Why Do Women Opt for Backstreet Abortions?: A Sociological Study

by

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I hereby declare that the mini-dissertation submitted for the partial fulfilment of the degree Masters of Arts in Sociology at the Rand Afrikaans University, apart from the assistance recognised, is my work, and has not been formally submitted to another university for any other degree.

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ABSTRACT

In 1996, the South African Government implemented the Choice on Termination (CTOP) Act to curb maternal mortality. This study emerged after an observation by experts in the field that there were a growing number of women who were admitted in antenatal care units with incomplete abortions, commonly known as miscarriage. These experts observed that some of these women, on closer observation, had signs of either scared wombs or had foreign objects in their uteri. This was understandable in provinces where there were fewer health facilities offering TOP serves. In Gauteng, however, it was not understandable because this province has the most designated facilities in the country. It was, therefore, necessary to investigate why women had unwanted pregnancies and, more so, why they opted for back-street abortion services instead of accessing the many available legal services. It was discovered that most of these women had low socio-economic status, did not use contraceptives and did not know about the CTOP Act. The few who did know about the Act, did not use the legal abortion options because of the fear of being judged by health care workers. In addition, some of these women were turned away from health facilities because the list of women waiting for these services, was too long. Involved in assisting these women to terminate their pregnancies illegally were mothers, sisters, boyfriends/partners, traditional healers, pharmacists, nurses and doctors. It is suggested that intense education on the CTOP Act should be rolled out to the whole community; contraceptive services should be improved; health education with the emphasis on reproductive health and services should be expanded to private doctors and midwives.

Opsomming

Die Suid-Afrikaanse regering het in 1996 die sogenaamde “Choice on Termination” (CTOP) wetgewing in werking gestel,om moedermortaliteit die hoof te bied. Hierdie studie is geloods op grond van ‘n waarneming deur deskundiges op die gebied dat daar ‘n toenemende aantal vroue is wat in voorgeboorte sorg-eenhede opgeneem word met onvolledige aborsies, algemeen bekend as miskrame. Hierdie deskundiges het by nadere ondersoek gevind dat sommige van die vroue òf tekens van beskadigde baarmoeders getoon het òf vreemde voorwerpe in hul uterusse gehad het. Hierdie stand van sake was dalk verstaanbaar in provinsies waar daar ‘n kleiner aantal gesondheidsfasiliteite was wat wettige aborsiedienste gelewer het. In Gauteng was dit egter nie verstaanbaar nie, want hierdie provinsie beskik oor die meeste fasiliteite wat aborsiedienste lewer in die land. Dit was dus nodig om uit te vind waarom vroue ongewenste swangerskappe gehad het, en, nog meer belangrik, waarom hulle van agterstraataborsiedienste gebruik gemaak het, eerder as om van die groot aantal beskikbare wettige dienste gebruik te maak. Daar is gevind dat die meeste van hierdie vroue van ‘n laer sosio-ekonomiese statusgroep afkomstig was; nie voorbehoedmiddels gebruik het nie en nie van die aborsiewetgewing geweet het nie. Diè wat wel van die wetgewing geweet het, het nie daarvan gebruik maak nie, enersyds uit vrees dat hulle deur gesondheidswerkers geoordeel sou word, en andersyds omdat hulle weggewys is omdat die waglys vir aborsies te lank was. Partye wat hierdie vroue in die onwettige terminering van hul swangerskappe bygestaan het, was onder andere moeders, susters, kêrels/metgeselle, tradisionele geneeshere, aptekers, verpleegsters en mediese dokters. Daar word voorgestel dat opleiding ten opsigte van die aborsiewetgewing in die gemeenskap moet plaasvind; dat kontrasepsiedienste verbeter moet word, en dat gesondheidsopleiding met die klem op reproduktiewe gesondheid en -dienste na privaat dokters en vroedvroue uitgebrei moet word.

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CHAPTER ONE:
GENERAL INTRODUCTION

1.1 Introduction

In the year 2000, when this research was conducted, contraceptives in South Africa were still free, as they were in the Apartheid era. The difference between the two eras is that in the Apartheid era family planning was used to limit the growth of the Black population by forcing them (Black women) to use them instead of being used voluntary. On the other hand, in the post-Apartheid era family planning services are used by all races to control family sizes and prevent diseases. The unfriendly nature of the service delivery of family planning consequently made women to shy away from them and resort to home and or back-street methods. As this mini-dissertation will show, these resulted in serious injuries and deaths.

In 1994, following 46 years of apartheid rule, the first democratically elected government of South Africa implemented an equality based constitution that paved the way for transforming the sexual and reproductive rights of all South African women (Ipas South Africa). In October 1996, the South African parliament passed the Choice on Termination of Pregnancy (CTOP) Act. This Act allows women to terminate pregnancies on request up until the 12th week of pregnancy. It also allows abortion under specified circumstances from the 13th through to the 20th week, and under very limited circumstances beyond that point. However, despite the liberal nature of this law and a relatively high rate of contraceptive use, unwanted pregnancy and unsafe back-street abortion continue to be a public health and social problem in South Africa (Ipas South Africa).

1.1.1 Abortion legislation in South Africa: a brief historical overview

Historical sources indicate that abortion is not a new phenomenon in South Africa and that it has been socially condoned in the past. In looking at the history of abortion in South Africa, Bradford in Meade and Walker (1988: 122-125) showed that by the middle of the 19th century shocked Victorian officials in the Transkei recognised that abortion was universally practised by women of all classes. It was regarded as a way of regulating late pregnancies or dealing with problematic pregnancies. Even chiefs were found to be forcing adulterous women to abort so as to hide the embarrassment of an adulterous relationship or premarital sexual relationships.

Bradford in Meade and Walker further (1988: 122) demonstrated that abortions were practiced by all races and social classes and that abortifacients were regarded in a similar light as other home made remedies. She refers to an Afrikaner home remedy book published in the mid-20th century, which contained a folk recipe for abortion (Bradford in Meade and Walker, 1988: 125). "Ethnographers have argued that terminating pregnancy was perceived by women not as abortion, but rather as making their own bodies 'regular' and that the foetus, prior to quickening, was regarded merely as 'blood' or 'water'" (Jewkes, Wood & Maforah, 1997: 417). During this era herbs were widely used, by both Black and White women.

Bradford in Meade and Walker (1988: 128) went on to reveal that male, White, Western doctors slowly took over the 'abortion business' and tried to push the traditional healers out of the 'business'. Abortion pills were made from the same ancient herbs used by herbalists. White women started consulting these doctors.

The common law prior to the year 1975 permitted abortion if a pregnancy posed a threat to a woman's mental well-being. Doctors who performed abortions beyond this criterion took personal and professional risks, of whom many were

prosecuted or fined. In addition, financially secured upper-class and middle-class White women could go to Europe if they could not obtain abortions privately in South Africa. On the contrary, their Black, Coloured and financially less fortunate White counterparts had financial constrains to obtain a safe abortion which made it difficult for them to consult a private doctor (Bradford in Meade and Walker, 1988: 128-129). Because of these factors back-street abortions were their only option to rid themselves of an unwanted pregnancy.

In 1975, the South African government passed the Abortion and Sterilisation Act. Its passing was promoted by the doctors who were involved in illegal abortions and by some liberal women's groups. This Act permitted abortion only when a pregnancy could seriously threaten a woman's life or her physical or mental health; could cause sever handicap to the child; or when the pregnancy was a result of rape or incest (Guttmacher et al, 1998). This Act, however, provided limited access to abortion services, compelling many women, especially Black women, to resort to back-street abortions.

In 1996 the new South African Government of National Unity under the leadership of the African National Congress (ANC) passed the Choice on Termination Act (CTOP). This Act has wider conditions under which women can terminate unwanted pregnancies. Under this Act women can obtain abortions upon request, in cases of rape and incest; if the pregnancy threatens the woman's mental and physical health and for socio-economic reasons. This Act was passed to, among other reasons provide an opportunity to improve women's reproductive health by substantially removing the risk of death and disability associated with this centuries-old fertility regulating procedure. Unfortunately, as will be shown in the following chapter, women still use old methods of terminating unwanted pregnancies as well as other illegal back-street abortion methods.

1.2 Problem statement

Back-street abortions have fatal consequences for women…death. Each year a number of women die because of self-induced or back-street abortions. It is estimated that 46 million back-street abortions are performed worldwide each year, of which nearly 20 million are illegal. Nearly 90% of these occur in developing countries (Alan Guttmacher Institute (AGI), 1999: 25). Back-street abortion is recognised worldwide as a leading cause of maternal deaths, causing 13% of pregnancy-related mortality. Abortion-related maternal mortality is infinitely higher in developing countries (330 deaths per 100,000 pregnant women) than in developed countries (0.2 - 1 deaths per 100,000 pregnant women). In addition to this, mortality due to abortion is highest in Africa, with an estimated 680 deaths per 100,000 pregnant women (AGI, 1999: 26).

It is clear from these statistics that deaths resulting from abortions are a serious problem and therefore worthy of investigation in South Africa.

1.3 Conceptualisation

In order to gain clarity about the issues related to deaths as a result of abortion it is necessary to conceptualise the concept *abortion*.

1.3.1 Abortion

Abortion is the expulsion of a foetus from the womb before it is able to survive on its own (Branford, 1988). This expulsion can either be natural, commonly known as miscarriage, or it can be induced. An induced abortion can either be legal or illegal, depending on the country's legislation.

1.3.2 Legally induced abortion

Countries have laws regulating whether women can have an abortion or not. In most countries though, abortion is legal (AGI, 1999: 22 - 23), but the legality

comes with restrictions. Some countries allow abortion in order to save the mothers life and to protect her health, in cases where the foetus has a birth defect and where the pregnancy is as a result of rape or incest. Some allow it in cases of rape. Better still, some countries allow abortion on all accounts with gestational age being the only restriction. It has been found though that even in cases where the best-case scenario exists; some women still opt for illegal abortions.

1.3.3 Illegally induced abortions

As mentioned above, the legality of abortion in a country does not necessarily equate to all abortions in that country being legal. Women terminate their pregnancies illegally by consulting people who are not medically trained to induce abortions or who perform abortions in environments not suitable for the procedure and who may use dangerous equipment that have high fatal consequences for women. These people can either be medical personnel or lay people. These illegally induced abortions can be either safe or unsafe.

1.3.4 Safe versus unsafe abortions

It must be acknowledged that the safety of an abortion, legal or illegal, is relative. It is anecdotally assumed that illegal abortions done by medical professionals are safe and would mostly be done using tried and tested methods. Unsafe abortions then would constitute abortions done by medically untrained persons using methods that could harm or even kill women.

It is not all cut and dry though as explained above. Medical professionals have been found to be involved in assisting women to abort illegally, as was also found in this study. Doctors illegally give women tablets to induce the abortion. Women are then sent to hospital for womb scrapping. In some cases women do not go for scrapping, leaving them with all kinds of infections.

Traditional herbalists and healers have been using herbs and other concoctions to successfully abort foetuses for centuries. Though the results of these abortions were not documented, it is assumed that some were not successful. These traditional methods are still being used today, and more often than not, they cause harm to women's health.

Both these methods can be unsafe within each context and are considered to be illegal in South Africa. Women who access these services are subjecting themselves to unsafe back-street abortion services.

This study aims to investigate these back-street abortions in South Africa, specifically those done in the Gauteng province. Back-street abortions are thus considered to be abortions done outside designated health facilities using mechanisms that are harmful to women.

Abortion in South Africa is legal. Nonetheless it is evident from the literature that back-street abortions still occur. In trying to develop a better understanding of the occurrence of this phenomenon, one first needs to review what the abortion legislation entails. Following, is a brief overview of the abortion legislation in South Africa.

1.4 Aims of the study

This study aims to investigate the context within which back-street abortions take place as well as the reasons why they still happen in South Africa. Following are specific research questions which assisted in answering the question: why do some women in South Africa still use back-street abortion even after the implementation of one of the most liberal abortion acts in the world?

1.5 Research questions

Against the background of the brief overview of the abortion legislation in South Africa, it is essential to investigate women who still opt for back-street abortions. In this study reasons for unwanted pregnancies are sought. Having different reasons for defining their pregnancies as being unwanted, women were asked why they preferred to terminate the pregnancy by using back-street methods. The final research question explores role players, people who assisted women in terminating their pregnancies using back-street methods.

1.5.1 Why is the pregnancy unwanted?

As mentioned above, reasons for pregnancy to be unwanted vary from social pressure to contraceptive failure. These pressures lead women to take drastic measures that may sometimes put their lives in danger.

1.5.2 Why resort to back-street abortions?

Back-street abortions are not exclusively performed in countries where abortion is illegal. There is evidence that even in countries where abortion is legal, women still use back-street methods. The aim of this mini-dissertation was to investigate the reasons why women in Gauteng, South Africa, use back-street services. Based on these reasons, recommendation for education about the Act will be made.

1.5.3 Who is involved in assisting women in undergoing back-street abortions?

In order to know how to target the information and/or education with regard to the Choice on Termination of Pregnancy Act, it is essential to know who are the other role players in the process of illegally terminating a pregnancy. The people, who assist women to terminate their pregnancies by making use of back-street abortions, might not know the dangers of their services and most probably do not know about the CTOP Act.

1.6 Significance of the study

The significance of the study lays in the development of a better understanding of the reasons why some pregnancies are viewed unwanted and the reasons why some women decide to terminate their pregnancies using back-street abortion services. In addition, the study reveals a possible group that needs to be targeted when focussing on education regarding the CTOP Act.

In addition, this study (a) will contribute to future research on monitoring the implementation of the CTOP Act; (b) will be published as a report and peer reviewed journal article, and (c) will provide information to the Department of Health on the most important barriers in the implementation of the Act.

1.7 Dissertation outline

In the following chapter, *chapter two,* an overview is given of the existing literature on unwanted pregnancies and abortions. This chapter will discuss the literature as per the research questions discussed above. Discussed in this chapter are the definition of abortion, reasons for abortions, South African abortion legislation and suggestions on ways to improve abortion services.

Chapter three outlines the research methodology used to conduct the study. It describes the population, sample, research design, data collection procedure and data analysis.

Chapter four provides a discussion of the results of the study as per the research questions of the study. During the interviews, respondents were divided into two groups. One group (105 women) said they did not induce the abortions, which means that they had a 'natural' miscarriage. The other group consisting of 46 women who admitted to have used back-street methods and services to terminated their pregnancies. This chapter will compare the circumstances of the

women in these two groups concerning a number of issues such as their knowledge of the Choice on Termination of Pregnancy (CTOP) Act.

This mini-dissertation finds its conclusion in *chapter five.* In this chapter an overall discussion of the results are given and recommendations, based on the study, are made.

CHAPTER TWO:
UNWANTED PREGNANCIES: ABORTION AS A SOLUTION

2.1 Introduction

> *"Abortion has been practised since the earliest of times. No criminal sanction or constitutional provision has ever or will ever stop women from seeking abortion" (Irish Family Planning Association, 1998: no page).*

The conditions under which a woman obtains an abortion are often influenced by the country's abortion laws, the role of advocacy groups in influencing the formulation and enforcement of those laws, and the availability and adequacy of health services (Alan Guttmacher Institute (AGI), 1999: 7). Worldwide, the subject of abortion was seldom discussed until 1960s. But the outcry, as presented in studies done by the World Health Organisation and other international agencies, on the increasing rate of maternal mortality due to unsafe back-street abortions, placed the abortion issue on the international agenda. Subsequently abortion was legalised in many countries.

Even though abortion was legalised, some countries still found themselves admitting or burying women who have induced their abortions using back-street methods. This chapter will explore the definition of abortion with an intent to clarify what back-street abortion is. Reasons why women opt for abortions will also be explored. Thereafter an overview of international legal issues will be given. Abortions in South Africa will then be traced from pre 1975 to post 1996. Because of the liberal Act that was passed in 1996, the barriers to accessing safe legal abortions will also be investigated. The chapter will end with suggestions on what could be done to prevent unwanted pregnancies and to improve the use of legal procedures in terminating pregnancies in South Africa.

2.2 Definition of abortion: spontaneous and induced

According to Branford (1988: 2), abortion is the "*natural or induced expulsion of foetus from womb before it is able to survive especially in first 28 weeks of pregnancy*". From the definition one can deduce that there is a natural abortion, commonly known as miscarriage and an intentionally (induced) abortion. Most countries have laws, which regulate intentionally induced abortions. In the following discussion, a distinction will be made between legal and illegal induced abortion.

2.2.1 Induced abortion: legal and illegal

Abortion can be induced either legally or illegally depending on the country's abortion legislation.

(a) Legally induced abortions

A country's laws, as mentioned above, influence the legality of the abortion. AGI (1999: 24) assets that "the political situation in individual countries probably has the greatest influence on the likelihood of change in abortion laws…Success in changing the law can hinge on the determination and energy of a few individuals or a single advocacy group".

Some countries have restrictive laws, which allow abortions only on the bases of saving a woman's life. "More than two in four women live in countries where laws permit abortion on conditions (such as only to preserve the mother's health), but even these laws impose certain limitations and restrictions on the procedure" (AGI 1999: 20). These restrictions are among other factors leading women to procure the abortion illegally using back-street services.

It is also important to note that the campaign for the liberalisation of abortion laws was based on the need to improve women's reproductive health and reduce maternal mortality due to unsafe back-street abortions (AGI 1999: 24). The limitations then force women to resort to illegal services, resulting in illnesses and in some cases death. Many countries, such as the United States of America, China and Cuba, have liberalised abortion laws to avoid the increasing mortality and morbidity of women due to clandestine abortions. It has, however, been found that liberal abortion legislation does not guarantee that women will refrain from using illegal (and sometimes dangerous) abortion practices.

(b) Illegally induced abortions

Illegally induced abortions include abortions done by both medical professionals and by lay practitioners. Medical professionals usually perform abortions in their consulting rooms. These abortions can be dangerous in that when complication arises they usually do not have necessary equipment and / or medication to deal with it. The World Health Organisation (WHO) pointed out that "even if performed by physicians, abortions carried out in unauthorised facilities or in a country where abortion is illegal place women's health and lives at risk" (cited in AGI, 1999: 32). Lay practitioners, on the other hand, include women in the neighbourhood, traditional practitioners and the pregnant women themselves. These lay practitioners induce abortions by using dangerous abortion methods such as toxic liquids, including household detergents.

As will be discussed, it is surprising that even in countries where abortion is legal…people still procure terminations using back-street services. India legalised abortion in 1971 but many women still procure abortion illegally. AGI (1999: 32) writes that this could be because (a) these women are from rural areas and could therefore be ignorant about the law or (b) these women to not have access to adequate facilities. The study presented in this mini-dissertation looked at, among other things, why women still use back-street abortion services

in Gauteng, South Africa, especially in light of the fact that this province has the highest number of health facilities providing abortion services.

2.2.2 Illegal abortions: Safe and unsafe

Illegally induced abortions can be either safe or unsafe. Some illegal abortions are successful (though this is *ad hoc* information). These can be done by both health professionals, in their consulting rooms using recommended medications and tools or general knowledgeable women in the comfort of their homes. The WHO defines an unsafe abortion as a "procedure for terminating an unwanted pregnancy carried out either by persons lacking the necessary skills or an environment lacking minimal medical standards, or both" (AGI, 1999: 32).

2.3 Why do women have abortions?

In order to understand why women have induced abortions, it is necessary to research why they consider the pregnancy to be unwanted in the first place.

2.3.1 Why do unwanted pregnancies occur?

Research have shown that women list a wide range of reasons why they consider a pregnancy to be unwanted and why they view the unwanted pregnancy as justification for seeking an abortion. In the following discussion, an overview will be given of some of these reasons.

