abortion, but I didn't have a choice. I want children but not alone in this world.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

I am staying so far away from men from now on. No more men for me.

RESPONDENT F

1. Age 21

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 19

5.1. How many sexual partners have you had? 1

5.2. Have you ever been treated for venereal disease?

Yes	No
-----	-----------

5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
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7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

Forgot to take it

7.4. How far pregnant were you?

10 weeks

8. Have you been pregnant before?

Yes	No
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8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

Don't mind how many

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We've been together for almost a year now and we are living together. My parents don't know this and would freak. I am Hindi and he is black and older than I am. Not much, he is 28 but in an Indian family, going out with a black man is not the best news. They live in Durban and that is why they don't know. I have never told them. I know that is probably not right, but I am scared of what they would say.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Yes, he is. He is very unhappy about it. He wants lots of children.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

No...yes. In a way, it's a bit difficult. He didn't want me to have the abortion, he wants a big family and was very happy when I told him I was pregnant. But, I did not know what to do. He says he supports my decision, but I don't think so. He is very kind and loves me very much. I think that is why he tries to be supportive, but I can see that he is not happy.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

They would freak. I would never tell them. We are a big family and they are very traditional. If they knew that I was dating a black, and we were living together, and I was pregnant they would die. I would be kicked out of the family. No, they don't know and they will never find out. No way, no.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

I am using the pill but forgot to take it.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

I went to my gynaecologist and he did a blood test.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

Shock...horror. I couldn't believe it. This could not be happening to me. I am a bit of a scatter brain and my boyfriend always joked that I would get pregnant because I forgot to take the pill.

Q: DID YOU EVER CONSIDER USING A CONDOM AS WELL?

We should have, but you think it will be Ok, you are on the pill.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

My family would freak if they found out I was living with a black man and was pregnant. I also think I am too young and would like to concentrate on my career. I am working in an advertising company and next year want to go study it. It is really a passion of mine and I would like to do that. No, there are just too many things that counted against me having this baby.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

I only thought about it because he wants children. I couldn't, not now.

Q: DID YOU CONSIDER ADOPTION?

No.

Q: WHY NOT?

That is worse. At least you know what happened to your baby with an abortion. With adoption, you will always wonder and will never know.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

No. my gynaecologist gave me the details of the clinic and I phoned and made an appointment.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

Very good, yes, I would definitely recommend it to someone in the same position as I am. You aren't scared here.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

Yes, they do all the medical tests and tell you what is happening as they are doing it. You also feel that they understand.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Yes. It is scary and after the abortion my boyfriend was very upset. It helped me to handle him.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Yes, I don't see what else I could have done. I do want children but not now.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

I am going on the injection and we will use a condom.

RESPONDENT G

1. Age 26

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 20

5.1. How many sexual partners have you had? 1

5.2. Have you ever been treated for venereal disease?

Yes	No
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5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
-----	-----------

7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

N/A

7.4 How far pregnant were you?

11 weeks

8. Have you been pregnant before?

Yes	No
-----	-----------

8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

2

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

I have been married since I was 20. I have been married for 6 years. I have been trying to fall pregnant for the past two years and it finally happened. I was so happy when I found out I was pregnant. I have been trying for two years and was starting to get worried. When I told him I was pregnant I could see that something was wrong but I thought it was just the stress of having a family. When I was two months pregnant I found out that he was having an affair. Can you believe it, here I am preparing for the most important thing in our lives and he has been having an affair for almost three years.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Yes, he brought me for the abortion. He did not want me to have the abortion but I am trying to cope with the fact that he has been having an affair. How can I have a child if I don't even know if I am going to get divorced or what is going to happen. I don't know if we are going to make it. I don't know what to do.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

No, he wants me to keep the child and is against abortion. So am I, but I just didn't know how to cope. I waited. I couldn't wait any longer. I was 11 weeks pregnant and if I decided to have an abortion later on, it wouldn't be possible. I had to do it now. I didn't have a choice.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

Everyone knew that I was pregnant. I was so happy that I told the entire world but now they all know that he is having an affair, which is enough stress. I couldn't still tell them that I am going for an abortion. They would never understand. Never. I cannot have a child by myself and I don't know if we are going to get a divorce or not. We are in counselling but I just don't know. I told everyone that I had a miscarriage. I had to lie; I couldn't tell them I killed my own child. They wouldn't understand. Abortion is wrong, but I didn't know what else to do.

Q: TELL ME ABOUT YOUR FAMILY?

