Narrative analysis on abortion:

Psychosocial, ethical and religious dimensions

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

The year 1994 ushered in democracy for the citizens of South Africa, and 1997 saw the promulgation of the Termination of Pregnancy (TOP) Act, 92 of 1996. This Act allows all South African women access to abortion on demand up to twelve weeks of pregnancy, from 13 to 20 weeks on the recommendation of a medical practitioner, and beyond 20 weeks on the recommendation of two medical practitioners (TOP Act, 1996).

Although women have the right to choose abortion, the decision is not a simple one because women's experiences of abortion are complex (Lakartidningen, 2005). Making the decision involves various psychosocial, ethical, and religious considerations. Research, policy debates, and advocacy have focused on the rights of the mother and the rights of the foetus with minimal attention being focused on factors affecting such a decision. Subsequently, insufficient investment is being made in attending to the needs of women, in general. This research was designed to obtain a holistic and comprehensive understanding of the psychosocial, ethical, and religious aspects of abortion.

This chapter identifies the research problem, places the research in context, and presents the rationale for the study. It discusses the aims and objectives of the study, the research design, the theoretical framework, and the anticipated value of the study.

1.2 Problem identification

Global statistics reveal that at the end of 2004 there were approximately 42 million abortions, that is, 125 000 abortions per day (Alan Guttmacher Institute (AGI), 2011). This approximates the present population of South Africa, which stands at approximately 50

million. Thirty five million of these abortions were in developing countries. The statistics on legal abortion by only Marie Stopes in South Africa for 2009 were:

- almost 43 000 abortions in total;
- over 5 000 in the under 20 age group (12%);
- just under 30 000 in the 20 - 30 age group (66%);
- over 9 000 were over 30 years (-22%); and
- 4 620 (11%) of the total abortions being in the province of KwaZulu Natal (KZN) (Marie Stopes, 2010).

Change in abortion law does not translate into greater societal acceptance of abortion. This study focused on the extent to which moral, ethical and psychosocial considerations affected the abortion decision since the new legislation in SA. Men and women, particularly women, are faced with a number of complex issues in making the decision. Internal pressures include moral and ethical values while external pressures include individual and social circumstances, familial and societal attitudes, and religious and cultural considerations. Health professionals too, are faced with similar pressures in providing the service.

Although abortions are common in South Africa, a survey of South African literature indicates that not many studies have explored the experiences of women, men and health professionals related to abortions (Boulind & Edwards, 2008) which is similar to the international trend (Mojapelo-Batka & Schoeman, 2003; Olivier & Bloem, 2004). I have located some studies, which have focused on other aspects of abortion, for example, HIV and abortion, Knowledge of the abortion Act, Hinduism and abortion, Adolescence and abortion, and Abortion statistics and legislation (Ngwena, 2003; Engelbrecht, 2005; Johnston, 2010;). Furthermore, the available information on abortion in South Africa has been drawn from hospital records, which provide a limited perspective of abortion in this country. The studies do not address the ethical, religious, and psychosocial dimensions of the abortion decision. This study is aimed at filling this gap. It explored the psychosocial, religious and ethical considerations which affects women's decision-making,

and men and health professionals' views on abortion. Considering the high rate of abortion amongst the various age groups, the need for research in this field in South Africa is urgent.

1.3 Context of the study

The practice of abortion, which constitutes a global and local phenomenon, has been present since the beginnings of the history of humanity. Religious, ethical, moral and medical considerations are amongst the factors that influence the legalising of abortion. Even in countries where it is legalised, abortion remains a controversial issue between those advocating for the rights of the mother (pro-choice groups) and those advocating for the rights of the unborn (pro-life groups).

In South Africa abortion was legalised in 1997 with the passing of the Choice on Termination of Pregnancy Act (TOP), 92 of 1996. The Act allows females from the age of twelve years to secure an abortion. Since the legalising of abortion in South Africa, approximately 650 000 legal abortions have been performed during the period of 1997 - 2007, with 90 000 in KZN. Approximately 60 000 abortions are performed, on average, each year (Johnston, 2010). In 2010, there were 80 000 legal abortions performed in South Africa with approximately 5 000 legal abortions in KZN.

Men and women and their families, as well as health professionals are affected by the implementation of the TOP Act, 92 of 1996. The consent of parents, spouses, and partners is not required even in the case of minors as young as twelve years old. Nurses, even those who are not directly involved with abortion, are required to nurse the patient during and after the procedure. Where there are no doctors, who are willing to perform abortions, available, medical doctors, who are in governmental employ, are required to provide the service despite their ethical, moral and religious views (Meisol, 2008).

With South Africa being a highly pro-life and pro-natalistic society (Sewpaul, 1995), this research was designed to understand the experiences of women and men who have opted for abortion. More particularly the research was interested in exploring how men and

women negotiate the ethical and moral dilemmas that might be attached to the decision, and whether or not the abortion choice has impacted their relationships with people around them. The research also focused on the potential dilemmas faced by health professionals who, within the same dominant pro-life context, are required to provide the service despite their socialisation, and their values and beliefs that might be pro-life.

This research was conducted in the Durban metropolitan area in the province of KwaZulu-Natal (KZN), South Africa. KwaZulu-Natal is the province with the largest population in South Africa with approximately eleven million from the country's 50 million people. This translates to 21, 3% of South Africa's population occupying 7.7% of the land. The main language is isiZulu (nearly 81%), followed by English (76%), and Afrikaans (1.5%) (S.A.info, 2010). Many of the Zulu and Afrikaans speaking people also speak English as their second language. The Durban metropolitan area, one of eleven municipalities in KZN, has a population of over three million people.

1.4 Rationale for the study

The legalising of abortion in South Africa in 1997 has resulted in the widespread advertising of 'safe abortions' in almost every street of various city centres, and in many community newspapers. A local community newspaper (Eastern Express, 2010) reported that there was an increase in the number of abortions even among girls under the age of 18 years.

The decision to have an abortion is not an easy one. Pregnancy itself, planned or unplanned, is a complex emotional and physical experience. Abortion, which is a traumatic decision and experience for the women and men involved, is motivated by many internal and external factors, and elicits mixed emotions (Astbury-Ward, 2008). My professional and casual experience with women who were contemplating and/or continued with the abortion is that the experience is traumatic during the decision-making phase as well as during the actual abortion, and after the procedure itself. In view of the complexities of abortion, Premier Zweli Mkhize, in a State–of–the Province address on SABC 3, 2009, said, with

reference to unplanned pregnancies and abortion, that ‘prevention is better than cure.’ I also met doctors and nurses who found the experience traumatic. This kindled my interest in pursuing a study into the psychosocial, ethical and religious considerations of abortion. Since women and men are both affected by the experience and are different in their outlook about ethical (amongst others) issues, I included both females and males in the study.

1.5 Main aim of the research

The main aim of this research was to explore the psychosocial, ethical and religious considerations of abortion.

1.6 Objectives of the study

The objectives of this study were to:

- Establish how the abortion decision is made;
- Analyse how current contextual realities affects the abortion decision;
- Explore the role that religious beliefs, personal value systems and cultural values play in the abortion decision;
- Understand how right and wrong is negotiated among men and women within the context of religious and cultural expectations;
- Explore whether men and women experience abortion differently;
- Analyse what motherhood and fatherhood means to those who opt for abortion;
- Ascertain what support systems/structures are available to those who have opted for abortion; and
- Explore the impact of dominant discourses on motherhood and fatherhood on the abortion decision, and the consequences of abortion.

1.7 Underlying assumptions

Since pregnancy, whether planned or not, is a complex emotional and physical experience (Astbury-Ward, 2008), my assumptions were:

- The decision to abort is a complex one involving psychosocial, ethical and religious dimensions;
- The support systems available to the individual affect decision-making and the ability to cope with the consequences of the decision;
- The abortion decision is ultimately a woman's decision;
- Women are more intimately involved in making the abortion decision than men, as child bearing and child rearing are considered to be primarily the responsibility of women;
- The decision produces guilt for both men and women. Women however, might experience higher levels of guilt than men as the decision challenges the taken-for-granted assumption of the 'maternal instinct', and society's expectation that women protect their unborn;
- The guilt experienced is over-ridden by psychosocial contextual realities at the critical moments of making the decision to abort. Feminism therefore demands that relational ethics rather than principled ethics guide the understanding of the abortion decision;
- Health professionals too are faced with ethical dilemmas. Legal imperatives however, over-ride their ethical concerns; and
- Isolating their personal values from professional principles that focus on the self-determination of the service user, helps health professionals to cope with the ethical dilemmas engendered by them providing the abortion service.

1.8 Anticipated value

I was unable to locate South African studies into the psychosocial, ethical and religious considerations in abortion. A study of this nature is necessary and important to inform

policies and programmes designed to support and guide women both through the abortion decision-making and post-abortion recovery. It will also inform the role of relevant role players in impacting the lives of women. To this end, this study contributes to the knowledge base of abortion in South Africa. Particularly in the South African context, the study offers insight into African Traditional values and beliefs and how these are negotiated with respect to abortion.

The findings also serve to facilitate further research, both quantitative and qualitative, with regards to the various aspects of abortion in the planning and implementation of formal and informal life skills education programmes, and to assist service providers in the structuring of pre- and post-abortion care for both women and men, the training of personnel for the task, and for the inclusion of important others in the process of decision-making and recovery. On the macro level this study lends itself to the drafting and implementing of policies and structures to eradicate structural oppression of women, to deconstruct and reconstruct dominant discourses that negatively affect the circumstances of women, and both to empower women and to facilitate the process by ensuring that they have access to the good life as envisaged by the constitution of our democratic South Africa.

1.9 Theoretical framework

The study adopted a feminist framework which takes seriously the experiences of women. It is based on the need to know and understand better the nature of the hurt that women sustain, to empower women in a direct and personal way (McInnes, 1994; Wadsworth, 2002), and to challenge oppression (Kirsch, 1999).

There is no specific methodology for feminist research which is distinguished by the manner in which data are collected. Feminist research moves away from traditional methods where participants are seen as passive 'subjects' to be observed or studied (Kirsch, 1999) to having active roles in the research. Feminist researchers therefore make the effort to involve participants in the research process thereby attempting to eliminate the unequal power relationships between researchers and participants. The researcher creates a mutually

beneficial, interactive and cooperative relationship with the participants, in which the research questions validate the women's experiences (Kirsch, 1999). Feminist research also emphasises research of women by women (Kirsch, 1999), and research that is "qualitative, action-oriented, and reflective of women's experience" (Hall, 1992, p.2). The basic goals for feminist research are to level the relationship between researchers and participants and to build knowledge for women, which lead to an understanding of the experiences of women. This in turn reduces self-blame and feelings of inadequacy among women, and guides women towards political action in their own interests (Armstead, 1995). The value of doing feminist research is that participation of women in the research process allows them to make a contribution to social issues. Feminist research is therefore therapeutically valuable. It also makes women become aware of their own individual suffering which they may otherwise accept as normal (Sewpaul, 1995), as is expressed by Waldrop (2004, p. 242): "The opportunity to discuss a difficult experience with an interested and non-judgemental researcher can generate positive feelings and hope for change among those who feel disenfranchised." As women engage in reflective dialogue they may re-evaluate themselves and become inspired to change aspects of their lives.

The feminist researcher listens to women and men's account of their life stories (Hall, 1992; Wadsworth, 2002). It is important for women to voice their stories within their social reality, which is shaped by their experiences and understanding. Nevertheless, both women and men can be researched (Wadsworth, 2002). Of importance in the experience of women, are their relationships and the subsequent responsibility arising from such relationships. Feminists therefore view human beings as interconnected and interdependent individuals: not in isolation and independent of each other. Whether understood and accepted or not, what affects women affects men, and to a greater extent the children (Saul, 2003). The aim of feminism is a society where men and women are treated as equal and allowed to use available opportunity to rise to their full potential as human beings (Crown, 2005). Feminist research therefore does not exclude men: it focuses on relationships between men and women, and draws on men's stories to obtain a wider picture of the experiences of women. It does however, make women's lives and experiences central to the research (Sewpaul, 1995). Thus, while women constituted the main sample in this study and pre-eminence is

given to their voices, I included men with the intention of obtaining a wider picture of the abortion issue. Keeping women central to feminist studies, feminism attempts to affect social institutions and situations which discriminate against women (Wadsworth, 2002).

The choice of feminist theory for this study therefore, was based on the concerns and motives that it brings to the study. Furthermore, feminist theory is most aligned with this study in that the study:

- Arose from the interests and concerns of women;
- Involved as many women as was feasible;
- Respected and valued women's experiences of abortion and their accounts in relation to those of men;
- Heard and reflected exactly what the experiences were;
- Represented the complexity, interconnectedness, and contextualised nature of the abortion experience;
- Researched various factors contributing to women's oppression (for example their subjugation by men, bureaucracies, poverty, class, service providers, and the media);
- Began with the standpoints and experiences of participants (Brayton, 1997, p. 5): This study focused on women's experiences, their own explanations of social phenomena, and on what they want and need. Studying women from the perspective of their own experiences helps them to understand themselves.
- Removed the power imbalance between the researcher and the participants (Brayton, 1997, p. 5). This was important to this study because women who have had abortions tend to feel that they have done something wrong and hence are secretive about it. Viewing and referring to them as participants rather that 'subjects' gave the feeling of involvement in the research process. Women are experts in telling their own stories. This closed the gap in power imbalances as participants were valued and respected.
- Is action based and has a role in changing social inequality (Brayton, 1997, p. 5): This study gave women and men the opportunity to share their experiences, which will inform empowerment programmes. It also provided participants a platform to re-

evaluate their own lives. In hearing and reflecting on their stories, participants were able to analyse their lives.

- Reports women's claims which will enable other women to make judgements;
- Contributes to women better understanding the abortion situation (Wadsworth, 2002, p. 5-6).

Feminist inquiry yields a better quality of research because it allows for the researcher to get involved rather than observing participants from the outside (Kirsch, 1999). I was able to collect data that reflects participants' perspectives, knowledge, and experiences.

There are different types of feminism that emerged to suit the different forms of thought (Moore, 1993; Garrett, 2000). They vary from the basic 'core feminist theory' to different degrees in their values and beliefs, and define feminism according to their emphasis and the understood causes of the oppression. The different types of feminism, however, are all committed to women and the interests of women. Basically, they oppose domination by men (Scraton & Flintoff, 1992) and aim at uncovering everyday oppression and inequality (Garrett, 2000). Liberal feminism does not focus on radical action but on working with the existing institutions to change laws and policies to accommodate women and provide opportunities for them thereby achieving equality. It was the liberal feminists who were successful in getting the Equal Rights Amendment passed through Congress and most of the states in the US, although this was initiated by the radical feminists (Enns, 2010). Adopting a rights-based approach, liberal feminism focuses on the individual and the individual's right (Enns, 2010) but ignores the multiple social interactions and influences on the individual. To this end, women are not seen in the context of their social milieu, and how they are affected and affect those around them when making the personal decision of abortion. One cannot negate the importance of liberalism in the whole abortion debate. As mentioned above, liberal feminism did successfully gain a range of rights for women. The discourse of abortion, however, goes beyond a rights-based approach as borne out in this study. Abortion is linked to issues regarding patriarchy, systems of oppression, and structural conditions that force women to choose abortion. The choice is not a rights-based

one but a conditioned one. Radical feminism views the oppression of women as the most basic form of oppression existing in society. Oppression is evident in all race, culture, socio and economic class groupings (Turnier, Conover & Lowery, 1995). Radical feminism emphasises patriarchal division of society along gender lines, which privileges men with power in all aspects of life, while at the same time, oppressing women. Male supremacy is considered in itself a systemic form of domination. It involves more than poor male attitudes towards women in that the dominance and superiority is institutionalised. Men have power and privilege and defend their interests. Existing political and social organisation is viewed as being based on and promoting patriarchy, which makes radical feminists skeptical of political action within the existing system. Their demands are that patriarchy needs to be changed on every level of society for there to be meaningful changes for woman. This calls for radical changes. This is what radical feminism demands. Radical feminists also attempt to separate biologically-determined behaviour and culturally-determined behaviour. To this end, cultural change that undermines patriarchy and its hierarchical structures is promoted.

As the study progressed, I opted for the radical feminist approach after exploring and understanding the detrimental effects structural conditions and dominant discourses have on the creation of gender inequality and oppression. Radical feminists can be pro-life and challenge those patriarchal and structural factors that put women into positions that make them consider abortion as an option. If children are to be held as sacrosanct it is necessary to challenge dominant discourses and provide conditions that are conducive enough for women who are pregnant out of wedlock not to be ashamed of their pregnancies. It was indeed a journey for me in terms of reflecting on my values. Supervision and engaging with critical theories and radical feminism provided the space and context for the development of a critical reflexivity, particularly in terms of my initial starting point located within a liberal feminist standpoint. As abortion is both a complex and sensitive issue, the study demanded a great deal reflectivity on my part. As the study unfolded, and I engaged with the participants in a non-judgemental way, I was able to appreciate the difficulties experienced by women in making the decision, and the factors that contributed to them making the decision.

Amongst the important characteristics of feminist research is the use of *reflexivity*. Reflexivity is an understanding of the subjective experiences of the researcher and of the research process (Pillow, 2003). It is the self-critical introspection and analysis of the self as researcher which leads to self-discovery and insights in respect of the research questions. It enables the researcher to acknowledge her role and the circumstances of the research (Finlay & Gough, 2003). Reflexivity therefore becomes a tool to analyse personal, interpersonal and social processes. It can make the researcher more aware of the relationship between researcher and participants (England, 1994), and can also be used to analyse and reflect on the responses from participants (Pillow, 2003). The 'how' of data collection is important to the interpretation and presentation of the data. In qualitative research the researcher not only collects data; he/she is actually an instrument in the collection of the data (Sewpaul, 1995). Where participants become comfortable with the researcher and are confident about her/his trustworthiness they are able to share important parts of their lives (Rew, Bechtel & Sapp, 1993) as is evident in this study.

1.10 Definition of terms used

For the purposes of this study, the following definitions were used for the terms in the research:

Abortion - Medically induced termination of pregnancy (The British Medical Association, 2012).

Abortifacients – An agent that induces the expulsion of an embryo or foetus; a drug, herb other chemical that dilates of the cervix (The British Medical Association, 2012).

Cervix - A small, cylindrical organ comprising the lower part and neck of the *uterus* and separating the body and cavity of the uterus from the *vagina* (The British Medical Association, 2012).

Conception - The fertilisation of a woman's ovum by a man's sperm, followed by implantation of the resultant blastocyst in the lining of the uterus thus starting a pregnancy (The British Medical Association, 2012).

Embryo – The unborn child during the first 8 weeks of its development following conception; for the rest of the pregnancy it is known as a foetus (The British Medical Association, 2012).

Infanticide - The killing of a newborn infant (The British Medical Association, 2012).

Pregnancy – Pregnancy begins with the fertilisation of an ovum (egg) and its implantation (The British Medical Association, 2012).

Uterus – The hollow, muscular organ of the female reproductive system in which the fertilised ovum (egg) normally becomes embedded and in which the embryo and foetus develop. The uterus is commonly known as the womb (The British Medical Association, 2012).

Zygote – The cell that is produced when a sperm fertilises an ovum. A zygote, measuring about 0.1 mm in diameter in humans, contains all the genetic material for a new individual (The British Medical Association, 2012).