2.3.1.1 Family planning, contraceptive use and abortion

Worldwide many women desire to have fewer children, approximately two children per woman (AGI, 1999: 14). Africa seems to be an exception because of cultural beliefs that still exist, stating that having many children is a sign of wealth. These beliefs are further illustrated by the fact that Africa has the lowest

number of people using contraceptives. Those who are utilising contraceptives seem to be using the less effective methods such as the withdrawal method and periodic abstinence. This does not mean that other methods do not fail, seeing that all contraceptive methods have some degree of failure.

Even where family planning services are available, they may not respond to people's needs and preferences. In many countries, shortcomings in the quality of family planning programmes include:

- A focus on quantitative goals (such as percentage of women using contraceptive method) instead of on helping clients achieve their personal goals for the number and timing of their children.
- Poor information and counselling. Studies in sub-Saharan Africa found that only 25 - 54% of new contraceptive users were informed about side effects.
- Promotion of methods that may be inappropriate for a particular client. This may be because (a) the health facility has a limited supply of contraceptives, or (b) service providers do not spend enough time discussing client's needs, or (c) service providers decide for their clients what methods they should use.
- Poor clinical skills and procedures for example, during pelvic examinations, sterilisation and IUD insertion, which can cause the client unnecessary pain and infection
- The weak link to our reproductive health services, including treatment of STD that are needed to preserve a women's health and future fertility (Safe Motherhood fact sheet, 1998).

A fertile sexually active woman is capable of having 12 children in her 25 childbearing years. To avoid unplanned pregnancy and therefore abortion, women have to use contraceptives very diligently (WHO scientific group). Varieties of contraceptives are available. Women can use: traditional methods (sexual abstinence), avoidance during fertile days of the menstrual cycle

(periodic abstinence), coitus interrupts (withdrawal) or modern contraception which is divided into three categories namely: short-term (e.g. Pill, hormonal injection, long term (e.g. IUD, implants) and sterilisation.

> *"Whether couples will be successful in preventing unplanned pregnancies is to a large extent determined by the effectiveness of their contraceptive use. The chance of an unexpected pregnancy is almost non-existent in couples that use sterilisation and very low for users of IUD, injectable or implants. It is moderate for pill and condom users, and very high in couples relying upon periodic abstinence, withdrawal and spermicides. Since all method may fail, many millions of couples around the world who are using contraceptives still face some risk of an unwanted pregnancy" (AGI, 1999: 16).*

Unplanned pregnancy results from a failure of the complex, often tricky, balancing act engaged in by most women and men to reconcile two aspects of their lives: sexual intercourse and the wish or reluctance to have children. Contraceptive use can mediate the tension between the two, but contraception is not always available, and neither are all methods fail-proof (AGI, 1999: 10). Why then do methods fail? Some of these reasons include (a) women do not know how to use the contraceptives, (b) they have difficulty in accessing contraceptives, (c) non use or failure can also be because of social pressure and (d) not knowing where to obtain contraceptives.

Although nearly 60% of women and men around the world use modern contraceptive methods, 350 million couples do not have access to a full range of family planning methods, services and information. The proportion of married women 15 to 49 years of age who know where to obtain a modern contraceptive varies widely within regions (AGI, 1999: 10).

Social taboos and unequal power relations between men and women often prevent women from using contraceptives. Opposition from husbands is one of the most common reasons women give for not using contraception (Safe Motherhood fact sheet, 1998).

Another attribute to women not using or using contraceptives secretly is because women (especially the young ones) are forbidden in some communities to use contraceptives. Other reasons for the failure to use birth control include women believing that they cannot have children; they are too old to conceive, they experience side effects as a result of their contraceptive use and then decide not to use them.

2.3.1.2 Social pressure, unwanted pregnancies and abortion

A foetus may be unwanted for a number of social reasons. In China, for example, the sex of the foetus plays an important role. A boy child is preferred to a girl child. Because China was a patriarchal society, women made sure that they gave birth to boys because they had a better chance of surviving and taking care of the family. Female foetuses were aborted or when girls were born, they were given up or left to die (Brannigan & Boss, 2001: 178). This though has recently been reversed since the abortion law in China now allows abortion on a wide range of circumstances.

For some women other social influence may play a major role in their decision to have an abortion. Premarital chastity, unacceptability of childbearing outside marriage or disapproval of having children late in life or too close together could all be catalysts to a pregnancy being unwanted. Other aspects of community life that may lead a woman to define a pregnancy as being unwanted, include religion, cultural values, the country's law, marital status of women and patterns of demographic change.

(a) Socially unaccepted pregnancies

Most societies and religions approve of sexual intercourse and childbearing only within the sanctity of marriage and tend to discourage people from having sexual partners outside marriage. Ideally a man and a woman marry, have children and then stay in that relationship till they die. But in reality, many women and men have sexual intercourse before marriage. The extent they do so varies among and within societies. Socially unaccepted pregnancies include conceptions from sex before marriage, sex outside of marriage and rape or incest.

1. *Sexual intercourse before marriage*: There are many variations in social, cultural and economic factors determining when sexual intercourse and marriage are considered desirable for women. There are also broad regional differences regarding the age at which girls start having intercourse and the likelihood that their sexual lives will begin before or within marriage. Sexual intercourse at a young age is, however, common in many countries. In Bangladesh and India, for example, many girls are married before their 18th birthday. In other developing countries, unmarried women have sexual intercourse, for example 56% in Cote d'Ivoire, 45% in Kenya and 22- 28% in Brazil and Colombia (AGI, 1999: 11).

The premarital behaviour of women in Asia, the Middle East and Northern Africa is not documented. This is largely because sex before marriage is strongly challenged due to religious reasons; therefore national surveys usually do not ask this question. This makes it more likely for women to seek abortion in cases of unwanted or disapproved pregnancy. In developed countries on the other hand, early sexual intercourse and childbirth before marriage are common even though they are publicly disapproved (AGI, 1999: 11).

2. *Sexual intercourse outside of marriage*: extra-marital relationships are common in most societies. Marriages end because of divorce, separation, and death of one partner (these days largely because of AIDS, worldwide). However,

being single does not mean the end of the desire for sexual intercourse. AGI (1999: 12) states that there is a number of previously married women who are sexually active and they do not desire to have a child because of the difficulties of raising the child alone.

3. *Involuntary sexual intercourse*: women who are young, poor and uneducated are prone to sexual abuse by men who have power like landlords, creditors, men with high status and older men. Young women are known to have "sugar daddies" (older men) that provide them with school finances and material objects in return for sexual favours. Admittedly though, some are led to this by family breakdown such as the death of the breadwinner in the family. Victims of rape and incest are often desperate to end a pregnancy conceived in this manner. Fortunately most countries allow abortion on these grounds (AGI, 1999: 12).

(b) Small families

Attitude about the ideal family size and the best time to have children is often a product of social expression, cultural values and economic circumstances.

An increasing number of women around the world want a small number of children. The desire for small families has increased since the mid 1970s (AGI, 1999: 13). As countries become more urbanised and women join the work-force, less and less time is spent at home and therefore the need for fewer children. In addition, families who find themselves in low socio-economic classes, may consider a big family as a burden.

On the other hand, politics can influence families decision on how many children they should have. In China for example, abortion was used to control the population rate (AGI, 1999: 6). One-fifth of the world population lives in China. It has the highest population in the world. In the past, a big family was treasured, as young people played the role of taking care of the old. In 1953, the

government passed a "birth control" policy that contradicted these values. The policy was amended in 1974 to force couples to have a maximum of two children. This policy was later amended to (the limitations of) one child per household. Should women request an abortion, an Intra-Uterine Device or sterilisation, they were given an incentive of a few days leave off work. Violators of the birth control policy were punished and even forced to have an abortion during the last trimester.

Because of worldwide opposition to this one-child policy, China has decided to lax its enforcement. China now provides abortion to save the life of the mother, to preserve her physical and mental health, in cases of rape and incest, when the unborn child has medical of birth defects, for social and or economic reasons and lastly on demand with no need for reason given (Pregnant Pause, 2002).

(c) Timing of birth

In some countries, women have enough children at an early age, resulting in them wanting to delay pregnancy or not wanting any more children by the time they are married or reach an older age. Contraceptive services are for example not provided by the public sector in Bolivia. They are only provided by pharmacies and private medical clinics. This leads to a number of unwanted pregnancies. Women have their desired number of children (an average of six children) and then have no means of controlling their fertility. This then subsequently leads to a high number of abortions taking place in this country (Bailey *et. al*, 1988: 27). This brings to the fore the importance of examining a county's abortion legislation in the attempt to gain a better understanding of the prevalence of back-street abortions.

2.4 Abortion and legal issues: a global perspective

The legal environment surrounding abortion is a significant factor affecting women's ability to end an unwanted pregnancy. One in four of the world's women, most of them in the developing world, live in countries that ban abortion, or permit it only to save the woman's life (AGI, 1999: 20).

Many countries passed laws restricting abortion during the early twentieth century. "Abortion remained a taboo topic in most of the world until the 1960s" (Brannigan & Boss, 2001: 177). Japan, China, parts of Scandinavia and Eastern Europe legalised abortion by 1965. Between 1960 to 1970 many countries had legalised the termination of pregnancies (Brannigan & Boss, 2001: 177).

In an article titled *Summary of Abortion Laws Around the World*, Pregnant Pause (2002) summarised the abortion laws of 192 countries. They indicated that most countries permitted abortion for the following reasons:

- to save the life of the mother;
- to preserve the mental health of the mother;
- to preserve the physical health of the mother;
- in cases of rape and incest;
- when an unborn child has medical problems or birth defects;
- for social and / or economic reasons, e.g. if the mother cannot support the child and
- on demand with no reason needed (Pregnant Pause, 2002).

In countries were abortion is legal, women need to know and understand the abortion legislation in order for them to access the services. The distribution and communication of the information concerning the legislation have to be clear and accessible to women of all social status. In countries where abortion is legal, it does not always translate to all abortions being safe and abortion services being accessible. Women in rural areas may not know about the law. In some cases health care workers may be unfriendly and unappreciable, and thus discouraging women to pursue a legal abortion (AGI, 1999: 32).

The liberalisation of abortion laws has in some countries had a significantly positive effect in that it reduced the maternal mortality rate. However, as AGI (1999) states, there is evidence that legalisation of abortion does not always have desired results. The abortions rate increased in countries where abortion trends were researched after being legalised, as was found in Eastern and Western Europe. "Because statistics is not collected where abortion is prohibited, few countries that have reformed their laws know how frequently the procedure was performed before legalisation This makes the assessment of the impact of the legalisation difficult if not impossible" (AGI 1999: 28).

Notably, in some countries abortion is offered with restrictions. These vary from providing an abortion only in the first trimester to not providing an abortion in some cases at all (e.g. Zimbabwe does not provide abortions on demand). Countries such as Angola, Benin, Central African Republic, Congo, Dominica, Gabon, Indonesia, Laos and Somalia offer abortion only if it threatens the women's life.

Countries such as Chile and Nepal, have the strictest enforcement of the law. Women are imprisoned for inducing abortions. Most of those who get this punishment are poor, since the well-off are able to get safe treatment in private practice or go to countries were abortion legislation is less restrictive.

Even with all the work that has been done to show the importance of legalising abortion, Chile, Elsavador, Malta and the Vatican City still do not offer abortion under any circumstances, that is, abortion is illegal (Pregnant Pause, 2002). Following is a look at the situation in South Africa.

2.5 Abortion and legal issues: the South African context

In many countries the criminality of abortion result in unsafe abortions, which cause the death of thousands of women every year. The strict laws of abortion in South Africa before 1996, clearly increased the number of back-street abortions with serious health consequences. For medical reasons, abortion is not an appropriate method of family planning. It should, therefore, be viewed as a solution to a 'crisis' (an unwanted pregnancy or problematic pregnancy) rather than as a means of regulating one's fertility. Some examples where a crisis may exist for health/medical, social or economic reasons, are:

- a mother of six children who can neither mentally nor physically cope with any more children;
- it may be a mother of a disabled child who decides that it is not fair to that child, or to her other children, to have yet another child with or without a similar disability;
- it may be a woman who does not wish to carry her pregnancy to full term as she knows that her child will not be capable of surviving separation from the uterus; or
- in extreme cases, it may be a minor who cannot cope with a pregnancy as a result of rape.

(Irish Family Planning Association, 1998: no page)

For a woman who has an unwanted or problematic pregnancy, that pregnancy may bring about a crisis, which can have a long-term effect on her welfare and the well-being of the other members of the family.

The South African constitution states that all people should have a right to health care, including access to reproductive health care (South African Constitution, 1996). The inequality of race and class has been demonstrated in South Africa in relation to women's access to safe abortion. During the rule of the apartheid government, abortion was only accessible to a minority group of the population who could afford to pay a gynaecologist to guide them through the bureaucracy required by the state before the pregnancy could be terminated. Of a total of 868

reported legal abortions in 1988, 68% were requested by white women; of which most of these abortions were performed on the grounds of threat to the mother's or baby's health (Dickson-Tetteh and Rees, no year: 190). The following discussion outlines the full journey of the abortion Act in South Africa.

2.4.1 Family planning and abortion during the apartheid era

During the apartheid regime, the Afrikaner-dominated National Party government advanced separate population policies for White, Black and Coloured (mixed race population). The South African government was fuelled by fear of unsustainable population growth. This fear took on a racist tone when the government felt that the Black and Coloured population was growing too quickly, placing a burden on the country's resources, while the White population growth was stagnant.

This was epitomised by MC Botha (Minister of Bantu Administration and Development) when he asked white citizens of South Africa to sacrifice by "...having enough children to ensure continued existence as a Christian and Western country on the continent of Africa" (Cope cited in Guttmacher *et al*., 1998: 191).

The Afrikaans Protestant churches opposed the legalisation of abortion but supported the notion that the White population must grow to maintain its supremacy. In addition, government tax incentives were used to encourage White women to procreate. On the contrary, Black women were encouraged to use contraception.

Adding to this, White women were sent to school and had greater access to employment opportunities. Nevertheless, many who reached managerial positions found the idea of a small nuclear family more appealing and

maintainable. This increased the demand for contraceptives and abortion services (Guttmacher *et al.,* 1998: 191).

During the Apartheid era, abortion was illegal, but wealthy White women had an array of options including having abortions done at doctors rooms or going to England where the procedure was accessible. Black women on the other hand could not afford a safe abortion, pushing them to back-street services performed by untrained midwifes, non-registered doctors or traditional practitioners. Women who did not want to go 'back-street', induced the abortion themselves by using dangerous methods such as knitting needles or detergents (Guttmacher *et al*., 1998: 191). Brandford (1988: 120) adds that talking publicly about abortion was to break a taboo. She found that abortion was spearheaded by Black herbalists whose service was later banned and taken over by White doctors.

This situation changed with the introduction of the 1975 Abortion and Sterilisation Act.

2.4.2 The introduction of the 1975 Abortion and Sterilisation Act

Health practitioners and women's organisations such as the Abortion Reform Action Group (ARAG) pressured the government for the reform of the abortion act. Health practitioners wanted to protect themselves from the technically illegal abortions they were performing (Guttmacher *et al*., 1998: 191-192).

Because the government had pronatalist attitudes, they elected an all white and all male committee, which wrote and passed the Abortion and Sterilisation Act of 1975. This Act was formulated in such a manner that it seemed to be granting freedom to women seeking the service. However, scrutinising it closer, this law made it more difficult to procure abortions. It stated that abortions could only be performed when the pregnancy seriously threatens a woman's life or her physical or mental health; could cause severe handicap to the child; or was a result of

rape (which had to be proved); incest or other unlawful intercourse. On the face of it, it looked as if women could seek abortion for a number of reasons. However, a stiff procedure of red tape had to be followed before getting an abortion. Approval had to be obtained from two physicians, psychiatrists or a magistrate. Approved procedures had to be performed in state hospitals and records were strictly kept (Guttmacher *et al*., 1998: 192).

The campaign to liberate abortion laws was not only grounded in liberation politics, but also supported on public health grounds by national data, which showed that, during the apartheid era, approximately 425 women died each year as a result of clandestine unsafe abortion procedure (Dickson-Tetteh and Rees, no year: 190). The study by Dickson-Tetteh and Rees also showed that of the 44,686 women admitted to public health facilities for incomplete abortion procedures, a third had medical complications that indicated that they had induced abortions unsafely (this was a review prior the implementation of the CTOP Act). This number excludes unreported cases of women who died in the community after attempting to self-induce the abortion. Complications of unsafe abortions, during the existence of the Sterilisation and Abortion Act of 1975, caused 14% of pregnancy related deaths (Dickson-Tetteh and Rees, no year: 192).

2.4.3 Impact of the 1975 Act

In one sentence: the act failed to increase access to safe legal abortion. Women continued seeking illegal abortions despite the fact that they placed their lives at risk. The gynaecological wards increasingly admitted women presenting with incomplete and septic abortions. Maternal mortality and morbidity also increased. Clandestine abortions were estimated to have ranged between

120,000 to 250,000 per year during the years 1975 to 1996 (Guttmacher *et. al*. 1993: no page).

The Medical Research Council (MRC) of South Africa did a study (Rees *et. al*. 1997: 435) attempting to monitor and understand the epidemiology of induced abortions. This study, done in 1993, found that approximately 45,000 women were admitted to public health facilities with spontaneous abortions or complications due to induced abortions. This study, however, did not include women who did not report to health facilities because they either successfully induced the abortions or died before reaching the health facility.

The MRC study documented the impact of this legislation (1975 Act) on creating inaccessible services. Impacts documented included: (1) high numbers of women treated for complications from incomplete abortions, (2) high rates of mortality and morbidity amongst those treated for incomplete abortions and (3) inaccessible services for young black single women (Rees *et al,* 1997: 437).

2.4.4 The new South African government and the new abortion law

When the African National Congress (ANC) came to power in 1994, access to legal abortion was an integral part of their national health programme. They emphasised that every woman must "have the right to choose whether or not to have an early termination of pregnancy according to her own belief" (Reconciliation and Development Programme 1994 cited in Guttmacher *et al*., 1998). On their electoral victory they prepared a new abortion law for review by the nation's parliament.

The call to replace the 1975 Abortion and Sterilisation Act caused an expected heated debate between the anti-abortionists and pro-choice groups. Two-dozen anti-abortion groups including church groups and Doctors for Life, held demonstrations in protest against the proposed 1996 Act. On the other hand

groups such as the Women's Health Project, the Reproductive Rights Alliance (RRA), Planned Parents Association of South Africa (PPASA) and Abortion Reform Action Group (ARAG) supported the ANC in creating greater gender equality as well as furthering women's rights.

The historically racist population control policy left African women confused and sceptical of the new law. They saw it as another ploy to control population growth. This confusion was especially among ANC members who were devout Christians or Muslims (Guttmacher *et al*., 1998: 193).

Prior to the vote in the South African National Assembly many representatives wanted to vote according to their individual conscience. The divided ANC voted according to party platforms. Pro-choice sentiments dominated the national assembly. The legislation was passed 209 to 87, with 5 abstentions and 99 absentees (Guttmacher *et al.,* 1998: 193). This subsequently led to the 'birth' of the Choice on Termination of Pregnancy (CTOP) Act of 1996 in South Africa.

In February 1997, the Choice on Termination of Pregnancy Act (CTOP) (South African Government Gazette, 1996) was introduced in South Africa as part of an effort to promote reproductive choice and rights, and to reduce abortion-related morbidity and mortality. The Act permits termination of pregnancy upon request of the woman up to and including 12 weeks of gestation. From the 13th up to and including the 20th week of gestation, the pregnancy may only be terminated if a medical practitioner, after consultation with the pregnant women, is of the opinion that the pregnancy would pose (a) a risk to the woman's physical or mental health; (b) a substantial risk of foetal physical or mental abnormality; (c) the pregnancy resulted from rape or incest; or (d) the continued pregnancy would significantly affect the social or economic circumstances of the woman (McQuoid-Mason, 1998: 578). After the 20th week of gestation, the pregnancy may be terminated if it endangers the woman's life, would result in severe malformation of the foetus or would pose a risk of injury to the foetus (McQuoid-

Mason, 1998: 578). In cases were a woman is a minor, she is counselled to sort advice from a parent or guardian with no consent necessary form the guardian or the person who made her pregnant.