I am an only child and have a wonderful mom and dad. We really get on well, but this would kill them...it really would. They believe abortion is wrong and would never understand. I know they would support me and help me but I have to sort out my marriage first.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

No, I wanted to fall pregnant.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

My doctor did a blood test and told me. I really wanted to be pregnant.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

I was so happy. It was wonderful news. I was really really happy.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

Because of my marriage. I don't know if we are going to get a divorce. I don't think it is right for a child to only have a mother and I couldn't cope with the stress. It is just too much for me. I had to focus on one thing and couldn't think about the baby now.

Q: DID YOU CONSIDER ADOPTION?

No way. I had to focus on one thing and I would rather keep the baby than give it up for adoption. But I had to focus on my marriage first.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

No, my doctor told me about the clinic and I came here.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

It is very good. They are very helpful and nice.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

Yes, because I wanted the baby but now couldn't, they were very understanding. Very nice, very helpful.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

It is difficult when you wanted the baby but had to have an abortion. Yes, I think it did help. At least I could talk to someone about how I was feeling. It did help.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

I don't know. Everyday I wonder if it was the right choice. I don't feel that I had a choice but killing your baby, that is something else. I don't know, I don't know. I will always wonder. What if I can never have children again? I don't know what I would do then.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

I don't know what is going to happen in my life or my marriage. As they say, one step at a time. I will have to see if I can sort things out. I don't know if I will ever forgive him.

Q: FORGIVE HIM FOR HAVING AN AFFAIR?

That as well. I really feel that he is the cause of me having to have made this decision. I wanted a child and he made me have an abortion.

RESPONDENT H

1. Age 26

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 18

5.1. How many sexual partners have you had? 3

5.2. Have you ever been treated for venereal disease?

Yes	No
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5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
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7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

Condom broke

7.4. How far pregnant were you?

10 weeks

8. Have you been pregnant before?

Yes	No
-----	-----------

8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

Lots

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We have been living together for five years.

Q WHERE DID YOU MEET?

At university. We are both studying law and are in the same classes.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Yes.

Q: DID YOU RECEIVE ANY SUPPORT FROM HIM?

Yes.

Q: WAS HE UPSET THAT YOU DECIDED TO HAVE AN ABORTION?

Yes, no. I don't really know. We talked about it but we don't talk about it anymore. We are putting it behind us.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

No.

Q: WHY NOT?

They would have wanted me to keep the baby.

Q: TELL ME ABOUT YOUR FAMILY?

What do you want to know?

Q: DO YOU HAVE A BIG FAMILY, HOW MANY BROTHERS AND SISTERS?

We are five children. I am the oldest and my youngest sister is 7.

Q: WOULD YOUR PARENTS HAVE WANTED YOU TO KEEP THE BABY?

Yes.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

Yes. We used a condom but it broke.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

I was scared after the condom broke but didn't worry too much. Then I went to the doctor and he told me I was pregnant.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

Scared.

Q: WHY DID YOU FEEL SCARED?

I just did.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

I am studying and have a bursary. If I stop now, I couldn't come back to finish my studies.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

No.

Q: DID YOU CONSIDER ADOPTION?

No.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

No.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

I heard about it from a friend. They were very friendly.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

Yes.

Q: IN WHAT WAY?

I don't know.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

I don't know.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Yes.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

Yes.

Q: WHAT KIND OF CONTRACEPTION?

Injection.

RESPONDENT I

1. Age 31

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (<i>Matric</i>)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 21

5.1. How many sexual partners have you had? 2

5.2. Have you ever been treated for venereal disease?

Yes	No
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5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
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7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

N/A

7.4. How far pregnant were you?

9 weeks

8. Have you been pregnant before?

Yes	No
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8.1. If yes, how many times?

1

8.2. If yes, how many miscarriages?

0

8.3. If yes, how many abortions?

0

8.4. If yes, how many live births?

1

8.5. If live births, how many children are still alive?

1

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

1

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

Ag, dit was 'n one-night stand gewees. Ek kan dit nie glo nie. Ons is vriende. Hy is eintlik my verloofde se vriend. En wragtig, toe raak ek swanger by hom. Ek en my verloofde het deur 'n moeilike tyd gegaan, vreeslik baklei en so aan. Toe gaan hy Kaap toe vir besigheid. Ek was eensaam en sy vriend het mooi na my gekyk. Hy het kom kyk of ek en my seun OK was. Ons het een aand uitgegaan, ek moes bietjie weg kom, en toe raak ons lekker dronk. Toe slaap ons by mekaar en toe word ek swanger.