1.11 Structure of the report

This report comprises nine chapters and is divided as follows:

Chapter One - Introduction and Background

This chapter covers a background to the study, the research questions, rationale for the study, the context of the study, the main objective of the study, the theoretical framework, the research approach, ethical considerations, and the value of the study.

Chapters Two to Five deal with various aspects of the literature review

Chapter Two - Literature review - Abortion: Background, History, Policies and Statistics

This chapter reviews the international history, the existing policies of various countries, available global statistics, and the feminist view of abortion. The South African TOP Act 92 of 1996 is reviewed in some detail.

Chapter Three - Literature review - Medical aspects of abortion

This chapter reviews the types and methods of abortion, and the physical consequences of abortion from a medical perspective.

Chapter Four - Literature review - Abortion: Religious, Cultural, Ethical and Bioethical Considerations

This chapter reviews the religious, cultural, ethical and bioethical perspectives of abortion. The views of the major world's religions and the African Traditional religion of the Zulus are discussed. The ethical issues are discussed from the perspective of women, the unborn, men, and health professionals.

Chapter Five - Literature review - Psychosocial considerations

This chapter reviews the psychosocial perspectives of abortions. The various socio-economic factors contributing to abortion namely the structural determinants of abortion and absent fathers are reviewed. The chapter also reviews the psychological impact of abortion.

Chapter Six - Research Methodology

This chapter presents and describes the research methodology employed in this study. It includes the design of the research, the selection of the participants, the data collection and analysis, ethical issues, reliability, validity and limitations of the study.

Chapter Seven - Analysis and Discussion of research results

This chapter first introduces the participants with a profile on each participant. It then introduces the data analysis, which spans chapter seven and chapter eight. Chapter Seven limits the analysis to the first theme that emanated from the analysis of the data, namely, *the abortion decision*. Critical discourse analysis (CDA), which is in keeping with the feminist theoretical framework, is used in the analysis of the data.

Chapter Eight - Analysis and Discussion of research results

The other three themes, namely, the demonising of women, the pro-life/pro-choice dichotomy, and the structural factors that contribute to the oppression of women that emanated from the data analysis are presented in this chapter.

Chapter Nine - Conclusions and Recommendations

The final chapter is a critical discussion of the major findings that emerged, and recommendations which includes recommendations made by participants for practice, policy and further research. The chapter ends with a summary and a conclusion.

CHAPTER TWO - LITERATURE REVIEW

ABORTION: BACKGROUND, HISTORY, POLICIES AND STATISTICS

2.1 Introduction

Although the practice of abortion has been present since the beginnings of the history of humankind, only subsequent to the 1973 United States Supreme Court ruling (Justia Supreme Court, nd) did the modern abortion debate intensify. Due to various religious, ethical, and moral considerations abortion continues to remain illegal in many countries. Even in countries where it has been legalised, abortion remains a controversial issue between those strongly advocating for the rights of the mother (pro-choice groups) and those strongly advocating for the rights of the developing foetus (pro-life groups).

At least three main perspectives arise when one considers the background to abortion. These are the recent secular legal history on abortion, mainly in the US, the question of abortion and the constitution of South Africa, and the question of the choice one makes in respect of religious, ethical and bioethical (based on medical information) issues. The recent secular legal history on abortion in the US is important because it is where the debate developed intensely and extensively over the last two decades (Chang 2005). Since South Africa's democracy in 1994, one of the main changes that took place is the legalisation of abortion in 1997. The abortion debate in South Africa therefore needs to be developed to enable its citizens to make informed decisions concerning abortion. Finally, before addressing the social, economic and other contextual issues on abortion, abortion needs to be addressed on a metaphysical level and on the basis of medical information available.

The literature review in this chapter covers the global history of abortion, abortion policies of various countries, and international abortion statistics.

2.2 History of abortion

Illegal abortion goes as far back as recorded history. Abortion is, and by and large, continues to be considered deviant and pathological behaviour owing to society's strong moral and religious values (Badenhorst, 2005). Women who attempted abortions were burnt on stakes by the Assyrians under the Assyrian code of law. Only in 1312 did the church in Vienna accept abortion during the first trimester (Welton, 2001). In ancient Greece and Rome however, abortion was common and accepted because, in the absence of scientific prenatal information, both the Greeks and the Romans held the view that the foetus is only alive at 40 days after conception (Millar, 1934). During the eighteenth century, the view that the foetus is alive from conception was accepted. The foetus was therefore given full protection in the first abortion statue of Britain namely the Ellenborough Act of 1803. Those who broke this law were punished with a fine if the abortion was done in the early stages, and with a death sentence if the abortion was done later in the pregnancy when movement of the foetus was felt (Simon, 1998).

In the 1920s Russia, Japan, and several East European nations allowed abortion at the woman's request (Potts, Diggory & Peel, 1977; Solomon, 1993). In 1948 the Japanese government implemented the Eugenic Protection Law where abortion was available on demand up until 22 weeks. The aim of the Japanese Law was to develop a genetically strong nation by utilising both contraception and abortion. Abortion continues to be accessible to women in these countries. With the exception of Poland, European countries continue to allow abortion for a wide range of reasons (Simon, 1998). In 1996 the Eugenic Protection Law in Japan was replaced with a new legislation limiting abortions up to 24 weeks for rape, incest, economic or social reasons, and the health of the mother (Norgren, 2001). In the 2000s, in view of its declining younger population, Russia had amended its abortion laws restricting access to abortion until twelve weeks, and until 22 weeks in instances of rape, incest, and severe foetal anomaly (Kishkovsky, 2011; Parfitt, 2011).

In the West, prior to the 1800s, abortion was permitted until the 18th week, that is, before movement of the foetus was felt. In the 1800s the view as to when life began changed. Life

was accepted as beginning at fertilisation and abortion was therefore totally forbidden and the foetus was given rights even after the demise of the mother (AGI, 2003). By the 1820s however, abortion was once again allowed until the fourth month before 'quickening', that is, when movement was felt by women (Joffe, 1991). By 1880 abortion, except for therapeutic abortion, was once again not permitted in most of the US except for therapeutic abortions.

In the 1800s women groups (feminists) took up the rights of women in a patriarchal society. At that time women were seen and treated solely as homemakers. If they needed to, or chose to go out to work, there were minimal job opportunities. Further, and they were not paid the same wage as men, even for the same jobs. This led to women becoming financially dependent on men and subsequently forced to accept the poor treatment received as wives and as women in general. The women's groups, at that time, focused on issues affecting women which included rape, domestic violence, infanticide, abortion, prostitution, sex education, with women's right to vote and the right to equal wages having become the main issues. Child murder, infanticide and abortion were common at the time. In their fight for equality and freedom for women, early pro-life feminists did not demand abortion, but rather viewed abortion as indicative of the structural and patriarchal abuse of women. They argued that circumstances of depravity of abuse and need forced women to have abortions, and advocated that if women are granted equality and freedom there will be no need for abortion (Lewis, 2011). The early feminists saw women as victim of circumstances in a male-dominated society that forced women to make such decisions, and held men responsible for the plight of women, as reflected in the words of Gage, "I hesitate not to assert that most of this crime of child murder, abortion, infanticide, lies at the door of the male sex" (Gage, 1868 as cited in Feminists for Life, 2004, p. 3). Abortion was illegal and therefore a crime in society at that time, while women were not able to access contraceptives even when these were available. This, feminists viewed as contributing towards the degradation of women and women having to bear unwanted pregnancies which many were forced, by circumstances, to terminate. Feminists therefore looked at empowering women by giving them the means to prevent unplanned pregnancy with readily available contraceptives. Although contraceptives alone do not alter the

circumstances of women it does allow them the opportunity to plan their pregnancies at least to some extent. It is one way of granting women power. Modern feminists too view sex education, birth control, health care, and improved social and economic circumstances of women as a preventative measure against abortion (Lewis, 2011).

By 1900, medical doctors worked towards eliminating abortions except when the woman's life was at risk. In the middle of the twentieth century the US once again considered abortion only in instances of rape, incest, threats to the health of the mother, and severe foetal anomaly. Various groups arose fighting for, and against, the legalising of abortion (Lewis, 2011). In the 1960s, various states began reforming their strict anti-abortion laws. At the time of the US Supreme Court ruling in 1973, legal abortions were available in 17 states (AGI, 2003). The Supreme Court ruling in 1973 legalised abortion on demand until the 12th week of pregnancy. The Supreme Court categorised the foetus as 'potential life' which deprived the foetus of any rights and subsequent protection by the US government's constitution (Lewis, 1990). The foetus was regarded as the property of the mother who had the right to dispose of it for any reason.

Four of the most populous countries namely China, India, Japan, and the Soviet Union had, by 1973, already permitted legal abortion in early pregnancy. During 1973 and 1974 policies in Austria, Denmark and Tunisia were liberalised to permit abortion on request during the first trimester of pregnancy. The new statute in South Korea in 1973 permitted abortion where the woman's health was at risk. At the same time Guatemala and El Salvador permitted abortion to save the life of a woman. In 1975, abortion upon request was permitted in France, and in the same year abortion for economic indications become legal in West Germany. Nineteen years after the 1973 Supreme Court decision, in 1992, a further development took place in the US because the 1973 decision was constantly being challenged. Although the 1973 decision was not overturned, there had been several amendments made due to pressure from pro-life groups. Since 1992 counseling and a subsequent 24 hour waiting period became mandatory, and files of all abortion providers are required (AGI, 2013). Since 2000, partial-birth abortions, medically known as intact dilation and extraction (IDX) is no longer a viable option, and parent (guardian) notification

and consent for under 18 years are required in many of the states (AGI, 2013). Anti-abortion groups are very passionate about abortion. They organise placard demonstrations, block access to abortion clinics, and occasionally become violent especially concerning IDX - partial birth abortions (Lewis, 2005). The person named in the 1973 Roe-Wade decision, Norma McCorvey (alias Jane Roe) who did not have the abortion, has, subsequent to the case become an activist fighting for women's reproductive rights. Norma McCorvey was pregnant with her third child at that stage. In 1995 Norma McCorvey changed her stance and actively promoted the rights of the unborn together with the rights of women to better care, including health care (Mohr, 1996; Napikoski, 2012).

While governed by the Roman-Dutch law, South African Law permitted abortion when the life of the mother was in danger. In 1975 the Abortion and Sterilisation Act, No. 2 of 1975 was introduced, permitting abortion where there was a threat to the woman's life, physical or mental health, instances of rape or incest, or sex with an 'idiot or imbecile', and in instances of serious foetal anomaly. With the advent of democracy in 1994, the TOP Act, 92 of 1996 (discussed later in this chapter) replaced The Abortion and Sterilisation Act in 1997. The new Act allows women the right to abortion without the consent of parents, partner, or spouse. Subsequently, abortion has become one of the most contentious issues facing South Africa. Pro-life organisations oppose the TOP Act. Anti-abortion groups representing doctors and nurses have made known their intention to refuse to take part in any abortions or to refer women to abortion clinics. Pro-life nurses and doctors refuse to perform abortions. Some nurses are said to insist on imposing their own beliefs on women seeking to terminate pregnancies (WHO, 2010). In 1998, various groups challenged the Act arguing that the life of the human being begins at conception.

Since 1997, there have been widespread international developments with respect to abortion policies. Abortifacients are being accepted by many countries. While more countries namely Benin, Bhutan, Cambodia, Chad, Colombia, Ethiopia, Guinea, Iran, Mali, Nepal, Niger, Portugal, Saint Lucia, Swaziland, Switzerland, Thailand and Togo have broadened their policies on abortion, other countries namely El Salvador and Nicaragua changed their policies to restrict abortion (AGI, 2009). Many states in the US are

introducing new conditions and prerequisites for abortion. Abortion has become a political issue in many countries, where, with each new leader the policies on abortion change or are modified. This has resulted in the many changes since the eighteenth century. Where the leadership is pro-choice and outspoken in terms of women's reproductive rights, abortion is readily legalised. This can change anytime with future leadership not subscribing to the same views.

2.3 Abortion policies

Abortion legislation can be defined according to the following four categories:

- Illegal where abortion is prohibited under all circumstances
- Restrictive where abortion is only permitted in life-threatening circumstances.
- Conditional where abortion is permitted on certain grounds, including eugenic (genetic) factors, humanitarian factors (rape or incest) and broad health indications.
- Liberal where abortion is permitted on demand (Badenhorst, 2005).

Abortion laws vary from one country to another ranging from absence of policies, total banning of abortion to total liberalisation. In many Roman Catholic and Islamic countries abortion is illegal but permitted where the mother's life is at risk. Since 1973, abortion is available on demand in all states in the US. Recently, however, new laws prohibiting abortions after viability of the foetus, except in cases of the mother's health or serious foetal anomaly, were enforced (AGI, 2013). Politics reflect the strong opposing views on abortion especially in the US where there are strong pro-life and pro-choice groups. In the US, the Supreme Court monitors abortion rights, making the legalising of abortion in line with the political stance of the country. This affects the consideration of abortion as a women's rights issue from one election to another. In the UK, since the National Health Service handles abortion, the view of abortion is more consistent (Jagnayak, 2005). In South Africa, abortion is a political issue in so far as the ruling political party supports abortion as a

woman's right to reproductive health. This may change with a shift in power in South Africa since there are fairly strong opposing stances on abortion.

International organisations have, since the International Conference on Population and Development in 1994, taken into account the needs of women including sexual and reproductive health, and the majority of women live in countries where abortion is available on demand (Correa, 2003). Despite abortion being available on demand, women often lack access to the necessary information and services, and the accompanying power to make healthy, informed decisions about their sexual and reproductive lives. The social and developmental consequences of poor sexual and reproductive health services for women has far-reaching consequences for women, children and therefore for families, including men. Unintended pregnancies, which end in unsafe abortions and death, leave young children and families without mothers (Population Action International, 2010). The concepts of reproductive rights, sexual health, reproductive health which includes the right of women to sexual and reproductive health information and services, and the right to privacy, confidentiality, respect and informed consent were included in the programme of action at the International Conference on Population and Development in Cairo in 1994 (Population Action International, 2010). The United Nations Fourth World Conference on Women (Beijing, 1995) regarded equality between women and men as a fundamental principle, with the rights of women and girls being affirmed as a universal human right (Europa, 2004). The agreed upon goals for reproductive health at the International Conference on Population and Development (Cairo, 1994), the United Nations Fourth World Conference on Women (Beijing, 1995), and their five-year follow-up review conferences were once again reaffirmed in 2004 by WHO (2004). The third of the Millennium Development Goals (MDG) is to promote gender equality and empower women, and the fifth is to improve maternal health (United Nations Development Programme, 2013 - UNDP, 2013). The Cairo programme definition of reproductive health is:

> Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system, and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex

> life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicitly in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulations of fertility which are not against the law and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.
>
> Reproductive health should include, *inter alia*: family planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breastfeeding and infant and women's health care; prevention and treatment of infertility; *abortion* (italics included) as specified in paragraph 8.25; treatment of reproductive tract infections, sexually transmitted infections (STIs) and other reproductive health conditions; and information, education and counseling on human sexuality, reproductive health and responsible parenthood (Cairo Programme of Action, Chapter vii).

WHO (2004), guided by national human rights, has in place strategies to achieve the MDG which includes reproductive and sexual health services. Globally there is focus on achieving the international goals of reproductive health as listed in the Cairo programme's definition of reproductive health, and the MDG. To this end, countries are reconsidering their laws, policies and practices. In countries where there are policies on reproductive health, changes are being made, while countries without policies are working on introducing them (AGI, 2013). Health care workers too are included in many policies. For example in South Africa health care workers are not compelled to perform abortions, and they are allowed conscientious objections, that is, based on their values and beliefs. However, they are required to refer the patient to other health professionals who offer the service (WHO, 2004). In the absence of resources in public hospitals, health practitioners may have little/no choice in practice.

Fifty four countries either totally ban abortion or limit it to extreme cases. Three countries have, to date a total banning on abortion namely The Holy See (Vatican), Malta and Chile

(Correa, 2003). A total of 189 countries allow abortion in order to save a woman's life. In countries where abortion is legal, many namely Colombia, Ethiopia, Guinea, Iran, Mali, Nepal, Benin, Bhutan, Chad, Swaziland, Switzerland, Thailand, Niger, Portugal, Saint Lucia and Togo are extending the grounds on which abortion is allowed. Six states in Mexico and one state in Australia have also done so (AGI, 2009). South Africa, Seychelles, Ghana, Tunisia and Burkina Faso, in Africa allow abortion on demand. In Asia 16 countries permit abortion on demand, 17 limit abortion to save a woman's life, and 13 restrict abortion to emergency situations (Correa, 2003).

In Asian countries, the rate of abortions has been directly influenced by national population policies, inadequate contraceptive services, and a preference for sons. China has the one-child policy, and North Korea has the two-child policy (WHO, 2000). Vietnam had a two-child policy which was discontinued in 2003 due to the decrease in birth rate (Doan, 2013). The Japanese and the Chinese governments legalised abortion to limit population growth in the 1970s (Jiang, 2009). In North Korea, women in prison are raped by police, and forced to abort the subsequent pregnancies (Brooks, 2003; Global News, 2014). Hundreds of other women, who either attempted to escape, or who have escaped to surrounding countries only to be returned, are held in concentration camps where there are raped and forced to abort. Many women, who escaped to other countries and were raped by police in those countries before being returned, are also forced to have abortions (Brooks, 2003). A summary of abortion policies is presented in Table 2.1.

Table 2.1 - Worldwide abortion legislation

Summary of abortion policies (Johnston, 2005)

Abortion policy	**Largest countries in category**
Mandatory and on demand	PR China, North Korea, Vietnam (1988- 2003)
On demand	Canada, France, Germany, Italy, South Korea, United States, Russia, South Africa, Turkey, Ukraine, Vietnam (from 2003)
Hard cases*/economic/ social reasons	India, Japan, Mexico, United Kingdom
hard cases*****	Algeria, Argentina, Brazil, Ethiopia, Kenya, Morocco, Nigeria, Pakistan, Poland, Spain, Sudan, Tanzania, Thailand
only to save mother's life	Bangladesh, Columbia, Congo, Egypt, Indonesia, Iran, Myanmar, Philippines

***** hard cases – women's physical or mental health, rape or incest, severe anomaly in foetus

While a few countries have tightened their abortion laws, many countries have introduced or liberalised their abortion laws in response to the commitment of the international community to set goals to meet women's needs including those relating to sexual and reproductive health. In the light of information provided by WHO, where the rates of unsafe abortion is increasing and accounts for one third of global abortions (WHO, 2004), countries legalise abortion in order to protect women. Table 2.1 presents the chronological order in which the various countries legalised abortion.

Table 2.1 - Worldwide abortion legislation

Countries that have introduced or liberalised their abortion laws	Countries that have tightened their abortion laws
Guyana (1995)	Japan (1996)
Albania (1996)	Poland (1997)
Burkina Faso (1996)	El Salvador (1998)
South Africa (1997)	Russia (2000)
Cambodia (1997)	Nicaragua (2006)
Guinea (2000)	
Chad (2002)	
Mali (2002)	
Nepal (2002)	
Switzerland (2002)	
Benin (2003)	
Bhutan (2004)	
Ethiopia (2004)	
Saint Lucia (2004)	
Iran (2005)	
Swaziland (2005)	
Niger (2006)	
Colombia (2006)	
Portugal (2007)	
Togo (2007)	
Mexico City (2007)	
Fiji (2009)	
Indonesia (2009)	
Monaco (2009)	
Timor-Leste (2009)	
Kenya (2010)	
Spain (2010)	

Prior to 1988 abortion was illegal in Canada. Subsequent to 1988 when abortion in Canada was decriminalized, Canada has no policy on abortion (Richer, 2008). Abortion is permitted at any time, and for any reason. It is viewed a medical necessity and the health insurance pays for abortions performed in hospitals. Abortions are, however, not easily accessible in all areas depending on the location with areas in the outskirts having minimal access to abortion services. Not all hospitals offer abortion and the ones that do, have long waiting lists (Browne & Sullivan, 2005; Palley, 2006). The statistics therefore indicate the rates amongst the higher socio-economic groups.