The Termination of Pregnancy Act provided the first legal step in enabling women to make a choice concerning termination of pregnancy. However, service availability, access, and knowledge are all prerequisite enabling factors for choice. Few people make decisions or perform actions without considering the opinions and views of those around them. People are constantly under pressure to act in certain ways. How they respond will depend on whose opinions have the most influence on them (Hubley, 1993). Social pressure cannot be ignored in understanding women's choice to terminate a pregnancy. This factor will also be explored as being either a motivating factor or barrier to accessing legal pregnancy termination services.

Reproductive Rights Alliance (1998: 1) did an overview of South Africa over the first year of implementation of the CTOP Act in the nine provinces. They found that between the period February to December 1997, 66% of TOP performed were first trimester and 34% were second trimester pregnancies.

The national directorate, representative of provincial directorates and health facilities, rallied to ensure that the rights of women as stipulated in the Act were given real meaning and that facilities could provide services to women. The implementation of the Act gave rise to a healthy debate on what the rights and choices of health care providers were in relation to the responsibilities that they had as health care providers in meeting the health needs of women. This was not only seen as an obstacle, but also raised a debate on the quality of care that comprehensive reproductive health care services should entail.

2.4.5 The 1996 CTOP Act in practice

A total of 248 public health facilities were designated to provide legal terminations of pregnancy and of these only 73 (28%) are currently providing abortion services (these are mostly at hospital level). Of the facilities providing TOP services, only two are community health care centres, both located in Gauteng province (Varkey & Fonn, 2000: 7).

Reproductive Rights Alliance (2000: 30) reported that two years after the implementation of the CTOP Act, the number of abortions performed was at nearly 70,000 and slowly increasing. Nearly half of those were performed in Gauteng alone, making it the province with the highest number of abortions performed in the country.

In one hospital study, the increased availability of legal services has led to a significant reduction of incomplete abortions, although there has been no decrease in the total number of uncomplicated incomplete abortions. The increased number of incomplete abortions was linked to the possible use of Misoprostol (a drug approved by the South African government used to medically induce termination of pregnancies) by private practitioners (Varkey & Fonn, 2000: 6).

Kay *et al.* (1997) (cited in Varkey & Fonn, 2000: 8) estimated that in 1994 the government spent R18.7 million in treating incomplete abortions. A review of international studies comparing the two methods of inducing abortion, manual vacuum aspiration (MVA) and sharp dilatation and curettage (D&C) in induced and incomplete abortions, reported that MVA reduced inpatient load and cost to the health sector and decreased the levels of major induced abortion complications.

At the parliamentary committee hearings on abortion, which took place on the 7th of June 2000, anti-abortion doctors and nurses expressed their strong feelings about being required to subjugate their personal moral and religious beliefs to

those of the state. They presented that health workers who were forced to perform TOP suffered from posttraumatic stress syndrome, drug and alcohol abuse and even committed suicide. They also presented that nurses were distressed and confused by their own ambivalence towards abortion. Some felt guilt arising from a conflict between their own moral values and beliefs, depression resulting from cumulative stress and fear of harassment. The spokespersons for the two anti-abortion groups represented at this meeting said that health care workers should not be forced to perform abortions including referring women to facilities which provide TOP procedure (O'Sullivan, 2000).

The head of Obstetrics and Gynaecology at Cecilia Makiwane hospital suggested that South Africa should adopt the Swedish abortion law implemented in 1976. After the implementation of the TOP Act in Sweden, government was faced with opposition from doctors and nurses. This was overcome by the implementation of a law that everyone concerned with women's health must be willing to offer a complete service and total care including TOP (Reproductive Rights Alliance, 1998: 1).

In a radio interview on the SA FM afternoon Live show (hosted by Thabiso Matima on the 17th of July 2003 at 15h05 to 15h25), Ms Thandi Tshane from the South African National Department of Health reported that the abortion rate is on the increase and that Gauteng province has the highest rate. She attributed the high rate in Gauteng to, among other things, the fact that Gauteng health facilities are referral points for many provinces. The TOP clientele in Gauteng health facilities is from a vast catchment area (including at least four other provinces in the country). Ms Tshane reported that in 2002 alone, 18,000 women terminated their pregnancies in Gauteng.

Four years after the implementation of the CTOP Act there is evidence that back-street abortions are still common in South Africa. This is understandable in areas with few facilities that provide termination of pregnancy (TOP) services, but

Gauteng has the highest number of health facilities providing the service, so why are women in this province still aborting back-street? What are the barriers preventing women to access legal services? What can be done to help them access safe services? This study aimed to answer the above-mentioned questions by exploring situations under which women induce abortions using illegal services.

2.5 Barriers preventing safe and legal abortions in South Africa

In the following four sub-sections issues are discussed that were found to be common barriers to accessing legal termination of a pregnancy.

2.5.1 Abortion laws

The Abortion and Sterilisation Act of 1975 had obvious flaws that lead to the inaccessibility of safe pregnancy terminations. As discussed above, it is clear that the 1975 Act's restrictions lead to a situation where abortions were only available to a minority of women. This culminated in a continued use of herbs and, for those that could afford, the consultation of doctors who were prepared to perform abortions illegally.

In 1996 the South African government passed the CTOP Act which allowed women to decide whether to have a child or not. "However, while the removal of obstacles to the right to choose when and if to have children is an essential component, it is not sufficient" (Varkey & Fonn, 1999: no page).

Varkey and Fonn (1999) found that providing services and ensuring equitable access to services is now a challenge. The CTOP Act has been passed but the implementation thereof seems to be a problem: (a) few facilities are providing abortion services; (b) few health care workers, especially midwifes, have been trained to provide abortion; (c) even fewer health workers know about the Act

(mostly because they do not want to be associated with abortion because of the stigma it holds); and (d) referral mechanisms are not in place mainly because of health workers who do not refer women to facilities that perform legal abortions. Pre and post counselling play an important role in ensuring non-repeat of self-induced abortion and increase contraceptive use.

2.5.2 Termination of pregnancy services

According to Horning (1998), Reproductive Rights Alliance (1998) and Varkey & Fonn (1999), less than one-third of the hospitals designated to provide abortions services in South Africa, were actually providing services nationally. Unfortunately, this lack of services meant that back-street abortions were still being carried out (De Jonge, Pattinson & Mantel, 1999: 14).

Of the 248 designated public health facilities 73 (28%) are currently (in the year 2000) providing services and 99% of these are hospitals. The provincial breakdown of health facilities that provide TOP is as follows: Eastern Cape 10, Free State 3, Kwa-Zulu Natal 6, Gauteng 18, Mpumalanga 6, Northern Cape 2, North West 7 and Western Cape 15 (Reproductive Rights Alliance cited in Varkey & Fonn, 2000).

With so few public health facilities providing TOPs, access and cost become major barriers to choice, particularly for rural women. Other barriers preventing women from seeking safe and legal abortions include lack of knowledge about the Act, lack of awareness concerning early pregnancy signs, fear, denial, the stigma of openly seeking assistance and preferences for traditional medicines (Horning, 1998: 113).

The lack of trained staff is a further matter that complicates the availability of legal abortion services. According to Varkey and Fonn (1999), 90 midwives have completed theoretical abortion training and 45 of these have completed clinical

abortion training. A total of 31 out of these 45 midwifes are involved in the provision of abortion services. Twenty-two physicians have been trained in manual vacuum aspiration (MVA), acting as provincial resource persons. These 22 physicians have trained another 124 physicians in the MVA technique. With 248 designated public health facilities for TOPs, it is evident that lack of trained staff is a major problem that contributes to insufficient service provision.

There is evidence from Kalafong Hospital that there has been a decrease in the number of patients with complicated abortions, but no decrease in incomplete abortions (Horning, 1998: 113). The decrease in the number of septic abortions is not entirely credited to the availability of legal services, but rather to the introduction of "Misoprostol" as the premier abortifacient (Horning, 1998: 114). During the “Misoprostol Use”-study, conducted by the Reproductive Health Research Unit, the investigator found that doctors and nurses were giving this tablet to women with the instructions that women should use it to self-induce an abortion. On the commencement of bleeding they are to go to hospital or a clinic for evacuation (Dickson Tetteh, *et. al*. 2000)

The majority of women seeking TOP services were over 18 years of age, multiparous, single and unemployed (Mahlasela, 1998: 2; Varkey & Fonn, 1999). These findings imply that few South African adolescents use TOP services. Yet, safe abortion was the first priority for female youth. It is possible that the discrepancy between behaviour and needs is related to low contraceptive coverage; poor understanding of the use of contraceptives; social pressure from partners, attitudes of family and health care workers; or fertility perceptions (Jewkes, Wood & Mafurah, 1997: 418; Mafurah, Wood & Jewkes, 1997: 80).

2.5.3 Health care workers as barriers

In an interview in the True Love magazine (June 2003) Ferguson reports that health care workers in South Africa were still deterring women from accessing

TOP services. She found that women go from one clinic to the other looking for a nurse who will write a referral letter. One woman was quoted as saying that the nurse told her that abortion was "murder" and wanted to call a pastor for her.

In many developing countries health care workers, doctors and nurses do not receive adequate training or have equipment that allow them to deal with termination of pregnancies. They therefore refuse to perform abortions. Some refuse to perform abortions because they do not understand the abortion legislation or because they do not personally support abortions. When women have complications because of unsafe abortions, good medical care is often unavailable. Lack of training, medications, protocols, misdiagnosis, negative attitudes of health care workers and / or overcrowded emergency wards can result in life-threatening situations and costly delays for women seeking treatment. Family planning is not always offered to women who suffered or have been treated for abortion complications. This can lead to a circle where women will have unwanted pregnancies, did not have access to TOP services and then opt for back-street abortion.

Despite Ward's early eloquent plea concerning the responsibilities of health care workers towards their clients, the judgemental attitudes of staff, not directly involved in TOP procedures, continue to hamper the implementation progress (Varkey & Fonn, 1999: no page).

2.6 Abortions services provided: what is happening on grass root level?

In the subsequent discussion a brief overview will be given of the statistics concerning requested TOPs between the periods February 1997 to January 1999. Also shown is the fact that just over half of the terminations in the country are requested and done in Gauteng province.

In the first year of implementation of the Termination of Pregnancy (TOP) act, a significant number of legal abortions were requested and performed. Of the 28,978 legal terminations performed in the first year (February 1997 to January 1998), almost all of these abortions were performed in tertiary centres in urban areas; 52% of all terminations were performed in Gauteng Province alone (Mahlasela, 1998: 3). As observed by Mahlasela (1998: 3), the overall TOP rate was estimated at 1.2 per 1,000 women, significantly lower than the worldwide average of 35 per 1,000 women as was later observed by The Alan Guttmacher Institute (1999: 25). The majority of terminations (66%) were performed in the first trimester, (that is first three months after conception), which was slightly higher than the 61% reported in the national study by Rees *et al.* (1997: 434). According to Varkey & Fonn (1999), 40,568 TOPs were performed during February 1998 to January 1999, a 40% increase in procedures performed.

2.7 The high incidence of back-street abortions: what can be done?

To try to solve the challenge concerning access to safe legal abortions, practical programmes need to be put in place. Secondly, contraceptive use needs to be encouraged and family planning services suitable to women's life style need to be more readily available.

2.7.1 Preventing unwanted pregnancies

Family Care International (cited in Safe Motherhood fact sheets 1998) suggests that government and donors need to make programmatic changes to:

- ensure that all individuals - including adolescents and unmarried women - have access to good quality, confidential family planning services which offer a full range of methods, including emergency contraceptives. These services must also be responsive to the needs and lifestyle of their clients;

and enable women and men to have the number of children they want, while protecting themselves against sexual and reproductive health problems.

- ensure that all providers of health care have the supply, information, technical and communication skills necessary to offering high quality care.
- offer reliable information and compassionate counselling to all women with an unwanted pregnancy, including information about when and where a pregnancy may be legally terminated.

Family Care International (cited in Safe Motherhood fact sheets 1998) continue to say that policy makers need to address regulatory, social, economic and cultural factors within communities and at national level to:

- ensure that women have control over their sexuality and reproduction, rectify power imbalances between men and women, and promote caring, responsible behaviour among men in sexual relations, ensure that they have control over their pregnancy and child care.
- address sexual coercion and all forms of sexual violence against women
- address the problem of unwanted pregnancy among young people and modify attitudes that stigmatise pregnant girls.

2.7.2 Emergency contraception

Emergency contraception (EC) is a method of preventing pregnancy that can be used after unprotected sexual intercourse took place. The most common method is for the women to take a special dose of oral contraceptive pills, called the emergency contraceptive pills (ECP) within a few hours or days after sexual intercourse. ECPs are not considered a method of abortion. EC has a potential

to considerably reduce unwanted pregnancy. However, it is not yet widely available in many countries (Safe Motherhood fact sheet, 1998).

2.8 Conclusion

A country's abortion legislation plays an important role in decreasing deaths as a result of back-street abortions. Internationally, abortion is recognised as a health hazard and therefore many countries have liberalised their abortion laws in response. There are few developing countries which are still struggling with recognising this fact. Lessons learnt from countries permitting legal abortions can be suggested to countries where abortion is still illegal. It is, however, important to bear in mind that the legalisation of abortion does not necessarily translate into the end of back-street abortions. As is evident in countries such as South Africa and India, women with incomplete abortions from back-street services seek help from health care facilities.

"Prevention is better than cure". This proverb can be rightly applied to the use of contraceptives, and in cases where 'mistakes' happen, emergency contraceptives are a solution. Unfortunately social factors such as culturally defined taboos, misinformation about contraceptives, patriarchal dominance and inaccessibility to contraceptives contribute to the difficulty of preventing unwanted pregnancies. Disheartening evidence also exist that some women use termination of pregnancy services as a form of contraceptive.

The microscopic view of the back-street abortion situation is gloomy. Before presenting the results of what is happening in Gauteng province, the methodology used to gather the information will be discussed.

CHAPTER THREE:
RESEARCHING BACK-STREET ABORTIONS IN SOUTH AFRICA

3.1 Introduction

Abortion researchers will agree that this is a challenging topic to research. The fact that abortion is legal does not erase the stigma it still carries in the community. The plan, therefore, to talk to the community (in this case women who have decided to terminate their pregnancies) about the topic of backstreet abortions should include a sensitive interviewer and questions that will not be intimidating and which are non-judgemental. This section will give an overview of the methodology used in obtaining data from women who were admitted with incomplete abortion, in four public health facilities in Gauteng province.

The reader's attention is drawn to the fact that this mini-dissertation is based on a study done by the Reproductive Health Research Unit (RHRU) and the Medical Research Council of South Africa (MRC). The investigator, was at the time, part of the internship programme at the MRC. The investigator collected all the data and was given permission to use it to pursue an MA. It is, therefore, for this reason that some questions in the questionnaire were irrelevant to this study and some did not yield satisfactory information.

The aim of the study was to investigate why women in Gauteng province were still resorting to back-street abortions, four years after the implementation of one of the most liberal abortion laws in the world.

3.2 Choice of research technique

The study was a cross-sectional survey of women who were admitted to public hospitals in Gauteng with incomplete abortions (miscarriage). A research questionnaire with a combination of close and open-ended questions was used

to collect information. It was a descriptive study, focussing more specifically on women who presented to health facilities with incomplete back-street abortions in Gauteng province. This description lead to an explanation as to why they turn to illegal services when legal services are available.

At each of the four hospitals, the researcher spent a period of approximately two weeks (the days were not always consecutive) and interviewed all consenting women presenting with incomplete abortions.

3.3 Unit of analysis

The study population was women of reproductive age arriving at health facilities with incomplete abortions (induced and spontaneous). For the purposes of the study the focus fell on four public hospitals in Gauteng province. However, these women were not only from the catchment areas of the health facilities, a few came from other provinces.

3.4 Sampling

Under this section I discuss facility sample and respondent sample,

3.4.1 Facility sample

Four public hospitals in Gauteng (Chris Hani Baragwanath, Kalafong, Leratong and Pholosong), were sampled using a stratified random sampling method. A list of all public hospitals designated to provide termination of pregnancy (TOP) services was used. From this sampling frame the four health facilities were drawn as they are found approximately in the South, North West and East of the Province.

3.4.2 Respondent sample

Abortion is still stigmatised in South Africa. This may lead to a situation where women who have induced abortions themselves often try to conceal the fact. For this reason it was felt that it would not be possible to identify women who have induced an abortion illegally. In order to conceal the distinction between women who have induced abortions illegally from those who spontaneously aborted, it was decided that all women who were admitted to ante-natal care units with incomplete abortions (commonly known as miscarriage) would be approached. Even though in some parts of the analysis the two groups were compared, the group mainly investigated was the women who aborted using back-street methods. A methodological flaw was that a tally of refusals was not kept. The women interviewed were therefore sampled conveniently.

3.5 Data collection

Data was collected using a pre-coded semi-structured questionnaire. Entrance to the health facilities was gained through getting permission from the facilities Chief Executive Officers who in turn informed the nurses at the ante-natal care units of the facilities. The researcher introduced herself to the nurses-in-charge of the ante-natal care unit (ANC) on the first day of visit and further explained the study and the procedure to them. Subsequent to the first visits, the investigator arrived at the facilities in the mornings, sat in a visible position at the ANC wards and was then approached by a nurse, should a patient with an incomplete abortion be admitted. Data collection took place during the months of April to June 2000.

3.6 The research instrument

A pre-coded questionnaire was used to collect data. It covered demographic characteristics, pregnancy history, circumstances of pregnancy loss, knowledge

of Choice on Termination of Pregnancy (CTOP) Act, knowledge of emergency contraception (EC), and the nature of social support received.

The **demographic information** obtained assisted in determining the socio-economic status of the women. This was important in light of the fact that the socio-economic status of a woman may influence her choice in using illegal services to terminate a pregnancy. The demographic variables included the following: age, race, province where the woman lived, suburb and name of nearest city, educational qualification, marital status, employment status, level of exposure to media, number and age of children and previous pregnancy loss (where applicable).

The information regarding **the circumstances of pregnancy loss** guided the investigator in separating women who had spontaneous abortion from those who had induced abortions. This section also gave an indication of women's knowledge of their bodies. Information on levels of contraceptive use and knowledge was also obtained from women. Women's reaction to the onset of bleeding after inducing abortion was also sort in this section. Questions regarding methods used to induce the abortion and people who assisted in the process of the abortions were also asked.

The information regarding the respondent's **knowledge of the CTOP Act** gave an estimate of the following: (a) number (percentage) of women who knew about the Act, (b) number of women who knew about the Act and did not use the legal abortion services and (c) reasons for not using the legal abortion services. This information was then cross-tabulated with the demographic data.

Social support: Information sort here concerned whether or not women received support from their significant other during pregnancy and the loss thereof. Women were also asked if anyone else supported them.

3.7 Piloting the questionnaire and procedure

Four public hospitals were visited over a two-month period. The period was divided into two four-week blocks. In each time block, the researcher spent a week at each hospital. The order of hospitals in each block was independently and randomly determined.

A pilot study of three weeks was carried out at one hospital (Chris Hani Baragwanath) in order (a) to pilot test the reliability and validity of the questionnaire and (b) to estimate the number of incomplete abortions that would be found in a two-month study. During these three weeks, the researcher also spent one day in each of the other hospitals (Pholosong, Ga-Rankuwa and Leratong) to gather information on the number of women presenting with incomplete abortions per day, length of waiting time before patients were helped and a sense of the hospital staff's attitude towards patients.

3.8 Data analysis

Quantitative data was double entered into an Epi info database and exported to the statistical package SPSS for statistical analysis. The data was summarised using descriptive statistics utilising SPSS version 8. Frequency tables and cross tabulations were used to investigate the role of socio-demographic factors in illegal abortions.

