

**COMMUNITY PERCEPTIONS REGARDING LEGAL CHOICE OF
TERMINATION OF PREGNANCY**

by

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DECLARATION

I declare that **COMMUNITY PERCEPTIONS REGARDING LEGAL CHOICE OF TERMINATION OF PREGNANCY** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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COMMUNITY PERCEPTIONS REGARDING LEGAL CHOICE OF TERMINATION OF PREGNANCY

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ABSTRACT

The Choice on Termination of Pregnancy Act (Act 92 of 1996) states that “reproductive rights must be guaranteed and reproductive health services must promote people’s rights to privacy and dignity”, but most communities seem to lack proper information about this legislative aspect.

The purpose of the study was to explore the community’s perceptions regarding legal choice of termination of pregnancy in order to have a broader understanding how the community views termination of pregnancy, and whether they are able to access legal termination of pregnancy.

An exploratory qualitative study was conducted. The exploratory and descriptive research assisted the researcher to have adequate time to explore and describe the community’s perceptions about termination of pregnancy. The researcher purposely selected participants who consult at a particular Tshwane hospital as most of this particular community members presents with complications of illegal abortions. Both men and women above 18 years had an opportunity to participate.

Data was collected until saturation is reached. Thematic analysis was conducted. The findings reveal that the community still needs to be given more information about rights and laws surrounding termination of pregnancy. Recommendations were made to create more awareness and improve access.

Key concepts

Attitudes; beliefs; community perceptions; termination of pregnancy.

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Dedication

I dedicate this study to my late parents, Mr and Mrs Samuel and Emely Moshiga, my late brother Mokoka Moshiga and my late parents-in-law Mr and Mrs Johannes and Salome Mahanyele.

May their souls rest in eternal peace.

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LIST OF ACRONYMS

CLA	Christian Lawyers Association
CTOPA	Choice on Termination of Pregnancy Act (Act 92 of 1996), as amended by Act 1 of 2008)
DENOSA	Democratic Nursing Organisation of South Africa
GDOH	Gauteng Department of Health
GNHRD	Gauteng National Research Database
ICPD	International Conference on Population and Development
REC	Research Ethics Committee
RSA	Republic of South Africa
SANC	South African Nursing Council
TOP	Termination of Pregnancy
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter presents the orientation of the study and includes the background information about the problem statement of the research. A brief explanation of the purpose of the study is highlighted. The chapter further stipulates the aims and objectives of the study, and specify the research questions identified. All key concepts are defined in relation to the study.

Furthermore, the significance of the study is discussed to support the aims and objectives. The methodological issues are discussed, to put into context how the research questions are explored. A description of appropriate sampling methods for the study is demonstrated. Lastly, the scope and limitations of the study are briefly outlined and the structure of the dissertation is introduced.

1.2 BACKGROUND OF THE RESEARCH PROBLEM

Abortion laws have changed in South Africa over the years. There was transformation from the Abortion and Sterilisation Act (Act 2 of 1975) to the Choice on Termination of Pregnancy Act (Act 92 of 1996). All these were interventions to acknowledge and protect women's rights which are basically human rights. In terms of the CTOP Act (Act 92 of 1996), termination of pregnancy services can be accessed on request by a woman during the first twelve weeks of pregnancy without giving any reason for the request.

According to Ngwena (2007:319), the CTOP Act (Act 92 of 1996) promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early safe and legal termination of pregnancy according to her individual beliefs. Needle, Walker and Russo (2008:15) confirm that the important thing to remember is that TOP is one of the safest and most common medical procedure performed today, especially when performed early in pregnancy.

Despite the fact that TOP was legalised in South Africa in 1996, thousands of women resort to unsafe abortions in unhygienic conditions through desperation and lack of information about abortion. Unintentionally they feel fully supported by illegal providers and end up incurring the dangers of unsafe abortion. Furthermore, opposing individuals and organisations struggle for control and sway discussions about abortion. The contested nature of abortion yields emotional and psychological consequences for both the women and men involved (Morolong 2013:1). TOP issues are normally sensitive and volatile and sometimes difficult and uncomfortable to discuss.

Historically and culturally, terminations of pregnancy have been predominantly condemned and discouraged by most. The transition to democracy provided an opportunity for abortion laws to be reviewed and addressed. The predominant concern with human rights provided an opportunity “for addressing issues of women’s rights and health broadly, and abortion in particular” (Blanchard, Fonn & Xaba 2003:110). The CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008 opened doors for women and girls in South Africa who opt for safe abortions in case of an unwanted pregnancy.

According to Martinelli-Fernandez, Baker-Sperry and McIlvaine-Newsad (2009:77), whether and under what circumstances abortion should be legal is highly debated in many parts of the world, with arguments based on religious, moral, political, human rights and public health grounds. Research carried out by World Health Organization (WHO) (1998), suggests that, annually, one out of every 14 women of reproductive age undergoes an induced abortion. Globally, an estimated 46 million termination of pregnancies are performed each year, 19 million of them are outside the legal system and considered unsafe as they are performed by people who lack the necessary skills or in places that do not meet minimal medical standards (Mesce 2006:5).

The issue of termination of pregnancy has been a worldwide controversy. Many societies are divided into two groups “Pro-choice and “Pro-life. “Pro-choice standpoints defend women’s right to choose to terminate or to keep a pregnancy. The “Pro-life movement claims that a foetus is a life and therefore TOP is tantamount to taking a life (Everatt & Budlender 1999:102; Reiman 1999:9).

The interdisciplinary views on abortion by Martinelli-Fernandez et al (2009:34), stated that pro-choice and pro-life advocates have vehemently clashed on many issues regarding

abortion, including the woman's right to control her body. The morality of abortion in early and late stages of pregnancy, foetal rights, and controversial legislation such as parental notification and consent laws, waiting period and funding restrictions.

Furthermore, proponents of pro-life tend to define morality and humanity surrounding abortion differently. According to Kegobe (2010:1), it is described as follows:

- “The loosing of the meaning of life”.
- “The distortion of human nature”.
- “The imbalance of standards of values”.
- “The disorder of social life”.

The legislation of TOPs by the Republic of South Africa (RSA) (1996) government might pose ethical and/ or moral dilemmas on nurses expected to provide TOP services. The attitude of health workers towards termination of pregnancy in most instances creates a barrier for access to the services (South Africa 1996). Based on Department of Health estimates, only half of the facilities that should be offering TOP services currently do so (Trueman & Magwentshu 2013:397-399). According to Bateman (2011:302-304), only 57% of the designated facilities are functional.

Ethically, nurses as caregivers are taught to preserve life. In addition, the Democratic Nursing Organisation of South Africa (DENOSA) believes that nurses have the right to freedom of choice (Poggenpoel, Myburg & Gmeiner 1998:4). This means nurses have the right to choose not to provide termination of pregnancy services. The South African Nursing Council (SANC) (2002) released a statement on the nurse's Conscientious Objection that protects nurse's choice not to participate in TOP. According to Harries, Cooper, Strebel and Colvin (2014:16), the unregulated refusal by health care professionals to provide abortion services is one major obstacle to women and girls accessing safe abortions in South Africa.

From the researcher's point of view, in most communities, people still believe that it's only women with low morals who would go for a termination of pregnancy. They still strongly believe that any pregnancy is a gift from God and the foetus have a right to life, not taking into consideration the woman's right to decide the fate of her pregnancy. This statement emanates from an observation marked on most Saturdays at Marie Stopes clinics. The

pro-life people hold posters at the clinic gates displaying horrible pictures of dead babies alleged to have been caused by abortion. Their intention is to discourage communities from doing neither abortion nor visit abortion clinics.

The researcher's personal experience as a legal TOP provider was when interviewed by City Press about TOP. The researcher's picture was shown on the front page of the newspaper, City Press (2008:14). It was a big issue and taboo amongst family and neighbours on how the researcher agreed to be interviewed by the press on such sensitive issues. This shows that it is not only the women seeking abortion on the receiving end of ridicules and insults but equally, even service providers are not fully supported by some communities.

1.3 STATEMENT OF RESEARCH PROBLEM

The Choice on Termination of Pregnancy has been in operation since 1992, to secure the women's right to Reproductive freedom. However, to date, access to the legal termination of pregnancy services is still a challenge. As reported in the newspaper, Mail and Guardian (2014:43), Rebecca Hodes, a medical historian at the University of Cape Town stated that patients in this situation have little recourse and often turn to "Illegal abortions through 'lamppost' providers", referring to unlicensed abortion providers who advertise their services on the streets or lampposts across the country. The problem is further confirmed by Macleod, Seutlwadi and Steele (2014:1-10), by stating that there is a lack of knowledge in the general population concerning the legal status of abortion.

According to Jewkes, Gumede, Westaway, Dickson, Brown and Rees (2005:315-359), many women still procure abortion outside of designated clinics, consulting traditional healers. The problem is that communities seem reluctant and hesitant to utilise legal termination of pregnancy facilities and rather go to backstreet providers. The researcher observed that most of the members of this particular community reports to the legal termination of pregnancy facilities with failed terminations or with complications from backstreet providers. Are clients resorting to illegal abortions as they not aware of legal TOP services or is it their perception of TOP? The researcher therefore aimed to further explore the community's perception regarding TOP and their awareness of these legal services.

1.4 PURPOSE OF THE STUDY

The aim of the study was to explore and describe the perceptions of the community regarding choice on termination of pregnancy with the aim of increasing awareness and improving their understanding of the right of choice to TOP.

1.5 RESEARCH OBJECTIVES

The objectives of the study are to

- establish community's awareness regarding legal choice on termination of pregnancy services
- explore the community's understanding of legal choice of termination of pregnancy
- establish if the community can describe the circumstances under which a legal termination of pregnancy can be done
- establish if the community can identify a legal termination of pregnancy facility

1.6 RESEARCH QUESTIONS

The current study addresses the following questions:

- Is the community aware of the right of choice of termination of pregnancy?
- Does the community understand the concept, legal termination of pregnancy?
- Does the community understand the circumstances under which pregnancy can be legally terminated?
- Can the community identify a legal termination of pregnancy facility?

1.7 DEFINITION OF KEY CONCEPTS

Termination of pregnancy

The separation and expulsion, by medical or surgical means of the content of the uterus of a pregnant woman (Choice on Termination of Pregnancy Act (Act 92 of 1996), as amended by Act 1 of 2008.

In this study, it is a reproductive health right which gives women a choice to terminate their pregnancy in a legal and safe environment, by trained professionals, as stipulated in the Choice on Termination of Pregnancy Act (Act 92 of 1996), as amended by Act 38 of 2004.

Community

A group of people living in the same place, or having a characteristic in common (www.oxford-dictionaries.com). In the study, communities are women at their child bearing age and men residing around Tshwane district.

Perceptions

It is defined as the recognition and interpretation of sensory information and includes how people respond to the information (www.study.com/academy/lesson). In the study, it is the way in which communities describe termination of pregnancy or believe in termination of pregnancy.

Beliefs

A state or habit of mind in which trust or confidence is placed in some person or thing. (www.merriam-webster.com). In the study, it is the way in which communities have trust and confidence in the Choice on Termination of Pregnancy Act (Act 92 of 1996).

Attitude

A manner of thinking or behaving that reflects a status of mind or disposition (www.freedictionary.com). In the study, it is the way in which communities view termination of pregnancy and how they feel about termination of pregnancy.

1.8 SIGNIFICANCE OF THE STUDY

The significance of the study is to create awareness on the rights of women regarding sexual and reproductive health issues, specifically relating to TOP. A well-informed

community, understanding issues surrounding termination of pregnancy will encourage women to utilise legal services and avoid unsafe actions.

1.9 RESEARCH METHODOLOGY

As stipulated in Polit and Beck (2012:487), the researcher used an emergent design which evolved when making ongoing decisions reflecting what had already been learned. The researcher anticipated a six months period of planning and data collection. The researcher also ensured that the interview was conducted in a place where the participants felt safe, comfortable and protected. A private room was arranged at the hospital. In this qualitative approach, the researcher ensured that she does not impose her own meaning of experiences on the participants but rather, focused on what participants related regarding termination of pregnancy.

1.10 RESEARCH DESIGN

According to Polit and Beck (2012:488), the researcher had to make research design responsive to the situation and the phenomena under study.

A qualitative exploratory survey design, as a non-experimental research was used in the study. As stated again by Polit and Beck (2012:265), survey data could be collected in number of ways. The most respected was through personal interviews (or face to face interviews), in which interviewers met in person with respondents to ask them questions. Furthermore, a survey was helpful in exploratory, descriptive, predictive and explanatory research in some cases. Data was collected at one single point as a form of cross sectional survey.

Qualitative research could help us find out why these behaviours occurred or why people held this view. It is often the only methodology used when the aim is to get an in-depth sense of what people think of an object or event (Katzellenbougén & Karim 2007:318-319).

1.11 POPULATION

Qualitative researchers do not articulate an explicit population to whom results are intended to be generalised, but they do establish the kinds of people who are eligible to participate in their research (Polit & Beck 2012:515).

The entire set of individuals with some common characteristics was identified. The population for the study comprised of all men and women who were at their child bearing ages. The decision was based on the fact that they may directly or indirectly, at some stage, have an experience of or be in need of TOP services. These men and women, as they visit the hospital, were invited to participate in the study.

The criteria for inclusion in the study were that the participant should be between 18 and 46 years of age and willing to participate. Handwritten notes and tape recordings were used to attain a fuller record of notes.

1.12 SAMPLING METHODS

The method of purposive sampling that was used was the maximum variation sampling. Participants with diverse perspective and backgrounds, as well as people with different viewpoints about the phenomena under study were selected (Polit & Beck 2012:517). Conscious selection of participants at the hospital outpatient department was done and sample size was determined as the study unfolds.

“Sampling continued until saturation was achieved”. This means, the researcher continued with the gathering of data from multiple participants until the information became repetitive or a full understanding was achieved (Donalek & Soldwisch 2004:356).

1.13 SCOPE AND LIMITATIONS

The research will be conducted at one community hospital. Communities to be interviewed should be from the area close to the hospital since the identified research problem affects communities residing in this context.

Discussions about abortion are usually controversial and stigmatised. The nature of abortion might have an impact on participant's genuine response.

1.14 STRUCTURE OF THE DISSERTATION

Chapter 1: This chapter introduces the background and orientation to the study.

Chapter 2: This chapter discusses the research design and methods.

Chapter 3: This chapter discusses the research findings.

Chapter 4: This chapter presents the discussions of findings and literature control.

Chapter 5: It entails the conclusion, limitations and recommendations of the study.

1.15 CONCLUSION

This chapter outlined the overview of the study, research problem, purpose and objectives, significance as well as the scope and limitations of the study. Despite abortion being a highly controversial issue, in-depth research will uncover these controversies and identify all challenges which needs attention and ultimately build public support.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 presents a historical overview of abortion which includes the Choice on Termination of Pregnancy (CTOP Act 92 of 1996), and the factors influencing TOP as perceived by various researchers. The impact of the moral, legal and religious aspects on termination of pregnancy are discussed.

The perceptions of parents and health care providers are highlighted below. The chapter further explains the South African constitution and the right to freedom of conscience, how it conflicts with the issue of providing abortion related services by objecting in principle to a legally required or permitted practice. That is often referred to as conscientious objection. Information about the process of abortion is provided and subsequently, factors influencing access to legal termination of pregnancy is also reviewed.

2.2 A HISTORICAL OVERVIEW OF TOP

Abortion is a sensitive issue that permeates the cultural, social, moral, religious and legal dimensions. In view of the sensitive nature of the phenomenon, abortion continue to attract research interests from various academic disciplines such as sociology, medicine, cultural studies, and gender studies among others (Izugbara, Covan & Fugate-Whitlock 2015:482). The Abortion and Sterilisation Act (Act 2 of 1975) brought about changes which enforced stringent medical requirements before an abortion could be procured. According to this law, a woman could be allowed to terminate pregnancy only if the pregnancy posed a threat to her mental wellbeing. The Abortion and Sterilisation Act (Act 2 of 1975) required the conditions below:

- Pregnancy should be a threat to the woman's physical and/or mental health.
- The baby should be at risk of being born with a malformation.
- Pregnancy that is a result of rape (which should be proven) incest.