While each state in Australia has its own abortion policy, the central government covers medical funds for abortifacients up to 26 weeks of pregnancy (De Crespigny & Savulescu, 2004),. Abortion in India was legalised in 1971 and is available up to the 12th week in cases of rape, incest, health risk to the woman, foetal anomaly, and for social or economic reasons. Between the 12th and 20th week the consent of two medical practitioners is needed for abortion for the reasons listed previously (Hirve, 2004). Despite the requirement of medical consent, abortion in India has become widespread for purposes of sex selection. In 1994, the government of India attempted to end abortion for sex selective purposes by preventing the use of ultrasound to reveal the sex of the foetus. This, however, continues with no legal consequences (Jagnayak, 2005). With the passing of the Abortion Act of 1967 the United Kingdom witnessed the rates of abortion drastically rise to over 700%. This led to the consent of two medical doctors being required for up to 24 weeks of gestation. Abortion in the UK continues to be available at any time in instances of risk to the mother's health of serious foetal anomaly (Jagnayak, 2005).

In South Africa, the Roman Dutch Law permitted abortion only when the life of the mother was in danger. The Abortion and Sterilisation Act of 1975 (Act No. 2 of 1975) was introduced, as mentioned above, permitting abortion where there is a threat to the woman's life, as well as in instances of physical or mental health, where the pregnancy resulted from rape or incest, or sex with an "idiot or imbecile", and in instances of serious foetal anomaly. The application had to be approved by three medical doctors and thereafter presented to the court for approval. The district magistrate, after considering the evidence, including the

police reports during a court hearing, made a decision and provided written consent to the state hospital to perform the abortion. The state hospital only performed the abortion on receipt of the written permission of the court (Rees, 1991). Otherwise, abortion was illegal (Ehlers, 2000). With the advent of democracy in 1994, the TOP Act, 92 of 1996 replaced The Abortion and Sterilisation Act on February 1, 1997. The new Act allows women the right to abortion without the consent of parents, partner, or spouse. Girls as young as twelve years may have an abortion without parental consent. In cases of severe mental disability or long-term unconsciousness, the consent of a person other than the pregnant woman is considered (TOP, 92 of 1996). Abortion is available on demand up to twelve weeks, restricted access between 12 and 20 weeks, and thereafter if there is severe foetal anomaly or the mother's life is at risk. After the 20th week abortion is allowed on the grounds of incest, rape, the mother's health, foetal deformity, and the social and economic circumstances of the woman. The TOP Act, 92 of 1996 provides for:

- Women having a choice with respect to their pregnancies;
- Access to a safer, more effective, and an acceptable method of terminating a pregnancy;
- A surgically clean environment;
- The right to information;
- Non-mandatory counseling before and after the procedure;
- Consent not being required from the partner, parent, or guardian;
- The option of medical abortion hence reducing the need for anesthetic, and the risk of infection or trauma to reproductive organs (TOP Act, 1996); and
- Trained nurses to perform abortions since 2004 (TOP Act Amendment, 2004).

The issues of concern arising from the TOP Act, 92 of 1996 are that despite conscientious objection to abortion, the nursing staff is required to nurse women before and after abortion according to the Nursing Act 10 of 1997. Furthermore, a minor is entitled to abortion services without the knowledge/consent of the parent or guardian. Where complications do however arise, the consent of the parent or guardian is required before the child is taken to theatre (Walker, 2000). Although this may have been introduced to allow young girls access

to abortion, it actually allows for young girls to be abused by older men. The TOP Act makes no legal obligation for the health provider to report these cases to the police or to inform the parents. The Children's Act 38 of 2005, on the other hand, makes it mandatory to report all forms of sexual abuse, while the Sexual Offences Act makes the reporting of sexual abuse mandatory but based on the best interest of the child.

The right of a twelve year-old to access abortion is irreconcilable with the age of children that are considered under the Children's Act, 38 of 2005, and with the age for sexual consent which at present is 16 years for both male and female (Criminal Law, Sexual Offences and Related Matters Amendment Act, 2007), and the age of giving consent to the adoption of one's baby is 18 years (Children's Act, 38 of 2005). The provisions of the SA TOP Act therefore conflicts with the Criminal Law, Sexual Offences and Related Matters Amendment Act, 2007, and the Children's Act, 38 of 2005. The Children's Act has, however, been amended to allow children to consent to medical treatment from as young as twelve years (Children's Act, 38 of 2005). The second issue of concern, and one that I have observed, is that the restrictions with regard to abortion between twelve weeks and 20 weeks are not being adhered to. Thirdly, pre-abortion counseling is non-mandatory. This reflects in the casual approach to pre-abortion counseling which is afforded limited time and attention. The session is used to explain the basic routine for the procedure and to obtain consent. Women have a right to information and services and need to make healthy decisions about their sexual and reproductive lives**.** They should be allowed the opportunity to discuss their concerns and feelings and to ask about other choices such as adoption and fostering (Walker, 2000).

In South Africa, there are not many doctors and nurses who are willing to perform abortions especially in the rural communities where both the community and the staff do not support abortion (WHO, 2004).

2.4 Abortion statistics

Over recent years the global abortion rate has slightly decreased (AGI, 2011, 2008, 2009) from 42 million in 2003 (AGI, 2011) to 41 million in 2008. Of these 6.5 million were performed in developed countries and over 35 million in developing countries (AGI, 2011). In 2010 the global rates dropped to 40 million (Johnston, 2010; Worldometers, 2010). There is a huge difference in the abortion rates in developed and developing countries (AGI, 2011). Most abortions occur in Asia (On average 26 million per annum.) with nine million in China alone (AGI, 2009). From the Western countries Western Europe has the lowest rate of abortion, followed by Northern Europe, and then Northern America with 12, 17, and 21 per 1000 respectively (AGI, 2009).

In the US over 40 million abortions have been performed (AGI, 2006) since 1973, with the abortion rates more than doubling from under 745 000 in 1973 to 1.6 million in 1990. The rate thereafter steadily declined to 1.2 million in 2008 mainly among the under 24 year olds (Sedgh, Singh, Henshaw & Bankole, 2011). There was also a drop in the number of abortion providers (Jones, Mia, Zolna, Henshaw & Finer, 2005; Walker, 2010). The recent trends and variations in pregnancy, birth, and abortion rates among U.S. women have been associated with a variety of demographic, social, and economic factors, and related program and policy efforts. This includes improved access to contraceptives, increased use of contraceptives, effective education programmes that have resulted in sexual activity being postponed, or decreased access to abortion services which implies more births (Jones et al., 2005; NCHS, 2013). For teenagers, evidence shows that trends in the behavioral determinants of pregnancy are consistent with the declines in their pregnancy rates (NCSH, 2013). Abortion in the US is most prevalent amongst the poor and less educated, immigrants from surrounding countries, and Blacks (AGI, 2008) although the rates amongst African-American remained stable over the past few years (AGI, 2006).

In Canada, the abortion rates dropped in 2005 in comparison to the previous year, but once again increased during the 2006 - 2010 period from 96,815 in 2005 to 100 039 in 2010 (Johnston, 2010) in a population of just under 33 million.

With the US having a large population, mainly of immigrant status, and the many years where abortion was available on demand, it was difficult to compare their statistics with that of Canada or South Africa. The statistics for both South Africa and Canada are increasing as is evidenced by the trend of the past ten years in South Africa and the 2006 - 2010 period in Canada (Johnston, 2010). Within the ten year period 1997 – 2007 South Africa has, in terms of ratios, reached almost half of that of the US. The abortion rate in Canada is exceptionally high with almost 100 000 per year in a population under 33 million. South Africa has an average of 65 000 per year with a population of 50 million. South Africa does not have available statistics on the various racial or ethnic groups, the reasons for abortions, the different geographic areas, or the socio-economic status of women. The statistics as provided for 2009 by the Marie Stopes Clinic in South Africa indicate only the age groups, of which 36% are in the 17 - 20 age group; 64% are in the 21-24 age group. Over 20% of those who have had abortions were aged 22 years (Marie Stopes, 2009).

While Western Europe has the lowest abortion rate of 12 per 1000 (AGI, 2009), Eastern Europe has the highest rate of 90 per 1000 (Jagnayak, 2005). While abortion rates slightly decreased in the United Kingdom, in England and Wales from 198,499 in 2002 to 195,296 in 2007 (Department of Health, 2009), it rose to 210 529 in 2010 (Johnston, 2010; UKHealthCentre, 2012). Barrett (2005) asserted that women are becoming increasingly aware of, and accepting of the termination of unwanted pregnancies in order to focus on a future for themselves. In Scotland, during 2008 there were nearly 14,000 abortions (UKHealthCentre, 2012).

In China, on average, 13 million women with one child were forced by the Chinese government to terminate a second or later pregnancy (Jiang, 2009) with 7 632 539 abortions in 2010 alone (Johnston, 2010). In India abortions are very secretly performed in private hospitals making it difficult to obtain accurate abortion statistics (Jagnayak, 2005). The available statistics reveal that in 2010 there were 699 304 abortions performed in India (Johnston, 2010). During the 2001 – 2010 period the abortion rate in Australia dropped from 84 218 in 2001 to 71 861 in 2010 (Johnston, 2010), while there is a slight increase from 17 930 in 2006 to 18,510 in 2008 in New Zealand (Johnston, 2010).

Despite the drop in the rates of legal abortion among the under 24 year olds in the US (Sedgh, Singh, Henshaw & Bankole, 2011) as presented in this chapter, globally, the proportion of *unsafe abortion* has increased, with illegal abortion largely being accessed by women younger than 25 years (Haddad & Nour, 2009). The rising statistics in legal abortion in South Africa, together with the increasing rates of illegal abortions as asserted by Haddad and Nour (2009) has implications for importance of the study of abortion in South Africa.

In some countries even where it has been legalised, abortion remains a controversial issue between those strongly advocating for the rights of the mother (pro-choice groups) and those strongly advocating for the rights of the developing foetus (pro-life groups). The two groups are polarised in their thinking and debate. The pro-choice group is concerned about the plight suffered by burdened women while the pro-life group is concerned about the unsafe, unguarded unborn life. Hence the abortion debate continues from these particular dichotomised viewpoints and evokes strong, passionate responses from both sides of the debate. The pro-choice group does not consider the foetus while the pro-life group does not consider the circumstances of the woman in the debate. The pro-life/pro-choice dichotomy is discussed later in this thesis. The next chapter focuses on the medical aspects of abortion.

CHAPTER THREE

MEDICAL ASPECTS OF ABORTION

3.1 Introduction

Abortion involves a medical procedure. Legal abortion, according to the TOP Act of South Africa has to be performed in a medical service facility. Abortion within the first twelve weeks may be performed by a nurse who has been trained to do so, while abortion after twelve weeks has to be performed by medical doctors. With abortion being a medical procedure, this chapter discusses the medical aspects of abortion namely the types of abortion available, how it is performed and the possible physical consequences for women.

3.2 Abortion

Abortion is a procedure which causes a foetus to leave the uterus before it is fully developed. It involves the expulsion from the uterus of the products of conception before the foetus is viable (Dictionary of Medical Terms, 2012). There are the two general categories of abortion, namely spontaneous abortion and induced abortion. Spontaneous abortion takes place naturally with no external intervention, that is, the mother has no control. In some instances women miscarry before the foetus is viable. This may be due to medical complications either with the mother or the developing foetus. The second category of abortion involves an induced abortion, that is, abortion brought about by medical means. In South Africa, abortion is defined as the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman (S.A. Choice of TOP Act, 92 of 1996).

This study focuses on induced abortions. There are two types of induced abortions (Table 3.1) namely medical abortion (non-surgical abortion) and surgical abortion (WHO, 2007).

The type of abortion performed utilised depends on the stage of the pregnancy (UKHealthCentre, 2012). In the US over 61% of all abortions are performed during the first nine weeks of the pregnancy, and ten percent are performed in the second trimester (between the 13th and 20th weeks of pregnancy) (Kells, 2009). Table 3.1 below presents the types of abortion.

Table 3.1 - Types of abortion (Lowen, 2009)

Medical Abortion	Surgical Abortion
• termination of the pregnancy and expulsion of the embryo with the use of abortifacients	• Surgical removal of the foetus
• more private, and deemed to be more natural	• An invasive procedure that carries the risk of uterine perforation and infection amongst other possible physical complications
• may occur at anytime: it may even take weeks after the use of abortifacients	• faster method which is completed at the service centre
• may fail which can result in damage to the foetus; excessive bleeding can be experienced	• in control of the abortion provider
• may need to be followed with surgical abortion	• is adequate

There are a number of different methods of abortion (as set out in the Table 3.2). The choice of method depends on the gestational age of foetus, and the facilities available in the community. The earlier the abortion is to be performed the wider the choice of methods that can be used, while the later the gestation, the more limited the options (WHO, 2007; Kells, 2009). Being aware of the different methods of abortion available, allows women the opportunity to make informed choices. Table 3.1 presents the methods of abortion.

Table 3.1 (Simonds, Ellertson, Winikoff & Springer, 2001)

Stage of Pregnancy – Weeks	Method
Under 9 weeks	medical or surgical abortion
9 – 14 weeks	surgical abortion: dilatation and suction curettage (D & C)
over14 weeks	surgical abortion: dilatation and evacuation (D & E)
over 20 weeks	surgical abortion: labor induction prostaglandin labor induction saline infusion hysterectomy dilatation and extraction

In medical abortions, medications (drugs) rather than surgical procedures are used up to 63 days of gestation (AGI, 2010) after which the drugs used are not effective (WHO, 2007). Medical abortion became an alternative in the 1970s and 1980s when prostaglandins (in the 1970s) and anti-progesterone's (in the 1980's) became available. Where the use of Methotrexate is not successful a surgical abortion becomes necessary**.**

A more popular drug mifepristone (RU-486 - known as 'abortion pill') which is used in combination with misoprostol (WHO, 2007) is administered in the first trimester up to the first 49 days (seven weeks) of pregnancy. The use of this Pill causes cramping of the uterus and the expulsion of the pregnancy (Cronje & Grobler, 2003; AGI, 2010). In most instances, the embryo is expelled within four hours. Possible complications resulting from the use of this drug increase after 49 days of pregnancy (Simonds, Ellertson, Winikoff & Springer, 2001). If the pregnancy continues another set of RU-486 will be used (Kells, 2009), or a vacuum aspiration done. Where there is excessive bleeding a vacuum

aspiration, with possibly a blood transfusion, will be necessary (AGI, 2010). While medical abortion is a longer procedure than surgical abortion with the whole process taking up to 21 days, it is said to be emotionally less stressful since it works very similarly to a natural miscarriage (Kells, 2009). While medical abortion in South Africa is the accepted method of abortion in public health facilities, in the US and in Canada medical abortion is still being debated.

In drug-induced terminations the drugs may prevent the fertilised egg from implanting in the uterus, as in the case with the use of RU-486 (post-coital contraception), or may cause the fertilised egg to detach from the uterine wall resulting in an early menstruation (WHO, 2007). Post-coital contraception must be taken within 24 hours of intercourse (post-coital). Labor and delivery is part of the abortion process which can be very emotionally and physically traumatic. Possible complications include uterine perforation, infection, bleeding, amniotic fluid embolism, and anesthetic reactions (Kulier, Gülmezoglu, Hofmeyr, Cheng & Campana, 2007; eMedicinehealth, 2013) the risk of which increases as the pregnancy advances. The administration of hypertonic solutions, done in the first trimester, where saline or urea is injected into the amniotic fluid in the uterus, resulted in maternal complications and was replaced by uterotonic drugs (Jagnayak, 2005).

Surgical abortion involves out-patient surgery (Kells, 2009) where the woman is sedated during the procedure but remains awake and conscious (WHO, 2007) similar to that of an epidural. Different types of surgical abortions are performed during early pregnancy and during late pregnancy. Early pregnancy surgical abortion is performed between 6-14 weeks while late pregnancy surgical abortion is performed between 15-19 weeks. After 14 weeks the procedure becomes more complicated (WHO, 2007; Kells, 2009). Surgical abortion in the first trimester is relatively short as the embryo and placental tissues are still very small. Surgical methods namely vacuum aspiration and dilatation and curettage has been used since the 1960s. Surgical abortions can be emotionally stressful, especially at 15-19 weeks (Kells, 2009).

Vacuum aspiration is recommended after the use of Mifepristone or Misoprostol to ensure that the contents of the uterine are completely removed. Vacuum aspiration is also used as a primary procedure in abortion. During the first trimester vacuum aspiration is the most widely used method, accounting for 80% of first trimester abortions. Vacuum aspiration can be performed up to twelve weeks after the last menstrual period. The procedure takes between five to ten minutes to complete (Cronje & Grobler, 2003; UKHealthCentre, 2012). Vacuum aspiration, also known as aspiration, suction aspiration, suction curettage, or dilation and aspiration (D&A), involves the dilation of the mouth of the cervix, and the suction of the foetus after the head has been compressed to allow it through (WHO, 2006). On completion of the suction the inner walls of the uterus is scrapped to clear any remains (Cronje & Grobler 2003; Jagnayak, 2005). The potential complications of vacuum aspiration are a tear in the cervix or uterus, incomplete abortion, or a failed abortion, the retaining of products of conception, bleeding, infection, uterine perforation and psychological effects. Intense cramping continues after the procedure, with bleeding continuing from a few days to a few weeks (UKHealthCentre, 2012). Vacuum aspiration needs medical supervision with the patient being observed for at least two hours after the procedure (Cronje & Grobler 2003; Jagnayak, 2005).

Dilation and Curettage (D & C) is used towards the end of the first trimester at approximately twelve weeks. In D & C the cervix is dilated, and ring forceps are used to remove the foetus, piece by piece, from the uterus. A curette (a loop-shaped knife) is then used to scrape the remains of the foetus and the placenta from the uterus. Intense bleeding follows the scraping of the uterus (WHO, 2006).

The saline injection is used in the second trimester after 13 weeks of pregnancy. It is administered into the amniotic fluid in the uterus which results in a salt-poisoning abortion where the foetus breathes-in and swallows the fluid. Dehydration, hemorrhaging of the brain, organ failure, and burning of the skin contributes to the demise of the foetus which occurs one to two hours later. Labour begins the next day to deliver a dead, or in some instances, a dying foetus (Cronje & Grobler 2003; Jagnayak, 2005).

Dilation and Evacuation (D&E) is the most popular method of abortion during the second trimester, and has often replaced the saline method. D&E is performed between the 12th and 24th week of pregnancy where the uterus is first dilated before the evacuation is done (Jagnayak, 2005; UKHealthCentre, 2012). By the 12th week the bones of the foetus have begun to harden. These have to be crushed, together with the head, before it is removed (Lowen, 2009). During the latter part of the second trimester the foetus is first injected and allowed to die before the procedure is undertaken. D&E is also used in the third trimester but the procedure becomes more complicated with the foetus that is viable. To prevent the delivery of a live foetus, the foetus is first injected and allowed to die before the procedure. During the third trimester there is also the increased risk of bleeding, infection, uterine perforation, anesthetic reactions, and amniotic fluid embolism (Lowen, 2009).