Qualitative data was typed into Microsoft Word and then transferred to ATLAS TI version 4 for analysis.

3.9 Quality control

During the course of the study, emphasis was placed on rigorous data management and quality assurance. Each questionnaire was checked whether or not it was completed in full. Data was found to have minimal gaps. Because of the sensitive nature of the study, the investigator was unable to go back to the respondents to fill the gaps. The final data set was cleaned and approved by a statistician from the MRC for validity. Both the investigator and the data entry clerk cleaned the data. Double entry of quantitative data, as mentioned above, was also done to make sure that the data was properly entered.

3.10 Ethics

As is required of all scientific research, ethical approval was sort and granted by the Witwatersrand University ethics committee. They reviewed and approved both the protocol and the questionnaire used in the study.

Before each of the interviews, a consent form was read out to the respondent which was accompanied by an information leaflet. Women were asked to sign the consent form if they agreed to participate in the study. A semi-structured questionnaire (attached appendix C) was given to all consenting women by the researcher in the language of the respondent's choice, which was either Zulu, Sotho or English.

3.11 Methodological limitations / challenges

As mentioned in the introduction, abortion is not an easy issue to talk about, let alone investigate. The limitations of this study are as follows:

- *Personal challenge*: Even after familiarising herself with the research protocol and the instrument, the investigator struggled through the first

interview, which was during the piloting of the study at Chris Hani Baragwanath hospital. She struggled with her own beliefs concerning the morality of abortion and at the same time tried to remain as objective and professional as possible. As she listened to women telling their stories, one after the other, she understood the women's dilemma and the urgent need to educate them and the community at large about the safe legal abortion services.

- *Data collection*: Another challenge was during the data collection when long hours passed between interviews. Some days had gone by without any interviews being done. In addition, some respondents refused to answer certain questions.

- *Methodology*: adding to the fact that it is generally difficult to obtain information on the sensitive issue of abortion, using a mostly close-ended quantitative questionnaire limited the information gathered. Many questions arising from the given responses remained unanswered. Most questions were not explored to their full potential, resulting in gaps that will not be filled unless the study is replicated. Unfortunately, in such a case different respondents will be interviewed.

- *Sample size*: because the sample size in this study was small, the results thereof may not be generalised to the whole population of women in the Gauteng province.

- *Selected sample: Limited to hospital admissions.* This study presented results and drew conclusions about women who ended up in public health facilities. It is important to note that there are other women who might have successfully terminated at home, resulting in them not needing further assistance from health practitioners. Another group of women

whose demographics might not be represented in this data set, are those who died before reaching the health care facility.

3.12 Conclusion

The population of the study comprised of women of reproductive age who were admitted to four health care facilities in Gauteng. These women where admitted for incomplete abortions, and those who consented to be interviewed were included in the study irrespective of whether they induced the abortion themselves or miscarried spontaneously. Stratified random sampling was used to select health care facilities and convenience sampling was used to select women to participate in the study. One facility was used as a pilot site to test the reliability and validity of the questionnaire.

The research method chosen to collect data was not the best but it did yield information that assisted in answering the research questions. If a study of this nature could be done again, the investigator would recommend that a qualitative method of data collection be used because it may source out richer information. In the next chapter a discussion will be given of the results of data collected from 46 women who admitted to have used back-street abortion services to terminate their pregnancy and 105 women who said they had a spontaneous miscarriage.

CHAPTER FOUR:
A COMPARISON OF BACK-STREET ABORTIONS AND SPONTANEOUS ABORTIONS

4.1 Introduction

Despite the promulgation of the Choice on Termination of Pregnancy Act in 1996 statistics show that a significant number of women still resort to illegal abortions. This study aims to shed light on the circumstances of women who make this choice. In the previous chapter, the methods, ethics and research instruments were discussed. This chapter presents data that came out of interviews with 151 women who were admitted to the antenatal care units of four public health care facilities during a period of two months. These women were admitted with incomplete abortions (miscarriages) and were in need of womb scraping and / or medical observation because they were haemorrhaging or having abdominal pains.

During the interviews, these women were divided into two groups. One group (105 women) said they did not induce the abortions, which means that they had a 'natural' miscarriage (referred here forth as spontaneous abortion). The other group consisted of 46 women who admitted to have used back-street methods and services to terminate their pregnancies. This chapter will compare the circumstances of these women in two groups concerning a number of issues such as their knowledge of the Choice on Termination of Pregnancy (CTOP) Act.

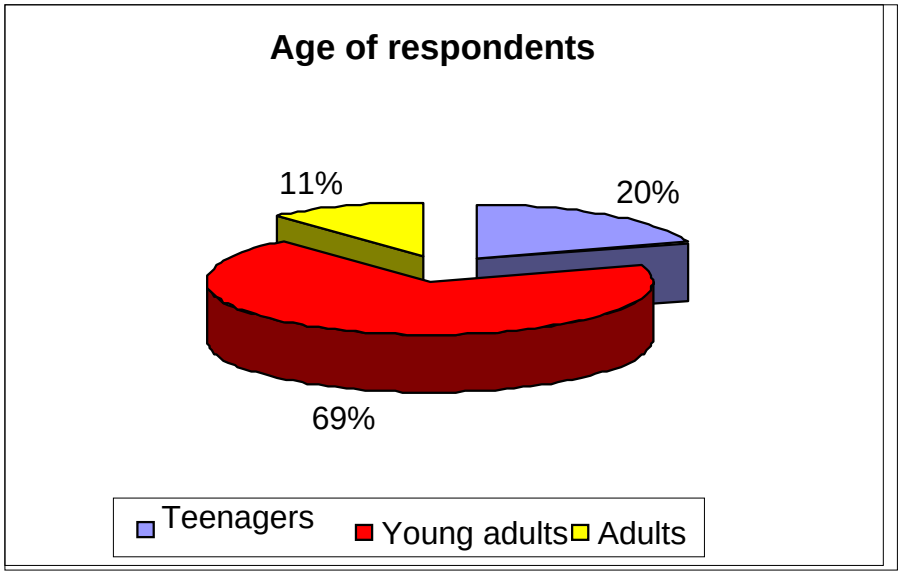
This chapter will further give reasons why the women who had back-street abortions, opted for this service instead of accessing legal services. In order to gain this understanding it is firstly necessary to look at their biographical characteristics.

4.2 Biographical characteristics

4.2.1 Age

Respondents were of reproductive age i.e. between 15 to 45 years of age. The two groups were on average at approximately the same age. The mean age of the back-street abortion group was slightly higher than the spontaneous abortion group, being 28.04 years and 26.6 respectively.

Figure 1: Age of respondent



There were only seven teenagers in the back-street abortion group with two aged 16, three aged 17 and two older than 20 years. The rest of the respondents were 21 years and older. The spontaneous abortion group also had seven teenagers: two aged 16, three aged 17 and another two 20 years of years. This shows that the majority of the respondents were adults or old enough to be either employment or married.

4.2.2 Race

The four health facilities visited were from Black areas (townships), namely Soweto, Attredgeville, Tsakane and Vosloorus. It is therefore no surprise that most respondents were from these areas. All but three respondents were Black. These three respondents were Coloured. Rees e*t. al*. (1997: 434) also found that Black women dominated the clientele of public health services.

4.2.3 Province

Because Gauteng province has the highest number of facilities providing TOP services, it is expected that people from provinces around the country would come to the province for the services. For this reason respondents were asked from which province they came. Contrary to the assumption above, 91% (n = 42) of the respondents who had back-street abortion and 96% (n = 101) of the respondents who had miscarriage came from Gauteng. The rest of the respondents were from Mpumalanga, Eastern Cape and Kwa-Zulu Natal provinces.

151 women were interviewed. Of these 46 admitted to having induced abortions illegally using back–street methods. The next section explores why were the pregnancies unwanted.

4.3 Unwanted pregnancy

In examining the unwanted pregnancies, it is proper to first look at contraception use, socio-economic status, socio-emotional status and decision making patterns with regards to abortion. Discussed is initially the question whether the women in this sample wanted to get pregnant or not.

4.3.1 Trying to get pregnant

Respondents were asked if they were trying to get pregnant. A total of 46 said yes and 59 said they were not trying to get pregnant. When comparing the two groups, it was found that fewer of the abortion group wanted to be pregnant.

Table 1: Have you been trying to get pregnant?

	Back-street abortion	**Spontaneous abortion**	**Total**
Count	10	59	69
% within have you been trying to get pregnant?	14.5%	85.5%	100.0%
% within two groups	25.0%	67.0%	53.9%
Count	30	59	59
% within have you been trying to get pregnant?	50.8%	85.5%	100.00%
% within two groups	75.0%	67.0%	46.1%
TOTAL	40	88	128
% within have you been trying to get pregnant?	31.3%	68.8%	100.0%
% within two groups	100.0%	100.0%	100.0%
Chi – Square = 19.565	**P < 0.005**		

Table 1 above shows the comparison of the two groups in relation to wanting to be pregnant. A cross-tabulation revealed a positive relationship saying that the spontaneous abortion group were more likely to have been trying to get pregnant than the back-street abortion group.

It would be expected that if a woman does not want to be pregnant, she would take preventative measures to ensure that it does not happen. If they did not want to be pregnant, let us see if they used contraceptives.

4.3.2 Contraceptive use

As mentioned in the literature, contraceptives play an important role in preventing unwanted pregnancy. In addition, as discovered in the data, women use contraceptives, but for some reason, these contraceptives fail. Next is a discussion on how many women in the sample used contraceptives and what methods they used.

Contraceptive use was found to be low. A mere 24% of all the respondents had been using some form of contraception and of those who were using contraception, a majority were on pills. Other forms of contraceptives used were the rope tied around the waist and quinine. A majority of the respondents were using conventional methods of contraception.

Table 2: Form of contraceptives used

	Back-street abortion		**Spontaneous abortion**		**Total**	
Form of contraceptive	**n**	**%**	**n**	**%**	**n**	**%**
Mini pill	3	8.1	2	5.4	**5**	**13**
Combined pill	6	16.2	13	35.1	**19**	**51**
Injection	2	5.4	3	8.1	**5**	**13**
Condom	3	8.1	2	5.4	**5**	**13**
IUD			1	3.0	**1**	**3**
Total using conventional methods	**14**	**37.8**	**21**	**57**	**35**	**93**

	Back-street abortion		**Spontaneous abortion**		**Total**	
Other (rope and quinine)	2	5.4			**2**	**5**
Total using traditional methods	2	5.4			**2**	**5**
Total	**16**	**43.0**	**21**	**57.0**	**37**	**100.0**

Twenty-one respondents from the spontaneous abortion group were on contraceptive. This means that they did not want to become pregnant. It is, therefore, possible that these women actually induced the miscarriage using illegal back-street methods but did not want to disclose to the investigator.

For condoms to be effective, it needs to be used rigorously during all sexual activities, without fail. Since we are living in the era of HIV/AIDS, condoms are the safer method of preventing unwanted pregnancies and sexually transmitted diseases. This is not to assume that they do not fail since they are known to break during intercourse.

Some respondents were not using any form of contraception. Although these respondents did not want to fall pregnant they nonetheless had unprotected sexual intercourse. There could be many factors contributing to this state of affairs. As discussed in the literature, women are raped, or they are forced to have sex with men in powerful positions. This was not explored in this study; one can only assume that some women had forced sex.

In case 42 (appendix A), a 25 year old respondent from an informal settlement in Johannesburg was using quinine as a contraceptive. Even though quinine has been used for centuries, it has never been scientifically proven as effective.

Should women have unprotected sexual intercourse, emergency contraceptives could be used to prevent pregnancy. Unfortunately, women do not know about this form of contraception. In this study, only one woman knew about emergency contraceptive pills and for reasons not explored, she did not use them.

4.3.3 Socio - economic issues

Discussed next is the likelihood that the pregnancy would be unwanted in relation to socio-economic issues. The two issues discussed are the employment status of the respondents and their education level.

(a) Employment

It was learned that the spontaneous abortion group was likely to been more employed than the group of women who aborted by using back-street services. More than half (67%) of the spontaneous abortion group were employed as compared to 33% of the back-street abortion group who were employed.

Table 3: Employment status of respondents

	Back-street abortion		Spontaneous abortion		Total	
Variable	**N**	**%**	**n**	**%**	**n**	**%**
Respondents who are employed	14	33	29	67	**43**	**100**
Respondents who are unemployed	32	30	74	70	**106**	**100**

Since most of the women who had back-street abortions were unemployed, it is proper to look at their educational qualifications to see if the employment status is a result of low education qualification. Education qualification of the respondents is discussed next.

(b) Education

The respondents in this study had low levels of education. Most of them (65% for the back-street group and 79% for the spontaneous abortion group) had secondary education as their highest standard completed. Even though the spontaneous abortion group had a slightly higher number of respondents with secondary and tertiary education qualifications, the numbers were still significantly low. Only three respondents from the back-street abortion group and ten from the spontaneous abortion group respectively, had tertiary qualifications. In running the cross-tabulations, it was found that there was no significant relationship between the two groups and the level of education.

Table 4: Education qualification

	Back-street abortion	**Spontaneous abortion**	**Total**
Count	13	12	25
% within primary level	52.0%	48.0%	100.0%
% within two groups	28.3%	11.4%	16.6%
Count	30	83	113
% within secondary level to matric	50.8%	73.5%	100.00%
% within two groups	75.0%	79.0%	74.8%
Count	3	10	151
% within tertiary	23.1%	76.9%	100.0%
% within two groups	100.0%	9.5%	100.0%
Total	46	105	151
% within education	30.5%	69.5%	100%
% within two groups	100.0%	100.0%	100.0%
Chi – Square = 6.6265	**P = 0.036**		

In addition to socio-economic issues, it was found that socio emotional issues were also related to whether the pregnancy was considered unwanted or not.

4.3.4 Socio-emotional issues

Most respondents who had abortion were single, unemployed and had low educational qualifications. This is a possible contributory factor to the pregnancy being unwanted. Unwanted pregnancies are also related to socio-emotional issues. These include the respondent's marital status, the number and age of children.

(a) Marital status

The majority of the respondents were single (59%) followed by the married or cohabiting category at 41%. These results concur with the study on the Epidemiology of incomplete abortion in South Africa done by Rees *et al* (1997: 434) who found that 66.8% of their respondents were single followed by 29.4% who were married. Because the respondents were mostly single, it is understandable why they considered their pregnancies to be unwanted.

Table 5: Marital status

	Back-street abortion		Spontaneous abortion		Total	
Marital Status	**n**	**%**	**n**	**%**	**n**	**%**
Single	28	60	61	58	89	59
Married/cohabiting	18	40	43	41	61	41
Total	**46**	**100**	**104**	**100**	**150**	**100**

The women who were single were also mostly unemployed. Even the women who were married had a low employment rate. It can, therefore, be assumed that the fact that the majority of the women who opted for back-street abortions were unemployed and that many of them were also single, could have played a role in their pregnancy being unwanted.

(b) Number of children

The number of living children, women already have, play a role in their decision whether they should have another child or not. A majority of the respondents (74%) who had back-street abortion, already had children. The number of children of the respondents ranged between one to nine children. A majority of them had either no children or one child (13 respondents).

The spontaneous abortion group on the other hand, had slightly fewer children than the back-street abortion group.

Table 6: Number of children

Number of children	Back-street abortion		Spontaneous abortion		Total	
	n	**%**	**n**	**%**	**n**	**%**
No children	13	28.3	34	32.4	**47**	**31.1**
1 child	13	28.3	38	36.2	**51**	**33.8**
2 children	5	10.9	20	19.0	**25**	**16.6**
3 children and more	15	32.6	13	12.4	**28**	**18.5**
Total	**46**	**100**	**105**	**100**	**151**	**100**
Chi – squire = 9.120			**p = 0.028**			

On running the cross-tabulation of the two groups and the number of children they have, it was found that the back-street abortion group were more likely to have a significantly higher number of children than the spontaneous abortion group.

A 45 year old respondent gave the following account of why she did not want more children.

> ***CASE 6: 45 years old women from Orlando, Soweto***
> *"I'm old and cannot afford to have more children. He [boyfriend] was right we could not have another child. The first two [children] are not his. It's a load".*

Another factor leading to women not wanting more children is as described by this respondent.

> ***CASE 22: 35 years old from Diepkloof, Soweto***
> *"I have four children and the youngest is 10 months old. The father wants more children, you know how Zulu men are, and I've had enough…"*

Since the women who had back-street abortions were likely to have more children, it was also necessary to analyse the average age of their children as this has an impact on their economic state.

(c) Age of youngest child

Of those respondents who already had children, the mean age of the youngest child was 4.39 (for the back-street abortion group) and 5.64 (for the spontaneous abortion group). The median age of the youngest child for both sample groups was four. Clearly the spontaneous abortion group had older children.

Table 7: Age of the youngest child of the respondents

Age of young child	Back-street abortion	Spontaneous abortion
Mean	4.39	5.64
Median	4.0	4.0
Mode	0	0
Range	0 – 13	0 – 19

Below are examples of some of the reasons why women did not want additional children. Age, unemployment and having other children were common reasons given for not wanting more children.

In some cases being employed did not mean that a woman will be able to support an unplanned child. This 28 year old respondent gave her account:

CASE 13: 28 years old from Orange Farm, Soweto

"The kind of work I do doesn't pay me enough to be able to support two kids. My boyfriend is around but not full time, you know how men are..."

Emotional situations, as discussed above, show that women may not have been coping, hence the decision to terminate their pregnancy. They were single, placing a strain on them being the sole provider for their children. They also had a lot of children they were supporting. Note should however be made that the number of children a women has does not solely lead to the inability to feed or care for them. Additional factors, as discussed above, such as employment and marital status also play a role. The decision to terminate the pregnancy using illegal services is explored next.

4.4 Decision making with regard to abortion

For many women, having an abortion is a lonely experience. Mostly because of the stigma still attached to it. To determine the level of stigma attached to abortion, women were asked if they discussed abortion with anybody including the level of support by the fathers.

4.4.1 Discussing abortion

In contemplating abortion, respondents received support from a variety of people. Half of the respondents (53%) said that they discussed abortion with someone. Another 47% said they did not discuss abortion with anyone. It is assumed that the people that women discussed abortion with encouraged them to use back-street abortion. These people could have done this not knowing that abortion is legal in South Africa.

Table 8: Number of women who discussed abortion

	n	%
Women who discussed abortion	23	53
Women who did not discuss abortion	20	47
Total	**43**	**100**

People who encouraged women to use back-street abortions were of varied relations to them but were mostly the women's sisters. The other people whom the women spoke to concerning abortion were husbands, boyfriends, mothers, nurses, doctors, relatives and a friend.

Table 9: People women discussed abortion with

	n	%
Husband	2	8.0
Boyfriend	3	12.0
Mother	3	12.0
Sister	6	24.0
Nurse	1	4.0
Doctor	2	8.0
Female relative	1	4.0
Male relative	2	8.0
Friend	1	4.0
Someone known in the community	2	8.0
Traditional healer	2	8.0
Total	**25**	**100.0**

Of the 25 respondents who discussed abortion with other people only two were told about the CTOP act. In cross-tabulating these variables, it was found that the two people who told the respondents about the Act were doctors. This translates to the rest of the people who discussed abortion with the respondents, being people who are not medical professionals and therefore uninformed about the Act. It is not surprising that they would advice and / or promote back-street abortion.

The father of the child is conventionally supposed to be more involved to any decision made about the pregnancy than friends, relatives and health care workers. The next section looks at the level of support women got from fathers.

4.4.2 Support from fathers

The respondents from both groups were asked if their partners knew about the pregnancies. A majority of them (74.2%) said their partners knew about the pregnancy.

They were subsequently asked about the father's reaction to the pregnancy. A small percentage of the fathers were found to play an active role in situations were women find themselves with unwanted pregnancies. A significant relationship was found between the partner's reaction to the pregnancy and the fact that the women aborted using back-street methods. The respondents, whose partners reacted negatively, were found to be more likely to have had a back- street abortion.