- The woman is mentally handicapped.

The Abortion and Sterilisation Act (Act 2 of 1975) was too restrictive and allowed woman no rights to their reproductive choices. The restrictive medical conditions made it practically difficult if not impossible for one to acquire TOP (South Africa 1975). The TOP Act (1975) was discriminatory, not only against women but also between women (Ngwena 2007:329). The International Conference on Population and Development (ICPD) held in Cairo in 1994 as attended by representatives from 179 countries was the first global forum where an agreement was reached that unsafe abortions should be recognised and addressed as a community health problem (Grimes, Benson, Singh, Romeo, Ganatra, Okonofua & Shah 2006:1908-1909).

In October 31, 1996, South Africa enacted one of the world's progressive abortion laws, recognising that every woman has the right to make choices about her own body and reproduction (Hord & Xaba 2002:5). The CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008, opened doors for women and girls in South Africa who opt for safe TOP in the case of an unwanted pregnancy. In some instances, women are unable to access birth control which may lead to unwanted pregnancies, TOP or unwanted births.

Above all, the legalisation of termination of pregnancy aimed at reducing and ultimately eradicating the burden of morbidity and mortality resulting from unsafe TOP. In terms of the CTOP Act (Act 92 of 1996) termination of pregnancy services can be accessed on request by a woman during the first twelve weeks of pregnancy without giving any reason for the request. These services include pre- and post-procedure counselling, contraceptive services and the termination of pregnancy procedure.

2.2.1 Choice on Termination of Pregnancy Act (Act 92 of 1996)

Termination of pregnancy is a safe procedure when performed by skilled health care providers in sanitary conditions. As the pregnancy progresses, there is a higher risk of complications hence after twelve weeks, advanced management services of registered medical practitioner are needed. In terms of section 2(1) of the TOP Act 92 of 1996 (Boezart 2010:25), the TOP by a qualified health practitioner is absolutely legal.

Table 2.1 TOP and gestational limits under CTOP Act (Act 92 of 1996)

TIMELINE FOR PREGNACY	CONDITION	ABORTION PERFORMED BY:
First 12 weeks of gestation	Termination of pregnancy available on request	Registered Medical Practitioner (Dr) Registered nurse or midwife (who has completed the training)
13–20 weeks gestation	Termination of pregnancy available under the following conditions: <ul style="list-style-type: none"> • Rape or incest • Danger to woman’s physical or mental health • Foetus not viable • Affect woman’s socio economic status 	Registered Medical Practitioner (Dr)
Above 20 weeks gestation	Termination of pregnancy available under very limited circumstances: <ul style="list-style-type: none"> • Severe threat to life of woman or foetus • Severe foetal congenital problems 	Registered Medical Practitioner (Dr)

(South Africa 1996)

The information on circumstances for termination of pregnancy should be made available to all communities. A well-informed community will be able to support women’s reproductive health needs, particularly the choice on legal termination of pregnancy.

2.2.2 Factors influencing TOP decision

Women’s abortion decisions are influenced by myriad complex factors. It is important for communities to become more sensitive to these complex factors thereby contributing towards improving women’s health. Needle et al (2008:115), cited by Roberts (2010:154), states that the situations below might be presented by women in justifying termination of pregnancy:

- Some women, particularly those with a history of eating disorders including anorexia, fear getting fat and cannot tolerate the idea of pregnancy.
- Some women, such as those with careers in modelling or acting and other areas where appearance is paramount, may feel they need to terminate their pregnancy in order to keep their careers but still feel guilty that their reasons are insufficient and thus they experience some ambivalence. As cited by Roberts (2010:154), the woman can have the abortion because she knows she will not otherwise be able to fit into an especially nice dress a couple of months.
- Women with medical problems with the possibility that pregnancy poses a danger to their health may really want to have children but choose to have termination and not take the risk.
- Some women think about terminating their pregnancies because they fear they will not be good mothers. Some of these women may have been exposed to poor mothering themselves, which gave them too much responsibility for their siblings.
- Others recognise that they cannot meet the needs of the children they already have. They may feel they are too young or too old or that they have too many other responsibilities or not enough money to support themselves and a child. However, these women do love children and feel badly that they want to terminate their pregnancies.
- She can have the abortion because she plans to leave in a few weeks for study in France.
- She can have the abortion because she doesn't feel like telling her boyfriend that she is pregnant.
- She can have the abortion because $2 + 2 = 4$.
- She can have the abortion because the coin she has flipped has come up heads.

All the above reasons qualify a woman to terminate her pregnancy particularly if she chooses to do so. Any woman who meets the eligibility criteria for an abortion, her choice is bound to be respected.

2.3 ACCESS TO TOP IN THE TOWNSHIP OF STUDY

According to census 2011, the city had a population of 334 577 population and 110 703 household. 173 912 males and 160 665 females (Statistics South Africa 2011). The above statistics includes men and women in their childbearing ages that might need termination of pregnancy services which are not provided. Clients are referred to public hospitals which are 30 km to 40 km away from the township that is the context of the study.

The referral centres does only five below twelve weeks TOPs per day for the entire Tshwane district. Even in the institutions where laws on TOP are expected to be operational, it is not so. For instance, the TOP Department at a nearby hospital was closed in August 2014 for renovations, to date; the Department is still not providing TOP services. The question is, are TOP services available and accessible to the community? In more recent decades, women's health has become a global priority, enjoying both worldwide attention and massive political support (Institute for Women's Health 2013). Access to safe and legal abortion services in the Township is only in theory because in practice, the cost of having a termination restricts access to this service.

Regardless of the CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008, ensuring that termination of pregnancy services are available, affordable, accessible and safe remains a daunting priority for government and policy makers. For the poor women, this culminates with financial challenges, creating more financial hardships for them and their families. Women are forced to pay for services that are supposed to be offered free in public sector facilities.

2.4 MORAL AND LEGAL ASPECTS OF ABORTION

The central legal aspect of the abortion conflict is whether foetuses have a basic legal right to live, or at least, claim to live. There are three main views of abortion, that is, the extreme conservative view, the extreme liberal view and moderate views which lie between both extremes (Schwarz 1990:2).

2.4.1 Extreme conservative view of abortion

Proponents of extreme conservative view English (1984:151-161) states that it is unsound to state that a foetus is a person or has personhood since it lacks at least rationality and self-consciousness. It follows that not every human being is also a person according to the legal sense, and thus and also lacks moral rights. English (1984:152) further explains personhood by grouping it into five sectors; the biological sector (being a human being, having extremities, eating and drinking). The psychological sector (perception, emotions, wishes and interests, ability to communicate, ability to make use of tools, self-consciousness). The rational sector (reasoning, ability to make generalisations, to make plans, learning from experience). The social sector (to belong to different groups, other people, sympathy and love). The legal sector (to be a legal addressee, ability to make contracts, to be a citizen).

According to English (1984:151-161), it is not necessary for a human life form to comply with all five sectors and different aspects to count as a person. Warren (1984:110-113), further argues that the foetus is no person since it lacks the criteria of personhood, referring to English's five sectors, and, thus, an abortion is justified.

2.4.2 Liberal view of abortion

As stated by Gert (2004:138), proponents of the liberal view contend that the morally significant break in the biological development of the foetus is at birth, meaning that it is morally permitted to have an abortion before birth and morally prohibited to kill the offspring after birth. Furthermore, he claims that the law can allow behaviour that some people regard as morally unacceptable, such as early abortion and it can prohibit behaviour that some people regard as morally acceptable, such as late abortion. No one thinks that what the law decides about abortion, settles the moral issue (Gert 2004:138).

2.4.3 Moderate view of abortion

Proponents of the moderate view often claim that the viability criterion is a hot candidate for a morally significant break because the dependence of the nonviable foetus on the pregnant woman gives her the right to decide about having an abortion. Thomson (1984:179) argues that everybody has a right of how his own body is used.

Roberts (2010:37) stipulates that a pregnant woman may have the early TOP for a good reason, for a poor reason or for no reason at all, she need not prove or believe that her foetus is defective, or argue that her health is at stake, or claim or provide evidence that she is the victim of rape or incest. She may do just as she pleases.

2.5 IMPACT OF RELIGION ON ABORTION

Religion and culture have a great influence on the belief systems and codes of conduct in any society, which subsequently lead to development of societal attitudes towards termination of pregnancy. From the religious point of view, this moral perception around abortion depicts termination of pregnancy as a dishonourable act or practice.

According to Van der Ven and Ziebertz (2013:125-126), the church declares that: “Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person- among which are the inviolable right of every innocent being to life”.

The Catholic Church has a very clear and strict position that conducting abortion is morally evil and gravely contrary to the moral law (Van der Ven & Ziebertz 2013:126).

The Islamic theologians had a different point of view with regard the issue of abortion. Even conservative Islamic scholars who oppose abortion consider reasons that may justify termination of pregnancy. With a very few exceptions, those reasons are exclusively based on the non-ensouled body. As stipulated by Kellner (2010:220) and cited by Van der Ven and Ziebertz (2013:129-130), the reasons below justify termination of pregnancy:

- First, there are economic reasons; when pregnancy prevents a mother from breastfeeding an older child, then the right of the born child outweighs the right of the unborn.
- Second, there are health reasons; when the pregnancy endangers the mother’s health or when she will be disfigured.
- Third, there are extramarital pregnancies or rape; terminating an extramarital pregnancy is, however, controversially discussed; many scholars believe that the

unborn child is innocent and should be allowed to live. The same applies to pregnancy resulting from rape.

- Forth, there are eugenic indications; some schools allow termination when the child will – without doubt-be severely handicapped and when the abortion takes place before the ensoulment. After the 120th day termination is only legal when the mother's life is at risk because of pregnancy.

In all other cases termination is not only immoral but a legally punishable offence. Brauning (2006:1), who writes from a religious perspective, proposes that, every man and woman of an aborted baby knows the truth. Their children are gone forever and cannot be brought back or replaced. There will always be a void in their lives – a void made more painful by their memories, and regrets, and dreams of what their child might have been.

2.6 SERVICE PROVIDERS' ATTITUDE REGARDING TERMINATION OF PREGNANCY

A study to investigate professional nurse's attitudes towards rendering termination of pregnancy services was conducted in the North-West Province of South Africa by Mokgethi, Ehlers and Van der Merwe (2006:32-39). The research results obtained indicated that most professional nurse's attitudes included that:

- Women should at least be 16 years of age to access these services.
- Women should not be able to access repeated TOPs.
- Nurses should work in TOP services by choice only.
- TOP centres should have better equipment, more resources and more staff members.
- Nurses working in TOP services would appreciate receiving more support from their families, friends, managers and communities.
- Nurses would prefer to administer pills rather than to use vacuum aspiration.

The professional nurse's views were acknowledged, however the termination of pregnancy services had to be provided as stipulated in the CTOP Act (Act 92 of 1996).

According to the study conducted by Gmeiner, Van Wyk, Poggenpoel and Myburg (2001:75) it was evident that many nurses displayed negative attitudes and/or experiences and suffered psychological discomfort due to the fact that they were directly involved with implementing TOP procedures. This showed that the CTOP Act (Act 92 of 1996) was not well-accepted by some of the service providers.

Another study done by Poggenpoel et al (1998:5), revealed that professional nurses who participated in their South African study on professional nurses 'attitudes towards TOP, found it difficult to associate themselves with CTOPs, or to approve the provision of such services. In the Barometer (1997:8), it was evident that the majority of nurses in the RSA refused to render TOP services or to work in hospital departments offering such services.

In order to try and address the negative attitudes of some health care professionals, the Planned Parenthood Association of South Africa has conducted value clarifications workshops in hospitals that provide abortion services. The main purpose of the workshop was to facilitate effective implementation and management of abortions. The focus was also to try and gain an understanding of TOP service providers' concerns regarding abortion and assist them in relating their values to women's needs (Lebese 2009:36).

According to Dickson-Tetteh and Rees (1999), value clarification workshop was done with a view to counter-acting resistance by health care providers to perform TOP, and altering their lack of acceptance of the fact that pregnant women have the right to termination of pregnancies. It was hoped that the opportunity for reflection on culturally determined beliefs about the morality of abortion, together with education about abortion might in many instances lead to an appreciation of the importance of pregnant women's rights and maybe even alter their moral stance.

A nurse's willingness to be involved in abortion services seem to be influenced by factors such as personal choice perceptions and public opinion. It becomes a challenge to exercise personal choice in a matter which is generally perceived as socially unacceptable. Despite the progressive legal framework, the judgmental attitudes of service providers seem to continue to hamper the full implementation of the CTOP Act (Act 92 of 1996) in the RSA. These attitudes are barriers to abortion services and the lives of pregnant women and girls are put at unnecessary risk.

2.6.1 Service providers' attitudes on young women regarding abortion

The CTOP Act (Act 92 of 1996) allows women under the age of eighteen to undergo a termination of pregnancy without the consent of, or even consulting her parents. This subsection of the CTOP Act, however, caused a fair amount of controversy to service providers as well as parents. Service providers sometimes use manipulative strategy of fear, advising young woman to consult their parents. This was evident on Special Assignment (SABC 3:2006). In this program, it was clear that the nurse's perception was that young women should not be allowed to continue with termination without consulting their parents. In the CTOP Act it is stated quite clearly that the only person required to give permission for termination is the woman herself. Health service providers may counsel young women to consult their parents, but cannot deny them a service should the woman refuse. The public policy of some states of America requires physicians to inform patients that TOP will increase their risk of depression and suicidal tendencies (Zolse & Blacker 1992:742), that abortion is linked to breast cancer, that the foetus could feel pain during the procedure of abortion and about the long-term mental health consequences after abortion (Guttmacher Institute 2014:1).

The above statement is the violation of the woman's right to adequate information about TOP that impacts negatively on the woman to make informed decision. The government and states has an obligation to provide women and girls with relevant information about abortion, and make TOP services safe and accessible to all communities.

2.7 PARENTS PERCEPTIONS ON YOUNG WOMAN REGARDING ABORTION

Price (1983:149-150) as cited by Hlalele (2008:9-21), contends that parents often respond to adolescent pregnancy with anger and may feel ashamed of their daughter's immoral behaviour. Family morals and culture have an impact on the young woman's decision to terminate her pregnancy. Young women who are minors should be advised to consult with their guardians before termination of pregnancy; however, they do have authorisation to undergo the procedure (upon their own consent) without the agreement or even knowledge of their parents or legal guardian (Macleod 2011:49).

Macleod (2011:48) explains that the sub clause of the South African CTOP Act (Act 92 of 1996) whereby parental consent or involvement is not required for a young woman to undergo termination of pregnancy caused sufficient controversy for the Christian Lawyers Association (CLA) to challenge it in the high court. The CLA argued that women below the age of 18 are incapable of making decisions concerning a termination of pregnancy in their own best interests without parental consent or control.

The rationale provided by the judge in his ruling stipulated that the CTOP Act (Act 92 of 1996) allows all women who have the intellectual and emotional capacity for informed consent to choose whether to terminate their pregnancies or not. As to whether that individual, irrespective of age, could give such consent, the Legislature has left the determination of the 'factual' position to the medical professional or registered midwife who performs the act (Christian Lawyers Association versus Minister of Health and Others 2005:509).

Parents argue that while a minor is under their care, they have the right to parental care and are bound to have a say in their child's decision to terminate a pregnancy. Weiten (2013:435), states that the period may differ amongst cultures, with notable physical changes, physiological changes, neural development and a search for identity. Therefore, parents believe that young women who are still at this transitional period, experiencing various developmental changes, are vulnerable and unable to make the right choices.