Hysterectomy is similar to a caesarian section. The uterus is cut open, the umbilical cord is cut to stop oxygen supply to the foetus, and the dead foetus is removed (Stubblefield, Carr-Ellis, Borgatta, 2004). If the foetus is still alive, it is removed from the uterus and left to die.

In prostaglandin chemical abortion, the prostaglandin hormone is injected into the amniotic fluid to initiate premature labour. A live foetus, which is not viable, is delivered. In prostaglandin chemical abortions, live births are therefore common. To end the life of the foetus before labour a saline injection is used to stop the heartbeat (UKHealthCentre, 2012). Prostaglandin chemical abortion is popular in Eastern Europe, China and India. The prostaglandin hormones come in the form of injections or suppositories.

Inter-cardiac injections are used for multi-foetal pregnancies (selective abortion) where one or more foetus is being aborted. Guided by ultrasound, a long needle it used to inject the heart of the foetus (through the uterus) with a chemical. The dead foetus is left to be absorbed by the body while the pregnancy continues (Stubblefield et al., 2004). Selective abortion in multi-foetal pregnancies commonly results in the abortion of the other foetuses as well.

Partial-birth abortion (intact dilation and extraction – IDX), also referred to as the 'brain suction' method, is performed anytime from the fourth month up until the end of the ninth month. In preparation for birth, during the last month of pregnancy, the foetus usually turns itself, aligning the head towards the birth canal. When the head emerges from the birth canal, it is considered a live birth. For partial-birth abortion the foetus is turned around to have the legs, rather than the head, facing the birth canal. The use of ultrasound determines the exact position of the head before and after the movement by the doctor. The foetus is then partially delivered with the head remaining in the birth canal. The skull is then punctured, the brain drained out, and the dead foetus delivered (Stubblefield et al., 2004). Since 2003, partial-birth abortion has been banned in the US. This was, once again, brought to court and upheld in 2007 (Fox news, 2007).

Medical abortions in the second trimester become more dangerous because the foetus is more developed. Compared to surgical procedures in the second trimester, medical procedures are both more dangerous and more expensive (Stubblefield et al., 2004). It is therefore very important to determine the gestational age of the foetus for which a uterine ultrasonography is used to provide an accurate means of estimation.

In South Africa third trimester abortions are illegal. It is only performed in extreme situations, for example, risk to the mother's life, or severe deformity to the foetus. In the US only 1.5% of abortions are performed after 21 weeks of pregnancy (AGI, 2006).

3.3 The consequences of abortion

Complications resulting from unsafe abortions account for approximately 13% of global maternal deaths (Grimes, Benson, Singh, Romero, Ganatra, Okonofua & Shah, 2006) and approximately five million with physical complications both in the short and long-term (Grimes et al., 2006; Singh, 2006). Almost all the maternal deaths occur in developing countries, with the highest being in Africa. The death rate was approximately 650 per 100,000 unsafe abortions in developing countries in 2003 and ten per 100,000 in developed regions (WHO, 2003). While some studies indicate that the so-called 'safe abortions' are

safe (AGI, 2010), others argue that even ‘safe abortions’ lead to various complications and sometimes to death (Reardon, 2002). In Zimbabwe ‘safe abortions’ is the major cause of death among women. The risk factors include oxytocic drugs and the evacuation of the uterus which is done during the first trimester, where anemia and sepsis are contributory factors (Mudokwenuy-Rawdon, Ehlers & Bezuidenhout, 2005). Deaths from legal abortions result from use of anesthesia, infection, undiagnosed ectopic pregnancies, and hemorrhaging. The risk of death increases during the later trimesters with “one death for every one million abortions at or before eight weeks of gestation, one per 29,000 between 16–20 weeks of gestation; and one per 11,000 from 21 weeks of gestation. The seven per 1 000 000 legal induced abortions increased by 38% for each additional week of gestation” (Bartlett, Berg, Shulman, Zane, Green, Whitehead & Atrash, 2004, p. 1).

Several studies indicate that many ‘safe’ abortions do lead to physical and psychological problems. This section focuses on the physical effects of ‘safe’ abortion. The psychological impact of abortion is discussed in *Chapter Five*. A small percentage, less than one percent, of women who have had ‘safe’ abortions suffer physical complications that require hospitalisation (AGI. 2008). Translated into figures, of the 42 million abortions worldwide, approximately 420 000 women who have had abortions experience complications. Relating this to South African statistics, it would suggest that of the 650 000 legal abortions performed during the period of 1997 – 2007, statistically almost 6500 would have experienced complications that led to hospitalisation.

Possible complications may occur immediately, within a month, or even later. It is argued that immediate complications, occurring within three hours of the abortion, although accounting for only ten percent, can be life threatening (Rue, Coleman, Rue & Reardon, 2004). Delayed complications may occur within twenty-eight days of the procedure and accounts, on average, for one in every 27 women (Major, Cozzarelli, Cooper, Zubek, Richards, Wilhite & Gramzow, 2000). There may be retained products of conception, women may become ill experiencing intense pain, bleeding, or fever. Failed abortions where the placenta has not been evacuated after the abortion in pregnancies less than six weeks are common. A failed abortion means that despite the procedure, the pregnancy

continues, and that the chemicals used for the procedure may affect the foetus. A repeat abortion will therefore need to be performed (UKHealthCentre, 2012). Late complications may occur after twenty-eight days.

The physical effects of abortion are increased in repeat abortions. Approximately 45% of all abortions are repeat abortions placing women at great health risks in the long-term. The physical risks and complications are also increased for young women both in the short and the long-term (Berger, Gold, Andres, Gillet & Kinch, 1984). This chapter covered the medical aspects of abortions and the physical consequences of abortion. The next chapter reviews literature on the religious, cultural and ethical considerations.

Despite the noted physical effects of abortion, it is argued that the physical effects of abortion is no more intense that those endured by women during pregnancy and childbirth. Women also die through complications during pregnancy and childbirth (WHO, 2012). In most instances, legal abortions can even be safer than childbirth (Raymond & Grim, 2012)

Conclusion

As a medical procedure, abortion carries with it the risk of potential physical complications for women. At the same time, medical complications are not limited to abortion but also to pregnancy and childbirth. This places the effects of pregnancy, abortion and childbirth within the experiences of women.

CHAPTER FOUR – LITERATURE REVIEW

ABORTION: RELIGIOUS, CULTURAL, ETHICAL AND BIOETHICAL CONSIDERATIONS

4.1 Introduction

Although historically abortion has been practiced in many parts of the world, it continues to arouse passion and controversy. Questions arise concerning human existence, namely: when does life begin? When does personhood begin? And what makes human beings human? There are conflicting and competing views within specific religious groups and across the various religions, and across the broad spectrum of secular society. Abortion brings into sharp focus debates on the rights of women over their own bodies in relation to that of the rights of the foetus, the rights of parents, and the rights of partners and spouses. It also raises questions about the responsibility of the state to protect the unborn human foetus. The acceptance of responsibility of one's own actions and its consequences with specific reference to one's sexual behaviour is debated: do human beings have only rights with no responsibility, or is responsibility for one's actions selective (Badenhorst, 2005)?

With abortion being fundamentally an ethical issue which is based on the interpretation of the available medical evidence, it is inevitable that major religions would contribute to the discussion. The legality and morality of the debate however, involves the personhood of the foetus, that is, on whether and at what stage, the foetus attains personhood. Personhood cannot be debated in a logical or empirical manner. Campos (2002) asserted that personhood is, in essence, religious or quasi-religious based on particular assumptions. Thus, religious, cultural and ethical considerations are central to the debates on abortion.

4.2 Religious and cultural considerations

With the major religions, there is much similarity on when abortion might be allowed. Abortion is generally permitted by the different religions only in the early stages of pregnancy, and where the health of the mother has to take precedence over interests of the foetus. Religion has, therefore, always had a powerful influence on abortion attitudes and the abortion debate (Adamczyk, 2009). While taking the life of an unborn foetus is generally considered to be in conflict with religious teachings, views on abortion do vary some from one religion to the next. I discuss the basic teachings of five of the world's major religions namely the three Abrahamic faiths (Judaism, Christianity and Islam) and two oriental religions (Hinduism and Buddhism), as well as African Traditional Religion and Culture. Not only does each religion vary in their views on abortion, but also within each religion there are different groups that follow and teach different values.

4.2.1 The Abrahamic Religions

Judaism, Islam and Christianity have a common origin and together form the Abrahamic religions. Although the origins and the basic value attached to life and its origins are similar in these religions, they deviate in their teachings. Judaism is the original of the three Abrahamic religions. The teachings of the Torah are explained, supported, and added to by other teachings and explanations that were brought down the generations orally through tradition. Together the Torah and the Traditional Teachings form the basics of Jewish teachings. Christianity is the second of the three Abrahamic religions. The birth of Christ marks the beginnings of Christianity. Christians take their teachings from the Bible, the first five books of which are common with the Torah (Hilton, 2007; Podell, 1998). The Abrahamic religions believe that there is one God, the creator of all life with the creation of mankind above all other creation. Mankind is held accountable on death, for actions towards fellow human beings and the rest of God's creation. The Abrahamic religions believe that mankind is created by God in His image, and have been blessed with free-will. This free-will however exists within the parameters of the religion's teachings (Podell, 1998). A fundamental teaching is responsibility for one's action. People are required to

take responsibility for their behaviour including their sexual behaviour. All behaviour, including sexual behaviour has consequences. Just as one is required to accept responsibility for the consequences of all other behaviour, so too must one accept the consequences of one's sexual behaviour.

Although 'abortion' is not mentioned in the Torah or the Bible, by application of their teachings abortion is not permissible. Since all mankind is created in the image of God life must be preserved and cherished from the time of conception (Podell, 1998). The Torah and the Bible discuss the injury to a pregnant woman who goes into premature labour. If the baby survives a small punishment of the offender is required; if the baby dies, the offender is to be put to death (Podell, 1998; Hilton, 2007). This forms the basis of the Jewish and Christian view of abortion.

Islam takes its teachings from the Koran, which teaches that life begins at conception but that the soul enters the foetus at 120 days. The foetus must, however be protected during this time because it is of no less value (Aramesh, 2007). After the soul enters the foetus, abortion is completely banned under all circumstances. There is disagreement in Islam, however, as to when the soul enters the foetus. There are three different views in this respect: 120 days; 40 days; at about twelve weeks, that is, when movement is felt. After 120 days, Muslim scholars are in agreement, an abortion cannot be done. Although permissible until 120 days it is only to save the life of the mother, and in cases of rape and incest which are considered the 'lesser of two evils' – a principle in Sharia (Muslim law) (Aramesh, 2007). There have been changes in conceding to abortion to include non-viable foetal anomaly, and to extend abortion beyond 120 days when the mother's life is at risk (Hedayat, Shooshtarizadeh & Raza, 2006). Debate amongst Muslim scholars continues with regard to including rape as grounds for abortion. Abortion on account of the socio-economic circumstances of the mother is not allowed.

The Abrahamic view is that abortion is only permitted to save the life of the mother and in cases of non-viable foetal anomaly. A woman is not permitted to abort the foetus just because the foetus is in her body which is in accordance with her not harming herself or

others. The mother is not seen as being solely responsible for the conception: it involves God, a man and a woman. Each person is required by God to protect everything created by God. Pregnant women in need must be assisted within the context of protecting life and helping our fellow beings (Podell, 1998). The foetus too is recognised as human life and is to be protected.

4.2.2 Oriental Religions

Oriental religions originated in greater India, the largest of which are Hinduism and Buddhism, and which share some basic common beliefs and teachings. Unlike the Abrahamic religions there is no one doctrine. The basic belief that runs through the various groups in Hinduism and Buddhism is ahimsa (non-violence), karma and reincarnation where the soul lives on from one from one life to another (Murti & Derr, 1999). Individuals go through many cycles of being born, living, dying, and being reborn. The present life determines the quality of the future life (Hilton, 2007). The soul relives several times, enters many bodies, and uses many forms until it attains perfection and becomes one with God. The form taken, or body entered into, will depend on the deeds done during the life cycle that just ended.

Hinduism views a person as consisting of *atman* (spirit), and *prakrti* (matter) and at the point of conception the soul is joined with the matter. Hinduism teaches that the soul enters the body at the time of conception. Abortion therefore is not accepted, unless to save the life of the mother. Different sects of Hinduism differ in their views as to when the spirit joins the matter. Some are of the view that this occurs at conception while the *Garbha Upanishad* states that ensoulment takes place in the seventh month (Moad, 2004).The purpose of life as a human being in Hinduism and Buddhism is to make progress toward liberation from the cycle of death and rebirth on this earth, that is, to reach *moksha*. According to the doctrine of reincarnation the soul is being reincarnated from a previous birth and the foetus is already a person from a previous life. It is not a future or potential person. The Hindu scripture teaches that the soul, during the time in the womb remembers its past life. This memory is destroyed during the process of birth (Hinduism's Online

Lexicon, 2002). With abortion the soul is hindered from its spiritual progress to reach *moksha* (Moad, 2004; Hilton, 2007; Michael, 2008; Damian, 2010). The belief in reincarnation leads to the belief that life begins at conception and that the foetus is the rebirth of a deceased and therefore demands the same respect as any person (Aramesh, 2007; Hilton, 2007; Damian, 2010). As with Hinduism, a fundamental belief of Buddhism is the concept of *ahimsa,* which is nonviolence and respect toward all species of life (Michael, 2008; Damian, 2010).

Karma is the principle of cause and effect. Hindus and Buddhists believe that every successive life depends on how the previous life is lived. This implies that the individual controls his/her own destiny (Hinduism's Online Lexicon, 2002). An abortion affects the karma of several people: of all those involved in the abortion process, namely, the authorities, the counsellors, the service providers, the father, the mother, their parents, and the child involved. Hindu religious leaders and the Hindu scriptures consider abortion at any stage as murder, unless it is to save the life of the mother (Hindu Ethics, Section 6; Murti & Derr, 1999). Abortion is also considered an act against *rita* (a universal cosmic law in Hinduism) and *ahimsa*, and is therefore considered a sin. Hinduism equates abortion with the killing of one's parents and the killing of a priest and those guilty of abortion are referred to as *foetus slayers,* and to have lost caste (Damian, 2010). Abortion is only permitted to save the life of the mother and in instances of non-viable foetal anomaly (Hinduism's Online Lexicon, 2002; Hilton, 2007).

Abortion, however, is presently freely available in India, which is the heart of Hinduism and where Hinduism is the religion of the masses. Traditionally the Indian couple is expected to have children to continue the family name and tradition. Abortion is seen as disobedience to this rule of tradition. On the other hand, tradition also favours sons who carry the family name. To this end abortion of female foetuses, although outlawed in India, is practiced in favour of the cultural preference for sons rather than conceding to the religious views (Hinduism's Online Lexicon, 2002; Hilton, 2007). The concept of reincarnation can also be used to support abortion on demand. The soul that is aborted can

be seen has still having many more chances to make spiritual progress (Hinduism's Online Lexicon, 2002).

Like the Abrahamic religions, Buddhism and Hinduism also teach responsibility for the consequences for one's actions. Abortion therefore, becomes a very personal decision, where one cannot escape the consequences, either in this lifetime or the next. Japanese Buddhists reconcile the act of abortion with their religious belief by performing the Buddhist tradition of mizuko jizo (Hilton, 2007). The tradition or ritual of mizuko jizo is performed to allow and lead the aborted foetus to rest in peace in the 'land of the dead' (Tedesco, 1996). This is similar to the isiZulu tradition, to which I now turn my discussion.

4.2.3 African traditional religions and culture

African Traditional Religion (ATR) and culture is intertwined forming the basis of African culture. The various ATRs have, over time, adopted one of the three Abrahamic religions and had incorporated the respective religious teachings into their traditional teachings. The common tenant amongst all African Traditional Religions is the belief in one God who is the Creator of all as is taught by the Abrahamic religions, and the belief in spiritual realities, material realities, and mystical forces. Human beings are seen as the highest and central creation of God, and as such humankind is to live in harmony with one another according to ethical values that protect one another (Nwaigbo, 2010). The African religious teachings cover sex, marriage, and the value of life, including prenatal life.

Life is highly valued as it is considered to be at the core to African philosophy, their existence and their teaching (Sindima, 1990; Nwaigbo, 2010; Shahadah, 2010). Great emphasis is placed on the continuity of the family life, and the continuity of life after death is the reason for the need for salvation. This forms the basic faith of every traditional African religion and of every African person – the continuity of life. Life is celebrated as in the repeating of the harvest, the first rains, and in the continual relationship with the ancestors (Burke, 1987).

Children are seen as a blessing in that they ritualise their parents and ancestors and ensure the continuity of the clan. The child is referred to as 'generation' (Shahadah, 2010). The child is presented to the ancestors during a special ritual. Being childless is considered a misfortune, or even a sign of a curse. To Zulu traditionalists, childlessness is the greatest of all misfortunes. No marriage is permanent until a child, especially a boy, is born (Every Culture, 2012). The inability to bear children is the only reason a marriage may be dissolved and the woman will have to accept the decision of the man. The man is then free to take another wife to bear him children. The first wife may even choose another wife for him in order to maintain family life. This gives women who cannot conceive a lower status in society and they were referred to in derogatory terms (Sewpaul, 1995). When a child is born the marriage cannot be dissolved. Hence children were seen as marriage-binders (Shahadah, 2010). The inability to bear children is seen as the woman's responsibility. The role of the male in the inability to produce children is not even considered. African women who do not produce children are seen to have failed her husband and the community (Sewpaul, 1995). Choosing not to have children in the African traditional culture is frowned upon (Burke, 1987). In light of the focus on the reproduction of life, contraceptives have no place in traditional African culture and are therefore not accepted. Pregnancy before marriage is forbidden. Women who are unmarried are considered promiscuous if they use any form of contraceptives (Patel & Kooverjee, 2009). This has led to men demanding their partners' non-use of contraceptives. Men who father children outside marriage are required to pay for damages or 'inhlawulo' (Ndinda, Uzodike, Chimbwete & Mgeyane, 2011). In practice however, neither communal responsibility for children nor responsibility to pay damages for women are observed.

ATR believes that the fertilisation of the egg begins a process, the destiny of which is guided by spiritual forces. Rituals are performed immediately after conception to thank God for His blessing, and during the pregnancy for protection of the child from evil spirits. Termination of pregnancy is construed as killing: a child is a precious gift from God and the ancestors. The rituals continue in the life of the child through to adolescence. This signifies the value of the unborn. The unborn is treated no differently from the infant, young

child or adolescent. The foetus has a life from the time of conception. Rape and poverty is not accepted as reasons for abortion. Traditional leaders, however, allow abortion only in case of rape and incest, and demand that rape and incest offenders be severely punished (Rakhudu, Mmelesi, Myburgh & Poggenpoel, 2006). The voice of society is considered the only defense, voice and protection of the unborn (Conteh, 2008) and those who had abortions are required to be cleansed with 'dipitsa' or herbs (Rakhudu et al., 2006). Childbirth actually consummates a marriage in African tradition (Burke, 1987), and a child belongs to a clan and is cared for by everyone (Morrell, 2006). Illegitimate children, however, were traditionally frowned upon in Zulu culture and illegitimate children referred to as 'bastards'. A child without a father is not recognised by the clan and did not stand to inherit from the father. Such a child is left to be, and feel, insecure (Morrell, 2006).