Even though some respondents were told to abort, clearly most partners (of those who knew about the pregnancy) were in favour of the pregnancy; this rules them out as a significant reason why women define their pregnancies as unwanted.

Decision making with regard to abortion was, as seen above, encouraged by people who are close to the respondent. The lack of support by the fathers was not helping the situation. After establishing that these 46 women did not have adequate support from the fathers, also established is that relatives, doctors and friends encouraged the abortion. Next, their knowledge of the legal ways of abortion is examined.

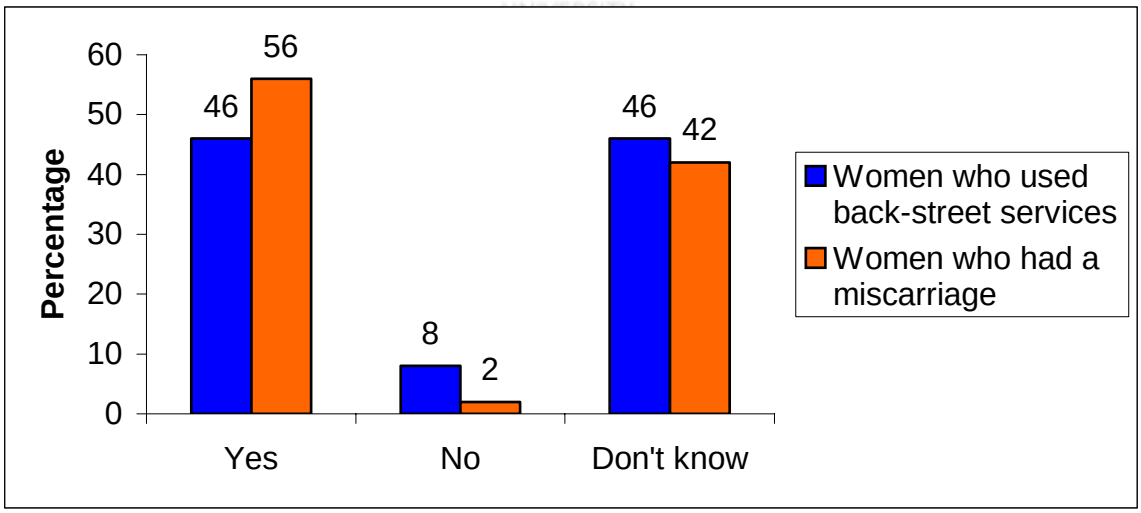
4.5 Choice on Termination of Pregnancy Act

The aim of this section is to determine the respondents' knowledge of the existence of the Choice on Termination of Pregnancy (CTOP) Act and find out why they did not use the legal services.

4.5.1 Knowledge of the CTOP Act

Figure 2 below shows a distinction between women who used back-street abortion services and women who had a spontaneous miscarriage concerning their knowledge of the Choice on Termination of Pregnancy Act. It clearly reveals that women who had a miscarriage knew about the Act more than the other group did. Forty-six percent (n = 21) of the women who had back-street abortion said they did not know if the law allows / permits abortion. Only 46% (n = 21 respondents) said that they knew about the law. This percentage is disappointing since, at the time of data collection for this study (year 2000), the Act had been active for four years. More disappointing is the 8% (four respondents) who confidently said that the law does not allow abortion, meaning they do not know that abortion is legal in South Africa.

Figure 2: Knowledge of the CTOP Act



4.5.2 Content of the CTOP Act

The respondents' knowledge was further assessed by asking them about the content of the law. They were asked: what are the reasons in the law that allow a woman to have an abortion? Even though 47% of the respondents who had back-street abortion knew about the law, only 37% knew that abortion was obtainable on request. Of the 56% of the respondents who had a spontaneous abortion, a low 39% knew that it is obtainable on request. This further confirms the lack concerning knowledge of the CTOP Act.

4.5.3 Reasons for not accessing legal TOP services?

As mentioned above, there were some women who knew that abortion or termination of pregnancy was available legally for free. Nonetheless these women chose to use back-street services. This section gives an account of reasons why.

Respondents who knew about the law and still made used of back-street abortion services were asked reasons for not using the available legal services. A total of 19 respondents answered this question and most of them said they expected staff at the public health facilities to be rude.

Some women said they did not access a TOP clinic because they did not now which facility offers the service. This woman from Zola (Soweto) expressed her reason by saying "… those bitches at hospital are always difficult to deal with. They think they know. They think they are better than us"

The other reasons respondents gave for not using legal services are given in Table 10. Only 14 of the 21 respondents who knew about the Act said they knew of a hospital or clinic that provided Termination of Pregnancy (TOP) services.

Table 10: Reasons for not using legal TOP services

	n	%
Expected staff at clinic/hospital to be rude	8	42
Was afraid people will find out she is procuring an abortion	5	25
She was more than 12 weeks pregnant	2	11
Know of somebody's experience	2	11
TOP waiting list was long	2	11
Total	**19**	**100**

The following 22 year old woman from Soweto knew that she could legally procure an abortion at the Chris Hani Baragwanath hospital but …

> **CASE 3:** 27 years old from Slovo Park, Soweto
> She did not go to the hospital because *"hospitals are a hustle".* She did not use the legal services at Chris Hani Baragwanath because she expected staff to be rude.

There is a common belief that health care workers at the family planning clinics and ante natal care units at public health facilities tend to chastise young girls for engaging in sex at a tender age. Young girls therefore avoid using these services as is evident in case 8:

> **CASE 8**: 17 years old from Johannesburg
>
> *"I didn't go to the hospital because I'm young and the nurses were going to look at me in a funny way. I was afraid they were going to insult me."*

A teenager (17 years old) from Mzimkulu (Eastern Cape province) knew about the CTOP Act and that it allows women to have a TOP on request, but did not

know up to what gestational stage can it be offered. She did not know of a hospital that offered termination of pregnancies and did not look for one because she did not want people to know she was pregnant (avoiding stigma). She therefore went to Gauteng where she drank Dutch medicine called Harlamans and ended up in hospital for haemorrhage endangering her life.

Late after application:

Termination of pregnancy can be performed in designated health facilities before or at 12 weeks of gestation. A few facilities have been designated to terminate up to 20 weeks. At times women decide early to terminate, but because they consult the wrong facility, and therefore end up being refereed from one provider to the other. This then leads to them being late. For example a 25 year old woman went to a doctor in Mamelodi and told him/her she does not want a child. The doctor referred her to Mamelodi clinic where they referred her to Mabopane clinic. In Mabopane they told her they don't do TOP to people who are three months pregnant. Another example:

> **Case 29:** 41 years old from Soweto
>
> *"I went to Chiawelo [clinic] and was referred to Bara [Chris Hani Baragwanath hospital] because I was late. When I got to Bara there was a long queue. I went back home then came back the following day in the morning. I thought they will do me immediately because I was late but they gave me an appointment to come back two weeks later. They said the register was full. I begged and begged but they refused."*

Stigma:

Abortion has had stigma for centuries. The legalisation of it did not de-stigmatise it. Women who knew about the legal TOP did "not go to hospital because [I] was afraid people will find out" (a 25 year old from Naturena (Johannesburg).

Access to a safe termination of pregnancy is as can be seen above, threatened by stigma, being late in pregnancy and rude staff. Discussed next are the respondent's responses to the question "why did they not use available services".

Respondents did not know about the CTOP act and those who knew about it avoided going there because of stigma and anticipated bad treatment. Next we need to understand who the role players are, that is who assisted the women to terminate their pregnancies using back-street methods.

4.6 Back–street abortion

Against the background of the reasons why the respondents turned to back-street abortion, it is important to discuss how these abortions were done and who the role-players were, i.e. the people who assisted the women in procuring an abortion.

4.6.1 Methods of inducing back-street abortions and role-players

Most respondents induced the abortions themselves using a variety of homemade concoctions. Health care practitioners such as general practitioners and nurses were also found to be involved in helping to women induce the termination of their pregnancies. Of the 46 respondents, five said that something was inserted into the vagina to induce bleeding. In order to obtain a back-street abortion, 18 women paid between R5.78 and R400. Two women used a medical aid card to pay doctors.

(a) General practitioners and nurses

One would expect health professionals not to be involved in back-street abortion practices. The investigator assumes that since at the time of data collection most health facilities had not trained staff on the approved TOP methods, that health workers did not know the correct procedures, hence they used the old dangerous methods.

The respondents in this study revealed that doctors and nurses assisted them in procuring an abortion outside designated settings. All but one gave women tablets to either take orally or insert into the vagina. Three kinds of tablets were given to women. These were Misoprostol, Ovrals and Gyno. The doses prescribed were consistent among practitioners. The one doctor who did not give or prescribe a tablet, inserted a “hard needle” in the respondents vagina.

The volumes taken by women were as follows:

- Four Misoprostol
- Ten ovrals
- 3 Gyno tables [not sure of the spelling] in white box

The amounts paid for the back-street abortion service provided by GPs and nurses ranged between R150.00 to R300.00. Medical aids were also used to pay for these abortions.

(b) Pharmacists

Pharmacists were found to dispense Misoprostol tablets to some of the women at a cost ranging between R80.00 to R150.00. There was no consistency in terms of number of tablets given. It is not clear from the CTOP Act what the pharmacist role is in assisting in the provision of the TOP service.

(c) Traditional healers and priests

The old methods of inducing an abortion are still used by some members of the community. Some of the respondents said that they were assisted by traditional healers and paid between R80.00 and R400.00 or their services. One woman said a priest assisted her in terminating her pregnancy:

Case 4: 20 years old, from Kagiso (Soweto)

"Our priest is a healer. He helps with all illnesses. When my mother found out [I was pregnant] from my sister she took me straight to him (Priest)". She got the "bitter traditional medicine" from the church to drink and the priest douched some into her vagina. She paid R100.00 for the abortion after discussing it with her mother.

(d) Closer to home

Some of the respondents mentioned that relatives (siblings and mothers) gave them concoctions to drink. These included traditional medicines, Dutch medicines and tablets.

The following are some of the concoctions given to the respondents:

- Traditional medicines
- Glass of something that look like dirty water and tasted like alcohol
- Dutch medicine (Harlamans) and milk
- 6 tablets from mother. Does not know the name
- Dutch medicine
- 6 tablets (does not know the name)
- Tablets taken over a week

One of the respondent's friends suggested traditional medication, which was obtained from an old woman in the neighbourhood. This traditional medicine cost R300.00.

(e) Partners

Some women were told by their partners to abort the foetus and in some cases, assisted the woman in terminating the pregnancy. Partners mostly gave or suggested to the woman to use contraceptive pills to abort. One respondent said her partner inserted a "stick" into her vagina:

Case 11: 33 years old from Orange farm (Johannesburg)

"I want a baby with all my heart. My boyfriend said he doesn't have money for a child and that I'm trying to hold him down with a child (blackmail him to stay in the relationship). I told him again and again that I will not need his help but he said I want to trick him. We fought until I gave up. He inserted a pencil under me (vaginally), and said I will thank him. He poked until I started bleeding. I have never been in so much pain".

(f) Self-induction

As already mentioned above, most respondents induced the abortion themselves at home. Like in the case with the assistance of relatives, they used homemade concoctions and medication obtained over the counter. They spent the least amount of money (R5.78 to R25.00) in comparison with abortions procured from other people (e.g. health professionals). The medication included vinegar, Dutch medicines, laxatives, alwyn, essence of life, quinine, methylamine spirit, mixture of tablets and traditional medicines.

The following is a list of medication taken by respondents to procure an abortion at home:

- Vinegar, Dutch, salt, sugar
- Dutch (Harlamans), milk
- Essence of life and Brokoon
- Laxative (brooklax * 2) (laxative)
- 2 packets brooklax (laxative)
- Alwyn (transparent bitter stone) with olive oil.
- White contraceptive pills
- Two bottles of Quinine
- Packet of ovrals
- 10 ovrals
- Cup of methylamine spirit
- Dutch medicine
- Castor oil (laxative)
- Vinegar, tartaric, 10 oral contraceptives and laxatives
- Mixture of tables
- Traditional medicine from ‘muti’ shop

Clearly a wide range of people believe that back-street abortions work. Because these women ended up in hospitals it shows that these methods are not only ineffective, but also dangerous.

4.7 Chapter summary

Back-street abortions still occur in South Africa. In this study we found that in Gauteng province, women resorted to back-street abortion on finding themselves with unwanted pregnancies. Factors leading to unwanted pregnancies were low inter alia economic status and unstable socio-emotional situations.

Women discussed abortion with other people and received support for obtaining an illegal abortion from relatives and friends. The majority of the women themselves and the people who helped them to abort the foetus did not know about the CTOP Act. The few who did know about the law, did not access it for fear of experiencing the rudeness of the staff at public health facilities and avoiding stigma attached to abortion.

Education and friendly services are a solution to both proper contraceptive use to prevent unwanted pregnancies and gaining access to safe legal abortions.

In the last chapter of this mini-dissertation a summary of the discussion of the results will be given and recommendations for future research will be made.

CHAPTER FIVE:
DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

The aim of this study was to investigate why women in Gauteng province still use back-street methods to terminate unwanted pregnancies. The main research questions asked were: (a) why was the pregnancy unwanted, (b) why did these women resort to back-street abortion? and (c) who were role players in assisting these women in terminating the pregnancy? During the two months' fieldwork period at the four public health facilities, 151 women consented to be interviewed. Of these, 46 admitted to have taken something orally or inserted objects in the vagina to induce abortion. In the previous chapter the results of the data collected from the 46 women who terminated their pregnancies using back-street methods and the 105 women who had a spontaneous abortion, is presented. In this chapter a discussion of the results of the study will be given.

5.2 Biographical information

Biographically; age, race and province were discussed. The respondents were mostly of reproductive age. Sixty nine percent (69%) of them were young adults. They were also mostly Black. This is understandable considering that the health facilities visited were located in or at the entrance of Black people's townships. There seemed to be no signs of migration to Gauteng province for health services as an overwhelming majority of the respondents were from this province.

5.3 Unwanted pregnancies

As discussed in the previous chapter, respondents were asked if they were trying to get pregnant. A total of 46 said yes and 59 said they were not trying to get pregnant. It was then understandable when it was found that fewer of the back-street abortion group wanted to be pregnant.

Contraceptives have been freely available in South Africa for decades, but some women are still ill–informed about them. Something is not done right. The problem could be either in the education campaign or service rendering plans. The programme implementers need to urgently review the way they have been running the campaign. A few surprises were found in relation to contraceptive use. Just over 40% of the respondents were not using any form of contraception but said they did not want or were not planning to be pregnant and 13.8% were on contraception but were trying to get pregnant. Clearly education on contraceptives and contraceptive use needs to be emphasised.

Also found was the lack of knowledge of emergency contraceptive. After unprotected sexual intercourse, emergency contraceptives are the best way of preventing unwanted pregnancies. Unfortunately, the majority of the respondents did not know about these contraceptives. Only one respondent knew about the EC and did not use them for reasons not established in this study.

5.3.1 Socio-emotional issues

The women in the sample were an exception to the rule, they were single. Of the few who were married it was found that they did not trust their partners in providing them with financial and emotional support.

Also found was the fact that the back-street abortion group were more likely to have a significantly high number of children than the spontaneous abortion group.

5.3.2 Decision making with regard to abortion

Discussed in this section was the persons with which respondents discussed the abortion and the support given by the fathers of the children. It was found that women discussed with their sisters, husbands, boyfriends, mothers, nurses, doctors, relatives and a friend.

A majority of partners knew about the pregnancies (both aborted and spontaneously lost). Their negative reaction to the pregnancy showed a positive link to women deciding to terminate their pregnancy.

5.4 Choice on Termination of Pregnancy Act

This study found that women did not know about the availability of legal termination of pregnancy in public health facilities. A few who did know about the Act, did not use the services mainly because of fear of the negative reaction of health care workers. This is exacerbated by the stigma that still surrounds abortion.

The major factor contributing to women opting for abortion is their lack of knowledge of the South African legislation concerning abortion.

Discovered in this study is the fact that health care workers at public health facilities ill-treat patients and clients. The unfriendliness of the health workers at public health care facilities contributes to people avoiding its use.

Other reasons for not using legal services were the fact that some women reported that they were informed that the services were fully booked. Some women were turned away because the list of women for termination of pregnancy services were fully booked (see attached summary of cases). Some were given dates that would lead them to be in the second trimester by the time it comes. This shows that the public health services are overcrowded. More health care workers need to be trained to provide the service and those with conscientious objection should be trained to enable them to treat women with dignity and refer them to providing health facilities.

5.5 Back-street abortion

Most of the women induced the abortion themselves. This finding indicates the importance of educating women with regard to contraception and the health care facilities available to them. The non-medical people who assisted them (friends, boyfriends / partners, relatives and traditional healers), also need to be involved in the intervention of eradicating this life threatening phenomenon. These people were found to play an active role in assisting women in terminating their pregnancies illegally and using back-street services. The respondents', relatives, friends and partners used objects and medication found at home or over the counter such as contraceptive tablets, detergents, pencils and quinine. These methods cost anything up to R80.00. Traditional healers also played an unavoidable role. They gave respondents traditional medicine mostly to be taken orally. Their service cost between R80.00 and R400.00.

Health care workers are not supposed to be involved in illegal abortion practices. Why would people in the medical fraternity be involved in assisting women endanger their lives? This may be a question answered to be explored by another study focusing on this dimension of abortion.

5.6 Recommendations for future research

Given the realities, it becomes apparent that the South African government must take urgent actions: priority must be given to providing contraceptives where these are not easily accessed and improving accessibility where inadequate. Government needs to maintain the high quality of contraceptive and abortion services. Increased political will is clearly needed if the many existing barriers to continuous and effective contraceptive use are to be lowered or removed. But if the availability of contraception methods and legal abortions are to be expanded, support is needed from both the private and public health sectors.

Policy options

- Provide comprehensive sexuality and family life education
- Improve access to contraceptive services
- Improve access to safe abortion services
- Improve access to all reproductive health care services for relatively disadvantaged groups
- Improve socio-economic conditions of disadvantaged groups
- Investigate factors that contribute to high levels of unplanned pregnancies

5.6.1 Policy makers should vigorously educate about contraception and contraceptive use.

Most women had induced themselves using medications such as Dutch medicine, Quinine, contraceptive tablets and laxatives purchased from the chemist. Some women did not use contraceptives and those that did clearly did not use it correctly since they ended up being pregnant. Programmes should be put in place where women are properly educated about these methods. Health workers, in conjunction with the women, should find methods that suit women's health and life style.

5.6.2 Health education with special emphasis on reproductive health to women would improve women's knowledge of the dangers they put themselves in when using dangerous methods to abort.

Eight point seven percent of boyfriends/husbands were involved in helping women induce abortions. One inserted a catheter up his girlfriend's vagina and the rest used contraceptive pills. Only one traditional healer used a mechanical method, the others gave women medication to drink, to douche and to emesis (gabha). Methods of back-street abortions are less mechanical but could still be fatal.

5.6.3 Involvement of the community at large, especially men and traditional healers, in the education on reproductive health will also help brake barriers to accessing TOP.

It is impossible to escape the conclusion that some of these women were fortunate in being able to achieve their goals to easily abort. They might have resorted to other measures if they had been unsuccessful. Only a minority sought formal help – whether from a traditional healer or health worker. Relatives, sister or mother, also helped to induce abortions using medication found at home.

The traditional healers and "gogos" (grannies) in the neighbourhood who are known to "master" this unsafe method should be involved and educated about the CTOP Act. Basically the whole community should be educated about this life saving method of terminating an unwanted pregnancy. This would cover the relatives, sisters and mothers who assisted women in this study.

5.6.4 People generally prefer the privacy of a private practitioner. Trained and designated private health practitioners will alleviate situations mentioned above. This could be coupled with a set amount to be paid for private services to avoid the financial exploitation of the clients.