2.8 CONSCIENTIOUS OBJECTION

Following the legalisation of termination of pregnancy, great pressure was put on Parliament to include conscientious objection clause in the CTOP Act (Act 92 of 1996). There have been challenges to the CTOP Act (Act 92 of 1996) and amendments to the CTOP Act were subsequently passed in parliament during August 2004. The rights of both the pregnant woman seeking abortion and the health care provider were addressed and an attempt made to balance this sets of rights, weigh priorities and offer possible solutions.

In 1998, the first challenge to the Constitution of South Africa Act (Act 108 of 1996), section 11 of the constitution, presented by the Christian Lawyers Association, was based on the fact that abortion violates the right of life of the foetus, while by law "everyone has

the right to life". This was rejected on the grounds that under the Constitution the foetus is not a person with a bearer of rights and that there was no intention under the law to distinguish between 'everyone' and 'every person'. It was found that section 11 of the Constitution did not apply to the foetus (Sarkin 2000:8). The Constitution is the supreme law of the land. No other law or government can supersede the provisions of the Constitution.

2.8.1 Abortion and the Constitution

The CTOP Act (Act 92 of 1996) is silent about the right to conscientious objection. However, section 15 of the South African Constitution implicitly accommodates conscientious objection to abortion. It is submitted that whilst the CTOP Act (Act 92 of 1996) fails to provide the principles for determining the limits of the right to conscientious objection, guidance can be derived from section 36 of the Constitution which supports the limitation of the right to conscientious objection where maternal right or health is in danger or there is a medical emergency. Furthermore, section 36 is also capable of supporting the imposition of a duty to at least provide the pregnant woman with information about where she might be able to obtain an abortion (South Africa 1996). South Africa's Constitution is one of the most progressive in the world and enjoys high acclaim internationally.

2.8.2 The impact of conscientious objection on health professionals and women seeking abortion

According to Ngwena (2000:36-39), the scope and limitations of the right of health care professionals such as doctors, nurses and midwives to exercise conscientious objection were examined. The findings of the study on conscientious objection by South African health care providers to involvement in the process of abortion are highlighted below.

Firstly, there was evidence of possible abuse of the right to conscientious objection by health care workers as opposed to the CTOP Act (Act 92 of 1996). The nature and form of opposition to the CTOP Act (Act 92 of 1996) among health care professionals has been varied. Some have merely dissociated themselves with participation in termination procedures. Others have, in addition to dissociation, declined to provide women seeking termination with information about which facilities they can approach to have a TOP.

Some health care workers have been openly hostile not only to women seeking abortion, but also to fellow health care professionals who are supportive of abortion or are involved in the provision of abortion services under the new law (Ngwena 2000:36-39).

Secondly, there were also reports of victimisation of health care workers who refuse to participate in abortion procedures on grounds of conscience. It has been reported by some health professionals that many health care workers have been coerced into assisting in abortion procedures against their will, and have faced harassment for refusing to comply. Some have felt under pressure to participate in abortion procedures to avoid jeopardising their careers. Health workers who have participated against their will have experienced problems of post-traumatic stress. It was thus important to articulate the parameters of the right to conscientious objection to abortion.

Health workers are expected to explain to clients what the law says about TOPs, and to also tell the woman where facilities are available. Section 6 of the constitution says no more or less than a woman requesting TOP shall be informed of her rights 'under the CTOP Act'. Regulation 9 goes further and adds that she shall be told 'of the locality of facilities for TOPs'.

It is important also to take note that section 10 of the Constitution criminalises certain conduct including 'Preventing the lawful termination of pregnancy or obstructing access to a TOP facility'.

2.8.3 SANC conscientious objection

The South African Nursing Council has affirmed its recognition of the rights of nurses to conscientiously object to participation with abortion, however, nurses are always expected to observe and apply fundamental ethical principles in their interaction with healthcare users. As stipulated by the SANC website, under the rights of nurses, SANC (2004:7), a nurse has the right to Conscientious Objection, on condition that:

1. The employer has been timeously informed in writing.
2. It does not interfere with the safety of the patient and/or interrupt his/her treatment and nursing.

2.8.4 Freedom of conscience

The right to freedom of conscience is not confined to religious beliefs only. It is all-embracing in the sense that it also protects the political, ethical or moral beliefs and practices that are genuinely held regardless of whether they are outside conventional religious doctrines or practices (Devenish 1999:183).

Outside parliament, public debates on Choice of Termination of Pregnancy bill preceding the CTOP Act (Act 92 of 1996) were marked by a pro-choice and pro-life divide (Ngwena 1998:44-46).

In parliament, uncompromising opposition to the bill by two political parties – The African Christian Democratic Front and the Freedom Front – were based on religious grounds. These two parties saw the Bill as irreligious and irreverent towards human life (Ngwena 1998:44). Even within the majority party, The African National Congress – there were Christian and Muslim Members of Parliament who were opposed to the bill, but were, however, denied a free vote by their own party's parliamentary caucus (Ngwena 1998:46).

The CTOP Act (Act 92 of 1996) has indeed, been challenged in court (albeit successfully) by a religious organisation, arguing that its liberal position is tantamount to a violation of the right to life of a foetus under the Constitution (Ngwena 1998:51-56).

Thus ethically, the exercise of freedom of conscience by health care professionals serves to protect moral integrity and perforce, human dignity. Wicclair (2000:207) states that few people would argue it is appropriate to allow conscientious objection to abortion as it is subject laden with moral controversy.

Respect for human dignity enjoins that we recognise moral diversity, individual autonomy and individual moral integrity as value that inform and govern the way health care professionals interpret and discharge their duties (Wicclair 2000:210-217)

2.9 TERMINATION OF PREGNANCY AS A HUMAN RIGHT

As stated by Needle et al (2008:96), clients often believe that they are committing a sin or engaging in a shameful act when deciding to terminate a pregnancy. It may be helpful

for them to be aware that the Constitution (1996) section 6 states that “no more and no less than a woman requesting a TOP shall be informed of her rights under the CTOP Act. Regulation 9 goes further and adds that she shall be told of the locality of the facilities for TOPs”.

Women should seek TOP from a state licensed facility. The service providers should be familiar with abortion procedures to help women making this choice sort out the accurate objective facts from those that are intended to manipulate or bias the women in one way or another. Reproductive health as a human rights issue includes women’s access to accurate information and funding for health care procedures and contraception in addition to access to safe abortion services, if needed (Needle et al 2008:96).

Community members need basic information about pregnancy and reproductive rights. Horde and Xaba (2001:21) states that, a study conducted by the Women’s Health Project on information regarding legal termination of pregnancy, found barriers to TOP implementation at the community level. In general, information among women was lacking or inaccurate about basic physiology, misconceptions about unwanted pregnancy, the passage of the CTOP Act (Act 92 of 1996), and the fact that women have the sole right to decide about ending an unwanted pregnancy. Some women did not know how to recognise a pregnancy, and others did not know how to find TOP services. The study found low community support for TOP and a range of negative experiences by community members when seeking TOP.

According to Ngwena (2007:329), the CTOP promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy considering her individual beliefs. Furthermore (Morolong 2013:28) said, on a liberal side, abortion is regarded as a woman’s right to choose to determine what happens to her body.

The CTOP Act (Act 92 of 1996) is further supported by The Universal Declaration of Human Rights. In 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights which brought general awareness “of the existence of rights which are inherent in all human beings, which thus pre-exist, and stand above, the state and all forms of political organisation” (Trindade 2008:2). Furthermore, the Universal Declaration of Human Rights in the Constitution, acknowledges that women

have the right to self-determination as well as the right to social assistance when they do not have the means to procure an abortion. Free abortion services provided through state facilities become a fundamental vehicle for ensuring that poverty ceases to be a determining factor for women's reproductive health risk and morbidity.

2.10 PROCESS OF STEPS FOR A TYPICAL TOP

Besides understanding the process of termination of pregnancy, communities should have accurate information on the actual techniques used. Needle et al (2008:81) confirm that there are three major procedures used in terminating a pregnancy: (a) dilatation and curettage with vacuum aspiration, or (b) dilatation and evacuation, or (D&C) and (c) medical abortion. All this information is communicated before a decision to terminate a pregnancy is taken.

It is of paramount importance for communities to understand the description of steps for a typical abortion so that perceptions could be based on this valuable information.

As stipulated by Needle et al (2008:79-81), in situations where the abortion is performed the same day that the woman comes to the facility, several functions are performed in a routine way. The surgical procedure is the least time consuming part of the process. A series of events will be interpreted from time of admission until patient get discharged.

- When a patient arrives for a procedure, she will check in with the person at the front desk, then take a sit in the main waiting room.
- The first time the patient is advised on a return visit for a sonogram to precisely determine the length of pregnancy, then return to the waiting room.
- Laboratory analysis will be done, which consist of urinalysis, RG, typing haemoglobin level analysis and blood pressure screening.
- The counsellor will discuss the patient's options, ensuring that she is certain about her decision to terminate the pregnancy.
- The counsellor will review the patient's medical history and informed consent forms for the procedure. The patient will receive both verbal and written aftercare instructions. In addition, the counsellor will discuss future birth control options for the patient after the procedure. If the patient has any questions, concerns or

problems, she is instructed to call the centre which has a 24-hour answering service and an on-call physician.

- Explanation of procedure as well as aftercare will be done.
- Service provider will further explain that it is a very safe and simple procedure that usually lasts approximately 3 minutes. It is done in a special room reserved for the procedure so it remains sterile and has whatever medical equipment is necessary.
- At the end of the procedure, the woman will then be in the recovery area.
- The woman is given oral and written aftercare instructions, birth control information and follow-up information.
- Within a few hours, the procedure is completed and the woman is discharged, encouraged to return home and rest for some time.

2.11 CONCLUSION

In chapter 2 the researcher outlined historical overview of TOP, the various factors influencing the TOP decision as described by other different researchers. The researcher further embarked on an assessment study conducted at the context of the study. One of the benefits of the legalisation of abortion in South Africa has been the generation of improved access to TOP services, particularly for women who do not have financial means to procure an abortion privately. The chapter indicated some of the challenges identified in implementing and reinforcing abortion laws, particularly accessibility.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

Chapter 3 discusses research design and the methodology used to explore community perceptions regarding legal termination of pregnancy. This section will cover the research design, research methods, target population, sampling technique, data collection process, data analysis procedure, ethical principles and measures enhancing trustworthiness.

3.2 RESEARCH DESIGN

Terre Blanche, Durrheim and Painter (2010:563) define research design as a strategic framework or plan that guides research activity to ensure that sound conclusions are reached. The study used a qualitative, descriptive and exploratory research approach aimed at understanding the meaning of a phenomenon and to explain systematic relationships in the phenomena of study which is TOP (Polit & Beck 2012:320). Explorative-descriptive qualitative researchers identify a specific lack of knowledge that can be addressed only through seeking the viewpoints of the people most affected.

According to Grove, Burns and Gray (2013:66), an exploratory descriptive qualitative research often indicates that a study is needed with a specific population to understand the needs of, desired outcomes of or views on appropriate interventions held by the members of the group.

In this study, the perception of community regarding legal choice of TOP will be explored and described. The goal is to create a program or an intervention to benefit the population. Explorative-descriptive qualitative researchers identify a specific lack of knowledge that can be addressed only through seeking the viewpoints of the people most affected.

3.3 RESEARCH METHODS

Research method refers to data gathering, data analysis and ensuring rigour in research. A qualitative research method was used aimed at exploring and describing community perceptions regarding legal termination of pregnancy in the identified township. Qualitative research is the only research approach used as the aim was to get an in-depth sense of what people perceive of termination of pregnancy (Joubert & Ehrlich 2007:135).

Once the phenomena of interest has been fully described and the research approach selected, the investigator should then proceed with the discussion of the actual application of the design (Streubert & Carpenter 2011:366).

3.4 THE TARGET POPULATION

According to Brink (2006:113), and as cited by Grove et al (2013:351), a population is the entire group of persons that is of interest to the researcher and that meets the criteria which the researcher is interested in studying. Due to the sensitive nature of the topic, hospital clients were targeted. A particular Tshwane hospital was selected based on the fact that the community members served as a context where a high number presents with incomplete termination of pregnancies. Participants felt more safe and protected in the hospital environment as that is where they consult for health care. Men and women who were at their child bearing ages, 18 to 46 years were identified.

3.5 SAMPLING CRITERIA AND TECHNIQUE

As defined by Botma, Greef, Mulaudzi and Wright (2010:201), a sample is a subset of the population that is selected for a particular study. The researcher determined the most typical characteristics of the participants that should be included in the sample. The criteria, which was based, on the judgement of the researcher was created. As stated by Botma et al (2010:230), only criteria-specific participants should be included in the sample.

In this study, the population consisted of men and women who met the criteria for inclusion. The inclusion criteria were as follows:

Inclusion criteria

- Both men and women in their child bearing ages, which were between 18 and 46 years.
- Were leaving in the identified township
- Were willing to participate in the study

Exclusion criteria

- Residing outside the identified study context
- Not willing to participate in the study
- Not meeting the child bearing age requirement
- Those who did not wish to be recorded during interview.

3.6 RESEARCH SETTING

The researcher's decision on where to conduct the study was based on the nature of the research questions and the type of information needed to address it (Polit & Beck 2008: 57).

In the study, all participants were interviewed in a selected health facility, where they felt more comfortable and protected since the interviews involved health issues and the environment dealt specifically with health matters.

3.7 DATA COLLECTION

Data collection is a systematic gathering of information relevant to the research sub-problems, using methods such as interviews, participant observation, focus group, discussion, narratives and case histories (Burns & Grove 2003:373).

In this study, data was collected in the month of August 2016. Interviews were done at Regional hospital. Due to the sensitive nature of the topic, the hospital environment was suitable since participants felt comfortable discussing health issues in a health environment. Before commencement of interviews, each participant was assured of

privacy and confidentiality, anonymity, right to withdraw at any time and informed consent. Permission to record the interviews was obtained.

The researcher used bracketing to separate her own perception from that of the participants during collecting, analysing and interpretation of data. Furthermore, the researcher did not disclose that she is a TOP provider to avoid “bias”. Grove et al (2013:284) state that, bracketing is “consciously identifying, documenting and choosing to set aside one’s own views on the phenomenon.

In the study, the researcher clarified her own personal values and identified areas in which the researcher was bias to maintain neutrality. Polit and Beck (2012:295) attest that bracketing can never be achieved totally, but researchers strive to bracket out the world and any presuppositions aiming to confront the data in pure form.

3.7.1 Pilot study

Pilot study was conducted with three participants before commencement of actual study. The three participants interviewed in the pilot study were not included in the findings. The purpose of the pilot was to assess and refine the interview guide and procedures, review recruitment strategies and criteria used to select participant, and gather information for improving the intervention (Polit & Beck 2012:196).

3.7.2 Pilot study setting

- The interview lasted for 12 minutes, which was shorter than anticipated, hence the interview questions had to be subsequently re-phrased.
- The researcher’s voice was not clear on the recorder, thus researcher had to improve and speak up.
- The site where interview was done was full of interruptions, thus, a more private environment was secured.
- Some interview questions had medical jargons which were difficult for the participant to understand, thus the researcher had to simplify the words and re-phrased the questions.
- The researcher noticed that some of the questions had the same focus. These questions were subsequently deleted from the interview guide.

3.7.3 Interview setting

The researcher was offered a room at the hospital. The room was private and conducive to conduct interviews. As stipulated by Terre Blanche et al (2010:298), it must be ensured that you are not going to be unduly disturbed in the interview context (an adequate degree of privacy), and if you are recording, ensure that the sound environment is not going to drown out your recordings. These principles were ensured during the interviews.