The male-female relationship and marriage is celebrated in all their worldviews and handiwork: rituals, art, language and works of wisdom (Shahadah, 2010). The bride is therefore highly valued and treated with much respect. She is seen as potentially producing future members of the community and possibly a great leader for the community. Ideologically women are therefore protected in African culture (Shahadah, 2010) while in reality, as this study shows, many are subject to oppression, exploitation, abuse and abandonment.

Although abortion is forbidden under normal circumstances by all the major world religions, it is not regarded as a simplistic, black and white decision (Hilton, 2007). While most of the major world religions strongly oppose abortion, there are slight differences from one religious group to the next, and between the various sects in any particular religious group. The various religions permit abortion, even if only in limited circumstances, where the life of the mother is in danger and in instances of non-viable foetal anomaly (Hilton, 2007).

Abortion is, and probably always will be, a very controversial topic. Religious values, which continue to play a large part in the abortion debate (Hilton, 2007), have huge influence on abortion attitude and behaviour (Jelen & Wilcox, 2003; Adamczyk, 2009).

Attitudes towards abortion may later impact decisions regarding abortion (Adamczyk, 2009). Religion and religious beliefs affect one's attitude and stand on moral issues (Baker, Haas & Cuca, 2003), and impact both the abortion decision and the subsequent effect of abortion (APA Task Force, 2008). The extent, however, to which one submerges one's own values to that of one's religious affiliation, affect the influence of religion on one's moral decision-making. Certain religious sects that have strong religious commitment are the most likely to disapprove of abortion (Elm, Kennedy & Lawton, 2001; Anstee, 2009). Those adhering to the values of these groups tend to feel strongly against abortion. Women's experience of abortion therefore varies according to their religious context (Bolzendahl & Brooks, 2005). Women who belong to religious denominational groups that oppose abortion may experience more conflict than those who do not.

From the religious perspectives abortion is murder. From the oriental religious perspective, it prevents the already existing soul from making progress to achieve its goal of making amends and reaching God (Murti & Derr, 1999). From the Abrahamic religious perspective, when one commits murder (abortion) one is separated from God. Abortion affects one's spiritual well-being as women report feeling alienated from God, unforgiven or unloved by God. They experience a sense of guilt, shame, self-hatred, self-judgment, and fear of God (Trybulski, 2005; Vukelić, Kapamadzija & Kondić, 2010). One needs to seek and accept forgiveness from God. Where the abortion is not shared with family members it makes it difficult, if not impossible, to perform rituals which normally include family members. In such situations the spiritual alienation may continue.

Politicians neglect, ignore, or overlook the religious nature of the abortion debate. The various religious groups believe in an immortal soul and that personhood rests on the existence of the immortal soul. Different religious groups however, have different views as to when the immortal soul enters the foetus. The terminating of a pregnancy therefore amounts to killing a person which is no different to killing a baby after birth, or an older person. The Human Sciences Research Council of South Africa (HSRC, 2004) found that the majority of South Africans did not approve of abortion on demand. A very small minority is in favour of abortion under particular circumstance. The majority of Blacks are

against abortion even in instances of non-viable birth-defects while Coloureds, Indians and Whites are more accepting of abortion in such circumstances.

4.3 Moral and ethical considerations

Abortion raises controversial and serious ethical questions that are often intertwined with religious and cultural beliefs. Firstly, the issue of human existence is debated. Questions arise as to the definition of life; at what point does life begin? what is life about? and what constitutes human life? This is discussed under *Bioethical considerations* later in this chapter. Secondly, society's norms and values on sexual behaviour are debated. Are people required to accept responsibility for the consequences of their actions or are the consequences of sexual behaviour different from other forms of human behaviour as is discussed under religion. Thirdly, women's rights with respect to their bodies are debated. Pro-lifers argue that the newly conceived is not part of a women's body and that this eliminates the women's right to abort the foetus. The debate is extended to when the pregnancy places the woman's life at risk, non-viable foetal anomaly, when a woman is raped, multiple foetuses where the pregnancy cannot continue full-term with all the foetuses, the pregnancy is unwanted or when the woman experiences socioeconomic hardship. Fourthly, the rights of the foetus are debated with respect to the foetus' right to life, the government's responsibility with respect to the unborn, the use of foetal tissue for research, eugenics, sex selection, the use of anesthetic on the foetus for late abortions, the birth of a live foetus, and the aborting of a twin. Fifthly, the debate surrounds the conflicting rights of the woman and the foetus. Sixthly, the right of the father is debated especially where the couple is married, and if not married, where the father wishes to have and care for child. The seventh issue being debated is the rights of various persons implicated in the right of women to have abortion, namely, parents whose young children seek abortion, the rights of health professional in state employ, the rights of surrogate and biological parents, the rights of the individual against the rights of society, forced/coerced abortions that occur because abortion is legal, and the consequences of illegal abortions.

Abortion is one of the most controversial ethical issues. It is not only women who experience an ethical dilemma when making the difficult choice. Health professionals too have to decide between the ethics of their profession (of providing care and preserving life) and the performing of abortion, and between their own morals and values against assisting their patients with abortion. Even where abortion is viewed as morally wrong, and that it is the taking of a life, it may be accepted under certain specified conditions, for example, the risk of death of the mother, non-viable foetal anomaly, where the conception occurred because of rape or incest (Hinman, 2013), or because of the negative consequences of the pregnancy. The role of government, parents, spouses and partners are viewed differently by those on either side of the debate.

Human beings adhere to values which may be determined by religion, culture and/or medical evidence. Commitment to a particular set of values guides both the process of the decision-making and the implementation of the decision. Moral arguments based on religious and medical views continue against the legal view that a foetus has not attained personhood. In comparison to abortion, adoption requires that the woman carry the pregnancy to term and deal with the reality of separation from the newborn, a painful experience even if the woman is highly motivated to give the baby up for adoption. Others who decide to have their babies, especially teenagers, may lack the ability and/or the resources to care for a child (Badenhorst, 2005). The ethical questions surrounding abortion are morally and politically driven, thus making it somewhat impossible to reach definite conclusions. The discussion on ethical considerations will focus on women, men, the foetus, and health professionals.

4.3.1 Women

Rape, incest, non-viable foetal abnormalities, and risk to the woman's health or life are accepted by the major religions of the world, and accommodated by most countries even in instances where abortion has not been legalised. Mielke (2005) argued that abortions under these circumstances contribute to a very small percentage. Four percent of the cases in the US are the result of the mother's health; under 0.5% as a consequence of rape and

incest; and three percent for non-viable foetal anomaly (AGI, 2011). Statistics in South Africa is not currently available in this regard.

It is argued that abortion for socioeconomic reasons, namely, inadequate finances, the age of the mother, relationship problems, secrecy, already having children, and the need to complete education which accounts for 23 percent of abortions on a global level (AGI, 2011), serve the interests women, and can be interpreted in various ways which makes abortion available on demand at any stage (Hilton, 2007). To avoid such a situation, the pro-life feminist movement, as discussed later in this chapter, advocated that the circumstances of women be elevated so that they do not have to consider abortion as an alternative (Matthews-Green, 2000; Pollitt, 2005). Society which also allows approximately seven million children (WHO, 2013) to die each year from preventable illnesses, especially from malnutrition, has to take responsibility for this. The justice system imprisons women (mothers of young children) who commit petty theft due to their socio-economic circumstances, with no concern for the circumstances that forced them to do so, or of the young children left behind when women are imprisoned, so why should socio-economic circumstances be considered in abortion? It is ironic that a government is willing to pay foster grants to parents to care for children, but will not provide financial relief to women in dire financial circumstances forcing them to abort (Mielke, 2005). If children are, indeed, as valued as espoused by all the major world's religions, and the overwhelming pronatalistic values of state and society, it is then incumbent upon the various social, political and religious institutions to create the conditions, conducive enough, where women do not have to revert to abortions, or to abandon their babies just because they cannot care for them.

While nominal foetal anomaly is cited as a reason for late term abortions, only two percent of the late-term abortions in the US are performed for this reason. The aborting of foetuses with nominal anomalies is viewed as an attack on members of society who, because of their disabilities, already feel in a vulnerable situation (Ludlow, 2008). It also pre-empts 'choice' whist most individuals with disabilities prefer life despite their disabilities. Disabled people have contributed in high profile capacity in various fields, with the medical field itself

having doctors with disabilities (Disabled World, 2006). Furthermore, the abortion of foetuses with anomalies promotes eugenic abortion, supporting the medical rather than the social model of disability (Wyatt, 2001). The medical model views the *impairment* as the problem and therefore sees it necessary to keep people with disabilities away from the mainstream of society to prevent an inconvenience for others. The social model views the *person* as disabled by society. Society's views and attitudes are seen as disabling persons rather than the physical or mental challenge. This calls for the examining and changing attitudes to allow those with any form of impairment to actively participate in and to contribute to society (Barnes & Mercer, 1997). Ludlow (2008) argued that advising the woman to abort the foetus with a disability is an indication of the medical professions attitude to disability. This also conveys to parents that she should not be 'burdened' with a child with disabilities, which may also affect their caring for children who present difficulties. Feminist relational ethics however, as discussed later in this chapter, views women's decision to abort as being a responsible one that takes into consideration the future care of the unborn. Where women have several children and left to assume total responsibility on their own, as is common in South Africa, bringing another child into the world becomes unfair on herself, her children, and the new born (Jones, Frohwirth & Moore, 2007). This becomes more complicated and demanding, on the woman, if the child is born with any form of anomaly which will demand all her time and attention.

4.3.2 The Foetus

Strong (2008) argued that the ending of the life of a foetus is the ending of human life and that this is not a debatable issue. Life is not created by politicians and as such politicians have no moral right to decide on whether and when the life of a foetus can be ended. The *rights of the foetus* in respect to the right to life are discussed later in this chapter under *4.3 Bioethical.* It is argued that if it is wrong to kill an adult in that it deprives him/her of a life and of a future; similarly, aborting a foetus deprives it of a life and of a future. That makes abortion morally and ethically wrong (Brown, 2000; Strong, 2008).

The use of foetal tissue for medical research and as a source of cosmetic products is used as justification for abortion (AGI, 2001), where abortion is promoted by those who run such lucrative businesses. No permission is necessary for the use of foetal tissue which lends itself to abuse and unethical practices. It is argued that the use of foetal tissue for medical research and a source of cosmetic products is unethical.

Many countries use abortion for sex selection, for example China, South Korea, and India. This is fast becoming a feature in the US and other Western countries where family size is being limited and couples want to ensure that they have a son (Science News, 2011). This is a notable trend with Asian immigrants in the US where abortion providers have targeted these groups in their advertising (Population Research Institute, 2011). Sex selection has impacted the demography of the countries concerned with drastic imbalance in the male/female ratio which is, in turn, affecting the choice of marriage partners where men are not able to find female partners. Sex selection has therefore led to further abuse of women where older males are marrying girls, sometimes as young as eleven years old, because of the scarcity of single, adult females (Moazam, 2004). In some Eastern countries, little girls are being abducted and sold as future brides for boys (Johnston, 2006). Sex selection therefore contradicts the very purpose legalised abortion is intended for, that is, to promote the welfare of women. Dickens (2002) argued that sex selection, imposed in patriarchal societies, reinforces male dominated sexism and women's subordination. With the aborting of female foetuses the world over, abortion is being used to maintain and perpetuate the dominant discourse of women as being inferior. In Bombay, 7 999 out of 8 000 abortions were female foetuses; in the US, 21 out of 46 female foetuses are aborted while only one out of 53 male foetuses are aborted; in China where couples are allowed only one child only female foetuses are aborted. In just one hospital in India, during the period 1976 to 1977, from the 700 prenatal sex determination tests done, 430 of the 450 female foetuses were aborted. The 250 male foetuses were not affected. Between 1980 and 2010, it has been estimated that up to twelve million female foetuses were aborted (Balakrishnan, 1994). This makes the global ratio of female/male births 90:100 (Kim, 1999; Sen, 2001).

Whilst these are legitimate concerns, it is the implementation of the policy, as with all other policies in South Africa that has to be given consideration and attention (Brynard, 2005) as discussed later, instead of depriving women in dire circumstances, access to 'safe' abortions.

4.3.3 Men

The father's right to decide on the future of the foetus comprises another ethical issue for debate. It is argued that the father, his rights and concerns are not considered in the abortion debate which focuses on the mother and the foetus. In most countries the consent of the father, either married or unmarried, is not needed. In South Africa, the woman has the right to abortion without the consent, and even against the desires of her husband, partner, or ex-boyfriend (TOP, 1996, Section 5). Men have, in many countries, unsuccessfully taken the matter to court in an attempt to prevent their former partners' from undergoing abortions (Sharrin, 1989).

It is argued that because both men and women are responsible for a pregnancy, both should be fully involved with respect to the existence and future of the pregnancy. A man is expected to be financially responsible for the care of a child even though he may have requested that the pregnancy be terminated. Women have the right to choose to be mothers while fathers are deprived of the right but expected to fulfil the subsequent responsibility for a child (Sheldon, 2003). This poses an ethical dilemma for men as to whether they should be financially responsible for the child while they are not allowed to participate in the decision concerning the pregnancy, and especially where they had requested an abortion but the women chose not to. This is a reinforcement of women being accorded primary agency with regard to all issues regarding pregnancy, childbirth and child rearing, while double messages are given to men by society. These legal provisions, that reflect dominant discourses in society about the roles of fathers/men, may be argued to be a factor influencing men and their behaviour and responsibilities toward their children. With men receiving messages that imply that they are not important in deciding the future of their unborn, it could create, reinforce, and perpetuate the notion that they are also not important

in the lives of children. While many men in South Africa abandon their partners when they learn of the pregnancy and many others do not accept responsibility for the care and needs of the child *(Absent fathers* are discussed in *Chapter Five, Psychosocial Considerations)*, there are fathers who accept the responsibility and care for their children.

Whilst men's involvement in the lives of their partners and their children should always be sanctioned and encouraged, this, however, does not seem feasible with abortion. The abortion decision is a time-bound one with extremely limited time being available to women in which to make a decision. The earlier the abortion, the safer it is for women and the less complicated it is for the health professional (WHO, 2000). The decision therefore, does not permit the involvement of partners and long-drawn court battles. Besides, the privilege offered men could lead to further control and abuse of women as it may compromise a woman's ability to secure an abortion. Men may totally deny women the ability to secure abortions, or they may only delay the abortion and still abandon their partners leaving them with no support for the children. The involvement of men in the abortion decision, therefore, compromises the well-being of women. While it is true that legislation that precludes men might reinforce messages about the less important role of men, the reality is that the legislation was formulated on account of men being abusive, controlling over women's sexuality and reproductive choices and not taking responsibility for children that they have. The rates of sexual violence in South Africa is as high as 27 per day (The Guardian, 2013). Had circumstances been different where men assumed responsibility for their partners and their children, the rights of fathers in this regard will need to be considered.

4.3.4 Health professionals

Although abortion is openly discussed in many parts of the world it remains a highly controversial one among health care providers. All realities of life have a moral aspect which demands a system of morals. For most realities in life there is a moral dimension which falls under the realm of ethics which can be considered as a system of morals used by people to evaluate their experiences and plan their course of action. Every profession

has a professional code of ethics, by which health professionals' behaviour in the practice of the profession is guided. Emphasis is on personal moral integrity as the basis for professional practice (Smith & Davis, 1980).

The ethics of abortion continue to confront doctors, nurses and many other interested parties, because the question of life and death is involved. Present day health professionals are therefore faced with a wide range of ethical dilemmas. While more women seek abortion, the dilemma increases particularly for health professionals who are either directly involved in the procedure or in the subsequent care of the women. While the professional ethical code demands that they observe the law and provide abortion, they are, at the same time, required to preserve life. Moral and ethical issues with regard to abortion therefore impact both the service delivery for health professionals and women seeking abortions (Smith & Davis, 1980). The health professionals, who should be key persons in the abortion debate, have been omitted with their ethical views not even being considered. It is argued that while women often opt for abortion because they are told that 'it is only a blob of tissue' (Smith & Davis, 1980), it is the health professionals who have to deal daily, even hourly with collecting the parts of a tiny foetus, or dismembering the more developed foetus, incinerating foetal remains, emptying the container of foetal remains, and still having to counsel the woman that all is well since it is a 'blob of tissue' that was removed. Abortion is far from being uneventful for the health professional involved (Smith & Davis, 1980) as is evident in this study.

It is argued that abortion contradicts the principles of the Hippocratic Oath both in its original form, and in its reformulation. The Hippocratic Oath, by which all doctors are sworn into the profession, specifically eliminates abortion as an option. The Declaration of Geneva (1948, p. 3) states that "I will maintain the utmost respect for human life from the time of conception; even under threat I will not use my medical knowledge contrary to the laws of humanity." The International Code of Medical Ethics (1949, p.1) states that "a doctor must always bear in mind the importance of preserving human life from the time of conception until death" while The Declaration of Oslo (1970) reaffirmed the "utmost respect for human life from the time of conception" (Code of Ethics Collection, 2011, p.1).

In performing abortions these ethics are compromised. Doctors do have the right, on the grounds of conscience, to refuse to perform abortion. In some countries, such as the US, Britain and in South Africa medical professionals can refuse to perform abortions but are required to provide women with information and details of health professionals who do perform abortions. Mathieson (2008) argued that this in itself presents a dilemma for doctors because the referral itself implies one's participation in the abortion process.

Many nurses too are opposed to abortion. The legalising of abortion has presented them with increased ethical dilemmas concerning the performing of their duties while remaining true to their personal convictions (Harrison, Montgomery, Lurie & Wilkinson, 2000). Nurses are required, despite their personal views, to nurse the patient pre- and post-abortion (Hannah, 2005; Pera & van Tonder, 2005) without consideration of the well-being of the nurse who feels very strongly about abortion. The job therefore becomes emotionally demanding (WHO, 2010). It is asserted that nurses involved in abortions felt stressed and experienced conflicts between their values and the abortions they were involved in. In the face of numerous available options to prevent pregnancy, most nurses are of the view that abortion should only be available in instances of rape, incest or a threat to the mother's life or health. They are opposed to those women who use abortion as a contraceptive, or seek abortion because of their socio-economic circumstances (Harries, Stinson, and Orner, 2009), and they find it difficult to care for women who refuse contraceptive methods, or fail to use them correctly, and come in for repeated abortions (Cohen, 2007; WHO, 2010). Although women may not have been on contraceptives for various reasons, resolving the dilemma is stressful for nurses. Nursing women who demand abortion for convenience on the one hand, while at the same time nursing women who are grieving and mourning the loss of their babies on the other hand, presents a real dilemma for nurses (Harrison et al., 2000). Nurses admit bias in such situations.

Nursing is crucial to the well-being of society, and it is expected of nurses to be persons of integrity, who have internalised the nurses' code of ethics as a way of life. The same nurses are expected to end the life of a foetus. Where nurses choose not to perform abortions, they are required to inform the employer in writing. This however, does not include the nursing

of women prior to, and after the abortion (Pera & van Tonder, 2005). Health services are not clear as to how nurses can put into effect their rights to conscientious objection and how this will affect service provision (Harries et al., 2009). In South Africa nurses who do perform abortions in the first twelve weeks have volunteered to, and are trained to do so. The general nursing staff is not required to perform abortions but is required to nurse women, which includes the delivering of foetuses where women have been hospitalised. They have no options in this respect. Where women come in for day procedures, they are attended to by the nurses who have volunteered and were trained to undertake the procedure.