Q: IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

Ja, hy dink ook dit is die beste. Ek wil nie moeilikheid met my verloofde hê nie. Hy (verloofde) is die pa van my kind, my ander seun. Hy is vyf jaar oud. Die ou wil ook nie moeilikheid hê nie. Hy (verloofde) is 'n goeie pa en ons het maar net deur 'n moeilike tyd gegaan. Ek is lief vir hom en wil he ons moet trou. My seun is ook baie lief vir sy pa en ek wil nie hê hy moet weet nie, nee, hy sal my dadelik los en wat dan van my kind?

Q: DID YOU RECEIVE ANY SUPPORT FROM THE FATHER OF THE FOETUS?

Ja, soortvan. Hy dink ook dit is die beste ding om te doen. Hy is maar hartseer, want hy wil graag kinders he, maar ek moet aan my ander kind dink. Ek wil nog 'n kind hê maar wil hê dit moet dieselfde pa wees as my seuntjie.

Q: DID YOU TELL YOUR FAMILY OR FRIENDS ABOUT THE PREGNANCY OR ABORTION?

Nee, nooit nie. Hulle sal my verkwalik dat ek swanger is by 'n ander man. My verloofde is baie goed vir my en my kind. Baie goed.

Q: COULD YOUR FIANCÉ NOT BE THE FATHER OF YOUR CHILD?

Nee, toe ons so baklei het en deur moeilikheid gegaan het, het ons nie bymekaar geslaap.

Q: TELL ME ABOUT YOUR FAMILY?

My familie bly in die Kaap en hulle sou regtig nie gelukkig gewees het as hulle weet ek het 'n aborsie gehad nie. Hulle is groot Christene en glo dat jy nie 'n aborsie mag he nie. Ek sal hulle nooit vertel nie.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

Nee. Soos ek gesê het, ons was dronk en dit het net gebeur.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

My ginekoloog het vir my gesê.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

Baie hartseer. Ek weet die pa van die kind wil graag kinders hê, veral seuns. Sê nou dit was 'n seun. Ai, ek was regtig hartseer want ek wil ook nog kinders hê, maar met my verloofde.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

Ek moet aan my seuntjie dink. Kan jy dink hoe die ander hom sal terg as sy boetie of sussie nie dieselfde pa het nie. My verloofde is baie goed vir ons en ek is baie lief vir hom. Ons het net deur 'n moeilike stadium gegaan. Dit moes nooit gebeur het nie. As my verloofde die pa was, sou ek nooit 'n aborsie gehad het nie.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

Ja, maar wat van my seun en my verloofde?

Q: DID YOU CONSIDER ADOPTION?

Nee.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

Nee, my ginekoloog het die nommer vir my gegee.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

Baie goed. Baie tuis en gemaklik laat voel. Baie oulike mense.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

Ja, baie, want ek was baie hartseer. Ek probeer maar net dink dat dit nog nie 'n mens was nie. Hulle sou seker nie 'n aborsie gedoen het as dit al soos 'n mens gelyk het nie. Sou hulle? Nee, ek dink nie hulle sou as dit al handtjies en voetjies gehad het nie, nee.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Ja. Hulle kyk of jy alright is en of alles reg is. Ek voel beter omdat iemand omgee want ek en die pa kan nie daarvoor praat nie. My verloofde is terug en ons werk nou hard aan ons verhouding. Dit gaan baie goed, so dit is goed om met iemand daarvoor te praat.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Ja. Dit was nie lekker nie en ek wil nog kinders hê. Maar ek moes dink aan my seun en my verloofde. Ja, dit was die regte besluit maar ek is tog hartseer.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

Ja, definitief, maar ek sal nooit weer met iemand anders slaap nie. Ek en my verloofde is weer bymekaar en dit gaan goed. Ek het die inspuiting gekry want ek wil nie nou weer swanger raak nie. Ek dink ek sal te veel wonder. So ek sal maar wag en dan sal ek nog 'n kind hê.

RESPONDENT J

1. Age 24

2. Race

African	Coloured	Asian	White
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3. Level of education

Grade 7 (Std 5)	Grade 10 (Std 8)	Grade 12 (Matric)	Currently studying at a tertiary institution	Completed tertiary education
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4. Employment status

Scholar	Student	Unemployed	Employed
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5. Age at first sexual intercourse 24

5.1. How many sexual partners have you had? 1

5.2. Have you ever been treated for venereal disease?

Yes	No
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5.3. If yes, for which disease? N/A

6. Relationship status with the father of the foetus?

One-night stand	Less than 3 months	More than 3 months	Living together	Married	Separated	Divorced	Widowed
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7. Were you using contraception?