The researcher prepared a written topic guide for conducting semi-structured interviews. As stipulated by Polit and Beck (2012:537), a list of areas or questions to be covered with each participant is reflected in the interview guide (Annexure E).

3.7.4 Interviewing process

The following series of events unfolded during interviewing:

- The researcher opened with a warm introduction and made sure that the participants were comfortable and ready for the interviews.
- The purpose of the research was explained and voluntary written consent was obtained.
- The participants were also reminded that they were free to withdraw from the interview.
- The interviews were conducted individually for 20–30 minutes. Only the participant and the researcher were in the room. In-depth, face-to-face, one-on-one interviews were used.

3.7.5 Use of communication skills

- The most important skill for in-depth interviews was being a good listener. The researcher listened attentively as participant narrated his/her story.
- The participant was not interrupted, led or offered advice during the interview.

- To maintain consistency, the researcher used an interview guide which is a set of predetermined, open-ended questions that guide and do not dictate the interview (Botma et al 2010:209).
- The interviewer encouraged participants to talk freely about the topic on the guide and to tell stories in their own words, as illustrated in Polit and Beck (2012:537).
- A tape recorder was used to capture the interviews, a second recorder was put aside in case there was a need.
- Interviews were conducted in English and concepts clarified in the participant's language when a need arose.
- Elaborations were done where clarity was needed.

3.7.6 Saturation

- According to Polit and Beck (2012:742), saturation is the collection of qualitative data to the point where a sense of closure is attained because new data yield redundant information.
- During the interview session, the researcher could detect the point where no new information was obtained from the participant.
- Towards end of interview, participants were asked if there was anything more they wanted to say in relation to the topic under discussion. Following the final comments, participants were thanked for participating in the study.

Process notes about the interview were written and stored the tape recordings in a safe place.

3.8 DATA ANALYSIS

Data analysis for qualitative research is “a process of examining and interpreting data to elicit meaning, gain understanding and develop empirical knowledge” (Grove et al 2013:279). As illustrated in Polit and Beck (2012:556), data collection and data analysis occurred simultaneously. The purpose of data analysis was to bring order, structure and meaning to the mass of collected data (De Vos, Strydom, Fouché & Delpont 2011:397).

3.8.1 Qualitative analysis process

Audiotaped interviews and field notes are a major data source in qualitative studies. Verbatim transcription of the tapes is a critical step in preparing for data analysis and researchers need to ensure that transcriptions are accurate and that they validly reflect the interview experience (Polit & Beck 2012:557).

The following active and interactive process was followed:

- Following each interview, the researcher transcribed the interview, and did careful conventions of the transcripts.
- The researcher checked the accuracy of the transcribed data, identified any omissions, errors or alterations.
- The reading and re-reading of notes and transcripts and repeated listening to audiotaped recordings assisted the researcher to become familiar with the phrases used by different participants.
- Development of important themes and sub-themes emerged gradually, data was converted to smaller, more manageable units that could be retrieved and reviewed.
- The researcher interpreted the analysed text and compiled a written account of the interpretation.

3.9 ETHICAL CONSIDERATIONS.

Streubert and Carpenter (2011:61) state that researchers must observe certain basic principles when conducting any form of research that involves human subjects.

Ethical considerations should be the fundamental concern of all researchers in data collection in order to protect the welfare of research participants. In this study, the researcher adhered to the following principles of ethical conduct.

3.9.1 Permission from relevant authorities

Permission to conduct the study was obtained through a written request to the management of selected hospital (Annexure B).

- The researcher obtained ethical clearance from UNISA's Department of Health Higher Degrees Committee (Annexure A) before the research could commence.
- The Provincial Protocol Review Committee from the Gauteng Health Department (GDOH) (Annexure C1) approved the research.
- The Hospital Research Committee (Annexure C2) granted the researcher declaration of intent to conduct the study at the hospital.

3.9.2 Informed consent

Polit and Beck (2012:730) state that informed consent is an ethical principle that requires researchers to obtain the voluntary participation of subjects, after informing them of possible risks and benefits. Streubert and Carpenter (2011:61) further explain that at a minimum, participants should have information about the purpose and scope of the study, the type of questions that will potentially be asked, how the results will be used, and how their anonymity will be protected. In this study, the researcher provided the information below:

- Information about the purpose of the study was explained in a language the participants understood.
- The researcher explained the type of participation expected and how long it will take.
- The researcher ensured that the participants understood the objectives of the study and are competent to give consent.
- It was further explained that participation in the study is voluntary, thereafter the consent was obtained to protect the rights of the participant (Annexure D).

3.9.3 Confidentiality and anonymity

The participants were reassured that the information they provide will not be publicly reported in a manner that identifies them, and will not be made accessible to others. According to Streubert and Carpenter (2011:64), guaranteeing confidentiality implies that the research subject's data will be used in such a way that no one else, but the researcher, knows the source. Information provided by participants was stored securely, under lock

and key. Access to confidential information was limited to the researcher and the supervisor.

3.9.4 Right to privacy

Polit and Beck (2008:174) state that the participants have the right to expect that any data they provide will be kept in strictest confidence. In this study, interviews were conducted in the designated office, where only the researcher and the participant were present. Participant's privacy was maintained throughout the study.

3.9.5 Right to withdraw from the study

The participants were informed that they have the right to withdraw from the study at any time of the study, regardless of having signed the consent form. They were further informed that they won't be liable of any penalty if they decide to withdraw from the study.

3.9.6 Principle of beneficence

The researcher observed the above ethical principle by protecting the welfare of the participant. The participant must not be harmed in anyway, be it legally, psychologically, emotionally, spiritually, socially or economically.

3.10 MEASURES TO ENHANCE TRUSTWORTHINESS

The primary concern of qualitative research is trustworthiness. The rigor in qualitative research was demonstrated through researcher's attention to and confirmation of information discovery. In the study, participant's views and understandings were explored. Common themes that the participants emphasised were identified and confirmed through re-reading the transcripts. Trustworthiness is the degree of confidence that qualitative researchers have in their data and it is assessed using the criteria of credibility, transferability, dependability and confirmability. (Botma et al 2010:232). As cited by Streubert and Carpenter (2011:49), these four criteria for judging the rigor of qualitative research are important, they define for external audiences the attention qualitative researchers render to their work.

3.10.1 Credibility

According to Polit and Beck (2012:585), credibility refers to confidence in the truth of the data and interpretations of them. In this study, the researcher conducted activities in such a way that credible findings were produced. The researcher's prolonged engagement with the participants ensured truthfulness and consistency of the findings. Maintaining consistency assisted the researcher to gain a high level of trust with participants thus establishing credibility.

3.10.2 Dependability

Dependability is a criterion met once the researcher has demonstrated the credibility of the findings (Streubert & Carpenter 2011:49). According to Polit and Beck (2012:585), this refers to stability (reliability) of data over time and conditions. It was further emphasised that credibility cannot be attained in the absence of dependability. In this study, the availability of the recorded data proved reliability of the processes followed. The findings were checked for consistency and made open for scrutiny.

3.10.3 Confirmability

Polit and Beck (2012:585) state that confirmability refers to the objectivity that is the potential for congruence between the two or more-independent people about the data accuracy, relevance or meaning. In this study, confirmability was maintained by ensuring that:

- The recorded data represented the information the participants provided.
- Findings reflected the participants' voice and not the researcher's biases, motivation or viewpoint.
- Evidence and thought processes that led to the conclusions were illustrated through recordings.

3.10.4 Transferability

According to Polit and Beck (2012:585), transferability refers to the potential for extrapolation, that is, the extent to which findings can be transferred to or has applicability

in other settings or groups. This is the ability to generalise from the findings to larger population (Botma et al 2010:233). In this context, the researcher provided findings which made transferability process possible thus benefiting the study.

3.11 CONCLUSION

Chapter 3 described the research design and methods, population, sampling, and ethical considerations. Further discussions on data collection and measures undertaken to establish trustworthiness were covered. Research findings will be discussed in chapter 4.

CHAPTER 4

ANALYSIS, PRESENTATION, DESCRIPTION AND DISCUSSION OF RESEARCH RESULTS

4.1 INTRODUCTION

Chapter 4 presents data from interviews conducted at the Regional Hospital in Tshwane. The objective was to explore community understanding of legal choice of termination of pregnancy. Data conducted with fifteen participants is presented. A brief description of the participants is provided to create some context of the participants. Analysis of participant's views regarding legal choice of termination of pregnancy is also presented.

4.2 DATA ANALYSIS

In-depth semi structured interviews were used to collect data. Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2012:725). De Vos et al (2011:397) state that, qualitative analysis transforms data findings which involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. The researcher used an interview guide to collect data from participants. All interviews were audiotaped and transcribed verbatim. Data saturation was reached with fifteenth participant.

4.3 DISCUSSION OF RESEARCH FINDINGS

Responses are presented in relation to the themes and sub-themes that emerged out of data collected. Six themes emerged from the analysed data as knowledge and understanding, identification of legal facility, support of family members, circumstances leading to abortion, opinions on illegal abortions and opinions on termination of pregnancy. Literature control on the themes and sub-themes were explored to validate or argue the findings.

4.3.1 Demographic data

Fifteen participants were interviewed (who will be referred to as participant one to participant fifteen), twelve of the participants were females and three were males.

Table 4.1 Sample characteristics (N=15)

Criterion	Characteristic	Frequency
Gender	Male	3
	Female	12
Age	20–30 years	6
	31–40 years	8
	41–46 years	1
Level of education	High school	10
	Tertiary	5
Marital status	Single	8
	Married	4
	Living together	3
Employment status	Employed	11
	Unemployed	3
	Student	1
Religious background	Christian	13
	No religion	2
Number of children	No children	2
	One child	2
	Two children	5
	Three children	4
	Four children	2

The research findings are from the data collected from both men and women who were willing to participate in the study. It was paramount to collect data from different genders to explore TOP understanding from different gender perspectives. As argued by Morolong (2013:1), men are often not given much attention when it comes to the issue of abortion.

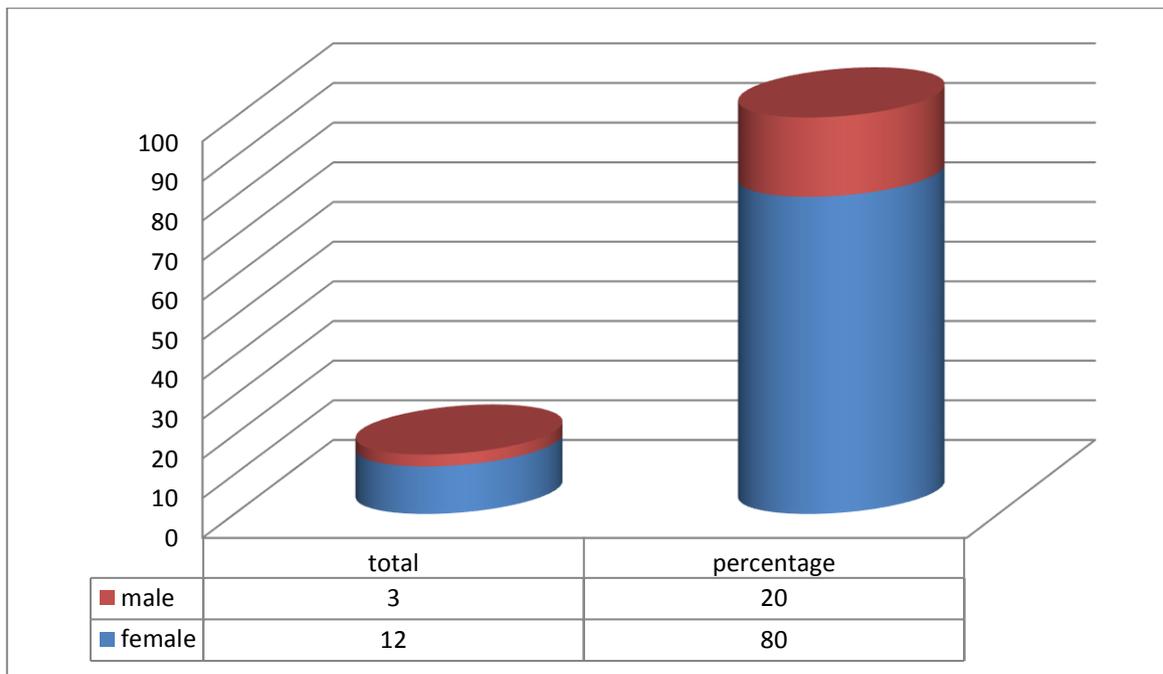


Figure 4.1 Participants' gender (N=15)

Fifteen participants were interviewed, twelve were females and three were males. Most men were uncomfortable being interviewed on TOP issues.

Discourses that acknowledge the role that men can play in issues of reproduction and abortion need to be produced in to alter some of the longstanding normative stereotypical ideas surrounding what it means to be a man (Morolong 2013:32) The Choice of Termination of Pregnancy Act (Act 92 of 1996) somehow immobilises men as the law gives women the right to have TOP without their partner's consent.

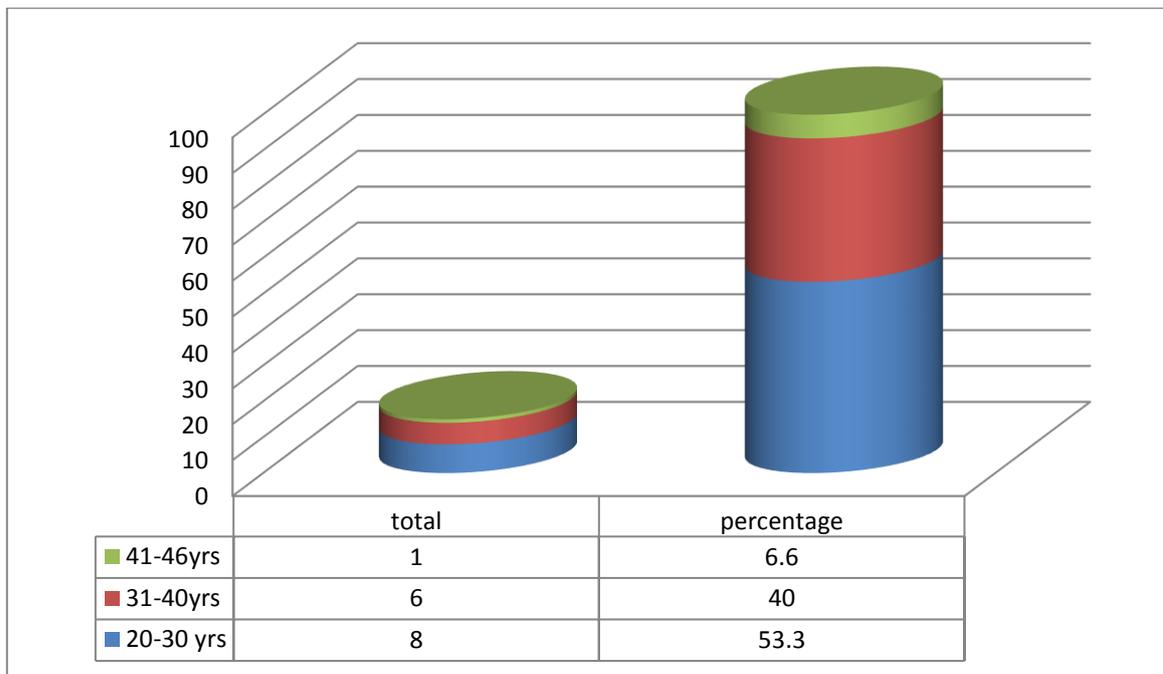


Figure 4.2 Participants' age (N=15)

Six participants were between ages of 20 to 30 years, whereas eight participants were between 31 and 40 years. One participant was 46 years old. All participants were still at their child bearing age. The majority were at a safer child bearing age as per Guidelines for Maternity Care in South Africa (South Africa 2007:30) which stipulates a checklist of all risk factors requiring referral to hospital or advanced management. That includes a woman falling pregnant when she is below 16 years of age or above 34 years of age. A man's age does not affect his child bearing status.