Some of the reasons why health professionals refuse to perform abortions are personal/own experiences, their moral or religious values, the reasons why women seek abortion, and the gestational age of the foetus. Subsequently, there are too few medical doctors and nurses to perform abortions, and the numbers available are gradually decreasing over the years (WHO, 2010). Those who are willing to do so are left with an extra workload. Doctors and nurses also refuse to perform abortions due to the stigma attached to the task, burnout where they have to carry the load of those who refuse to participate in abortions, the comments and attitudes of colleagues, feelings of isolation (WHO, 2010), being highly affected by the procedure and the repeated exposure to a dying foetus, the emptying of the suction bottle and the disposing of the foetus, and where they cannot handle the situation where foetuses are born alive and left to die while the Hippocratic Oath demands that they attempt to save the baby (Williams, 2006). Ehlers (2000) argued that in conceding to the rights of women with respect to their bodies, health professionals should also have rights to refusing their bodies to be used to perform abortions without being discriminated in the recruiting of health professionals.

In the US there has been a steady decline of abortion providers, while in SA all the governmental clinics and hospitals are unable to offer the service because the majority of health professionals refuse to perform abortions (Varkey, 2000). In view of there being too few health professionals who are willing to perform abortions or to refer patients to those health professionals who do so, the US and Britain were considering passing resolutions to

change the Act to allow women to make a complaint where doctors refuse to perform an abortion (Caldwell & Ross, 2010). Mathieson (2008) argued that to be forced to perform actions which go against their morals and values is an attack on the human rights of health professionals. This may result in a new turn in the abortion debate. Do health professionals' right to conscientious objection to abortion take precedence over the woman's right to abortion or vice versa? Can health professionals be forced to dishonour their professional ethical code (Lithwick, 2008)?

For health professionals who are willing to participate in, or perform abortions up until a certain time of gestation, there is difficulty in deciding at which point to refuse to do so (Cane, 2008). Furthermore, health professionals and abortion facilities in the US have been the target of various forms of violence by those who passionately oppose abortion. The violence experienced by service providers includes stalking, assault, arson, bombing, murder, attempted murder, and kidnapping in the US (AGI, 2010).

Despite their own dilemmas, there are health professionals who voluntarily perform abortions and consider it as service. Their decisions are based on a humanistic perspective of the circumstances of women where they consider the need for the service to go beyond their professional, personal, ethical or religious codes (WHO, 2000).

4.3.5 The legalising of abortion

Although the legalisation of abortion in South Africa is argued to have decreased morbidity, the decrease is said to be insignificant (Jewkes, Brown, Dickson-Tetteh, Levin & Rees, 2002). It is further argued that the socio-economic circumstances that force a woman to abort speaks ill of a society, not willing to make concerted efforts to eradicate the injustices rather than resorting to legalising abortion and exposing women to further harm. Mielke (2005) argued that the legalising of abortion also gives rise to and promotes further social injustices against women because a disregard for human life is subsequently perpetuated. Furthermore, the attitude and action of ending the life of the unborn solely

because society is unable or unwilling to care for them can likewise be extended to the chronically ill, the frail aged, the disabled, and others totally dependent on society.

In legalising abortion both religious and cultural values are being undermined. Scripturally, the major religions promote and value life. By legalising abortion the values and principles, which form the basis of the major religions, are compromised and undermined. The discrediting of religious values at policy level subsequently undermines other religious values and teachings which directly affect society. At what point are followers of the various religions in South Africa required to adhere to religious and cultural teachings when the very basic teaching of the value of life is overthrown by legislation?

Besides contradicting religious and cultural teachings abortion contradicts the Hippocratic Oath, the South African Code of Ethics for Nursing Practitioners in South Africa undermines the 1949 Universal Declaration of Human Rights, the 1959 Declaration of the Rights the Child which explicitly refers to such rights as applying to the unborn, and the 1976 International Covenant on Civil and Political Rights. The Declaration of the Rights of the child state that "The child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth" (Preamble Point 3), while the Universal Declaration of Human Rights state that "Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." Although 'human family' has not been defined in the Universal Declaration of Human Rights, it is argued that an unborn *human* of-spring belongs to no other family but that of the human family (Johnston, 2002).

The legalisation of abortion has resulted in various forms of coercion and forced abortion being used by abusers, which include immediate family members, to continue their criminal behaviour (Fontes, 1993). Where legalised abortion should be meeting the needs of women, it is being used to hurt them. In the US, 0, 5% of all abortion is teenagers who were forced by their parents to have the abortion (AGI, 2011). Governments, too, in an effort to curb the population growth, force abortions and even post-natal infanticide

(Saharso, 2003). In 2002 *The (London) Times* reported a woman forcefully being administered a saline abortion during her third pregnancy. The foetus survived and was drowned by governmental authorities despite the pleas of the parents (Saharso, 2003). Forced abortion and coerced abortion, even by authorities, violates the rights of a woman.

Not being in a position to give informed, voluntary consent also constitutes coercion. Women who have lived in submission all their lives will experience difficulty in making their own decisions and will readily accept the opinion of those in authority. Women are required to give consent on their own (International Community of Women Living with HIV/AIDS (ICW), 2008) without adequate professional intervention and support. Circumstances too, as discussed in *Chapter Five*, can also be coercing factors in the decision to abort. These are directly related to unequal treatment, oppression, and structural constraints experienced by women.

Legalised abortion also allows couples to abort a twin for convenience. Studies on twins indicate the unique bonding that take place prior to birth (25 weeks into the pregnancy) and continues thereafter (Pregnancy and Baby Bookshelf (PBS), 2011; Weaver, 2011). Pre- and post-natal psychotherapists argue that pre-natal experiences leave an impression in one's mind which remains throughout one's life. The aborting of a twin may have negative consequences for the surviving twin where the surviving twin faces a loss of someone who she/he had bonded with (Leonard, 2002). The psychological effects of the loss of a twin in the prenatal stages include incompleteness, abandonment, rejection, and restlessness (always searching), amongst others (Hayton, 2011).

It is difficult to assess whether abortion is being advocated for the need of women or for the purposes of business as indicated by a health professional in this study. Smith (2005) based her argument of the origins of Planned Parenthood who had, as its agenda to limit the population of the lower socio-economic groups which comprised mainly the Blacks in the US. The agenda of legalised abortion is therefore constantly being questioned especially since, as argued by Rue et al. (2004), the welfare of women whose rights legalised abortion was intended to be enforcing, is not the focus of such services. To this

end, minimal if any pre-abortion care is offered by abortion service-providers. Where pre-abortion care is offered, it is superficial, covering just the abortion procedure and the obtaining of consent. The out-of-hospital abortion with local anesthesia at ten weeks' gestation cost $451 in the US (AGI, 2009) and R1990 in South Africa. This increases to R3200 for 18-20 weeks in South Africa. It is argued that sex selection too is a lucrative business venture. There are ultra-sound clinics throughout India, including the rural areas where poverty is widespread with lack of basic facilities (Oomman & Ganatra, 2002). The legalising of abortion also provides a legal defense for those who were already performing abortions for large sums of money. It also provides a regular source of supply of foetal tissue for research and for the human genome project. To obtain foetal tissue from legalised abortion does not require consent, yet tissue from a deceased requires consent from family members. The justification used is that foetal tissue is used to save lives.

The legalising of abortion is argued to have led to the abuse of pre-natal testing, the purpose of which was the intended provision of medical intervention for foetuses with complications. Instead of helping the unborn as designed to, it is being used to determine the sex of the unborn with the intention of aborting it (Taylor, 2001). Determining the sex of the foetus is possible as early as five weeks with a simple blood test kit. This is being marketed to the American consumer as a business venture. Subsequently the rate of sex selective abortion in the US is expected to steadily increase (Almond & Edlund, 2008).

The testing and aborting of foetuses with disabilities leads to ethical dilemmas as discussed earlier in this chapter. Eugenics judges others on the basis of their circumstances: personal (mental and physical) and social which contradicts the constitutional principal that everyone are equal irrespective of their physical, mental, or social circumstances or, religious, racial or cultural affiliation. Oliver (1996), a physically challenged academic, argued that the lives of disabled people are threatened not only from ordinary people in their everyday lives but by the policies of countries as well. Siebers (2008), also a physically challenged academic, questions whether having an able body and mind determine whether one is a quality human being, and whether disabled people are worth less than non-disabled people (Siebers, 2008). It is further argued that prenatal testing for

disability can also promote the notion of ‘perfect’ children where society and parents become intolerant of those with any types of limitations or defects (Haymon, 2011).

While Jewkes, Brown, Dickson-Tetteh, Levin, & Rees (2002) assert that deaths from abortion in South Africa fell by 91% after liberalization of the law in South Africa, Barot (2011) argued that the legalising of abortion may actually have led to an increase in abortions, both safe and unsafe. This is evidenced in the increase in unsafe abortions internationally from 19.7 million in 2003 to 21.6 million in 2008. This statistics is expected to increase unless the reasons behind unsafe abortions are addressed (Barot, 2011). Those who may not otherwise have abortions, subsequently have the legitimate opportunity to do so. The legalising of abortion in South Africa has led to the thriving of illegal abortion providers amidst a so-called ‘safe’ environment. There is a sharp increase of bogus doctors who openly advertise ‘cheap abortions’. Many women opt for illegal abortions for various reasons. Those who cannot afford the expensive medical procedure, or wish to save some money may go for the procedure at minimal cost. Others, who wish to keep the abortion secretive, may not want to access public facilities. Subsequently the legalising of abortion has resulted in an increase in maternal death rates. Mauritius which has one of the hardest laws against abortion has the lowest maternal death rate in Africa namely 15 abortion deaths for every 100 000 live births while Ethiopia has a rate of 720 abortion deaths for every 100 000 live births. South Africa, with the most liberal abortion laws in Africa (Brookman-Amissah & Moyo, 2004) has a rate of 400 abortion deaths to every 100 000 live births (Tankard-Reist, 2006). As noted earlier, prior to the TOP Act of 1996, South Africa reported 425 deaths per annum and approximately 14 000 per annum receiving treatment at hospitals for complications caused by illegal abortions (Dickson-Tetteh & Rees, 1999). AGI (2012) argued that a liberal abortion law does not ensure the safety of abortions. The increased number of incomplete abortions is being linked to the possible use of misoprostol by private practioners (Varkey & Fonn, 2000). Unsafe abortion is estimated to have increased to approximately 20 to every 100 live births each year (Haddad & Nour, 2009). Abortion has led to a lowered birth rate with a declining population in many countries where the population of young children is not in keeping with that of the adult population.

The abuse of policies should not, however, prevent those who genuinely need the service from accessing it. As is evident in societies, various acts and policies designed to meet the needs of citizens are abused to suit the desires of those who hold the power. This is indicative of the oppression, discussed in *Chapter Five*, which women have to endure. The abuse of policies should, therefore, not be criteria for replacing the policy. Rather, its implementation should become more strategic and effective. While it is argued that there has been an increase in abortions, there could be any number of reasons for the increase in the incidence of abortions, rather than the legislation of abortion per se. The global economic crisis, for example, has been having a huge impact on the survival of families and individuals in many parts of the world (Sewpaul, 2014). Any legislation can and will be abused as argued above, for example, the Domestic Violence Act is being abused, to some extent, when woman cry foul and accuse men of rape, harassment, and violence (Mail Online, 2013). For every false claim however there are many who are genuinely abused, harassed and raped. Women may abuse the abortion legislation, but the majority of women do not.

4.4 Bioethical considerations

Bioethics is concerned with the ethical and value considerations that arise from the information made available by modern developments of science, technology, and biomedicine (Whitcomb, 2010). There is much debate as to when life begins, when personhood begins, the humanity of the unborn, and the unborn's right to life. These issues are addressed in this section.

4.4.1 When does life begin?

The different views as to when life begins directly affects the debate on abortion because at whatever point life does begin, it has to be protected. Those who debate that life begins at conception, oppose abortion outright, while those who debate that life begins at a later stage are more liberal toward abortion at different stages of the pregnancy. Without

available scientific evidence, Aristotle was of the view that life began at 40 days of gestation for boys and 80 days of gestation for girls (Millar, 1934). Discrepancies such as this continue to exist today. Despite the differing views that exist, the question as to when life begins is a scientific one. Logically, the question can only really be answered by scientists (specifically human embryologists), and not politicians and theologians who have done so for approximately 2 000 years.

Lefevere (2003) argued that in the 20th and 21st century modern technology has made available what has not previously been seen or known and that question of *when life begins* can now be answered in terms of basic biology. Advances in neuroscience have led to broadening the original concept of the development of the foetus. Fetology, which is the study of the foetus, is able to view and understand the nine months of pregnancy, observe the development, movement, touching and responding to external stimuli of the unborn. Four-dimensional ultrasound provides a whole view of the foetal world providing information that is unknown 25-30 years ago (Andonotopo, Stanojevic, Kurjak, Azumendi & Carrera, 2005; Kurjak, Vecek, Hafner, Bozek, Funduk-Kurjak & Ujevic, 2005). While foetal movement is only felt by the mother at around four months, the foetus is seen to move at six weeks; while foetal heart rate is initially heard at 17 weeks, it is now seen at three-and-a-half weeks (Wyatt, 2001; Becher, 2004).

Modern technology identifies the foetus as being alive from the initial stages. The embryonic period, from conception to week seven, is observed as the stage of the greatest and most rapid changes in the life cycle of a human being. From zygote, to embryo, to foetus, this period is when rapid differentiation occurs and when all the internal organs are formed. Almost the entire adult body structure is formed during the embryonic period making it also the most crucial time of development in life (Becher, 2004). The detailed observation made possible with ultrasound had led to the recording of development of the foetus each day and week during the first trimester. The first trimester is the most active period of development, when the most developmental changes take place. By the end of the first trimester, all foetal organs have been formed and external features are recognisable.

After the embryonic stage, the foetal stage begins and the unborn is referred to as a foetus. During the foetal stage, between the 11th week and birth, the foetus grows longer and gains weight rapidly (Rodeck & Whittle, 2001; FamilyDoctor.org, 2011). Foetuses that were studied while in the womb, and then followed-up as babies were observed to display behaviour that is similar to their prenatal behaviour (Hall & Oppenheim, 1987).

4.4.2 When does personhood begin?

While the viability of the foetus is used as a determining factor as to whether the foetus qualifies for protection from the law, Irving (1999) asserted that although modern science had clarified when life begins, the issue of personhood belongs to the philosophical and theological world. Establishing when personhood begins is a debate in itself in the absence of an accepted definition of personhood.

Traditionally philosophy included 'reason' in the definition of a person. Singer (2000) argued that since the foetus is not self-aware and does not have temporal awareness, abortion is acceptable. In keeping with this view he argued that infanticide is acceptable up to three months after birth as self-awareness has still not been acquired. Irving, (1999) challenged this view with respect to the personhood of the physically and mentally disabled, the alcoholic and drug addict, the accident victim who has been left incompetent, the aged, those who develop motor-neurological problems, young children who are not moral agents, and those who are not able to reflect. He argued that Singer's view is in line with his view of human life as being no different from animal life.

Personhood is also defined on preconditions, which are used to justify whether abortion is acceptable. The pro-choice view is that until personhood can be established, the state has no right to make decisions about abortion, while the pro-life view is that until personhood can be determined it is wise not to abort. The latter holds the view that if personhood begins at different stages before birth, society is guilty of murdering millions of babies, and if personhood begins after birth no one has been hurt (Johnston, 2002).

Irving (1999) argued that in the interests of society it is important that objective scientific facts form the bases of policies, in that the definitions of human beings, when life begins, and when personhood begins all have repercussions for other areas in life, namely that pregnant women can become indifferent to their pregnancies, newborn infants may easily be abandoned because the mother's circumstances are not conducive to her caring for a child, little children who demand too much of the caretaker's emotions may be abused, and the elderly and the disabled neglected if they do not fit into the definition of personhood (Irving, 1999).

4.4.3 The unborn and the right to life

Johnston (2002) argued that in a society where humanity is so prevalent that it extends not only to tamed but to wild animals, to the birds and the trees, and even to our buildings, it should follow naturally that society is ethically responsible to protect human offspring, and that the responsibilities of parents and of society towards the unborn should be that of protection and nurturance. The human foetus belongs to the human family because it cannot belong to any other but society has gone as far as eliminating the foetus whose sex they are not happy with, and that nothing prevents society from excluding all undesirable traits – too short (dwarfism), too fat, below average IQ, etc. (Johnston, 2002).

4.5 Ethical decision-making

Moral development and moral reasoning become increasingly complex when considering ethical dilemmas. Ethical dilemmas have both individual components *(What ought I to do?)* as well as relational components *(What is my duty to others?)* (Shaw, 2011). Men and women handle moral dilemmas differently. While men generally use logical reasoning of justice, rules, and individual rights even in moral issues, women generally take into consideration relationships, caring, and compassion (Anstee, 2009; Gump, Baker & Roll, 2000; Jaffee & Hyde, 2000; Skoe, 2002). Tronto (2001) asserted that for women, c*are*, and the *taking care of* involves action. It involves flexible standards and principles which include those of the carer but should also be determined by the values and lifestyle of those

being helped. Caring should be based on people living their lives as well as possible. Given the various ethical and bioethical concerns discussed in the foregoing sections, ethical decision-making with respect to abortion is not a simple, straightforward process. The norms, values and attitudes of the family and the community also influence one's decision in personal issues (Ekstrand, Tydén, Darj & Larsson, 2009).

Davis (1999) suggests a seven-step guide to ethical decision-making namely 1) identifying the dilemma, 2) and 3) involves considering and analysing what makes the dilemma. Thereafter the 4) and 5) identifying and analysing the various options, before 6) making a choice, and 7) reviewing the six previous steps. This step-by-step approach implies that ethical decision-making is eminently rational, and devoid of the messiness of complex emotions. In evaluating the options, Davis suggests that the questions asked include which option will produce the most good and do the least harm? (Utilitarian Approach); which option best respects the rights of all who have a stake? (Rights Approach); which option treats people equally or proportionately? (Justice Approach); which option best serves the community as whole, not just some members? (Common Good Approach); and which option leads me to act as the sort of person I want to be? (Virtue Approach) as is recommended by the Markkula Center for Applied Ethics (2000). These questions are linked to the various types of ethical reasoning, which include justice based ethics, right based ethics, duty based and virtue/character based ethics. Ethical decisions are either driven by core values, by the consequences, or by judging rights. The teleological, also known as the utilitarian or consequentialist approach considers the consequences, which must be for the greater good for most people. It is the group, and not the individual, for whom happiness is at stake. A morally right choice is one that benefits the majority, where the end justifies the means. The Rights-based approach respects the rights of all who are involved. The Justice approach focuses on all people being treated equally or proportionately. The Common Good approach focuses on the community as a whole rather than on the individual person. The virtue approach does not focus on the outcome, but on personal values and morals that contribute to personal development. The deontological approach considers actions as inherently good or evil. Subsequently some choices are morally forbidden, irrespective of their consequences. A choice is considered to be 'right'

when it conforms to a moral norm.