Most of the back-street abortions are not preventable because women have a first line strategy of using ways that have always been used in their communities even though they know they can go to the hospital for the services. Since people more and more prefer the use of private services and also because of a stigma still attached to abortion, registered general practitioners and midwives should be trained and licensed to provide the TOP service.

Stringent steps should be taken to punish and or deter health workers who risk women's lives, like the one who inserted a 'hard needle' into a woman's vagina and charged her R300.

5.7 Conclusion

Unplanned pregnancies are a worldwide phenomenon. They are welcomed if a woman is in a stable relationship and financially stable. But, as seen in this mini-dissertation, they become unwanted if the woman is unemployed and have other children to support. Being in an unsteady relationship and single is another contributory factor to unwanted pregnancy. With these factors, women then consider abortion as a way out.

In 1996 the South African government passed legislation which allowed women to terminate pregnancy in a safe and legal environment. Unfortunately, women do not know about this law. Therefore, back-street abortions still occur. Women induce themselves or get assistance from mothers, sisters, traditional healers, pharmacists, nurses and doctors. The three major contributing factors to women

resorting to back-street abortions are the lack of knowledge of the fact that abortion is legal in South Africa, the non-use or incorrect use of contraceptives and the inaccessibility of legal abortion facilities. The latter two factors can be tackled together since they both fall under the umbrella of reproductive health. Even though no woman died during the data collection for this study, it is a known fact that they do.

Even though this was a small scale study, I hope that it shared some light on some of the contributory factors as to why do women still resort to back-street abortion.

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APPENDIX A - The qualitative data of the women's stories

CASE 1: QUESTIONNAIRE 13 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 27 DECEMBER 2000

The respondent was 23 years old from Orlando (Soweto). Her highest standard of school was between standard six and nine. She was single and unemployed. In the past week before the interview she had read a newspaper and watched television. She has one child who is four years old. She has never been hospitalised for loss of a pregnancy and has never had an unwanted pregnancy.

She missed two periods before she found out she was pregnant. She found out about her pregnancy early in December 2000, her last period was in October 2000. She did not want to be pregnant and therefore was using a mini pill as a form of contraception. She did not know about the emergency contraception.

She started bleeding on the 26th of December 2000, was relieved and did nothing to stop the bleeding. She took a bottle of quinine (50ml) for which she paid approximately R20.00. She was not familiar with the Misoprostol tablet. She did not discuss abortion with anyone. She was not willing to discuss in detail what really happened she said, " I just had to do it".

She did not know about the Choice on Termination of Pregnancy (CTOP) Act. No one knew about her pregnancy including the father of the child.

CASE 2: QUESTIONNAIRE 14 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 27 DECEMBER 2000

The respondent was 17 years old from Dobsonville (Soweto). Her highest standard passed was between standard six and nine. She was single and unemployed. In the week before the interview she had read a newspaper and watched television. She does not have children. She has never been hospitalised for a loss of a pregnancy and has never had an unwanted pregnancy.

She missed one period before she found out she pregnant. Her last menstrual period was on the 24th of October 2000 and she found out about the pregnancy late November 2000. When she discovered she was pregnant she did not want to be pregnant. She was not using any form of contraception and did not know about the emergency contraception.

She started bleeding approximately on the 22nd of December 2000. She was relieved when she started bleeding and did nothing to stop it. She took four Misoprostol tablets orally from the doctor (general practitioner). She did not insert them per vagina. She does not know how much the services were because her sister paid the doctor.

"When I told my sister I was pregnant I was scared and she told me we must tell my mother. She took me to a doctor (can't mention the name). The doctor gave me tablets [Misoprostol] to drink and I was to go see him the following day (25th of December 2000). When I went too see him he was not available. I checked him again yesterday (26th of December 2000) then decided to come here (Chris Hani Baragwanath Hospital) because I was in pain". She did not know about the Choice on Termination of Pregnancy act even the doctor who helped her induce abortion did not tell her.

The father knew about the child and was angry. At the time of the interview, he did not know that she had terminated the pregnancy. No one else except the sister who took her to the doctor knew about the pregnancy.

CASE 3: QUESTIONNAIRE 15 INTERVIEWED AT CHRIS HANI BARAGAWANATH HOSPITAL 27 DECEMBER 2000

The respondent was 27 years old from Slovo Park (Soweto). Her highest standard passed was between six and nine. She was single and employed. She has never read a newspaper in the week before the interview but has watched television. She has one four- year old child. She has never been hospitalised for a loss of a pregnancy. She had once had an unwanted pregnancy and she terminated it back street.

She found out she was pregnant late October 2000 two months after her last period in September 2000. When she realised she was pregnant, she did not want to be and she was using condoms as a form of contraception. She did not know about the emergency contraception.

She started bleeding approximately on the 22nd of December 2000. She was relieved when the bleeding started and did nothing to stop it.

She induced the termination of the pregnancy by drinking a bottle of one of Dutch medicines (she forgot the name) she also drank a bottle a bucket of traditional medicine and then through up (*Ukugabha* in Zulu). She did not take any tablet and did not insert anything PV. She paid R70 for the medication.

“I have never been so scared in my life. I do want a child but not now. I’m not working full time so I will not be able to afford. Man are not reliable. He (the father) didn’t know I was pregnant, I was angry with him. I went to a women who

is a traditional healer and my friend for help". The traditional healer did not mention that she could have a legal abortion I a hospital or clinic.

She knew about the South African law that allows women to have an abortion but she does not know at which stage in the pregnancy can they go to the hospital or clinic for termination of pregnancy (TOP). She knows a woman can have a TOP on request and also that Chris Hani Baragwanath hospital offers TOP. She did not go to the hospital because "hospitals are a hustle". She did not use the legal services at Chris Hani Baragwanath because she expected staff to be rude.

No one else knew about her pregnancy including the father of the child.

CASE 4: QUESTIONNAIRE 16 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL (NOT DATED)

The respondent was 20 years old, living in Kagiso (Soweto) and passed standard ten. She was single and unemployed. In the week before the interview she had read a newspaper and watched television. She does not have children. She has never been hospitalised for a loss of a pregnancy and has never had an unwanted pregnancy.

She found out about her pregnancy in December 2000 a month after her last period, which was late September. She did not want to be pregnant and was using traditional herbs and condoms for contraception. She did not know about emergency contraception.

She started bleeding approximately 5 days before the interview and she was not sure how she felt when it started. She got the "bitter traditional medicine" from the church to drink and the priest douched some into her vagina. She paid R100.00 for the abortion after discussing it with her mother.

“Our priest is a healer. He helps with all illnesses. When my mother found out [I was pregnant] from my sister she took me straight to him (Priest). No one mentioned to her that she could have had a legal abortion at a clinic or hospital. She did not know about the CTOP act.

The father of the child did not know about the pregnancy. Her mother and her sister were only people who knew.

CASE 5: QUESTIONNAIRE 17 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL (NOT DATED)

This respondent was a single, 22 years old women from Soweto. She competed standard 10 and is unemployed. She has read a newspaper and watched television in the week before the interview. She does not have children. She has never been hospitalised for a loss of a pregnancy and has never had an unwanted pregnancy.

Her last menstrual period was in October and she found out about the pregnancy two weeks before the interview. She did not want t be pregnant and was using the mini pill as a form of contraception. She knew about morning after pills (emergency contraception) but did not think about them after having unprotected sex because she was on a pill.

She stated bleeding the day before the interview and was relieved. She took four Misoprostol orally. She got the tablets from a doctor. She used the medial aid to pay so she does not know how did the doctor claim.

“I am doing my first year at the university the last thing I need is a child. I know there is a law but I have a medical aid so I used it. I went to a doctor and she

gave me those tablets (Misoprostol) to take orally. She said I can come to Bara to be cleaned because she does not have cleaning equipment".

The doctor did tell her about the CTOP act. She said that women could have a termination when they are up to three months pregnant. The respondent also mentioned that women can have a TOP on request or when raped. She knew that Baragwanath hospital offers TOP but said "it's easy and private at the doctor's rooms". Her main reasons for not going to Baragwanath hospital were that she expected staff to be rude and was afraid people would find out.

The father of the child knew about her pregnancy and he had told her to abort. He knows that the pregnancy was terminated and no one else knew about the pregnancy.

CASE 6: QUESTIONNAIRE 27 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 20 OCTOBER 2000

The respondent was 45 years old from Orlando (Soweto). She has completed less than a year of schooling. She is single and her means of income is through selling. She has not listened to a radio or watched a television in the week before the interview. She has eight children and the youngest was 5 years old. She has never been hospitalised for a loss of pregnancy and never had an unwanted pregnancy.

She found out her pregnancy on the 24th of September 2000 about two months after her last period in July 2000. She did not want to be pregnant she just forgot to go for her injection. She did not know about emergency contraception. She started bleeding on the19th of October 2000 and was relieved when it happened. She drank quinine and boiled Coke. She did not use Misoprostol or insert

anything PV. She paid approximately R25.00. She discussed abortion with her boyfriend. No one helped her to abort.

"I m old and cannot afford to have more children. He [boyfriend] was right we could not have another child. The first two [children] are not his. It's a load."

She knows about the CTOP act but does not know up to what stage can women request terminations. She said that women could have TOP on request at Bara. She tried to have a termination at Bara but there was a long waiting list and she could not wait for the given date. The person who made her pregnant told her to abort. He knows that the pregnancy is terminated.

CASE 7: QUETIONNIRE 28 IINTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 20 OCTOBER 2000

This respondent did not know her age. We took an approximation that was in her patient file. She is approximately 35 years old. She is from Chiawelo (Soweto) has completed less than a year of schooling. She is married or living with a man and unemployed. In the week before the interview she had never read a newspaper but has watched television. She has four children and the youngest is 12 years old. She has never been hospitalised for a loss of a pregnancy. She has had an unwanted pregnancy but she did nothing she had the baby.

She does not know for sure when she found out about the pregnancy. Her last menstrual period was in September. She did not want to be pregnant and was not using contraception because she is sick; she has ancestral spirits (*amadlozi)*. She did not know about emergency contraception. She started bleeding on the 15th of October 2000 and was relieved when the bleeding started.

She used traditional medicine to terminate her pregnancy. She did not pay for the medication because the person who gave it to her, is her friend. Beside her friend she discussed abortion with her husband. Her friend did not mention the TOP act to her and she did not know about it.

The father of the child knew about the pregnancy and was happy. He did not know about the termination. No one else knew about the pregnancy.

CASE 8: QUESTIONNAIRE 29 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL

The respondent was 17 years old staying in Johannesburg. The highest standard she passed was between six and nine. She was living with a man or married and was employed. In the week before the interview she has never read a newspaper or magazine but has watched television. She has one four years old child. She has never been hospitalised for loss of pregnancy. She has been pregnant when she did not want to be, she did nothing but had the baby.

Her last menstrual period was in September 2000 and she found out about the pregnancy two weeks before the interview. She did not want to be pregnant but was not using any contraception. She did not know about emergency contraception. She started bleeding five days before the interview. She said she was sad when the bleeding started but she initiated it by taking three Misoprostol tablets from the chemist. She had discussed this with a friend. She paid R150.00 for the tablets.

“Was afraid of the nurses at the hospital. Somebody who was also pregnant bought them [Misoprostol] at the chemist. She advised me to also do the same. I went to the chemist and asked for Cytotec tablets and paid R150.00 for all three”.

The respondent knew that the South African law allows women to have an abortion on request. She said women could request TOP up to the second month. She knows that Baragwanath hospital.

“I didn’t go to the hospital because I’m young and the nurses where going to look at me in a funny way. I was afraid they were going to insult me.” She expected the staff to be rude. The person who made her pregnant did not know about the pregnancy.

CASE 9: QUESTIONNAIRE 30 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 25 OCTOBER 2000

The respondent was 25 years old from Soweto and had completed a post school degree or diploma. She was married or living with a man and employed. In the week before the interview, she had read a newspaper or a magazine and watched television. She has one nine years old child. She has never been hospitalised for loss of pregnancy and has never been pregnant when she did not want to.

Her last menstrual period was in August and she found out about her pregnancy one month later in September. She did not want to be pregnant but was not using any form of contraception. She did not know about emergency contraception. She started bleeding on the 24th of October 2000 and felt indifferent about the bleeding. She did not do anything to stop the bleeding. She drank two cups of vinegar mixed with Dutch medicine, sugar and salt. She got these ‘ingredients’ from her cupboard at home.

“I don’t have a story. I just did it. It was the best thing to do”.

She knew about the law and said that women can request TOP up to the third month. She does not know which hospital/s offer TOP services. The father of

the child was happy about the pregnancy and knows now that it has been lost. Her parents where the other people who knew about the pregnancy.

CASE 10: QUESTIONNIARE 31 INTERVIEWED AT KALAFONG HOSPITAL NOVEMBER 2000

The respondent was 40 years old. She was from Mpumalanga in a township called Kangala. Her school level ranged between sub-A and standard 3. She was married or living with a man. She was working. In the past week she has read a newspaper or a magazine and has watched television. She had four children and the youngest was 5 years old. She has never been hospitalised for loss of pregnancy and has never had an unwanted pregnancy.

Her last menstrual period was in September 2000. She realized she was pregnant when she missed her October period. She did not want to be pregnant but was not using contraception. She did not know about emergency contraception.

She started bleeding on the 8th of November 2000 and was relieved when the bleeding started. She was not willing to share what she used to induce abortion. “I just took the thing out OK? I just did it”. She did not discuss aborting with anyone. “I didn’t want the baby so I took it out finish”. She said she did not know about the CTOP act.

She had called the father of the child to tell him about the pregnancy and she is not sure how he felt about it. No else knew.

CASE 11: QUESTIONNAIRE 32 INTERVIEWED IN CHRIS HANI BARAGWANATH HOSPITAL OCTOBER 2000

The respondent was 33 years old from Orange farm (Johannesburg). Her school qualifications range between standard four and standard five. She is single and unemployed. She did not read a newspaper or a magazine in the week before the Interview. She has however watched television. She has one child who is 5 years old. She has never been hospitalised for pregnancy loss and has never had an unwanted pregnancy.

She found out about her pregnancy on the 3/4 October 2000 one month after her last period in August. She wanted the child but the boyfriend did not want it. She started bleeding approximately on the 18th of October 2000. She is not sure how she felt when the bleeding started. She did not do anything to try and stop the bleeding.

The boyfriend inserted a stick/catheter in her vagina.
"I want a baby with all my heart. My boyfriend said he doesn't have money for a child and that I'm trying to hold him down with a child (blackmail him to stay in the relationship). I told him again and again that I won't need his help but he said I want to trick him. We fought until I gave up. He inserted a pencil under me (vaginally), and said I will thank him. He poked until I started bleeding. I have never been in so much pain"

She didn't know about the Choice on Termination of Pregnancy Act "and I wanted the baby".

CASE 12: QUESTIONNAIRE 33 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 23 OCTOBER 2000

The respondent was 17 years old from Mzimkulu (Mtata) in the Eastern Cape. She had come to see her boyfriend in City Deep, Johannesburg. She was still a scholar at secondary level (between standard 6 and 9). She was staying with her mother in Mzimkulu. She did not have a child, has never lost a pregnancy nor has she ever been pregnant when she did not want to.

Her last period was in July 2000, she realized she was pregnant two months later in September. She had first told the interviewer that she wanted to be pregnant but later revealed that she did not want the baby and that she induced the abortion. She was not using contraception to prevent unwanted pregnancy. She admitted to have drunk one bottle of Dutch medicine called Harlamans mixed with 1 cup of milk. She paid R25 for the Harlamans bottle. She did not discuss abortion before she did it.

“I do not want a child, I heard from an old woman long time ago that the Dutch medicines are used for inducing so I did it. I didn’t want to tell any one that I’m aborting”.

She knew that there is the CTOP act that allows women to have a TOP on request, but did not know up to what stage can TOP be offered. She did not know of a hospital that offered terminations. She did not look for it because she did not want people to know she was pregnant. The boyfriend knew she was pregnant and was happy. He also knew that the pregnancy was lost.

CASE 13: QUESTIONNAIRE 34 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL OCTOBER 2000

The respondent was a 28 years old woman from Orange farm in Johannesburg. She had completed standard 10, employed and single. In the week before the interview she had read a newspaper or a magazine and had watched a television. She has one child who is six years old. She has never been hospitalised for losing a pregnancy nor has she had an unwanted pregnancy.

Her last menstrual period was in August 2000 and she realised she was pregnant one month later in September. She did not want to be pregnant and was not on any contraception. She also did not know about emergency contraception. She started bleeding approximately on the 19th of October 2000 and was relieved when it happened. She had induced the bleeding by taking traditional medicines. She paid R150 for the medicine and had discussed the termination of the pregnancy with the boyfriend.

‘”The kind of work I doesn’t pay me enough to be able to support two kids. My boyfriend is around but not full time, you know how man are. I told him I am sick and the doctor said I couldn’t carry a child so I have to abort. He said we should go to the hospital for abortion but I refused because of a friend’s experience. He agreed to go to a sangoma who could do it”.

She knows that there is a CTOP act and that women can request terminations up to three months. According to the respondent, women can have TOP on request and if raped. Terminations of pregnancy are done Chris Hani Baragwanath (Bara) hospital. She did not use this facility because she expected the staff to be rude and her friend had a bad experience:

"A friend of mine went to Bara to have a TOP. She was first told to make an appointment, as she was doing that, they interrogated her about her baby's rights and asked her if the father knows that she wants to kill a child. She went back to Bara because was traumatized. She then found out about this sangoma who does it well. I went to the same sangoma and I don't feel sick its just minor pains which I expected."

The boyfriend knew about the pregnancy and was happy about it until the respondent told her the doctor said she couldn't carry a child. He and the respondent's parents knew about the pregnancy and that it had been terminated.

CASE 14: QUESTIONNAIRE 35 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL NOVEMBER 2000

The respondent was 37 years old from Chiawelo (Soweto). She had passed standard 10 and was married or living with a man. She was unemployed. In the week before the interview she had not read a newspaper or a magazine but had watched television. She had three children with the youngest aged thirteen. She had never been hospitalised because of a loss of a pregnancy neither had she had an unplanned pregnancy.

Her last menstrual period was in September 2000, she realised she was pregnant one month later in October 2000. She did not want to be pregnant and was using condoms as a means of contraception. She did not know about emergency contraception. She started bleeding on the 11th of November 2000 and she was not sure how she felt when she started. She used essence of life and brokoon to induce the abortion. She paid approximately R10 for these medications. She discussed the abortion with her sister-in-law.

“Went to Bara clinic and was told to come back after two weeks”. She couldn’t wait for two weeks because she had to go back home in Venda. “I took essence of life (the whole bottle) but the baby was stubborn. It didn’t want to come out even though I was in pain. I thought of taking Jik (detergent) but couldn’t take the smell. Then I took this medication that works like the essence. It at least helped start the bleeding. When I got to the hospital I begged the doctor to take it out. He told me the baby is there. He asked me if I was sue I said I was very sure. He suggested sterilisation and I said no since I might want to be pregnant again when I win LOTTO. I am happy and relieved that it’s over”. She said that she knew about the CTOP act and that women can have it on request up to 12 weeks. She named Bara as one of the hospitals that offer the services. When she went to request TOP at Bara she was 5 weeks pregnant.

The person who made her pregnant didn’t know about the pregnancy only her relative

CASE 15: QUESTIONNAIRE 36 QUESTIONNAIRE 35 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 17 NOVEMBER 2000

The respondent was 35 years old from Zondi (Soweto). She had only completed primary education (between Sub A and standard 3). She was married or living with a man and unemployed. In the week before the interview she had read a newspaper or a magazine and had watched television. She had three children and the youngest was two years old. She had never been hospitalised for a loss of a pregnancy nor has she had an unwanted pregnancy.