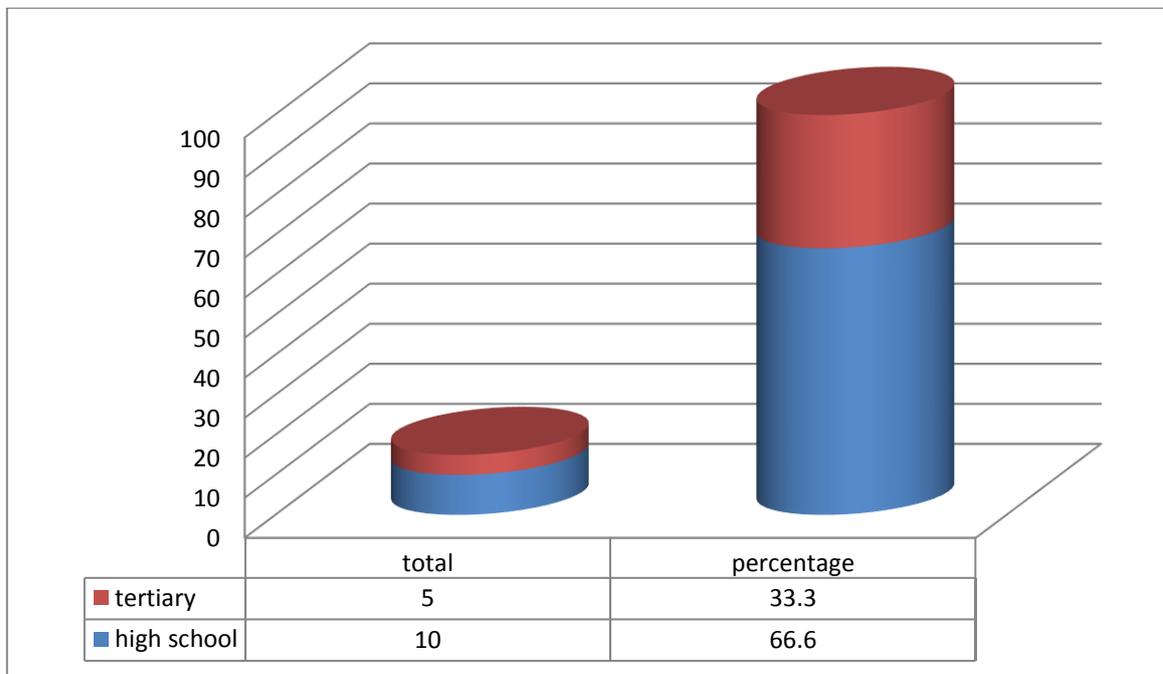


Figure 4.3 Participants' level of education (N=15)

Ten participants reached high school, whereas five participants acquired tertiary education. This figures reflect that, less than half of participants obtained tertiary education. The educational level had an impact on how participants understand termination of pregnancy, which was further explained and stated in their responses.

Participant 4 reached high school, when asked about her knowledge regarding TOP her response was:

“I don't know, I don't understand anything about abortion cos I don't believe in abortion.”

Participant 6 reached high school and her response was:

“No, I don't have any information, I just heard rumours but I'm not sure. Ei ... they are talking about abortion, but where, how is done, I don't know. I don't know anything about abortion.”

Participant 14 passed standard seven and her response was:

“Ok, I’m not definitely sure about abortion but what I can tell you is that, when I was pregnant with my second born I did try to abort by hearing somewhere when they tell me you can drink this and that, and that thing never worked.”

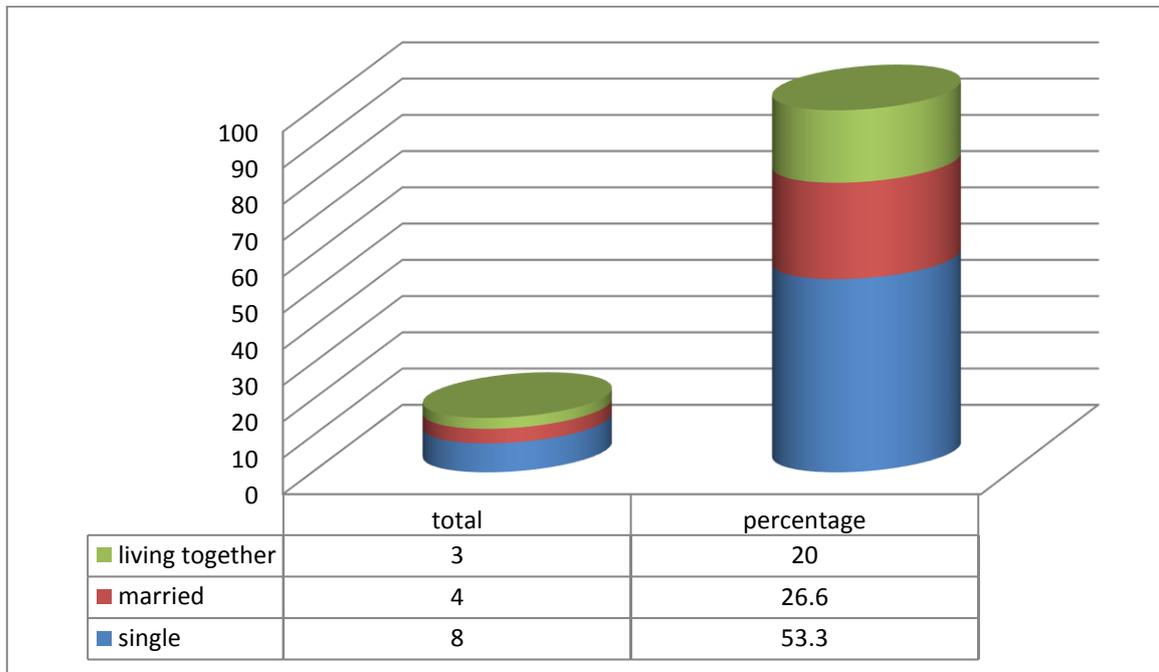


Figure 4.4 Participants’ marital status (N=15)

Three participants were living together with their partners, four participants were married and eight participants were single. The study suggests that more single people tend to engage in abortion as compared with married people. For an example, participant 14 states:

“I am not married at this moment and I’ve got two children. And I’m working but the money that I earn is not much more that I can make a baby again.”

In the African culture, a woman who gets a child outside marriage is regarded as “cheap” or as “second hand” (Hlalele 2008:24). The researcher further suggests that having a child and being single at the same time disrupts continuation of schooling (Hlalele 2008:16).

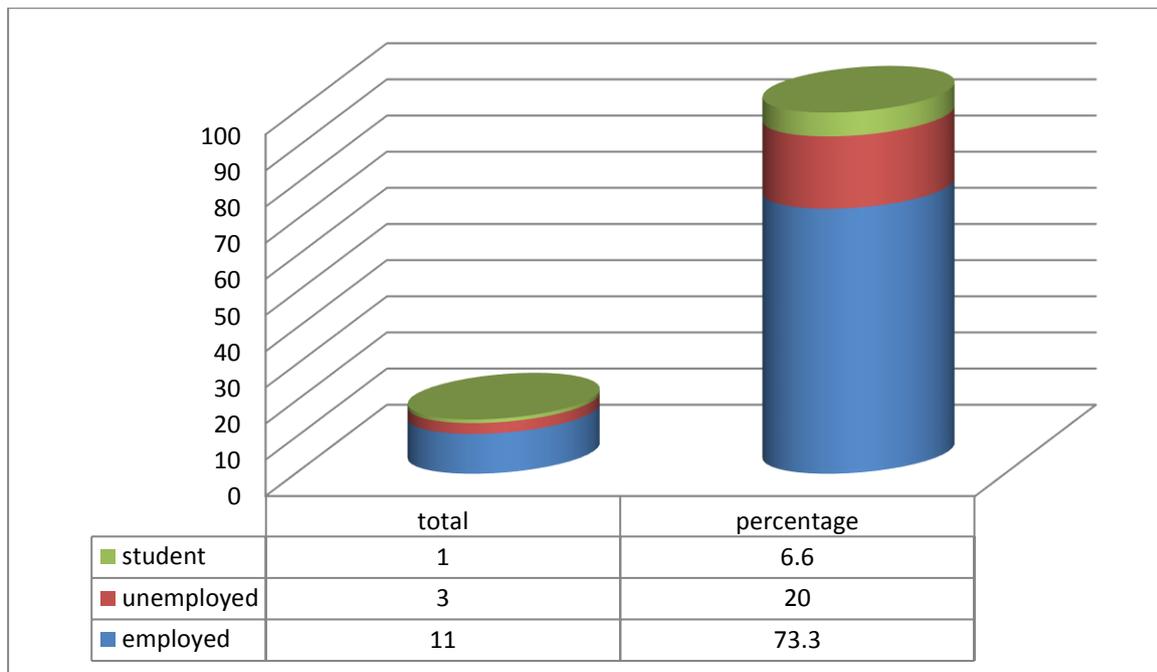


Figure 4.5 Participants' employment status (N=15)

One participant was a student, three were unemployed and eleven were employed. More than half of participant's views regarding termination of pregnancy were not dependent on their employment status. Their views were based on their personal beliefs. For instance, Participant 10, who was 21 years old, completed matric and unemployed gave this response when asked about her views on TOP:

“Ahh ... according to me abortion ... eish! Not good to abort a child. I think they are careless. They should use condoms or contraceptives to avoid being pregnant, until they think they are ready. I will just admit my mistake and continue with pregnancy.”

According to Little (2003:12), for many women who contemplate abortion, the desire to end pregnancy is not centrally, a desire to avoid the nine months of pregnancy, it is to avoid what lies on the far side of those months, namely motherhood.

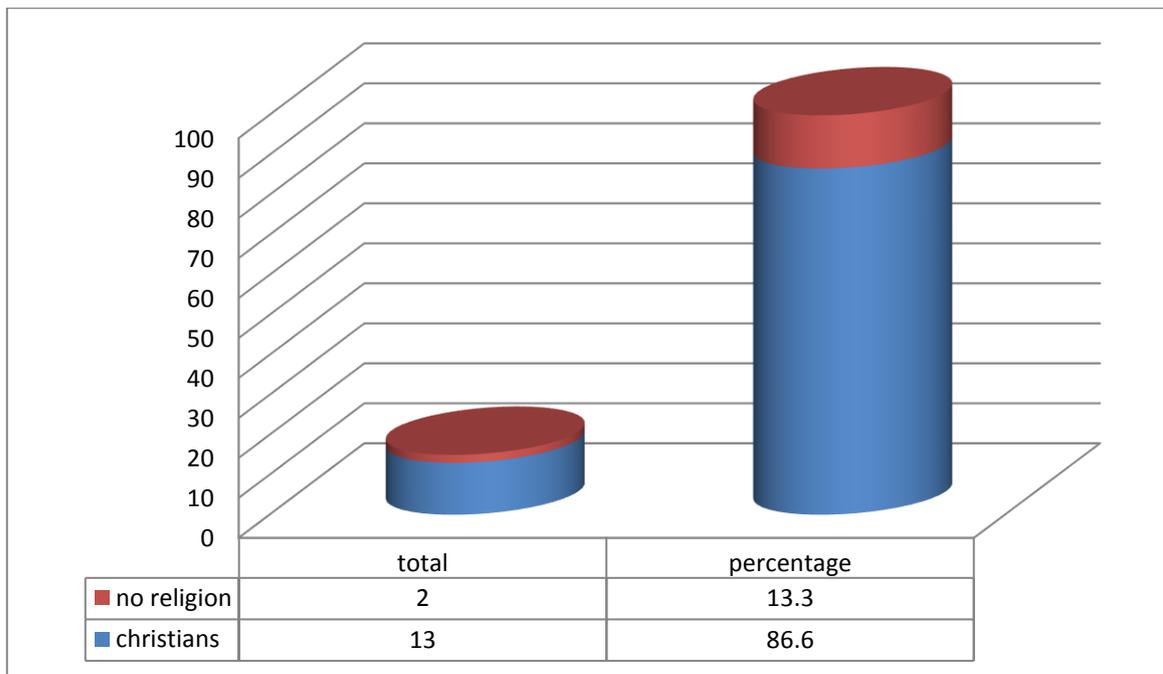


Figure 4.6 Participants' religious background (N=15)

Two participants belonged to no religion and thirteen participants were Christians. Most participants indicated that abortion was against their church doctrines but argued that if they are confronted with some circumstances whereby it would be difficult to keep the pregnancy, they would terminate the pregnancy. See below one of the participant's response.

Participant 3:

"Personally, will leave with it, will just have the baby. But, I know there are circumstances which may course you to do abortion or terminate the pregnancy. Like for instance if you are pregnant and the doctor tells you that the child, the unborn child is not going to be normal, personally, I may choose to have abortion."

Religious beliefs affect community perceptions regarding termination of pregnancy, thus dictating a belief system and codes of behaviour. Many Christians believe that abortion is murder and thus inherently immoral. Many South Africans are Christians, one participant who is a Christian commented as follows:

Participant 14:

Eish! Abortion ... from my side abortion is killing and according to my religion killing is not what God wants.”

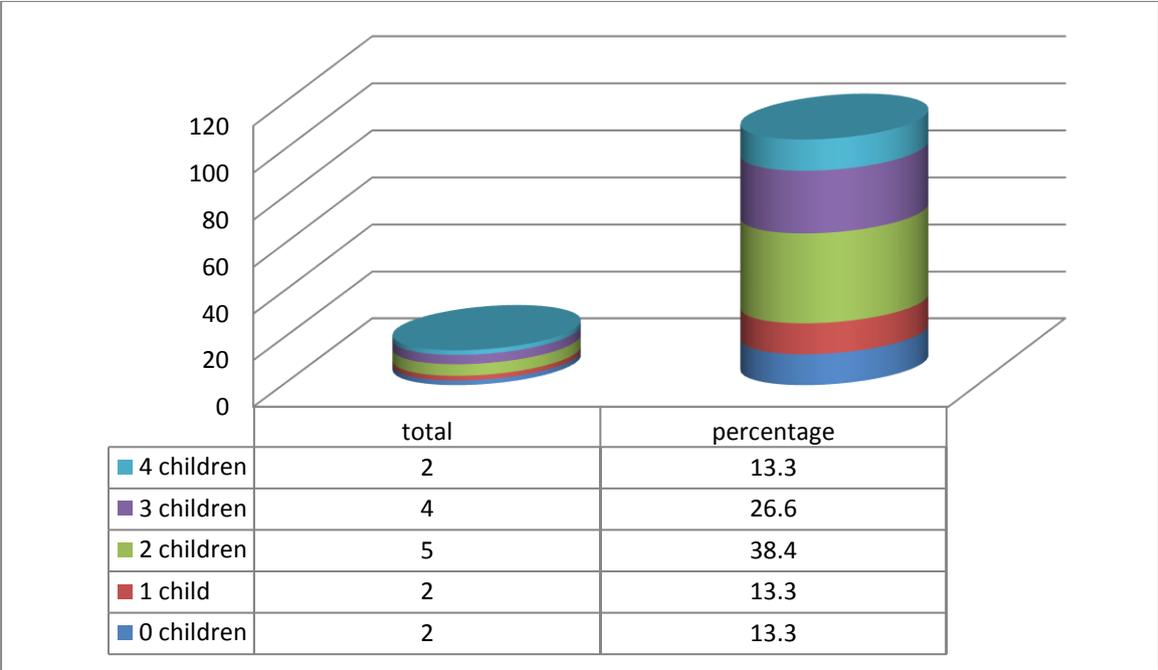


Figure 4.7 Participants’ number of children (N=15)

Two participants had no children; two participants had one child. Five participants had two children. Four participants had three children and two participants had four children.