Kant's principled morality approach involves the consideration of what is right and what is wrong, while situational/relational ethics views the reality of the situation, which will vary from time to time and from situation to situation. Principled morality takes into consideration principles and justice. Post-structuralism and post-modernism considers the complex and relational conditions at any point in time. They therefore argue that there is no universal right or appropriate action. This is referred to relational ethics where the moral decision is made taking into consideration the particular situation. There are many different ways to respond to a dilemma (Shaw, 2011). Morals and values determine acceptable behaviour and fit together to form a moral code by which societies and individuals operate. Such guidelines establish what one ought to do in a given situation, although in reality moral rules are not always consistent, and many moral questions cannot be answered from a clear-cut, black and white position (Fesmire, 2003). Moral knowledge is acquired through an ongoing process of trial and error. It is not something possessed by individuals in their heads, but something that is shared in families and community groups (Cottone, 2001). There is also public (overt, official) and private (covert, personal) beliefs, which may differ from each other at different times (Fesmire, 2003).

Relational ethics is interrelated with circumstances and a caring relationship. It emphasises both emotions as well as reasons. Relational ethics therefore also involves the context in which one comes to reflect on, think about and decide on one's obligations and responsibilities to self and other. This takes into consideration one's own and the community's values, morals and preferences, and the ability to separate the demands of others as expressed in this quote from Gergen (cited in Cottone, 2001, p. 44) namely "When individuals declare right and wrong in a given situation they are only acting as local representatives for larger relationships in which they are enmeshed. Their relationships speak through them."

Feminism demands that relational ethics rather than principled ethics guide the understanding of the abortion decision. A woman's choice to abort cannot be viewed in

isolation but in context of her reality (Pergert & Lutzen, 2012) where the abortion decision becomes peculiar to her and to her specific experience. This is in keeping with feminist relational ethics which asserts that women consider all the relational factors that affect them, and amidst their views of what is right and wrong (principled morality) they make the decision as they perceive as best for the time. Had circumstances been different at the time, women may have chosen differently. Being granted the reproductive right does not mean that all women will choose to terminate an unplanned pregnancy.

Conflict situations can be classified into three types namely approach-approach which has two positive aspects, approach-avoidance with both positive and negative aspects, and avoidance-avoidance which has only negative options. Double approach-approach conflicts are resolved more quickly than double approach-avoidance which in turn is faster than double avoidance-avoidance (Murray, 1975; Krebs, Denton & Wark, 2006). Women who are pregnant and not in a position to care for a child have three options available to them namely having an abortion, carrying the pregnancy to term and abandoning the child, carrying the pregnancy to term and giving the baby in adoption. The three options available to women are equally difficult. These women are therefore in an avoidance-avoidance conflict situation. Whichever option is chosen will negatively affect them. Ethical decision-making in this situation becomes extremely difficult which contributes to the complexity of the abortion decision. Women choose abortion as the least hurtful choice, as is discussed in the analysis of the results of this study. Women cannot bear bonding with the unborn during the nine months of pregnancy and to thereafter give the baby up for adoption. Neither do they want to abandon the child or allow the child to suffer without the basic necessities. The various options available to them were analysed during the decision-making process.

Conflict between law and ethics can produce dilemmas. The dilemma is when that which is legal may or may not be considered ethical, and that which is considered ethical may or may not be legal. Abortion is legal in South Africa but is considered unethical (Smith & Davis, 1980). Where abortion is considered to be fundamentally morally wrong, one is less likely to accept abortion. Moral responses to hypothetical moral judgments are impersonal

(Smetana, 1981). Where the dilemma is personal or where the decision has personal implications, decision-making is approached differently (Jaffee & Hyde, 2000; Haviv & Leman, 2002; Juuvari, 2006), with one becomes more accepting. Values and principles held may easily change or adapt to different personal circumstances.

Within the context of the right to choose, Saul (2003) introduced the argument of the strength of the right to choose. She asserted that even with this right the moral dimension cannot be ignored. Women battle with the moral issues despite knowing and having the right to abort. Besides, a unique intimacy develops between the woman and the foetus making the abortion decision a painful and complicated one. The decision therefore goes beyond the right to abort (Saul, 2003). Whilst feminism focuses on the circumstances of women that impacts decision, feminism does not overlook individual agency, and that women would, as moral agents, make the best decision and exercise responsibility and power (Pollitt, 2005).

When a woman chooses abortion, for any reason, does it make it any less ethical than society allowing over six million children (WHO, 2013), as discussed above, to die each year from preventable illnesses, especially from malnutrition?

4.6 Feminist views on abortion

Both pro-life and pro-choice views prevail amongst feminists. Historically abortion was not a feminist issue, and was actually opposed by the first wave feminists (Kopp, 1997; Foster, 2002) as articulated by Stanton in her statement that "When we consider that women are treated as property, it is degrading to women that we should treat our children as property to be disposed of as we see fit" (Stanton, 1948 as cited by Foster, 2002, p.1).

Abortion received visibility during the sixties (Humm, 1995). The original feminist movement viewed abortion as a 'horrible tragedy and a disastrous crime' and referred to abortion as 'child murder.' Abortion was considered a means of exploiting women. It was therefore termed "the ultimate exploitation of women" (Paul, as cited in Feminists for Life,

2004, p.1). Some pro-life feminists advocated that abortion be made illegal. Callahan considered the goals of women's empowerment and abortion to be antithetical: "Women will never climb to equality and social empowerment over moulds of dead foetuses" (Callahan as cited in Matthews-green, 2000 p. 2). Pro-life feminists argued that abortion hurts women, and killed the unborn, an action that a woman will never be able to forgive herself for (Matthews-green, 2000; Pollitt, 2005), and that women are forced by their circumstances to resort to abortion, with only a small number of women truly being able to make a free choice in abortion (Pollitt, 2005). The pro-life position was therefore considered an extension of feminism (Matthews-green, 2000), where the pro-life feminist movement viewed abortion as institutionalised violence against women and children, and as yet another act of male-domination. The pro-life feminist movement advocated that the circumstances of women be elevated so that they do not have to consider abortion as an alternative, irrespective whether it is legal or not (Matthews-Green, 2000; Pollitt, 2005). Therefore abortion was seen as not only denying the humanity of the unborn, but also denying the humanity of women, and that if society demands that the unborn to be treated as persons, women need to be treated as persons. Abortion was viewed as unfair because a woman had to expose her body to further abuse, as the partner would not accept responsibility and support the baby (Feminists Choosing Life, 2009). The concerns of the feminist group representing women of colour were the socioeconomic circumstances and community health issues affecting, especially of women of colour and poor women in general. This united women of colour and white women who focused on women's health issues and reproductive justice beyond abortion into a strong feminist group (Nelson, 2010).

Present day feminist groups also adopt either a pro-life view or pro-choice perspective which subsequently determines membership in a specific group (Jagnayak, 2005). While some feminists oppose abortion, as discussed above, to protect women from its effects, other feminists are in favour of abortion on demand. It is the second wave feminists who campaigned for the reproductive rights for women, which included the right health services, the right to contraception, the right to an abortion, and the right to motherhood. Central to pro-choice feminists is the reproductive rights of women, freedom of choice, and the

precedence of the rights of women over the rights of the foetus. Pro-choice feminists argue that it is women who are most affected by these decisions and therefore women should be left to make the decision (Jagnayak, 2005). One of the limitations of this view is its individualistic rights based approach, which do not factor in the structural determinants of women's lives. This is discussed in some detail later in the thesis. Pro-choice feminists assert that women have the right to control over their own bodies which entitles them to reproductive rights. To this end women have a right to legal, safe abortions where globally millions of women lose their lives because of illegal abortions. Even where rights are attributed to the unborn, pro-choice feminists assert that the rights of women should take precedence (Saul, 2003). Yet, women's choices are often conditioned by dominant societal discourses on pregnancy and childbirth that prescribe the ideal conditions within which these should occur and by socio-economic circumstances, which are discussed under *Psychosocial Considerations (Chapter Five)*. Instead of abandoning their newborn child many women opt for abortion. Women in poverty suffer the most, and so do the children born to them. The opportunity to end the pregnancy helps alleviate her suffering and that of another child. Abortion is therefore seen as an act of responsibility for one's self and one's family, and as a basic right of all women.

Feminists of today who advocate reproductive rights, view abortion in terms of the historic oppression of women, and the risks to their bodies and even their lives that women took where they underwent illegal abortions. The legalising of abortion is therefore considered as an achievement of their efforts in empowering women. Women now have the power to make decisions concerning their own reproduction, and women do not have to resort to unsafe abortions and risk their health and their lives (Pollitt, 2005).

This chapter reviewed the religious and ethical considerations in abortion balancing both the pro-life and pro-choice views. While all the religious groups contain clear religious teachings as to the sanctity of life, and therefore the need to preserve life, unwanted pregnancies present a religious dilemma to their members. Similarly, while society observes various ethical stances on life, unwanted pregnancies present an ethical dilemma to their members. These religious and ethical dilemmas impact the abortion decision.

Chapter Five reviews the various psychosocial considerations impacting the abortion decision.

CHAPTER FIVE

ABORTION: PSYCHOSOCIAL CONSIDERATIONS

5.1 Introduction

The abortion decision is a complex one. Both psychological and social factors and their interrelatedness have been found to influence both the abortion decision and the post-abortion recovery (Lorincz, Gyorffy, Raduch & Kopp, 2001). This chapter discusses the various reasons why women choose abortion, the psychological and emotional, and the social consequences of abortion, the consequences for men, and services provided to women prior to and after the abortion.

5.2 Why abortion

There are various reasons given for abortion *(*Bankole, Akinrinola, Singh, Susheela, Haas & Taylor, 1998; Finer, Frohwirth, Dauphinee, Singh & Moore, 2005; Johnston, 2005; Jones et al., 2007; AGI, 2011) where women consider their own needs, that of their existing children, the future of the unborn child if the pregnancy continues, and the needs of others implicated including the biological father (Kirkman, Rowe, Hardiman, Mallett & Rosenthal, 2009). The main categories identified in literature were woman-focused, other-focused, material-related reasons, the status of adoption in South Africa, and the dominant discourses on motherhood and fatherhood. These are related and interactive and cannot be neatly separated even for discussion purposes.

5.2.1 Woman-focused reasons

Woman-focused reasons or abortion for personal reasons include unmarried women who do not wish to become unwed mothers due to stigma attached to unmarried mothers amidst the dominant discourse on marriage and motherhood. Younger women who are still studying, or

are not ready for a baby and parental responsibility (Finer et al., 2005; Johnston, 2008) need to improve their lives by completing their studies and securing good jobs in the interest of their future families. Where they are totally financially dependent on their parents they realise that forfeiting the support of their parents would jeopardise their plans for a good future. Considering the historic past of women not having been able to secure good jobs, young women need to obtain higher education if they do not want a repeat of the past. Furthermore, the role of mother can be a very emotionally and physically demanding one, especially in a society where the majority of men play a minimal, if any, parenting role. The lack of social support also affects women's decision on abortion despite their personal feelings about abortion (Stotland, 2001). Where women do not have the support of a partner they turn towards immediate family and friends. Where no such support is forthcoming, many opt to end the pregnancy (Nakano, Sugiura-Ogasawara, Aoki, Kitamura & Furukawa, 2004). In circumstances where women are faced with physical abuse namely family, marital, and partner violence, their concerted efforts to emerge from the abusive circumstances speaks well of them. The severity of domestic violence was found to have increased the chances of women having to seek abortion (Kaye, Mirembe, Bantebya, Johansson & Ekstrom, 2006). With women being forced to accept such circumstances just because of their pregnancies, a bleak future awaits them. Instances of physical abuse may also lead to *coercion* where the woman has no choice in the decision. The majority of abortions in the US result from some form of coercion (McFarlane, Campbell, Sharpe & Watson 2002a; Reardon, 2002; Rue et al., 2004) which takes the form of pressure, emotional blackmail, threats, and/or violence by husbands, fathers, mothers or boyfriends and coercion by service providers, employers, and even school counselors and persons of influence (McFarlane et al., 2002a; Reardon, 2002; Rue et. al., 2004). Younger women are at greater risk for coercion into abortions which is a violation of human rights.

5.2.2 Other-focused reasons

Other-focused reasons may include those that were discussed under *woman-focused reasons*. Women are concerned about the future care of the unborn child. They want the best for their children and perceive it to be unfair to have a child and not be able to provide a good life for

her/him. Women are also concerned about the future care of the children they already have. They do not want to deprive the children they have by using their present limited income to care for yet another child. This concern is intensified where they are already experiencing severe financial difficulties in providing for the children they have, and do not wish another child to have to undergo deprivation. Older women who have completed their child-bearing feel responsible to care for the family they already have rather (Finer et al., 2005). They take into consideration their ability to care for their present children and how this would be affected by the birth of another child. They choose not to have their present children suffer material and emotional deprivation with the birth of another child. Where the partner denies paternity women choose to abort to protect the child from having to grow-up without a father, amongst other personal reasons (Finer et al., 2005; Jones et al., 2007). Considering the demands of motherhood as they perceived it, women who aborted did not wish to be inadequate mothers to the child. This could be considered as an act of responsibility as a mother (Boonstra, Gold, Richards & Finer, 2006).

Being HIV positive is one of the reasons women undergo abortions (De Vincenzi, 2011) because they fear for the future of that child without a mother, and the chances of HIV transmission to the child (WHO, 2006; ICW, 2008). Globally approximately 2.5 million women who become pregnant each year are HIV positive and there is evidence of an increase of stillbirths and miscarriages amongst women with HIV (Rutenberg, Biddlecom & Kaona, 2000; WHO, 2006; ICW, 2008).

5.2.3 Material-based reasons

Women find themselves incapable of assuming responsibility for a child for various *material-based reasons:* some are unemployed, others have no financial security, while others are abandoned by their partners leaving them dependent on family and state support. Inadequate finances prevent women from not only being unable to give the baby a quality life but also forces many families into poverty (Finer et al., 2005; Jones et al., 2007). Women in desperate financial circumstances therefore see abortion as the only option (Abortion Rights Coalition of Canada, 2006). Unemployment is a challenge in South Africa with an unemployment rate

which is considered to be amongst the highest in the world (Kingdom & Knight, 2004). Almost 26% (in the narrow definition of unemployment) as at September 2012 (Case & Ardington, 2004; Statistics South Africa, 2012), and 36% (according to the broad definition) of the population is unemployed despite having completed secondary education and even secured some type of post-school training (New African Magazine, 2012; Vavi, 2012) with women being the victims of this to a greater extent than men.

5.2.4 The status of adoption in South Africa

The reality is that South Africa has become a country with a large number of orphans from HIV/AIDS (International Adoption Guide, 2012). It has approximately 1.8 million orphans of which 1.5 million are adoptable. Of these only 0.2% are being adopted. The number is steadily declining with 38% of the adoptable kids being placed in foster care which is not a permanent solution (National Adoption Coalition, 2011). Adults in South Africa would rather foster orphans than adopt them (The SA Institute of Race Relations) because adoption requires the family to be able to provide for the child's needs, both financially and otherwise. No financial assistance is provided by the government. KZN, the province in which this study is based, has the largest number of orphans (South African Institute of race Relations (SAIRR), 2013).

While there were no statistics available on the race of adoptable kids and race of prospective adoptive families, the majority of adoptable kids are Black, which is in keeping with the demographics of South Africa. At the same time, the majority of those waiting to adopt are White. There is, therefore, an increasing number of Black children being adopted by Whites in cross-cultural adoptions which present unique problems arising from the alienation of a child from its culture and history. While there is a desperate need for black people to adopt babies, there is a stigma attached to adoption and black couples fear that an adopted child will be rejected by the community (National Adoption Coalition, 2011).

The dilemma for pregnant women who are not able to care for a baby is whether they do carry to full term only to leave the child to grow-up in an institution, or if fortunate, a foster home which is not a permanent arrangement (National Adoption Coalition, 2011).

The technologies affecting the adoption process is the legal requirements and time delays prior to a child being placed in adoption. The Children's Act 38 of 2005, while being very protective of children, has also slowed the process of adoption with the time requirements prior to finalizing adoptions. The adoption process is also a lengthy and demanding one, which often acts as a demotivater to prospective parents.

5.2.5 Discourse on motherhood

Social constructs of motherhood, where women are expected to place the needs of their families above their own, influence how women perceive their role. Social conditions of motherhood therefore impact the decision to abort. Women display strong emotions on learning of their pregnancies with many becoming excited about motherhood and, at the same time, confused by the reality of their circumstances (Jones et al., 2007) which dictate the decision to abort (Gilligan, 1982; Rossier, Michelot, Cocon Group & Bajos, 2006; Santelli, Speizer, Avery & Kendall, 2006). Women may not be in a position to accept the responsibility of a child at one stage but may, at a later stage, be able to do so. Although the decision to abort does not reflect one's view of motherhood or indicate a rejection of motherhood, it involves a choice to delay motherhood (Jones et al., 2007). Motherhood therefore, does, in a broad way, affect the decision to abort.

Women develop in a way that focuses on connections among people and with an ethic of care (Gilligan, 1977; 1982; Gump et al., 2000; Jaffee & Hyde, 2000; Skoe, 2002; Anstee, 2009). They operate from a more caring, nurturing and compassionate perspective (Gilligan, 1977), focusing on care and relationships, sensitivity to the needs of others, and on being responsible for others. They display emotion, empathy, intuition, and sensibility, which enable them to provide a warm caring environment for the family (Chambers, 1986). Although this is considered as a stereotype of women, Gilligan (1982) argued that women are different. This is what Gilligan (1982) refers to as the *different voice*. This is a feminine quality of care and justice. Women live their lives for others in their families, which forms their moral duty. Women's role in society has, subsequently, become closely related to constructions of motherhood, which depict women as carers. In the middle-class family in the 19th century

women played a central role in both the family and society. Women strove to fulfill what was accepted at the time of being the ‘good’ mother. ‘Good’ mothers are women who provide for the physical and emotional needs for the children and the extended family. Such women were both desired and admired by society (Altman, 2003). As a central figure in the home women traditionally held their families together, provided a warm, loving home, and attended to all the family’s physical and emotional needs. During this time the extended family formed part of the family. So they too were included in her caring and nurturing. Women took full responsibility for those under her care preparing them for their future roles in society (Altman, 2003). Women were therefore seen in the context of relationships, mainly in terms of the mother-child relationship (McMahon, 1995; Hammons, 2008), where all woman as viewed as needing to be mothers, and that all mothers need their children and that all children need their mothers (Paré & Dillaway, 2005). Abortion too is considered in terms of the mother-child relationship as explained in the quote by Cannold (2000, as cited in Davis, 2002, p. 213):

> The abortion issue is not separate from the complex web of women’s experiences, understandings, and feelings about mothering children, but part of it. Women’s decisions about abortion are the same sorts of decisions they make about mothering, only with different outcomes.

The abortion decision is, however, a complex one which involves more than that of the consideration of motherhood (Finer et al., 2005; Jones et al., 2007). The ethic of care and social responsibility affects women’s decisions (Gilligan, 1982; Cannold, 1998). Women consider others, their relationships and commitments, their present children, and the unborn. This is in accordance with their ethic of care and responsibility (Finer et al., 2005; Jones et al., 2007). While women do consider adoption, they need to maintain secrecy about the pregnancy because of fear and shame, and the concern that it might be too painful to carry the pregnancy to term and to then part with the baby, forces them to choose abortion instead (Jones et al., 2007).