Yes	No
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7.1. If yes, which method.

Condom	Female condom	IUD	Injection	Pill	Other
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7.2. If Other, which method?

N/A

7.3. Why do you think it failed?

N/A

7.4 How far pregnant were you?

11 weeks

8. Have you been pregnant before?

Yes	No
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8.1. If yes, how many times?

N/A

8.2. If yes, how many miscarriages?

N/A

8.3. If yes, how many abortions?

N/A

8.4. If yes, how many live births?

N/A

8.5. If live births, how many children are still alive?

N/A

9. Do you want to still have children?

Yes	No
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9.1. If yes, how many?

2

Q: TELL ME ABOUT YOUR RELATIONSHIP WITH THE FATHER OF THE FOETUS?

We have been going out for about six months.

Q IS HE AWARE THAT YOU HAVE TERMINATED YOUR PREGNANCY?

No. I didn't tell him that I was pregnant.

Q: WHY DIDN'T YOU TELL HIM?

I didn't want him to know. I was scared he would want to keep the baby. I don't. I am too scared to keep the baby. I didn't tell anyone that I was pregnant. Only my doctor knew.

Q: WHY ARE YOU SCARED?

I don't think I would be a good mother. Not now in any case. I don't have anyone that I can rely on to help me or to support me. I don't know if he would really help me. He is very nice and he is the longest boyfriend I have had, but I don't know. I am also too young and I am studying. I don't want to throw that away.

Q: WHY DO YOU THINK YOU WOULD BE A BAD MOTHER?

Um, I just do. I am too young and I don't have a mother that could help me. My mother died when I was very young, she committed suicide. What if I'm like her? What will happen to my child if this happens to me? I cannot let my child go through what I went through. I just can't; I found her and even after seeing psychologists I still think about it. No, I am very scared to become a mother.

Q: TELL ME ABOUT THE REST OF YOUR FAMILY?

My dad had to raise my sister and myself. By himself. It was very difficult for him. He did his best and we are all very close. We only have each other. My sister is 20 and was very young when my mom died. I had to take care of her, help my dad. It was very tough but we made it.

Q: DID YOU USE ANY METHOD OF CONTRACEPTION?

No. I didn't think it would happen. I am usually careful and monitor my cycle, but I was off.

Q: HOW DID YOU FIND OUT YOU WERE PREGNANT?

I did a pregnancy test at home. I actually tested three to make sure.

Q: HOW DID YOU FEEL WHEN YOU FOUND OUT YOU WERE PREGNANT?

I was very upset. I am too young, and ...really, I just couldn't even consider being a mother.

Q: WHY DID YOU DECIDE TO HAVE AN ABORTION?

Too young. I have only been with this guy for six months and don't know if we will get married. I'm still getting to know him. I am in my third year at RAU and, no, I just couldn't face it.

Q: DID YOU EVER CONSIDER RAISING THE CHILD?

No. I am too scared to think about being a mother.

Q: DID YOU CONSIDER ADOPTION?

No.

Q: DID YOU ATTEMPT TO HAVE THE ABORTION DONE AT A DIFFERENT FACILITY?

No.

Q: HOW DID YOU EXPERIENCE THE SERVICE PROVIDED AT THE CLINIC?

Very good. Friendly and supportive. I felt safe in their hands and they knew what they were doing.

Q: DO YOU FEEL THAT THE COUNSELLING SESSION HELPED YOU DEAL WITH THE ABORTION?

I think it is a very good idea. They make sure that you are sure about your decision. I think that this is important because it is not an easy decision. I think some women aren't sure and then regret that they had an abortion.

Q: DO YOU FEEL THAT THE POST-ABORTION COUNSELLING WAS OF VALUE?

Yes. I think it makes you feel less guilty about your decision.

Q: DO YOU FEEL GUILTY?

In a sense yes. it is not nice. It is not physically that painful, but I am very scared that the baby felt pain. I don't like to think about that. I just hope that it didn't feel anything. I feel very scared that it was painful for the baby.

Q: DO YOU FEEL THAT YOU MADE THE RIGHT CHOICE?

Yes. I really do.

Q: ARE YOU GOING TO USE CONTRACEPTION FROM NOW ON?

Yes. The pill. But I will be careful and think a lot. This cannot happen again. Maybe I need to get myself sterilised, yes, then this cant happen again.