Some participants indicated that the influence on their abortion decision was based on the number of children they had. Participant 9 had three children and this was her comment:

“For me now, due to affordability and due to my health, I would consider abortion because it’s my body and it’s my choice. I think we are being selfish this nowadays cos we don’t even look at our budget, we just go and make babies”.

Interpretive method was used to analyse data. Identified codes were collated resulting in patterns which used themes, categories and sub-categories. These themes were used to represent community perceptions regarding legal choice of termination of pregnancy. Themes are illustrated in Table 4.2.

Table 4.2 Major themes, categories and sub-categories

No	Major Themes	Category	Sub-category
1	Knowledge and understanding	Understanding of the concept "abortion"	<ul style="list-style-type: none"> • Definition of abortion. • Abortion process
		Access to information about TOP.	<ul style="list-style-type: none"> • How they got information • Where they got information
		Information about rights to TOP.	<ul style="list-style-type: none"> • Minor's rights • Partners' rights • Women's rights
		Information surrounding TOP laws	<ul style="list-style-type: none"> • Legal limit for abortion
2	Identification of legal facility	Professional environment	<ul style="list-style-type: none"> • Clean environment • Trained staff
		Availability of relevant resources	<ul style="list-style-type: none"> • Sterile equipment • Medication available
		Safety to be guaranteed	<ul style="list-style-type: none"> • Explanation of procedure • Explanation of side effects • Proper management of complications
3	Support of family members and staff	Readiness to do termination	<ul style="list-style-type: none"> • Solution for unplanned motherhood
		Lack of support from family	<ul style="list-style-type: none"> • Parental support • Partner support
		Lack of support from staff	<ul style="list-style-type: none"> • Judgmental attitudes
4	Unplanned pregnancy	Rape	<ul style="list-style-type: none"> • Sex without consent • An unplanned pregnancy
		Financial challenges	<ul style="list-style-type: none"> • Affordability • Socio-economic situations

No	Major Themes	Category	Sub-category
		Contraceptive failure	<ul style="list-style-type: none"> • Lack of consistency in contraceptive use • Lack of knowledge about drug interaction • Lack of knowledge about emergency contraception
5	Opinions on illegal termination of pregnancy	Safety compromised	<ul style="list-style-type: none"> • Fear of death • Fear of infertility • Fear of complications
		Provision of inappropriate procedures	<ul style="list-style-type: none"> • Unsafe procedures • Unsterile instruments • Pregnancies
		Call for government intervention	<ul style="list-style-type: none"> • Law enforcement
6	Opinions on termination of pregnancy	TOP prompted by negligence	<ul style="list-style-type: none"> • Deliberate unprotected sex • Alcohol consumption • Abuse of TOP services
		TOP as a health risk	<ul style="list-style-type: none"> • Recurring miscarriages • Infertility
		TOP is acceptable	<ul style="list-style-type: none"> • As an option of unwanted and unplanned pregnancy • As a prevention of pregnancy complications • As a woman's personal choice and right
		TOP not morally permissible	<ul style="list-style-type: none"> • Against religion • TOP is murder
		Opinions on ethics of creation	<ul style="list-style-type: none"> • Partner involvement • Fatherhood
		Opinions on ethics of destruction	<ul style="list-style-type: none"> • Abortion is killing • Insensitive decision

4.3.2 Theme 1: Knowledge and understanding

The knowledge and understanding of communities regarding what is termination of pregnancy and how it is done were explored. The participants' understanding about abortion was characterized by their different views and opinions.

4.3.2.1 Understanding of the concept “abortion”

Half of participants displayed an understanding of abortion, as reflected from the following responses, for example:

Participant 1:

“When you end your pregnancy deliberately and there is no birth at the end.”

Participant 7:

“Abortion is when you don’t want that pregnancy.”

Participant 9:

“With abortion, I understand that is termination of pregnancy.”

According to the CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008, termination of pregnancy means a separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman, which justifies the participant’s responses.

Abortion, whether induced or spontaneous, is the termination of pregnancy before the foetus is capable of extra uterine life (WHO 2008).

Other participant indicated limited knowledge that is far-fetched as stated below.

Participant 4:

“All they say they said it’s painful, and is not healthy, I didn’t understand.”

Participant 6:

“No, I don’t have information. I heard rumours, but I’m not sure.”

The above responses indicate the community's lack of basic information regarding TOP or the concept abortion. As highlighted by Horde and Xaba (2002:21), a study conducted by the Women's Health Project found barriers to TOP implementation at the community level. In general, information among women was lacking or inaccurate about basic physiology, misconceptions about unwanted pregnancy, the passage of the CTOP Act (Act 92 of 1996), and the fact that women have the sole right to make decide about ending an unwanted pregnancy.

4.3.2.2 Access to information about TOP

The CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008, stipulates that medical practitioners and midwives must provide women with information concerning their rights in relation to the CTOP Act (Act 92 of 1996).

Most information about abortion was accessed from radio, television, schools, pamphlet distribution and other participants heard from friends. This was highlighted from the examples below:

Participant 1:

"Mostly I heard about abortion when I was in high school in town".

Participant 5:

"I hear it, radio, TV, newspapers, magazines, even some of the peoples around."

Participant 10:

"I only heard is legal in South Africa from talking to my friends."

Participant 11:

"Hai ke sesi (No sister), I can hear from radios, from TV's or some people talking around."

The Promotion of Access to Information (PAIA) Act (Act 2 of 2000), section 32(1) states that, everyone has a right of access to information held by the state which is required for the exercise or protection of his or her rights.

Lack of access to relevant information about reproductive health matters will prevent communities from exercising their right to make informed choices on reproductive decisions. For an example, participant 14 had this experience:

“Ok, I’m not definitely sure about abortion but what I can tell you is that, ee ... when I was pregnant with my second born, I did try to abort neh, by hearing from somewhere when they tell me you can drink this and this, and that thing never worked. I think it was analdin, those tablets, analdin and something medication of, mix of ee ... mxm, what you call? Skanama, whatever mix of this, but it never worked.”

4.3.2.3 Information about rights to TOP

Almost all participants indicated an understanding about the right to TOP. They further displayed knowledge about personal choice and the right to privacy, the fact that it is legal in South Africa as reflected below.

Participant 2:

“You make a decision that you do want to do termination or you don’t want”.

Participant 3:

“You may choose to terminate or abort.”

Participant 7:

“When you don’t want that pregnancy, you can have abortion.”

Participant 8:

“Ke utlwisisa gore o na le tokelo ya go ka ntsha mpa”.

(I understand that one has a right to do abortion.)

Participant 9:

“I would consider abortion because it’s my body and it’s my choice”.

The above responses indicate that, access to TOP services is not only legally sanctioned; it is also a constitutional right for women who choose to terminate their pregnancies. The CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008 states that women should make their own decision whether to terminate or not.

Subsection (6) of the CTOP Act (Act 92 of 1996) further states that “a woman in terms of section 2(1) request a termination of pregnancy from a Medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under the act by the person concerned”.

The women’s right to choose is further supported by Roberts (2010:37) stating that the pregnant woman may have the early abortion for a good reason, for a poor reason or for no reason at all. She need not prove or believe that her foetus is defective, or argue that her health is at stake, or claim or provide evidence that she is a victim of rape or incest. She may do just as she pleases.

4.3.2.4 Information surrounding TOP laws

More than half of participants understood that the law allows a woman to terminate her pregnancy legally up to 12 weeks. Examples are highlighted below.

Participant 2:

“According to the months, I think is zero to three months.”

Participant 7:

“You can have abortion, but if you only have 12 weeks, not over 12 weeks.”

Participant 8:

“Go ya ka molao (According to the law), maybe three months.”

Five participants were not sure of the legal limit to terminate a pregnancy. Note the following responses:

Participant 1:

“As I said previously, I am not sure, but ... is five months, I’m not sure, yea.”

Participant 3:

“I am not sure, I think its 12 weeks, but I am not sure.”

Participant 9:

“Ahh ... 4 months hey ... I forgot.”

Participant 13:

“According to the law, I don’t know, they talking about 6 months/ I’ve heard about six months, but I’m not sure about it.”

Participant 5 didn’t know anything at all. His comment:

“I have no clue, because I never been in the situation before.”

The CTOP Act (Act 92 of 1996), section (1)(a) states that “a pregnancy may be terminated upon request of a woman during the first twelve weeks of the gestation period of pregnancy”. The lack of clarity and knowledge about abortion laws in many African countries, coupled with poor access to health services, often result in many women using clandestine, risky, unorthodox and unsafe means to induce abortion, thereby significantly increasing their risk of dying through complications as stated by Izugbara et al (2015:484).

4.3.3 Theme 2: Identification of legal facility

Most of the participants could explain what to expect from a legal facility, as reflected in table 4.2, when identifying a legal facility.

4.3.3.1 *Professional environment*

Participant 1:

“It must be a clean environment that for me is very important.”

Participant 2:

“If you can speak to a professional nurse like you, then I know that’s legal.”

Participant 8:

“Ke nahana ... ba fihla ba go bea fase, ba bue le wena.”

(I think ... when you arrive, they put you down and talk to you.)

Ba go jwetse ntho engwe le engwe, le gore ha o etsa tje, go tla etsahala tjenana.
Maybe ka kgolwa ke yona pleke e hantle.”

(They tell you everything, when you do this that will happen, I believe that is the right place.)

Participant 10:

“Ehh ... it will have to be a place where there are qualified nurses and doctors”.

As recommended by Needle et al (2008:79), women should seek an abortion from a state-licensed clinic whose staff participates with the several organisations that help set the guidelines for medically safe abortions. In terms of section 2(1) of the CTOP Act (Act 92 of 1996). Boezaart (2010:25) concurs with Needle et al (2008), that the termination of

pregnancy by a qualified health practitioner within the first twelve weeks of gestation is legal.

4.3.3.2 Availability of relevant resources

Abortion is a safe procedure when performed by skilled health care providers in sanitary conditions. The state is legally required to make the resources available in public sectors to promote access to safe and legal abortion. The WHO (2012:9, 87, 98) advises Governments that they have an obligation to “ensure that every woman who is legally eligible has ready access to safe abortion care”.

From the participant’s responses, the researcher could deduce that participants were familiar with most of the relevant resources necessary for providing legal TOP. For instance, the facility should have an ultrasound to confirm gestation, an autoclave machine to sterilise equipment, procedure bed to perform surgical procedures and all emergency equipment should be in readiness for proper management of any complications.

Participant 1:

“It must have all the necessary equipment like hospital beds, sonar machine, yea, and other machine they use.”

Participant 3:

“I think they must be having certificate, operating certificates on the wall to show that they are lawfully licensed people.”

Participant 7:

“You can ask for certificates, so that they can show you that, and you can be sure that this is legal clinic, yea.”

Participant 3 and 7 ‘s responses about certificates are very important, as it concurs with the CTOP Act (Act 92 of 1996) that TOP has to be performed by a registered medical practitioner or a registered midwife who has completed the prescribed training course.

Participant 9:

“They must have the registered number, and you can also google it.”

Participant 10:

“Then such a place will also have to have all the equipment that is necessary.”

According to the CTOP Act (Act 92 of 1996), TOP may take place only in a facility designated by the minister after ascertaining that all relevant resources are available in the facility. The procedure may only be carried out by a medical practitioner or by a registered midwife who has completed the prescribed training course.

4.3.3.3 Safety to be guaranteed

According to Grimes et al (2006:1908-1919), the International Conference on Population and Development (ICDP) held in Cairo in 1994 attended by representatives from 179 countries was the first global forum where an agreement was reached that unsafe abortion should be recognised and addressed as a community health problem.

In South Africa, termination of pregnancy was legalised to reduce and ultimately eradicate the burden of morbidity and mortality resulting from unsafe TOPs. The responses to follow embraces the safety of legal TOPs.

Participant 3:

“Abortion which is protected by the law it must spare you, maybe terminating it and becoming healthy again to have another child in the future.”

Participant 5:

“You ask someone that is professional and working there if, it’s safe, is it painful. Or... maybe after effects, things like that.”

Participant 6:

“Ba tla gofa dilo tse right tse di tshwanetseng mmele wa gago, ba gofa le-advise after aborting the child gore o tla dira eng ... ee.”

(They will give you appropriate medication and advice on post abortion care.)

Participant 7:

“You’ll never get hurt, they’ll never do anything wrong or something.”

Participant 10:

“And you know that if anything can happen to you, they will be able to handle whatever complications that can happen.”

The above responses explain the extent to which the participants feel safe and protected when they access TOP services in a facility which meets all the legal requirements as the Act obliges.

The CTOP Act (Act 92 of 1996), as amended by Act 1 of 2008, surgical termination of pregnancy may take place only at a facility designated by the Minister by notice in the Gazette for that purpose under subsection 2.

4.3.4 Theme 3: Support of family members and staff

Three participants expressed their readiness to do abortion should they be confronted with an unwanted pregnancy. They further displayed support from significant others like family members. Others reported lack of support from the professional staff. Responses are highlighted below.

4.3.4.1 Readiness to do termination

Women decide to terminate their pregnancies based on their life situations and the challenges they are experiencing over and above the burden of the unintended

pregnancy. Makutoane (2016:5) cited with this statement and states that most women seem to be content with the decision they made at the time. They managed to continue with their careers and keep their relationships.

According to Kimport, Forster and Weitz (2011:103), research has shown that while most women experience relief following abortion, some experience regret. A woman sometimes decides to abort because she is not yet ready for motherhood. As confirmed by Little (2003:12), that “gestation doesn’t just allow cells to become a person, it turns one into a mother”. The responses stated indicates readiness to terminate based on the participant’s circumstances.

Participant 1:

“I would abort based on my previous experience with my sister, and also like just based on the fact that I am just not ready.”

The decision to terminate seemed to have economic reasons as indicated in the response.

Participant 14:

“And I’m working, but the money that I earn is not much more that I can make a baby again.”

Financial implications were also highlighted by participants as stated in the responses.

Participant 2:

“I can’t take the risk of getting the child cos I’m not working, and I’m not ready.”

Participant 9:

“Like always, you do have another option which is abortion. If you are not ready, either do an abortion or you can ehh ... you can have your baby and take your baby for adoption.”

There was also an indication of knowledge regarding other options women could consider rather than abortion as reflected in this response.

Papadaki (2012: 159) shares same sentiments with the above participants by stating that it would be thought kinder for a woman to abort the fetus if she knows that she is unable to properly care for a child and attend to her needs.

4.3.4.2 Support of family

Three participants clearly indicated that they will never advice or support their family members to do abortion, even if they knew that it is legal, as expressed in these responses.

Participant 3:

“I will advise to keep the pregnancy as long as the baby who is inside is healthy.”

One participant further offered to assist with the upbringing of the baby.

Values and beliefs were also reflected in participant’s responses.

Participant 8:

“Ha a motlogelle, o tla mohudisa, re tla thusana.”

(She must keep the pregnancy, we will assist her.)

Participant 4:

“I will keep the baby. No, I won’t because I don’t believe in abortion.”

Two participants chose to support their family members to do abortion.

Participant 1:

“She was 17-years-old and found that she was pregnant. She decided that she would like to abort, and I supported her decision.”

Participant 13:

“Maybe let’s say maybe ee ... she jumped the pill, then we can notice kuthi (that) no, something is wrong. Then I’m gonna take her to the doctors to make it professional.”

Situations at home and issues like culture, religion and parental belief systems have an impact on decisions to terminate a pregnancy. Hlalele (2008:14-15) attests that, such constructs may influence the pregnant adolescent to terminate or not to terminate. Price (1983:149-150), contends that parents often respond to adolescent pregnancy with anger, and may feel ashamed of their daughter’s immoral behaviour. This view is not taking into consideration the challenges related to unplanned pregnancy. The interruptions of future plans, subsequently limiting the earning potential, subjecting them to financial problems.