Her last period was in August 2000 and she found out about her pregnancy in September 2000. She initially said she wanted the baby and was sad when the bleeding started, but later changed her story to say that she induced the abortion using tablets she was given by a nurse from the chemist which she took orally.

She was not sure if the tablets she took were Misoprostol (even after I showed her a sample). She paid R80 for the tablets.
She said she "just did not want a baby".

She did not know about the Choice on Termination of Pregnancy act.
The person who made her pregnant knew about the pregnancy and that it was lost. No one else knew about the pregnancy.

She told me a story about a girl she was with when she came to make an appointment, this girl was 16 weeks pregnant. She was turned away and was crying like a baby. She had been given money by the boyfriend to have TOP at the doctor, and she used the money hoping to have a free TOP at the hospital. The respondent wanted to help her but couldn't or was scared to involve herself she said she had her own problems to solve.

CASE 16: QUESTIONNAIRE 37 INTERVIEWED AT KALAFONG HOSPITAL 26 JUNE 2000

The respondent was 21 years old from Hercules Sunset view in Pretoria. She had completed between standard six and nine. She is single and unemployed. She has read a newspaper and watched television in the week before the interview. She has one two years old child. She has never been hospitalised for a loss of a pregnancy nor has she ever been pregnant when she did not want to. Her last menstrual period was on the 29th of April 2000 and she knew about her pregnancy on the 25th of May 2000. She did not want to be pregnant but was not using any form of contraception. She did not know about emergency contraception.

She started bleeding on the 25th of June 2000 and was relieved when it happened. A medical doctor who inserted a "hard needle" into her vagina

induced the bleeding. She paid R300 for the service and had discussed it with her mother.

She did not know about the TOP act. When she found out she was pregnant she told her mother and her boyfriend. The boyfriend did not want the child, he gave her money and told her to abort. She told her mother who also advised to abort. They did not know about the legal services so they went to Dr Madikarata [Boom Street, Pretoria], who inserted a hard needle up her uterus and told her to go. They had heard about the doctor from the people around the neighborhood. He did not tell her what was going to happen or what should she do when the bleeding started. This doctor did not tell her about the available legal services.

CASE 17 QUESTIONNAIRE 39 INTERVIEWED AT KALAFONG HOSPITAL

5 OCTOBER 2000

The respondent was 30 years old from Olivenhoudpotch in Alexander (Johannesburg). She had completed secondary education and was single and unemployed. In the week before the interview she had read a newspaper or a magazine and not watched television. She had two children with the youngest aged four years. She has never been hospitalised for a loss of a pregnancy. She had been pregnant when she did not want to but had the baby.

Her last menstrual period was in May 2000. She realised she was pregnant two months after in July 2000. She used a rope for contraception. She did not know about emergency contraception.

“Came back from meeting with the father of the child [he had denied it was his child]. I was depressed, we had a fight. I told my sister. She asked me if I want to abort. I told her I would do anything not to be pregnant. She gave a glass with something like dirty water. It tasted like alcohol. I drank it when I woke up I was in hospital”.

“I was not really aware that what my sister was giving me was going to induce abortion. Yes I didn’t want the baby but I didn’t want a painful process to take it out. I know a doctor who does it I was going to go to him”

She didn’t know about the Choice on Termination of Pregnancy act.
[I saw the respondent the day before the interview. tried to talk to her but she did not even know her own name. nurses said she had been disoriented since she came in].

CASE 18: QUESTIONNAIRE 40 INTERVIEWED AT KALAFONG HOSPITAL 4 OCTOBER 2000

The respondent was 25 years old from Laudium (Pretoria). She has never been to school, single and is working. She had never read a newspaper or a magazine or watched television in the week before the interview. She has two children her eldest was 11 years old and the youngest 10 years old.
She has never been hospitalised for a loss pregnancy. She has been pregnant when she did not want to but decided to have the baby.

She did not remember her last date of menstruation but said that she was two months pregnant before the termination. She did not want to be pregnant and was using Overall contraceptive pills to prevent pregnancy. She did not know about emergency contraception.
She started bleeding on the 3rd of October 2000 and was relieved when it happened. The pregnancy was terminated with the help of a traditional healer who inserted a stick (which was approximately 9 cm long) inside her. She paid the traditional healer R300 for the services.

She went to a doctor in Mamelodi and told him/her she does not want a child. S/he referred her to Mamelodi clinic where they referred her to Mabopane clinic. In Mabopane they told her they don't do TOP to people who are three months Pregnant. She went to Kalafong hospital and was told the same thing [that they don't do TOP to women who are three months and above]. A nurse in the hospital told her to "make a plan". She told a woman in a taxi about her situation who told her about a woman who does abortions in Marabastad (Pretoria).

She didn't know about the law, she had though that doctors do abortions, she was surprised when the doctor referred her to the hospital.
The boyfriend knew about the pregnancy and had told her to abort.

CASE 19: QUESTIONNAIRE 41 INTERVIEWED AT KALAFONG HOSPITAL 22nd of JUNE 2000

The respondent is 21 years old from Qasha in Lesotho. She had only completed primary school. She is married and unemployed. In the week before the interview she had read a magazine and watched television. She does not have any children. She has never been hospitalised for a loss of a pregnancy nor had she ever had an unwanted pregnancy.

Her last menstrual period was on the 28th of January 2000 and she only realised she was pregnant in May 2000. She initially said she wanted to be pregnant then changed her story.

When she started bleeding five days before the interview she was scared and did not know what to do. She used Dutch medicines to start the bleeding. She had come to her sister in Johannesburg (Lenasia) to terminate her pregnancy. Her sister helped her abort and she did not know about the Choice on Termination of Pregnancy Act.
The person who made her pregnant knew about the child and was happy.

CASE 20: QUESTIONNAIRE 42 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL

21 JUNE 2000

This respondent was 30 years old from White City (Soweto). She had completed secondary school. She was single and unemployed. She had read a newspaper or a magazine and watched television in the week before the interview. She had two children with the youngest aged four. She has never been hospitalised because of a loss of a pregnancy. One of her two children was a result of an unplanned pregnancy.

She found out about the pregnancy in April 2000 and her last menstrual period was on the 29th of May 2000. She did not want to be pregnant and was using the injection for contraception. She did not know about the emergency contraception.

She induced the bleeding by drinking the whole bottle of Harlamans Dutch medicine mixed with milk. She had discussed abortion with her sister. She said that the South African law does no allow women to have an abortion. The husband was happy about the pregnancy because he wants to have more children.

CASE 21 QUESTIONNAIRE 43 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 21 JUNE 2000

The respondent was 16 years from Protea Glen (Soweto). She completed Matric (standard 10), single and not working. In the week before the interview she had read a newspaper and watched television. She does not have children. Her last menstrual period was on the 23rd of March 2000 and she realised she was

pregnant on the 17th of April 2000. She did not want to be pregnant and was on a pill as a contraceptive method. She did not know about emergency contraception.

She was relieved when the bleeding started on the 17th of June 2000. She drank Sta-Soft (fabric softener) after which she vomited. She then ate two laxative tablets to induce the bleeding.

She had heard that women could have TOP at Bara when they are over four months pregnant. She heard that women can terminate when they don't want a child (on request) and in case of rape. She didn't want people to know about her pregnancy including the person who made her pregnant. Her parents were the only one who knew.

CASE 22 QUESTIONNAIRE 44 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 23 JUNE 2000

The respondent was 35 from Diepkloof (Soweto). She had completed primary level school, was staying with a man and selling as a means of income. She had read a newspaper or a magazine and watched television in the week before the interview. She had four children and the youngest was six years old. She had had an unwanted pregnancy before and had the baby.

Her last menstrual period was on the 15th of April 2000. She knew she was pregnant on the 27th of May 2000. She did not want to be pregnant but was not using contraception to prevent pregnancy. She did not know about emergency contraception. She started bleeding on the 22nd of June 2000 and was relieved when it happened. She ate two pkts of brooklux (laxative) to induce the abortion.

"I have four children and the youngest is 10 months old. The father wants more children, you know how Zulu man are I've had enough. When I missed my

periods I knew I was pregnant. I didn't was him to know. I though about this for days until I thought of terminating it. I took two packets of brooklux all at once. I started having cramps two days back and I thought after the baby was out I will be fine but I became sick the I came to Bara".

She did not know about the law and no one knew about her pregnancy.

CASE 23 QUESTIONNAIRE 45 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 20 JUNE 2000

The respondent was 33 years old from Dobsonville (Soweto). She had completed secondary school, was single and not employed. She had been exposed to media (newspaper and television) in the week before the interview. She has two children, the youngest is 9 years old.

She has her last menstrual period on the 20th of March 2000and realised she was pregnant two moths later on the 20th of May 2000. She started bleeding on the 31st of May 2000 and was feeling indifferent/confused when it started. To induce bleeding she drank Alwyn (a transparent bitter stone) with Olive oil.

She did not want t tell her husband about terminating because he was going to bit her up. He knew about the pregnancy and was happy about it.

She did not know about the Choice On Termination of Pregnancy act. And said even if she knew about it the husband would find out if she went to the hospital for TOP.

CASE 26: QUESTIONNAIRE 48 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 26 JUNE 2000

The respondent was 26 years old from Malibu (Pretoria). Her highest standard of school was less than one year completed. She was single and unemployed. She usually listens to radio but has not read a newspaper in the last week. She has a 13-year-old child, had a stillborn once and has never had an unwanted pregnancy.

She missed 2 periods before she new she was pregnant. She found out about the pregnancy in May, her last period was on the 21st of March. She did not want to be pregnant. She was not using any contraception. She did not know about the emergency pill.

She started bleeding on the 26 June 2000. She did not do anything to stop the bleeding. She took 10 overalls to clean stomach and blood. She took something to endue the bleeding. She did not recognize the Misoprostol pill. She discussed the abortion with a nurse.

She did not know about the Choice on Termination of Pregnancy (CTOP) Act.

CASE 27: QUESTIONNAIRE 50 INTERVIEWED AT PHOLOSONG HOSPITAL 11 July 2000

The respondent was 23 years old from Dalpark. The highest standard she passed was a post school degree, certificate or diploma. She was married and unemployed. She usually read newspapers and watched TV. She had no children. She had never been hospitalised for loss of pregnancy or had an unwanted pregnancy.

She first found out she was pregnant on the 7th of July 2000 and did not want the pregnancy. She was not using any contraception and did not know about the emergency pill.

She started bleeding on the 7th of July 2000 and did not do any thing to stop the bleeding. She was relieved. She took traditional medicine to start the bleeding. She had never seen a Misoprostol before. She was helped by a traditional healer and paid R80. She discussed abortion with her sister. Her sister discouraged from going o the hospital, she was afraid people would find out. "When I told my sister I was pregnant they said we should go to a traditional healer because I could not afford to have a baby now. We went there, I agreed because I also felt that I did not want a baby. I new I could go to a hospital but It's a hassle going there and I don't have money for Marie Stopes. She gave me Madison to drink."

She new about the Choice on Termination of Pregnancy Act, and she said that woman can terminate up to 13 weeks on request. The father of the child was happy that she was pregnant and she did not know that she had terminated the pregnancy.

CASE 28: QUESTIONNAIRE 51 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 28 JUNE 2000

The respondent was 25 years old and lived in Newcastle (Durban). She had passed a degree/diploma. She was single and unemployed. She usually watched TV and had read the newspaper in that passed week. She had a 5-year-old child. She has never been hospitalised for loss of pregnancy and has never had an unwanted pregnancy.

Her last menstrual period on 17th of April 2000 and se had missed 1 period before she knew she was pregnant in May. She did not want to be pregnant. She drank 6 tablets of which she did not know the name, with the help of her mother. " I missed 1 period and became worried, did not want to be pregnant. I complained of a head ache, reported to my mother, told her that I had missed a period. She gave me two tablets. I did not know the name. I came sick and bleed a lot, passed big clots and. I stopped bleeding after 2 days. I collapsed My mother gave me salted water with sugar. I became better. I left Newcastle to visit my uncle in JHB. I had headache, went to the doctor who gave me medication. The following day I reported to my Aunt about the pregnant, she took me straight to Bara."

[Was diagnosed as septic ICA perforated in theatre, she does not know about the CTOP. The father of the child did not know about the pregnancy.]

CASE 29: QUESTIONNAIRE 119 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 27 NOVEMER 2000

The respondent was 41 from Slovo Park (Soweto). She lived with a man and was not employed. She was not exposed to media the week before the interview. She had 5 children with the youngest aged 5. She had been hospitalised for loss of pregnancy. Her last menstrual period was in July and she found out about her last pregnancy in August. She did not want to be pregnant was using a mini pill. She started bleeding on the 22nd of November and she felt indifferent when it happened.

She induced the pregnancy by taking a packed of white contraceptives pills. The pills did not look Misoprostol pills. " I went to Chiawelo and was referred to Bara because I was late. When I got to Bara there was a long queue. I went back home then came back the following day in the morning. I though there will do me immediately because I was late but there gave me an appointment to come back two weeks later. They said the register was full. I begged and begged but they

refused. On my way out of Bara I met this lady as we chatted she told me I could use contraceptive pills to abort. I did. It was painful and the bleeding was too much. Nothing came out except blood I came to Bara"

She said she didn't know about the law but she want to Bara and was turned back because she was late.

The father new about the pregnancy and was happy but did not know about the abortion.

CASE 30: QUESTIONNAIRE 117 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 11 NOVEMBER 2000

The respondent was 34 years old from Zola (Soweto). She completed between standard six and nine of school. She was single and had been exposed to media in the week before the interview. She had three children and the youngest was nine years old. She had once had an unwanted pregnancy and aborted at a legal clinic.

Her last menstrual period was in October 2000 and found out about her pregnancy one month later. She did not want to be pregnant but was not using any form of contraception to prevent pregnancy. The bleeding started more than a week before the interview and had induced it by drinking two bottles of quinine. She had paid R5.78 for the bottles.

She knew about the CTOP act. She said that women could have TOP on request up to three months of gestation. She knew Bara offers the service but did not go there because she expected staff to be rude.

“Quinine had been used for years and years and those bitches at hospital are always difficult to deal with. They think they know. They think they are better than us”. The father of the child did not know about the pregnancy.

CASE 31: QUESTIONNAIRE 118 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 29 NOVEMBER 2000

The respondent was 20 years old from Protea (Soweto). She had completed standard 10 and was single. She was working. She had been exposed to media in the week before the interview. She had no children and had never been hospitalised for a loss of a pregnancy. She had had an unwanted pregnancy but lost the child through a miscarriage.

She had been on combined pill for contraception.

She had initially said she did not know she was pregnant till the day before the interview but later said she knew about it two weeks ago. She was not sure when her last period was. She told her sister when she missed her first period. The sister said she could not keep the baby. She did not want to abort because she was scared. The sister gave her tablets to take over a week (orally). She said “it will be a little bit painful but she would have to go the hospital. When I started bleeding heavy I fainted and woke up at doctors place who then referred me to Bara”

She didn’t know about the law and the father of the child did not know about the pregnancy**.**

CASE 32: QUESTIONNAIRE 52 INTERVIEWED AT KALAFONG HOSPITAL 06 JULY 2000

The respondent was 33 years old from Vlaklaagte (Kwa - Ndebele). She had completed between standard six and nine of schooling. She was single and unemployed. She had been exposed to media in the week before the interview. She had three children with the youngest aged seven year old. She had never been hospitalized for a loss of a pregnancy and has never been pregnant when she did not want to be.

Her last menstrual period was on the 14th of June 2000 and she found out about her pregnancy a month before the interview (30 June approximately). She did not want to be pregnant and was on combined pill. She did not know about emergency contraception. She started bleeding on the 24th of June 2000 and when it started she thought she had a "funny period". She induced the bleeding by taking a packet of overalls.

She could never go for an abortion in hospitals because "nurses think they are Gods and they treat people as if they are dogs. A friend had gone to hospital fro TOP and she was told she was even too old to be having sex". She expected staff to be rude.

She knows about the South African law that that allows women to request an abortion but does not know at what stage can they obtain this service. She knows that this service can be obtained at Kalafong hospital.

No body else knew she was pregnant, including the father of the child.

CASE 33: QUESTIONNAIRE 120 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 27 NOVEMBER 2000

The respondent was twenty-two years old from Rockville (Soweto). She had completed secondary education. She was single and unemployed. In the week before the interview she had been exposed to media. She had two children and the youngest was six years old. She had never lost a pregnancy nor been pregnant when she did not want to be.

Her last period was on the 10th of October 2000 and she found out about her pregnancy in November. She did not want to be pregnant and was not using any form of contraception. She did not know about emergency contraception. She used Dutch medicines and traditional medicines from gogo (granny) in the neighborhood for which she paid R300. a friend helped her.

"a friend told me about this gogo who helps with abortions. I went there and she gav me medication to apply in my stomach and to drink"/

She did not know about the CTOP act.
"Couldn't tell my boyfriend because he told me he doesn't want a child with me. He is married. So I had to act fast. A girl I know told me about gogo from around who does abortion. I went to her".

CASE 34: QUESTIONNAIRE 47 INTERVIEWED AT KALAFONG HOSPITAL 29 JUNE 2000

The respondent was 28 years old from Pretoria. She had completed primary education (between Standard 4 and 5). She was employed and married. She had been exposed to media in the week before the interview. She has one eight years old child.

Her last period was on the 30th of April 2000 and she found out about the pregnancy on the 15th of June 2000. She did not want to be pregnant but was not using contraception. She did not know about emergency contraception.

She was relieved when the bleeding started on the 29th of June 2000. She had induced the bleeding by taking a packet of triphasil contraceptive tablets. She had discussed aborting with her husband and a nurse.

"I was not ready to have a child. I went to the clinic and told them and they said they can't help me. My husband then decided we have to do something. I took the whole packet of triphasil".

She did not know about the CTOP act and the nurses at the clinic she went to did not refer her to the relevant facility.

CASE 35: QUESTIONNAIRE 49 INTERVIEWED AT PHOLOSONG HOSPITAL 11 JULY 2000

The respondent was 16 years old from Mtata, she came to Johannesburg on the 15th of June 2000 for school holidays. She was still doing her secondary school (Standard 6 – 9). She was single and unemployed. In the week before this interview she had been exposed to media. She does not have children and has never been pregnant when she did not want to be pregnant.

Her last period was in mid April 2000 and she found out about her pregnancy in June 2000. She did not want to be pregnant but she was not using any form of contraception to prevent being pregnant. She did not know about emergency contraception.

She started bleeding on the 24th of June 2000 and was relieved when it started. She induced the bleeding by drinking a cup of spirit.

She came to visit her mother for school holidays. She knew she was pregnant. She thought of telling her mother but was scared. She then decided she will take the spirit to abort. She also looked at laxatives but there were not there. (her mother did not have them in her cupboards). She then settled for the spirit. She drank a cup of it and hoped it will do the trick.

She did not know about the CTOP act. No one else knew about the pregnancy including the father of the child.

CASE 36: QUESTIONNAIRE 116 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 23 NOVEMBER 2000

The respondent was 30 years from Naledi (Soweto). She had completed secondary education (between standard 6 and 9). She is married and has three children the youngest is two years old. She is unemployed and is exposed to media.

Her last menstrual period was in July 2000 and found out about the pregnancy beginning September 2000. She did not want to be pregnant and was not using any form of contraception. She did not know about emergency contraception. She started bleeding the day before the interview (22 November 2000) and was relieved when it happened. She induced the bleeding by drinking 1 bottle of Dutch medicines. She paid R15 for it.

“Cost of living is too high and this man is not reliable. One day he loves me the next day he does not”

She knew about the CTOP act. She also knew that women could request it up to three months of gestation. Women can also have a legal TOP in case of rape. She said that Bara offer the TOP services.

I know for a fact that the nurses are rude and cheeky. I wouldn't do that to myself. I know I did the right thing and therefore didn't want to be told by them that I'm doing the wrong thing. I wanted it to be quick and no one must know even if you [the interviewer] can tell someone, I will sue you."