4.3.4.3 Lack of support from professional staff

Pregnant women’s rights to access legal TOP services might produce conflicts with professional nurses’ obligation to preserve life. Despite the advent of safe legalised TOPs in South Africa, many women might fail to access this services due to too few TOP sites and too few nurses providing this services (Albertyn 2002:13).

According to Rabelo (2002:42), nurses working in TOP clinics in the RSA were overworked and most of them did not want to work in these departments. Some participants were unhappy about the conduct and attitude of other professional staff when they requested termination of pregnancy, and stated that:

Participant 1:

“Yaa ... they were looking at us funny and we could feel the judgement basically, and it was just very uncomfortable.”

Participant 13:

“Ehh ... the question that I have was that when it comes to confidentiality that is the true. I have heard when patients goes to the clinic, you find that maybe a nurse is a Christian, they turn to react on that. They turn to get personal on that. I think they need to take them for training, cos eh...it's the patient's right to decide what they want.”

Health care providers are very concerned about teenage pregnancies since teenage mothers are at risk of higher morbidity and mortality rates during pregnancy including additional health problems like sexually transmitted infections and HIV, hence perceived as being judgemental (Ehlers, Maja, Sellers & Gololo 2000:43).

According to Mogotlane (1993:11), as cited by Smith-Battle (2000:85), teenage pregnancy is a global public health problem and has been a concern to health workers, community developers, educators and parents since the early nineties.

In South Africa, pregnancy statistics reveal that young girls aged 18-25 tend to terminate pregnancies more frequently than older women (Varga 2000:285).

Participant 9:

“Most of the girls goes to the backstreet. They are afraid to go to the local clinics. Being shouted at, being embarrassed, you know all that.”

Ethically, nurses as caregivers are taught to preserve life. In addition, the Democratic Nursing Organisation of South Africa (DENOSA) believes that nurses have a right to freedom of choice (Poggenpoel, Myburg & Gmeiner 1998:4). Therefore, the legislation of TOP by the Republic of South Africa's (RSA) government might impose ethical and or moral dilemmas on nurses expected to provide TOP services.

4.3.5 Theme 4: Circumstances leading to abortion

Most participants knew and could explain the circumstances that may warrant or lead to abortion as cited in the comments categorised below.

4.3.5.1 Rape

Five participants identified rape as one of the circumstances for doing termination of pregnancy. They acknowledged that this is one of the unforeseen circumstances which can be beyond the women's control when deciding to do abortion. Responses were expressed as follows:

Participant 1:

"Hmm, I would imagine that women would have various reasons to have an unwanted pregnancy, most common one for me would be rape, because I could imagine that women would not be willing to the child. It would be quite difficult to keep the child under those circumstances, painful circumstances."

Participant 3:

"It's either through rape, of which you won't plan to be raped."

Participant 4:

"When you walk in the streets, and then you are raped, yea, that's why unplanned."

Participant 7:

"Some pregnancies come like rape, at young age like girls."

Participant 8:

"Ba bang ke peto, o kgona go bana le mpa e eleng gore a wa ikemisetsa. Ke gore ke mpe ke etse abortion."

(Others is rape, one can have an unintended pregnancy through rape, I will just do abortion.)

It would be cruel and callous to force a pregnant woman who had been raped to give birth to a child. Judith Jarvis Thomson maintains in her article "A Defense of Abortion" that the right to leave does not include the right to make use of foreign body even if this means having the fetus aborted (Thomson 1984:174-177).

4.3.5.2 Financial challenges

From socio-economic perspective, lack of finances to support the baby was also highlighted as follows:

Participant 3:

"Financial implications I think is the most important thing that makes women do termination."

Participant 6:

"Maybe situation ya gage ko ntlung or ko a nnang e ka se be alright for ngwana. Le financially gore a ka kgona go mo hlokomela." (Situations at home are not ok and can't afford to take care of the baby.)

Participant 14:

"And I am working but the money that I earn is not much more that I can make a baby again."

From the above responses it was noted that participants did not want their live status to be changed by the birth of an unplanned baby as that will interfere with their affordability.

The reasons for terminating unwanted pregnancies were cited by other researchers as common reasons for wanting to do so. Needle et al (2008:88) confirmed that often women's reasons include inadequate finance and inability to assume the responsibility of a child at that particular time. Sometimes, the woman has no other children, whereas in

other cases she may believe that another baby will harm her ability to parent her other children.

Another frequent reason given is the fact that having a baby at that time would sufficiently change the woman's life in an unwelcomed way. The statement was also supported by Little (2003:9), stating that "women sometimes decides to abort even though they regard the fetus they carry as their child, because they realise, grimly that bringing this child into the world will leave too little room to care adequately for the children they are already raising".

Furthermore, Denis (2008:124) embraces a woman's decision to terminate if that pregnancy puts one in a position to struggle, diminishing the woman's agency, dignity, equality and making her financially dependent on others.

Other researchers like Lowen (2014:15) states that TOP by choice is more likely amongst those adolescents who are still attending school and are under pressure from a partner or parents. Unfortunately, they are also financially dependent on their parents and won't afford to continue with an unwanted pregnancy.

4.3.5.3 Contraceptive failure

Four participants acknowledged that sometimes non-compliance to contraception can lead to unplanned pregnancies which will lead to abortion.

Participant 1:

"Maybe you are on the pill and you are not taking the pill correctly, pill will result in not working effectively thus falling pregnant."

Participant 3:

"Using contraceptives like condoms, they may burst, then you fall pregnant."

Participant 7:

“Maybe will be you didn’t drink your pills, and maybe you were saying you are not going to have any children.”

Participant 10:

“I only discovered at that time that sometimes when you are taking antibiotics, and you are taking the pill, you can fall pregnant.”

The participants were aware of their right to make contraceptive choices, but lacked information about proper utilization of different contraceptive methods.

Other researchers have different views on contraceptive failure. Dworkin (1993:13) states that very few people regard abortion as moral equivalent of contraception. Most think a society better morally- not just by public health measures- if it regards abortion as a backup to failed contraception rather than as routine birth control. Reasons adequate for contraception often do not translate transparently as reasons adequate for termination of pregnancy.

4.3.6 Theme 5: Opinions on illegal TOP

Half of participants commended about the inappropriate procedures provided by illegal people, which subsequently have negative implications to women’s health.

4.3.6.1 Safety compromised

All 15 participants were concerned about the danger of doing illegal abortion that could lead to complications like infertility and furthermore emphasised the fear of dying. Some of the comments are as follows:

Participant 13:

“But if she goes there on the other side, the backstreet, you won’t know what will happen, she can die.”

Participant 10:

“Sometimes women can’t have kids anymore, and sometimes women die in those places.”

Participant 9:

“You might die, you will definitely die because you might bleed to death.”

Participant 7:

“They will cause problems to your body, doing harm to your body. So, I don’t think is right to go to illegal places.”

Participant 3:

“You might die, or they might take out your womb and you will never have children again.”

Complications may include future miscarriages, future premature deliveries and low birth mass, ectopic pregnancies, placental complications or sterility. Psychological problems may be depression, anger, nightmares, grief, and regret, loss of interest in sex or fear of punishment (Gouws, Kruger & Burger 2000:173).

4.3.6.2 Provision of inappropriate procedures

Participants were aware of inappropriate procedures done by inexperienced, untrained providers in unhygienic conditions with a complex of possible risk factors that include infection.

Participant 1:

“They might have unorthodox procedures which are not safe. It might be like unhygienic, they might not be cleaning the instruments as often as they should.”

Participant 6:

“You can die because they don’t know how many weeks you have, how many months you have, you can, and you will die.”

Participant 12:

“So, I-back abortion is very dangerous because a ba kuenzi nge ndlela e fanele. Ba kuenza nga ma-needle. And then ba kuenza le e-wumbini, ba hlaba na le womb nga ma-needle and izinto za khona is not sterilised.”

(Backstreet abortion is dangerous because is not done properly. They inject your womb with needles and their things are not sterile.)

Women and girls should not have to risk their lives and health to end pregnancy. Illegal abortions are generally unsafe and lead to high rates of complications, maternal deaths and injuries (WHO 2012:23, 46-47).

4.3.6.3 Call for government intervention

Some participants suggested that there has to be some legal interventions against all those who are providing abortion illegally of which Government should take control.

Participant 2:

“If I am the one from Government, I would say I must take action to close those places and teach people where to go.”

Participant 3:

“I think they must just be reported, and be arrested because they gonna end up killing people.”

Participant 6:

“Aaa ... tseo, ke nagana gore ba deale ka bona batho bao, because ba gobatsa batho, ba bafa le dipilisi tse wrong.”

(Those ones, I think they should be dealt with because they harm people, giving them wrong pills.)

Participant 12:

“Ma babanjwe, ba bonisiwe ukuthi uthetho unjani entweni ezifana nama back abortions.”

(Let them be arrested, and be shown how the law operates when coming to backstreet abortions.)

4.3.7 Theme 6: Opinions on termination of pregnancy

Participants used moral values to justify their opinions on termination of pregnancy. Others interpreted TOP as the results of one’s negligence, wrong and a gross violation of human life, others as a right, further saying people has the right of choice. Refer to table 4.2.

4.3.7.1 TOP prompted by negligence

Participants believed that women end up doing abortion because of their careless mistakes, and ignorant to use contraceptives as cited below. An emphasis was put on the use of a condoms.

Participant 1:

“Like maybe in a drunken state, they would have unprotected sex. They just have unprotected sex generally.”

Participant 5:

“Yes, because they cannot ehh ... expect to have sex and not get pregnant. Yes, the better way is to condomise.”

Participant 6:

“Because of careless, I think they are careless. They should use condoms or contraceptives to avoid being pregnant.”

Participant 8:

“Hobane le bana ba bannyane ba se ba etsa fela gore ba robale ntle le polokego, ga ba qeta ba tsamaye bailo gontsha mpa.”

(Because even young kids, they just sleep around without protection, then thereafter terminate that pregnancy.)

The stated responses regarding TOP as prompted by negligence are not evidence based. Jones & Kavanaugh (2011: 1358-1366) states that recent studies have shown that 45% of women have at least one abortion before the age of 45.

Feldman (1998: 270), emphasizes that to be a moral agent is to make choices and to have reasons for those choices. He further concludes that failing to consider women’s choices when it comes to pregnancy and abortion, considering abortion to be immoral is inadequate and ultimately illegitimate.

4.3.7.2 TOP as a health risk

Participants were convinced that abortion whether legal or illegal, it poses a health risk, as expressed below.

Participant 2:

“What we were afraid about is that there is a possibility that she can’t get pregnant again.”

In the above response, participant 2 was ill-advised by a health professional that if she supported her niece to terminate her pregnancy, she might not fall pregnant again, regardless of the procedure being done legally.

Participant 6:

“Maybe they will abort the baby and at the end, a se hlole aba le bana.”

(Not having children anymore.)

In the above response, the participant was concerned about her friend who terminated illegally, anticipating that she will be exposed to health risks like infertility.

Participant 8:

“Qetellong ba tlo thola e le gore ha bana bana, hobane ha ba tsebe seo ba se etsang.”

(At the end, they won't have children because they don't know what they are doing.)

Participant 15:

“Gonale moagishane o mong waka kamo gageshu kamo khi. O sale yena, o sale a ntsha ya mathomo, a bowa a ntsha ya bobedi, ya boraro a tlogela, ngwanantshe a feta. After go feta, until le gona jwale, ke a tshepha a ka be a lata bo ma-fifty, ga ana ngwana.”

(I had a neighbour at home, she did the abortion twice, and kept the third pregnancy, but the baby died. To date, she's in her fifties, and she doesn't have a child.)

Denis (2008:123) provides a more comprehensive, yet contradicting consideration of abortion by asserting that the pleasure associated with the impulses to have sex give rise to temptations to act on them in ways destructive to animal nature or demeaning to animal

nature. Furthermore, pregnancy labour and delivery often pose a credible threat to a woman's life.

4.3.7.3 TOP is acceptable

Some participants displayed to be pro- choice depending on the circumstances. They expressed they could even go to an extent of doing it or encouraging someone to do it if a need arises.

Participant 1:

"I think abortion is ok. I do not think any child deserves to come to the world and suffer."

The circumstances under which TOP could be undertaken were shared as follows:

Participant 3:

"Like for instance if you are pregnant, and the doctor tells you that the child, the unborn child is not going to be normal, personally I may choose to have abortion."

Participant 2:

"I'm not against it, because sometimes I can be pregnant, and by that time I don't want that baby, then I can go on do it."

More considerations if pregnancy was due to rape or incest were as follows:

Participant 7:

"If it's a rape, it's painful. It's going to remind you every now and then, you can have an abortion so."

One participant could not see any problem in terminating an unwanted pregnancy if it is legal.

Participant 10:

“If I’m aware that termination of pregnancy is legal, then is one of the options I can consider if I fall pregnant and I don’t want to keep that pregnancy.”

Choosing to have an abortion is a personal decision based on women and girl’s individual social or economic life circumstances. No matter how well fertility management services and information are implemented, there will always be a need to ensure access to abortion services.

In some instances, TOP is considered morally acceptable. Denis (2008:131) discusses abortion as morally acceptable if that pregnancy threatens the life of the mother, and attempting to carry such a pregnancy to term would be a violation of one’s perfect duties to herself.

4.3.7.4 Abortion not morally permissible

Most participants reported to be Christians. They regarded abortion as an act against God’s will and that is morally wrong. They believe that, that unborn child’s life is worthy of respect and that it is a gift from God.

Participant 2:

“So, we decided, let’s not do it. If it’s a blessing from God, then it’s fine.”

Participant 7:

“I will have to accept it, be pregnant for nine months and have a baby. God will help me; the baby will grow.”

Participant 12:

“So, I said to her you know is not right, I’ll never know this child is a gift from God and don’t do it.”

Participant 14:

“Abortion is killing, and according to my religion, killing is not what God want.”

Researchers have different views about the morality of abortion. In contrary to the participant's views, to put it simply, the right to life, as Thomson (1971:7) put it, does not include the right to have all assistance needed to maintain that life. Ending gestation will, at early stages at least certainly lead to the foetus's demise, but this does not mean that doing so would constitute murder.

Needle et al (2008:72) state that clients often believe that they are committing a sin or engaging in a shameful act when making the decision to terminate pregnancy. It may be helpful for them to be aware that the world community believes that it is one of their fundamental human rights to make this decision on behalf of their own needs.

McCoy (2011:151) states that aborting a fetus is morally problematic because such an action is a violation of our duty to cultivate morally useful sentiments, but aborting a fetus does not automatically destroy a woman's predisposition to such morally useful sentiments.

4.3.7.5 Opinions on ethics of creation

Six participants strongly felt that partners are responsible for procreation. They believe without partner's intervention, the foetus wouldn't exist at all. Biologically, they contributed towards conception. Furthermore, partners felt that they have the right to stop a woman from doing abortion. Views regarding these opinions are mostly from male participants and are as follows:

Participant 4:

“If the partner doesn't want the baby, yes he can because he is also part of the baby.”

Participant 5:

“Of cause 100%, because I am the one who impregnated you, so I don't think maybe it is a right for you to go to clinic to do abortion.”

Participant 7:

“But if the partner does not want, he can tell the woman not to do abortion, but to give birth to that baby, then bring it to the partner. Partner has the right.”

Participant 8:

“Ee ... onale tokelo, hobane e tla be e le ngwana wa hae le ena akere.”

(Yes, he's got the right, because is his child too.)

Participant 13:

“I think I should have the right also to stop her not to do it. I would like to be like that because is also my baby.”

Participant 15:

“If monna wa amogela, mosadi ga a amogele, o tshwanetse a kwe nna ga ke amogela kere aowa, ke ngwanaka, e.”

(If I don't agree, then the woman will have to abide by my choice, is my child.)

The above interview statements deduce that there is still some stereotypical ideas in men regarding issues of reproduction and abortion. According to Reich (2008:10), men's decision regarding abortion is informed, among other factors, by their own desire to be a father or rather to take on the identity of father and its accompanying responsibilities.

Above all, the views stated above are contrary to the Choice on Termination of Pregnancy Act (Act 92 of 1996), as amended by Act 1 of 2008, stating that women should make their own decision whether to terminate pregnancy or not.

One position, advocated by Thomson (1971:8) and some of the most recent treatments of abortion, is classically liberal one. It agrees that special responsibilities attach to parenthood but argues that parenthood is thereby a status that is assumed by consent.

4.3.7.6 Opinions on ethics of destruction

Three participants felt that men are responsible for the pregnancy, and it is unfair to be marginalised when it comes to the decision to abort. Furthermore, they viewed abortion as a failure of male partner to protect their unborn baby. In their view, ending gestation was tantamount to killing.

Participant 5:

“I really don’t promote it, I think it’s heartless.”

Participant 13:

“Very scary, very very scary. It feels like you are killing someone.”

Participant 15:

“Ee ... nkase bolaye ngwana o e leng waka ke mo tlisitse lefatsheng, ke sebe seo.”

(I won’t kill my own child, that’s a sin.)

According to Little (2000:3), “on the morality of abortion, it is stated that, on the usual view, it is perfectly obvious what to say about abortion on supposition of foetal personhood: If foetuses are persons, then abortion is murder. Persons after all have a fundamental right to life, and abortion, it would seem, counts as its gross violation”. As Dworkin (1993:3) puts it, the researcher locates issues of abortion in a different neighbourhood of our moral commitments: namely, “the accommodation we owe to things of value. That an organism is a potential person, may not make it a claims-bearer, but it does mean it has a kind of stature that is worthy of respect.” This statements support the participants’ moral point of view that abortion is killing.

4.4 CONCLUSION

Chapter 5 presented the findings of the study, extracts from interviews conducted with fifteen participants, twelve women and three men. Few men were interviewed since men viewed abortion as a women thing. Chapter 5 will discuss the conclusions, limitations as well as recommendations for the research.

CHAPTER 5

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

Chapter 5 presents the summary of the findings and conclusions. Discussion of limitations and recommendations of the study are also provided. The aim of the study was to explore and describe the perceptions of community regarding choice on legal termination of pregnancy. The conclusions answer the objectives of the study.

5.2 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the perceptions of the community regarding choice on termination of pregnancy, with the aim of increasing awareness and improving their understanding on the right of choice to termination of pregnancy.

5.3 OBJECTIVES OF THE STUDY AS HIGHLIGHTED

The objectives of the study were to

- establish community awareness regarding legal choice of termination of pregnancy
- explore the community understanding of legal choice of termination of pregnancy
- establish if the community can describe circumstances under which legal termination of pregnancy can be done

5.4 SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS

This study explored and described the community's awareness and understanding of legal termination of pregnancy. Fifteen participants were interviewed, and from the data collected, themes, categories and subcategories emerged. The first theme was established, then categories and subcategories were identified. The main themes identified are summarised below.

5.4.1 Knowledge and understanding

From this analysis, it was deduced that participants are aware of and understands what legal termination of pregnancy is through accessing information from radio, TV, schools and word of mouth. From fifteen participants interviewed, only two participants displayed lack of knowledge about termination of pregnancy. Most women had limited information about partner's rights, women's rights and minor's rights, as well as laws surrounding termination of pregnancy. This concludes that community could explain and define what termination of pregnancy is, but had inadequate knowledge and understanding of terminations of pregnancy rights and other factors.

5.4.2 Identification of legal facility

In this regard, participants could explain what to expect from a legal facility. They further explained what resources should be available in a professional environment. The participants also indicated that in a legal facility, their health safety is guaranteed since they will be attended to by well- trained providers in a hygienic setting who conducts safe surgical or medical procedure. From these findings, researcher could deduce that communities can differentiate a legal facility from an illegal one.

5.4.3 Support of family members and staff

Most participants expressed that they will not advice their family members including partners, to terminate their pregnancies, citing reasons, for an example, that they will help them to raise those children. Other participants mentioned lack of support from professional staff who are anti-choice and displayed some judgmental attitudes towards their decisions to request termination of pregnancy. These findings revealed that communities and other staff members are still reluctant to accept that the decision to terminate a pregnancy is a woman's choice.

5.4.4 Circumstances leading to abortion

Participants indicated various reasons why a woman can opt to terminate a pregnancy. They mentioned circumstances like rape, further explaining that it would be difficult to

raise a child who was conceived under those circumstances. Financial challenges which will create more socio-economic challenges if the unwanted pregnancy is not terminated. Contraceptive failure caused by non-compliance to the method was also highlighted.

These reasons were cited by most participants. The findings conclude that the need for abortion will always be there. The findings further confirmed that other pregnancies were unintentional and it was just impossible and difficult to avoid those unforeseen circumstances like for an example, rape. Participants understood that they have an option to terminate unwanted or unintended pregnancies legally and safely.

5.4.5 Opinions on illegal abortion

The majority of participants expressed concerns about the consequences of illegal TOP. They indicated how the inappropriate procedures compromised women's health, sometimes leading to death. These fears were supported by the participants' responses as stipulated in chapter four. Participants further appealed for government intervention so that these illegal providers could be closed down.

Some participants stated that other communities continue to utilise illegal facilities because they feel illegal providers will not divulge the information about TOP to anyone. Illegal providers want their illegal services to remain a secret. They don't want to face jail sentences due to their illegal actions thus deceiving vulnerable communities. Literature proved that illegal providers don't have stable addresses and landlines, hence they cannot be traced easily. The illegal advertisements were spotted on the streets or lamppost across the country, with mobile numbers only, no landline nor stable address provided.

The findings conclude that the community is against provision of illegal TOP based on the fact that termination of pregnancy is legal in South Africa.

5.4.6 Opinions on termination of pregnancy

Participants had different opinions regarding termination of pregnancy. Others argued that it is prompted by negligence, like deliberately engaging in unprotected sex. Others were totally against termination of pregnancy, giving reasons that it is a health risk which

can lead to infertility. Some said it is morally unacceptable and viewed abortion as ethics of destruction.

Other participants were pro-choice and indicated that legal termination of pregnancy is ok. The participants further expressed that they could terminate their pregnancies or advise someone to terminate if a need arises. The findings revealed that termination of pregnancy remains a contested terrain. The pro-choice and pro-life advocates will always have differing opinions or views regarding this matter.

5.5 LIMITATIONS

The participants in this study were mostly women, twelve women and three men were interviewed. Seven men were invited to participate in the study, four were reluctant to participate, and regarding TOP as a woman issue hence only three men were interviewed. This resulted into over-representation of women thus threatening generalisability. The topic of termination of pregnancy is very sensitive as such. Participants might have withheld some information thus compromising the study findings.

Notwithstanding the above limitations, the findings of the study can be used to improve access to termination of pregnancy services, and creating more awareness regarding community's rights to termination of pregnancy.

5.6 RECOMMENDATIONS

The recommendations for this study emerge from the study findings. Recommendations are for practice and further research.

5.6.1 Recommendation for practice

- Free, legal termination of pregnancy services should be available at the public facilities. Access of services where the communities reside is very crucial. It is important for communities not to travel several kilometres to access a termination of pregnancy service.

- There is a need to create awareness about TOP rights and empower community to exercise their rights in relation to termination of pregnancy issues.
- Government to have punitive measures in place for illegal providers, and illegal termination of pregnancy activities to be dealt with accordingly as failure to protect women from these illegal activities is a violation of the women's rights.
- Institutions should urge Health professionals to be supportive to communities requesting information regarding termination of pregnancy. Lack of support from health professionals was cited as a barrier to access legal termination of pregnancy services.
- Family planning services should be accessible and affordable to all. Contraceptive counselling to be provided, whereby all methods of contraception, including side effects are discussed. Allow women to choose their preferred method, taking into consideration the eligibility criteria for contraceptives.
- Teenagers to be informed of their rights to terminate their pregnancies, and no one has a right to deny them TOP service as long as they are within normal limits of gestation.

5.6.2 Further research

The following research project may be conducted:

- Explore why twenty years after legalisation of termination of pregnancy, access for the service is still a challenge in other areas.
- Establish measures which could be put in place to eliminate all illegal termination of pregnancy services and safe women's life.
- It is important to conduct other research studies in other context to expand the findings
- Explore TOP from the men's perspective.

5.7 CONCLUSION

The researcher aimed to establish community awareness regarding legal choice of termination of pregnancy. The findings of the study reflected that the purpose and

objective of the study were met. Most participants were aware of legal termination of pregnancy, having accessed information from various sources.

Much as community seemed to understand legal termination of pregnancy, it was evident that the community still needs to be given more information about the rights and laws surrounding termination of pregnancy to create more awareness. Above all, access to TOP services is still a challenge for many.

Most communities go to private providers for termination of pregnancy services, paying unnecessarily, whereas TOP services are supposed to be free and legal at public facilities. This study will urge relevant stakeholders at the Department of Health to designate more public facilities to provide free TOP services thus improving access.

Lastly, the researcher was interested in establishing if the community can describe the circumstances under which legal TOP can be done. The findings of the study revealed that the community was aware of these circumstances but their religious backgrounds and belief systems influenced their moral obligations regarding choice on TOP. Literature unveiled that the issue of morality and abortion still needs to be addressed widely. The study is justified since all the objectives have been met.

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ANNEXURES

ANNEXURE A: UNISA ETHICAL CLEARANCE CERTIFICATE



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

REC-012714-039

HSHDC/492/2015

Date: 9 December 2015

Student No: 882-961-6

Project Title: Community perceptions regarding legal choice of termination of pregnancy.

Researcher: Barley Balebetse Mahanyele

Degree: MA in Nursing Science

Code: MPCHS94

Supervisor: Dr MJ Mathibe-Neke

Qualification: PhD

Joint Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved

**Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B: APPLICATION TO CONDUCT THE STUDY (MAMELODI HOSPITAL)

PO BOX 53976
Wierdapark
0149

02 May 2016

The Manager
Mamelodi Hospital
Private bag x 0032
Rethabile
0122

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT YOUR HOSPITAL

Title of research: Community perception regarding choice on legal Termination of pregnancy.

My name is **Mrs Barley Balebetse Mahanyele**, a Masters Student at University of South Africa. It is required of me to conduct a research study as a requirement for obtaining the MA Health Studies degree. I will be conducting research on Community Perceptions regarding choice on legal Termination of Pregnancy. The purpose of the study is to explore the community's level of understanding regarding this Reproductive Health Choice. Primary goal of the study is to establish awareness on Termination of pregnancy legislation, where can the services be accessed and under what conditions or circumstances can a woman qualify for this service.

It is for the above reason that I request your permission to undertake the intended research at your Hospital. This institution was identified following the escalating numbers of unsafe abortions attempted by clients residing at the location nearer to your hospital. Statistics were retrieved from clinic records at BMM Reproductive Health Centre in Pretoria.

The format of the proposed research will involve conducting interviews, which will take about 30 minutes each client, and will not interfere with continuous patient care services. The number of men and women who will be interviewed cannot be determined at this stage as that will be determined as the study unfolds. Participants will be given adequate information about the research and will consent voluntarily to participate. All interviews will be audio recorded.

It is hoped that understanding the perceptions of the community and how they relate with termination of pregnancy clients will contribute significantly to increasing awareness about Reproductive health rights and choices.

Upon completion of the study, I undertake to provide the Department of Health with a copy of the full research report. If you require any further information, please do not hesitate to contact me on 082 832 2007 or 012 341 6777. Thank you for your time and consideration in this matter.

Regards

Barley Balebetse Mahanyele (MA Health Studies student)

ANNEXURE C1: LETTER OF PERMISSION TO CONDUCT THE STUDY (GDOP)



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Mrs Barley Mahanyele
Organization / Institution	UNISA
Research Title	Community Perceptions Regarding Legal Choice of Termination of Pregnancy.
Contact number	Address: N/A Contact no: 0123416777 Cell: 0828322007 Email: barley772@gmail.com
Protocol number	GP_2016RP21_548
Date submitted	13/01/2016
Date reviewed	10/05/2016
Outcome	Approved

It is a pleasure to inform you that the Gauteng Health Department has approved your research on Community Perceptions Regarding Legal Choice of Termination of Pregnancy.

Study sites: Mamelodi Hospital

The Provincial Protocol Review Committee kindly requests that you to submit a report after completion of your study and present your findings to the Gauteng Health Department.

Recommended/~~Not Recommended~~

Dr. B. Lkafeng
(on behalf of the PPRC)

Date: 10/05/2016

Approved/Not approved

Dr. LRR Lebethe
DDG: Clinical Service

Date: 16 05 2016

ANNEXURE C2: LETTER OF PERMISSION TO CONDUCT THE STUDY (MAMELODI HOSPITAL)



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MAMELODI HOSPITAL

Private Bag x 0032 P.O. Rethebe 0122
Tel no. +27 12 841 8300/8301

DECLARATION OF INTENT FROM THE CLINICAL MANAGER

I give permission to Barley Mahanyele (Name of researcher)
to do his or her research on Community perceptions regarding
legal choice of termination of pregnancy (Research topic)
in Mamelodi (Name of hospital).

Other Comments or Conditions prescribed by the Clinical Manager:

Research results to be made available to the hospital.

pp. P. P.

Signature:
Clinical Manager

Date 02 / 08 / 2016

ANNEXURE D: CONSENT FORM FOR PARTICIPANTS

Researcher: Barley B Mahanyele
MA CUR student
University of South Africa (UNISA)

Dear Participant

You are kindly requested to participate in the research study. See details below:

Title of Research: *Community perceptions regarding legal choice of termination of pregnancy.*

Purpose of the research: The aim of this study is to explore your level of understanding regarding Termination of pregnancy and you will be given adequate information about the research.

Voluntary participation: As participant you have power of free choice, you have the right to participate voluntarily in the research or decline participation. The interview will take a period of 30 to 45 minutes, and it will be recorded. During the interview, the participant has the right to withdraw from the research if he or she do not feel comfortable to answer or continue with the interview.

Confidentiality and Privacy: It is guaranteed that any information the participant provides, will be kept private and confidential. Participant's personal information will be protected.

Thank you for your cooperation

Yours sincerely

Barley B Mahanyele

I.....received detailed information pertaining to the research. I am aware that my responses will be recorded to ensure an accurate account of my views and opinions. I was also promised that my responses will be kept confidential and anonymous. Furthermore, I was also informed that I may withdraw my consent without any penalty by the researcher. I fully understand my expectations and hereby agree to participate in this study.

Participant's title, name and surname.....

Participant's signature.....

Researcher's name and surname.....

Researcher's signature.....

Date.....

ANNEXURE E: INTERVIEW GUIDE

Topic: *Community perceptions regarding Legal Choice of Termination of Pregnancy*

The following information will be requested from participants:

Residential area:

Age of participant:

Marital status:

How many pregnancies/children she/he has:

Employed/unemployed:

Level of education:

Kindly share with me your opinion of termination of pregnancy

I am interested in knowing your understanding of legal Termination of pregnancy.

Can you identify a legal Termination of pregnancy facility? If yes, how?

Do you know the hospitals or clinics in your area that provides legal termination of pregnancy?

Have you ever? Would you terminate pregnancy or would you support someone who wants to terminate a pregnancy?

If No/Yes, elaborate on WHY?

Kindly explain the circumstances or situations that allow a termination of pregnancy.

What would you do if you were in a situation whereby you were confronted with an unwanted pregnancy?

What is your opinion regarding the illegal Termination of pregnancy?

THANK YOU FOR YOUR VALUABLE PARTICIPATION!