No one else knew about the pregnancy including the father of the child.

CASE 37: QUESTIONNAIRE 1 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 9 MAY 2000

The respondent was 42 years old from an informal area called Freedom park in Soweto. Her highest standard passed was between standard 4 and standard 5. she was married or living with a man. She was not employed. She had seven children and the last child was 3 years old.

She had had an unwanted pregnancy before and had the baby. She had an abortion once. Her last menstrual pregnancy was between the 9th and the 5th of March and found out she was pregnant on the 5th of April 2000. She did not want to be pregnant and was using pills for contraception. She started bleeding a day before the interview and relieved.

She had a lot of pills to induce the bleeding including "prevention pills". Her husband gave her traditional medicine in addition to help her abort. "I have many children and I am not working. Didn't go to the hospital to avoid hustles and shouting". The husband helped her to induce the abortion.

She said she knows about the Termination of Pregnancy Act and that women can terminate up to 7 weeks. She said women could terminate because of the ill health of the mother or of the baby. She did not go to the hospital for legal services because she did not want to be shouted at.

The husband knew about the pregnancy and had told her to abort.

CASE 38: QESTIONNAIRE 2 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 6 JUNE 2000

The respondent was 38 years old from Soweto in Johannesburg. She was married and had only completed primary education and unemployed. She had 9 children with the youngest aged 3. She once had an unplanned pregnancy, she had the baby.

She last had her menstrual period in December 2000 and found out about her pregnancy in February 2000. she did not want to be pregnant but was not using any form of contraception. She started bleeding five days before the interview and was relieved when it happened.

Someone known in the community helped her induce bleeding by inserting a catheter. She paid R400.00 and she was still owing another R100.00. she did not go to hospital because she had a bad experience at the gynaecological ward. Nurses were asking her why did she get pregnant at her age. She did not know about the TOP act. The boyfriend did not know about the pregnancy.

CASE 39: QUESTIONNAIRE 3 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 5 JUNE 2000

The respondent was 29 years old from Orlando in Soweto. She was single and had completed her Matric (standard 10). She had one child aged 6. her last

menstrual period was in March 2000 and she found out about her pregnancy late May 2000. she was not sure about her pregnancy until two weeks before the interview.

She induced bleeding by drinking Dutch medicine and only her friend knew about the pregnancy. She did not know about the CTOP act.

Her boyfriend knew about the pregnancy and said its “OK”.

CASE40: QUESTIONNAIRE 4 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 4 JUNE 2000

The respondent was 28 years old from Naledi in Soweto-Johannesburg. She had completed standard 10 and married or living with a man. She was unemployed and was exposed to both print and electronic media. She had one child who was aged seven.

Her last menstrual period was on the 6th of December and she found out about this pregnancy in March. She did not want to be pregnant but was not using any form of contraception. When she started bleeding more than 5 days before the interview she felt indifferent. She used medical drugs including pain and flue tablets to induce the bleeding.

She knew about the CTOP act and that women can request TOP but did not know up to what stage women could terminate or at which hospital is this service available.

CASE 41: QUESTIONNAIRE 5 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 4 JUNE 2000

The respondent was 32 years old from Pimville in Soweto Johannesburg. She had completed standard 10. She was married and had three children with youngest aged 2.

In the past she had an unwanted pregnancy and she had an abortion by taking traditional medicine. Her last menstrual period was in January and she found out about her pregnancy in April. She did not want to be pregnant and was on an injection.

She started bleeding the day before the interview and was relieved when it started. She induced the bleeding by taking Misoprostol tablets from a nurse for which she paid R250.00.

She knew about the CTOP act but did not know at what stage of pregnancy could women request.

“I didn’t know about Baragwanath hospital] and I heard that this clinic is a same day service. I didn’t want to spend the night in the hospital I was given 4 Misoprostol tablets, two to drink and two insert. I had to go back after three days. When I went back the placenta was still inside and they could not take it out. I was then referred to Bara”.

Her partner knew about the pregnancy and was happy.

CASE 42: QUESTIONNAIRE 6 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 4 JUNE 2000

The respondent was 25 years old from an informal settlement called Naturena in Johannesburg. She had completed standard 10 and not working. She was living with a man and they had one child aged two. She once had back-street abortion.

Her last menstrual period was on the 6th of December and she found out about her current pregnancy in January. She did not want to be pregnant and was using quinine as a form of contraception. She did not know about emergency contraception.

She induced bleeding by drinking vinegar, tartaric, 10 oral contraceptives and laxatives and she was relieved when it started.

She knew about the CTOP act. She said that women can have TOP when raped, when the mother's health is in danger and when the women is abused.
"I did not want an extra burden, I am unemployed, my boyfriend is abusive [he] swears a lot, I did not want to change partners,…I am scared of AIDS.. I wanted to keep it a secret and do it fast but I failed." She did not go to hospital because she was afraid people will find out. Her boyfriend had advised her to abort.

CASE 43: QUESTIONNAIRE 7 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 4 JUNE 2000

The respondent was 21 years old from Kliptown. She completed standard 10. She was single and had no children.

Her last menstrual period was on the 4th of December and she discovered she was pregnant in January. She did not want to be pregnant but was not using contraception. She did not know about the emergency contraception.

“the traditional healer first told me I had stones in my stomach and I cannot conceive. He gave me medication to throw up and medication to drink. After a month he told me I was pregnant I went to Bara for TOP but had a bad experience…I was told it was fully booked for the whole month and they [nurses]kept asking me why do I want to kill, I am murderer. I went back to the traditional healer who gave me medicine to induce”.

The father of the child knew about the pregnancy and was happy about it. He did not know that it was lost . her parents knew that she had lost the pregnancy.

CASE 44: QUESTIONNAIRE 8 INTERVIEWED AT CHRIS HANI BARAGWANATH HOSPITAL 1 JUNE 2000

The respondent was 23 years old from Diepkoof in Johannesburg. She had completed secondary education and was single with no children.

Her last menstrual period was in February and she found out about her pregnancy in March. She was not using any form of contraception and did not know about emergency contraceptives.

She induced her bleeding using castor oil.

She knew about the CTOP act but did not know up to what stage can women request to terminate.

"after question C12 [emergency contraception] she asked the interview, er more about them and what they are called. The interviewer asked her if she was planning on using them in future. She said Yes. The respondent asked her why does she not use pills or injection she said she is from the rural areas of Natal and she constantly visit her mother and she skip clinic visits and nurses shout at her.

She lives in an informal area with friends who are from the same area in Natal. Her mother was not told about the pregnancy. Her friends suggested she "get rid of the pregnancy". She was scared and thought it was the wrong thing to do, until a week before the interview the boyfriend dumped her. Her friends gave her two bottles of castor oil to induce and she started bleeding four days later.

CASE 45: QUESTIONNAIRE 22 INTERVIEWED AT PHOLOSONG HOSPITAL (NOT DATED)

The respondent was 22 years old from Guluksdall in Brakpan. She had completed her standard 10. She was single and had no children. She was exposed to both print and electronic media.

She last had her menstrual period in July 2000 and found out about her pregnancy on the 18th of August. She was not using any form of contraceptive.

She had induced her bleeding by taking medicine from the muti shop. She did not know about the CTOP act. The person who made her pregnant knew about the pregnancy and was happy. He now knew about the loss of pregnancy and so do her parents.

CASE 46: QUESTIONNAIRE 38 INTERVIEWED AT KALAFONG HOSPITAL. 28 SEPTEMBER 2000.

The respondent was 43 years old from Attredgeville in Pretoria. She completed secondary education. She was married and has five children with the youngest aged 13. She lad her last menstrual period in July 2000 and found out about her pregnancy on the 14th of September. She did not want to be pregnant but was not using any contraceptives

She started bleeding five days before the interview. She induced the bleeding using tablets called Gynae [something like that] she took vaginally. The tablets were in a white box [the investigators query if it was Misoprostol]. She got the tablets from the doctor and paid by medical aid card.

“I was having lots of discharge. [I] went to a doctor, he said I must have blood tests. He took blood. I sent my husband to collect the results after three days

and he told me I was 8 weeks pregnant. We went to him again and told him I did not want another child. He gave me these gynae something, three tablets in a white box. They were white and to [be] inserted vaginally.

She knew about the CTOP act but did not know at what stage could a women request. She knew she could get TOP at Kalafong hospital.

“I know people like (gobhozing) gossiping. I know many people who work at the hospital. I didn’t want anybody to know what is happening. I know my husband doesn’t anymore children”.

Her husband knew about the pregnancy and said nothing when he heard the news.

CASE 47: QUESTIONNAIRE 46 INTERVIEWED AT KALAFONG HOSPITAL ON THE 19TH OF JULY 2000

The respondent was 22 years old from Attredgeville in Pretoria. She had completed standard 10. she was single and had no children. Her last menstrual period was in May. In June she had abnormal periods. They were in clots. She did not want to be pregnant but was not using any contraceptives.

She took pills from a doctor, and does not know the name. She paid the doctor by medical aid card.

“I don’t want a child. I am not ready for one yet. I was not sure if I was pregnant but since I had been having unprotected sex I thought I might be. I told the doctor and he gave me the tablets …to clean.

She did not know about the CTOP act. Her husband did not know about the pregnancy**.**

APPENDIX B – CONSENT FORM

SOUTH AFRICA 2000: INCOMPLETE ABORTION RESEARCH

STUDY OF WOMEN'S EXPERIENCES OF PREGNANCY LOSS
INFORMED CONSENT

TO BE CONDUCTED IN THE WOMAN'S FIRST LANGUAGE

Good morning, how are you? My name is _____ and I come from the Reproductive Health Research Unit Chris Hani/Baragwanath Hospital/Medical Research Council. I have come to tell you about the research that we are doing with women like you and to ask if you would be willing to help with this by being interviewed.

Many women in South Africa lose their pregnancies each year. For some of them, this is a very distressing experience, but others are pleased, as they did not want to be pregnant. This study is being undertaken in order to improve the health care of women who lose their pregnancies. The aim of this study is to find out what happens to women, why women think they lose their pregnancies, what women do to prevent this happening if they want to be pregnant or to make it start happening if they do not want to be pregnant and to find out whether women have information about health services available to help them. We hope that the knowledge that comes from this research will enable us to provide better services for patients and to provide information to help the government develop policies to assist women.

I would like to invite you to assist us by agreeing to be interviewed for the study. The interview will last about 30 minutes and I would like to record on this interview schedule what you have told me. The information that you provide in the interview will be kept completely secret. No one will be told what you say and we shall not use your name anywhere. If you decide you do not want to talk any more we can stop whenever you want to.

If you do not want to be interviewed, that is your choice. You do not have to agree. It will not make any difference to your care in the hospital and the doctors and nurses will not be told that you did not want to be interviewed. I shall give you a sheet with my name and contact number. If you want to talk about this more or to have more information please feel free to call me.

Do you agree to be interviewed?

Y	N

NAME:…….SIGN:……DATE:……..

APPENDIX C - QUESTIONNAIRE

STUDY OF WOMEN'S EXPERIENCES OF PREGNANCY LOSS

A.DEMOGRAPHIC CHARACTERISTICS I want to start by asking you some questions about yourself and your home.		
A1. How old are you?	_____ years	
A2. What race group do you consider yourself?	Black/African……1 Coloured……2 Indian/Asian……..3 White……..4	
A3. Which province do you live in?	Gauteng……1 Mpumalanga……2 Eastern Cape……..3 Western Cape……4 Northern Cape……5 Kwa-Zulu Natal……..6 Orange Free State……7 Northern Province……..8 North West……....9 Other_____10	
A4. What is the name of the village/township/suburb where you stay?		
A5. What is the name of the nearest town/city?		
A6. What is the highest (grade/form/year of schooling) you have completed?	Less than one year completed..1 Sub A -Standard 3……..2 Standard 4-Std 5……..3 Standard 6-Std 9……4 Standard 10 ……..……5 Post-school degree, certificate, diploma completed ……...6	
A7. What is your current marital status?	Single……...1 Married or living with man…….2 Divorced/Widowed/separated...3	
A8. Are you working or selling?	Yes……1 No……..2	
A9. Have you read a newspaper or a magazine in the last week?	Yes……1 No……2	

A10. Do you usually listen to radio/watch TV at least once a week?	Yes……..1 No……..2	
A11. How many children do you have?	Number _____	
A12. How old is your youngest child?	_____ Months if under 2 yrs _____ Years	
A13. I understand that you are in hospital because you have lost your pregnancy. Has this ever happened to you before?	Yes……..1 No……..2	
A14. In the past, have you ever been pregnant when you did not want to be?	Yes……..1 No……2	⇒ **B1**
A15. What did you do? I am going to read out three possible responses then ask you which of these you did?	I did nothing, I had the baby….1 I tried to stop the pregnancy but did not succeed and so gave birth……..….2 I tried to stop it and had an abortion……...3 Other (specify)……4	⇒ **B1** ⇒ **B1** ⇒ **B1**
A16. Where was the abortion done?	Legally in the hospital/clinic……1 Back street……2 Induced herself at home…….3	
A 17 In the past have you had an abortion once or more than once? How many times?	_____No. of previous abortions	

NOW I WOULD LIKE TO ASK A LITTLE ABOUT THIS PREGNANCY		
B. PREGNANCY		
B1. When did you first find out you were pregnant?	DATE: _____ dd/mm/yyyy Or _____ Weeks ago	
B2. Can you tell me how many periods you missed before you realised you were pregnant?	_____ Number	
B3. When was the last time you had a menstrual period?	_____month Or _____weeks ago	

B4. When you discovered the pregnancy, did you want to be pregnant or did you wish you were not pregnant?	Wanted to be……..1 Did not want to be……2 Not sure……3	⇒ **B6**
B5. Had you been trying to get pregnant?	Yes……1 No……2	⇒ **B10**
B6. Were you using any form of contraception to avoid getting pregnant?	Yes……1 No……....2	⇒ **B8**
B7. Which form of contraception were you using?	Mini pill……..1 Combined pill……2 IUD (loop or coil)……3 Injection……4 Condom……5 Female sterilization ……..6 Rhythm/calendar method…….7 Withdrawal……...8 Herbs……9 LAM (breast feeding)……10 Other (please specify)……11	
B8. Did you know at the time you got pregnant that there is emergency contraception which you can take after you have had sex which will stop pregnancy?	Yes……..1 No……2	⇒ **B10**
B9. Did you use or try to use emergency contraception? What were the reasons you did not use it? (please write all the details)		
B10. When did you start bleeding?	Today……1 Yesterday……2 2 – 5 days ago……3 More than 5 days ago……4	
B11. When you noticed the bleeding did you mainly feel sad or mainly feel relieved that you could be losing the pregnancy, or were you really not sure which you felt?	Relieved……1 Sad……2 Not sure/confused/indifferent....3	
B12. Did you do anything to try to stop the bleeding or stop you losing the pregnancy?	Yes……1 No……..2	⇒ **B14**

B13. What did you do to stop the bleeding? (please write all the details)		
INTERVIEWER CHECK: If B12 = yes, check if reaction to bleeding (Q.B11)= sad, check Q. B4, if this = wanted to be pregnant, then the woman is almost definitely having a miscarriage. Skip to Q. B28		
I know that if you get pregnant when you do not want to be you can feel really desperate and try all sorts of things to bring on menstruation.		
B14. Did you do anything or take anything which might have brought on the bleeding?	Yes……..1 No……..2	
B15. Did you take any drugs or medicines to start the bleeding ?	Used Misoprostol……1 Other medical drugs……2 Dutch medicines……3 Other medicines from chemist……..4 Traditional medicines……..5 None……6	⇒ **B19**
B16. What did you take and how much or how many tablets?		
B17. Interviewer shows the woman Misoprostol. **Did you take tablets like this?**	Yes……1 No……..2 Not sure……3	
B18. Did any one give you the tablets or help you get the tablets? Who did this?	Husband……1 Boyfriend……2 Mother……3 Sister……4 Nurse……5 Doctor……6 Another female relative……7 A male relative……8 A friend……9 Some one known in the community……10 Other……11 No one ……12	

B19. Did anyone put something up inside you to get the bleeding started or did you try to do this yourself?	Yes……1 No……2	⇒ **B22**
INTERVIEWER CHECK: IF SHE HAS NOT ADMITTED TO INDUCING THE ABORTION IN Q.B14, B15, OR B19, SKIP TO Q. B28.		
B20. What was used?	Bleach/detergents etc……1 A mechanical means……..2 (needle/ stick/ catheter) please specify:	
B21. Who did this to you or did anyone help you do it?	Husband……1 Boyfriend……2 Mother……3 Sister……4 Nurse……5 Doctor……6 Another female relative……7 A male relative……8 A friend……9 Some one known in the community……10 Traditional healer……11 Other……12 No one ……13	
B.22 How much did you have to pay?	_____Rands	
B23. Did you discuss ways of aborting with anyone before you aborted?	Yes……1 No……..2	⇒ **B25**
B24 Who did you discuss this with?	Husband……1 Boyfriend……2 Mother……3 Sister……4 Nurse……5 Doctor……6 Another female relative……7 A male relative……8 A friend……9 Some one known in the community……10 Traditional healer……11 Other……12	

B25. I am really interested in your story for my research, I know this can be difficult, but can you tell me again exactly what happened and I am going to write it all down.		
B26. Did anyone helping you mention that you could have got a legal abortion in a hospital or clinic?	Yes……1 No……..2 No one helped her……..3	 ⇒ **B28** ⇒ **B28**
B 27. Who mentioned this?	_____specify	
B28. Does the present law in South Africa allow women to have an abortion?	Yes……..1 No……..2 Don't know……3	 ⇒ **C1** ⇒ **C1**
B29. Up to what stage of pregnancy can a woman terminate her pregnancy legally?	_____ Weeks or _____Months	
B30. What are the reasons in the law that a woman can have an abortion? Any others?	Rape……1 Incest……2 Health of mother ……3 Health of baby……4 On request……5 If she is too poor to look after the child……6 Other ……7	
B31. Do you know of a hospital or clinic where a person can abort legally?	Yes……..1 No……..2	 ⇒ **C1**
B32. Can you name one place?		

B33. Did you try to have an abortion in a clinic or hospital?	Yes ……..1 No……..2	⇒ **B35**
B34. How many weeks pregnant were you when you tried to get an abortion there?	_____Weeks	
B35. Can you tell me what happened and why you ended up doing the abortion on the backstreet? RECORD STORY		
B36. What was your main reason for not using legal services?	Did not know about the law…….1 I was too late in my pregnancy…..2 Staff were rude……..3 Expected staff to be rude……4 Somebody I know had a bad experience……5 Waiting list too long……..6 I was afraid people would find out……..7 Other……8 Specify_____	
B37 If visiting Gauteng, Did you come specifically to Gauteng for an abortion?	Yes……..1 No……2	
I KNOW THAT THIS IS A VERY DIFFICULT TIME FOR YOU, SO I WANT TO ASK YOU ABOUT WHETHER YOU HAVE SUPPORT AT HOME		
D. SUPPORT		
C1. Did the person who made you pregnant know that you were pregnant?	Yes……..1 No……2	⇒ **C4**

C2. What was his reaction when he heard that you were pregnant?	Told you to abort……1 Denied it was his child…… .2 He was angry……3 He was happy……..4 Beat her……5 Left her……6 Helped her to abort……7 Other (specify)……8	
C3. Does he know that you lost the pregnancy?	Yes……1 No……...2	
C4. Have you told anyone else that you were pregnant?	No one else knew……...1 Parent/s……2 Friend/Colleague……3 Teacher……4 Sibling……5 Other relatives……6 Other……7	⇒ **END**
C5. Does any one else know that you have lost the pregnancy?	Parent/s1 Friend/Colleague……2 Teacher……3 Sibling……4 Other relatives……5 Other……6	

THANK YOU VERY MUCH FOR YOUR ASSISTANCE

INTERVIEWER GIVES OUT INFORMATION SHEETS