Circumstances, as discussed above, can be coercing factors in the decision to abort. These are often directly related to unequal treatment, abandonment by men and oppression. The

phenomenon of absent fathers, which is the consequence of several inter-related socio-economic, political and cultural factors, has become common in South Africa. In 2002, an estimated 57% of all children, and 63% of African children had no fathers present to care for them (Richter, Chikovore & Makusha, 2010). Women are being abandoned while still pregnant, after the birth of a child, or after the couple having more than one child. This directly impacts women's role as mothers and the decisions they make, particularly among Black women who form the majority of the population. Nearly 81% of KwaZulu Natal's eleven million people are Black, giving a population of approximately eight million. While the social construction of motherhood is a defining factor in the abortion decision, so is the social construction of fatherhood, as discussed below.

5.2.6 Gendered constructions of fatherhood and the phenomenon of absent fathers

A common practice in South Africa is where men do not wish to accept the responsibility that comes with fatherhood. In KZN in 2002, maintenance orders were made against 67 000 men in just the Umlazi area alone. Of these, only 7000 men complied with the orders. Morrell (2006) argued that this could be viewed as a direct result of the association of *manhood* with *biological fatherhood* where the social and economic responsibilities of fatherhood are not considered. Manhood is seen as being attained when reaching physical maturity. With a desire to attain manhood and with the pressure from peers, young men seek to, and impregnate young women (Morrell, 2006), making women the victims. It is difficult to establish who is a biological father in South Africa as many men do not know whether they have fathered a child. Many chose not to acknowledge paternity to escape the payment of *inhlawulo* (damages for impregnating a girl) or *lobola*, or escape the responsibility for children and family. It is estimated that between 45-50% of men 15 to 54 years of age (approximately 15 million men) may have fathered a child in South Africa without assuming responsibility (Richter et al., 2010). Hence, the majority of South Africa's children are deprived of a positive father/child relationship. South Africa has the second highest rate of father absence in Africa, low rates of maintenance for children and high rates of abuse and neglect of children by men. In the HSRCs *Fatherhood Programme* young fathers discussed the absence of their own fathers in their lives and how this has impacted their role as fathers. They did not have role models of fatherhood

and its responsibilities. Fifty percent of fathers in South Africa are not in daily contact with their children (Richter et al., 2010).

This varies amongst the different races with less than 40% of Black children under the age of 16 living with their fathers in 2002, whilst approximately 90% of White and Indian children did so. This is mainly the consequence of the legacy of apartheid and migrant labour, which continues to date, and the poor socio-economic status of the majority of Blacks in South Africa (Richter et al., 2010). Several factors have led to the non-involved or absent father in the majority of South African families. Men and women leave their families in the care of their grandparents and go into urban areas to work and provide for their families. This mainly affects the poor families. The level of income also determines whether couples could live together as families. Men have to be able to pay lobola before they can negotiate marriage with a girl's family (Montgomery, Hosegood, Busza & Timæus, 2005). Men therefore have to earn a good income in order to live with their children. Even where men choose to meet their responsibilities, financial difficulties due to limited income and high unemployment in South Africa, may contribute to them abandoning their partners and children (Morrell & Richter, 2006). Richter et al., (2010) found that those who were not able to provide for their families felt ashamed and saw themselves as failures, which further contributed to their staying away from their children.

Children also live with the extended family for various other reasons. Many live with relatives to keep the family relationships strong, to access proper schools, or to be away from the unrest in the family home or community. Father involvement therefore, goes beyond the physical presence of the father (Richter et al., 2010). The family is important for the well-being of children and fathers are an essential component of the family (Mkhize, 2006). With the increase of absent fathers and the subsequent increase in single-parent families, there is an associated increase in poverty. Generally poverty is linked to women headed families (Mkhize, 2006). Due to the vulnerability of children in South Africa who are living without fathers, several initiatives have been put into place to promote father involvement in the care of their children.

A father becoming increasingly more involved in the lives of their children is one definition of

a ‘good’ father, with the other being where the father provides his child materially without necessarily being present (Morrell, 2006). Of recent there are policies in place, which note the role of the father in order to encourage and to ensure the father’s involvement (Toynbee & Walker, 2001), and his continued involvement in the lives of his children (Ghate, Shaw & Hazel, 2000; Robb, 2004; Featherstone, 2006). The new Children’s Act, 38 of 2005 adopts a holistic approach to the care of children where both parents are given joint custody, and the Natural Fathers of Children Born out of Wedlock Act of 1997 gives all fathers the right to go to court to request access, custody or guardianship of their children. The Children’s Act however does not refer to the status of the unborn. The South African TOP Act too does not make reference to the status of the unborn should such a circumstance arise where the father wishes to have the child. A child is only given the father’s name when he accepts paternity and agrees to have the child registered in his name. Without the necessary consent of the father the child is registered on the mother’s name. Once a father acknowledges paternity the state requires that he support them, whether or not he is married to the mother or lives with his children (Richter et al., 2010). Where disputes do arise the court may order a blood test to prove paternity and issue an order of maintenance against the father. In an effort to encourage father-child bonding, legislation allows three days paternity leave. To assist parents who are experiencing financial difficulties, the South African social security system has implemented a Child Support Grant (CSG) for both female and male parents (Richter et al., 2010). In 1998 parliament recognised customary marriages by implementing relevant legislation and, by implication, polygamy. The legislation makes it compulsory for the man to provide for the needs of his wife (wives) and children. This extends to effective enforcement of maintenance for children. This co-exists with the right for fathers to see their children (Richter et al., 2010). The legislating of polygamy affects already oppressed women further. Men consider it acceptable to abandon their pregnant partners as is common in South Africa to take new partners, while women accept the treatment they receive as is dictated by culture and now, even the law. Contributing only financially is not sufficient for the upbringing of children.

Civil society organisations in South Africa reach out to men to motivate and teach them to become responsible and involved fathers. The HSRC steered the *Fatherhood Project* in 2003 aiming at making men responsible for and caring towards their families (Morrell & Richter,

2006). When men understand the predicament of women they become open to change as is seen in this programme (Peacock & Levack, 2004). Agisanang Domestic Abuse Prevention and Training also provides counseling for men enabling them to become husbands and fathers who care for their families without the use of violence (Richter et al., 2010). The cultural and social expectations of fatherhood and the nature of the social relationship between father and child are the key to understanding fathers' contributions in child care.

Fatherhood is a socially constructed role and changes over time and place. The dominant discourse on fatherhood is the traditional model in which the father, although present, is symbolic. Fathers were not expected to engage in intensive parenting, but they were increasingly expected to be involved parents, who help out with everyday childcare, and who develop emotional connections with their children (Shaw, 2008). The role of men in society has gradually changed in westernised societies over the past century (Olah, Bernhardt & Goldscheider, 2002). The changing relationship between men and women redefines the place and role of the father and mother with men becoming increasingly more involved in the lives of their children (Plantin, 2003; Johansson & Klinth, 2008). As fathers increasingly assume more responsibilities for the family, it places them in close physical proximity and in a close emotional relationship with their children (Castelain-Meunier, 2002). From being provider and protector only, he is becoming a caring parent who is committed to be involved in the lives of his children (Wall & Arnold, 2007). Arising from the social constructs of parenthood, fatherhood is presented with tensions and contradictions. Wall and Arnold (2007) argued that while spending more contact time with the children, the modern father remains a secondary parent with primary focus on him as breadwinner and protector of the family. This socially constructed role can be conflicting especially in a time of parents' role transition. On the one hand increasingly more and more parental involvement is required of fathers, while on the other hand, as argued by Castelain-Meunier (2002), the father is perceived as the 'external' parent. The mother-child relationship is considered basic and the father is seen as intruding on this relationship. The mother continues to remain the primary parent despite the level of fatherhood involvement.

Men too are considered victims of the socially constructed gender order. They are also required to behave in socially approved ways for example they are not allowed to display their emotions. A man seen crying is referred to as a 'sissy'. While violence is not approved of, men who do not fight back are referred to as 'sissy'. This leads to confusion for men regarding gender appropriate roles (Gilligan, 2001; Walker, 2005). Men hurt from their inability to provide, or inability to provide adequately for their families in the face of unemployment and poverty in South Africa. The social construct of manhood demands that the man be the leader in the home and that he provides for his family. This is becoming increasingly difficult in the face of unemployment (Salo, 2007). Men do become oppressed within their privilege. Multiple sources of privilege is viewed as complex, interrelated, and mutually influenced. Black and Stone (2005, p. 245) defined oppression as "an outcome in a society where privilege is unchecked and unchallenged" and listed five basic components of privilege namely that "it is a special advantage, it is granted and not earned through effort or talent, it is a right or entitlement that is related to a preferred status or rank, it is exercised for the benefit of the recipient and to the exclusion or detriment of others, and it is almost always outside of the awareness" of the person possessing it. The oppression that accompanies privilege has a negative impact on men. Men are expected to be more powerful and less emotional than women. Yet, despite privilege and patriarchy, not all men feel 'powerful' and many men experience difficulty in suppressing their emotions of fear, dependency, and weakness (Black & Stone, 2005), as expressed in the words of Freire (1970, p. 28) namely, "Dehumanisation, which marks not only those whose humanity has been stolen, but also (though in a different way) those who have stolen it, is a distortion of the vocation of becoming more fully human." While the discourse points to men being strong and powerful, violence is condemned in modern society and labeled anti-social. This leads to confusion with regard to appropriate gender roles, and with men sharing a nurturing relationship with other men (Gilligan, 2001).

Because the male gender and accompanying gender role are viewed as normal and preferred, most men have been and are quite unaware of their privileged status. Gender roles reinforce the paradox of privilege by trapping men in culturally expected behaviour (e.g., being dominant, being the stronger one, the leader, the unemotional partner) that may be personally incongruent with who they are (Black & Stone, 2005). Men who live in financial crisis

struggle to fulfill the gender and cultural expectation of being the provider or even the sole breadwinner. It is therefore possible to be simultaneously both privileged and oppressed (Dominelli, 2002a). It is necessary that in working towards true freedom and equality for women both the oppressors (men) and the oppressed (women) become aware of their roles in perpetuating and sustaining the oppression of women, and in reconstructing the discourse (Freire, 1970; Sewpaul, 2013a). Cultural beliefs have led men to believe that they have to dominate women to feel masculine or mucho. To this end violence against women, including sexual violence of rape, are used as methods or means of initiation into a group. It is of concern that violence against women can demonstrate and confirm male power and honour. In a study by Meintjies, Pillay, and Turshen (2001) participants attributed male violence on females to the male need for power over women. Meintjies et al. (2001) argued that patriarchal society allows and perpetuates this use and abuse of gender power through the social acceptance of violence, inequality of power, economic power, and the construction of masculinity and femininity. Violence against women needs to be seen in totality, and not segmented into sexual violence and other forms of violence. The construction of masculinity which places pressure on boys and men to become violent against one another, and against women who are seen as weak with characteristics that they despise in themselves as men. Men are seen as providers in an extremely materialistic world where the inability to provide in terms of the status quo instills a feeling of inadequacy which plays out in violence against women (Jewkes, 2002; Sathiparsad, 2008). Society does not offer men an alternate masculinity to substitute the one of domination and violence (Meintjies et al., 2001). The dominant discourse on masculinities and femininities needs to be deconstructed (Sathiparsad, 2008; Sewpaul, 2013a) with both men and women being re-socialised to value the inherent differences that comprise masculinity and femininity that are present in everyone to different degrees.

5.3 Structural determinants of the oppression of women

The Constitution of South Africa (Section 7 to 10) details the rights of all South Africans. Section Seven talks about the right to equality, Section Eight the right to human dignity, Section Nine the right to life, and Section Ten the right to freedom and security. When analysed against the present circumstances of women in South Africa, the majority of women in South Africa have their human

rights violated on a daily basis. What freedom, dignity and equality are women experiencing when a women is raped every 35 seconds in this country (Naidoo, 2013), and left to cope with the consequences on her own? Section 10 (1) c talks about being free from all forms of violence from both public or private sources; and Section 10 (2) a and b refers to reproductive rights. There are no special rights to protect women in South Africa. Considering the history of physical, emotional, sexual and economic abuse of women in this country, women need to be accorded special rights to bring them to a level where they are able to enjoy equality and the benefits of a democracy. Until women are brought on par with men with respect to their rights, true equality cannot be achieved as expressed by Sen (1999):

> Development can be seen as a process of expanding the real freedoms that people enjoy. Freedoms depend on social and economic arrangements as well as political and civil rights. Development requires the removal of major sources of 'unfreedom': poverty as well as tyranny, poor economic opportunities as well as systematic social deprivation, neglect of public facilities as well as intolerance of repressive states (p 1).

Women need to be treated as human beings with a basic quality of life, the opportunity to work, and access to the country's wealth. Bond (2004, p3) observed that "The reality is that South Africa has witnessed the replacement of racial apartheid with what is increasingly referred to as class apartheid - systemic underdevelopment and segregation of the oppressed majority through structured economic, political, legal, and cultural practices".

While Section Eight of the Constitution speaks of the right to human dignity, post-apartheid South Africa deprives its citizens of job opportunities. With South Africa allowing large imports of goods that can be produced by its citizens, it deprives its people of a livelihood. Sewpaul (2013b) details the impacts of neoliberalism in post-apartheid South Africa that denies millions of people the right to decent work, and its contribution to growing inequality.

Dominant societal discourses reflect and are part of the prevailing ideology. The dominant discourses of motherhood, fatherhood, religion, family/kinship structures, the legal system, the sexual division of labour, education and political resistance, amongst others, have largely

determined the 'status' of women within various societies. Individual cases reflect the dominant discourses of society (Hartmann, Winchester, Edgell & Gerteis, 2011). Much of the Western feminist writing focus on these themes and challenge the dominant discourses. The ideology is reflected in various structures that are reduced to a set of ideas whose internalisation by women and men contributes to its stability and perpetuation (Sewpaul, 2013a). These structures, both individually and interrelated, are viewed as the cause of gender inequality (Mohanty, 1988). Feminists have for many years campaigned for the reproductive rights for women. Reproductive rights include the right to health services, the right to contraception, the right to motherhood, and the right to abortion. Central to the demands are women's reproductive rights, and the right of women to make such decisions without the interference of men or religious institutions. It is argued that it is women who are most affected by these decisions and therefore should be left to make the decisions (Jagnayak, 2005). Abortion has become synonymous with the historical oppression of women, and with the risks that women faced with illegal abortions. Pro-abortion feminists view abortion within this context and consider the legalising of abortion as an achievement of their efforts in empowering women. Women now in many countries have the power to make decisions concerning their own reproduction, and they do not have to resort to unsafe abortions and risk their lives.

There are different models of understanding oppression, the simplest being the 'single-strand' model, where one form or source of oppression is believed to be fundamental to all others. Although gender inequality is often worse in poor societies, it exists in all societies even in relatively equal societies, and there is no automatic relation between poverty alleviation and gender equality (Sen, 1999). The parallel model of oppression acknowledges that there are multiple forms and sources of oppression that run parallel to each other. These oppressions do not intersect. Intersectional models of oppression, on the other hand, acknowledge that multiple oppressions which mediate and interact with each other (Mullaly, 2010). Social hierarchies exist. How the different social power relations mutually construct each other, intersect or interact needs to be analysed especially regarding the impact on women's lives in South Africa. There are also various forms of oppression for example personal, cultural, and structural. Oppression can be viewed as originating from a single source which if addressed will consequently eliminate all other forms of oppression. Oppression however rarely has its

basis in a single source. Therefore the eradication of poverty itself will not eradicate gender inequality. The model of multiple forms of oppression recognises that there are multiple forms of oppression which are interrelated, interdependent, and dynamic. The major sources of oppression namely poverty, inadequate education, poor economic opportunities, systematic social deprivation, absence and neglect of community resources, amongst others must be removed (Sen, 1999) if a society really wishes to address the oppression of its women. Women with no option but to return to abusive circumstances come to accept and live with their circumstances (Shankar, Das & Atwal, 2013). Mullaly (2010) asserted that both structural forces and human agency are crucial in the understanding of oppression and anti-oppressive practices. Gender inequality does not operate in a vacuum. It is linked to other structures and social identities, for example social class, social-economic status, race and ethnicity amongst others (Sewpaul, 2013a). The experiences of women are that they are oppressed by various social realities at various levels (Mullaly, 2010).

Three major dimensions of social stratification that leads to oppression of women are status, power, and economic inequality. Economic disadvantage, and poor quality education, contributes to unemployment or a low income, and subsequent poverty for women, thus perpetuating the cycles of poverty. Issues of socioeconomic hardship for women include a large family, an alcoholic or drug addicted spouse, rejection and abandonment by spouse or partner, spouse/partner violence, and the fear, stigma and shame of being pregnant and unmarried amongst others. Structural conditions underlying long-term poverty include employment vulnerability and unequal social power relations. The poor are likely to remain poor, and to have children who are likely to continue in poverty, and are least likely to benefit from a country's growth and development. They are referred to as 'the chronic poor' (Chronic Poverty Research Centre (CPRC), 2004).

Twenty years into democracy still sees poverty as the most pressing issue in South Africa. Progress made with respect to poverty reduction has been minimal. While it is claimed that the country's economy is growing, national income decreased from 1998 to 2002. While it is claimed that many new jobs were created, this did not absorb the increase in labour supply. The overall unemployment rate also increased. While the average remuneration has increased,

this increase benefited mainly the upper socio-economic groups and those in skilled jobs. While it is claimed that the rate of poverty declined, the number of South Africans living below the poverty rate increased. This indicates that poverty and inequality have increased in South Africa although the government denies this (Du Toit, 2005). Much is needed to include more citizens in the country's economy. Women are mainly excluded from the economy. This exposes South Africa's existing policy to scrutiny. Two extreme economies, which are structurally disconnected from each other, exist side by side in South Africa and the existing welfare policy is inadequate. A BIG (Basic Income Grant) for all citizens has been proposed to empower the poor (Taylor, 2002; Du Toit, 2005; Sewpaul, 2005; Triegaardt, 2006).

There are various views on the nature and causes of poverty in South Africa. Poverty needs to be more closely analysed in order to understand its structural determinants. In doing so, these can be addressed more appropriately (Du Toit, 2005). Women are victims of structural poverty where unequal opportunities are institutionalised through the legal, political, social and economic structures in society. The majority of women in South Africa are subject to no formal education or limited education of inferior quality. Presently many children in this country do not have adequate facilities to ensure a good basic education. Some schools lack even basic shelter. In South Africa illegal abortions are most common amongst the poor sector. Poverty and its impact on the reality of women need to be understood and addressed. Prioritising poverty will empower women to rise above their circumstances. Socioeconomic hardship may also include the communities' lack of adequate resources. Amongst the factors affecting young women's use of contraceptive include limited knowledge of and access to contraceptives (Williamson, Parkes, Wright, Petti & Hart, 2009). Where communities lack even basic contraceptive services to assist women whose families are unable to care for or provide for them, women resort to abortion as the only option. Hence in rural communities the rate of abortion is exceptionally high as compared to developed communities (WHO, 2004).

Gender, which is biological, differs from gender role and gender behaviour which is socially and culturally determined. Gender role and subsequent gender behaviour is a discourse constructed, shaped, maintained and perpetuated by culture, religion, society, class, caste, and race. Gender role refers to the social expectations of what is acceptable and appropriate

behaviour for males and females with respect to temperament, character, interests, status, worth, gesture, and expression (Evens, 2003; WHO, 2013). Members of specific groups are socialised into expected beliefs and behaviour. This has produced two different cultures and experiences for males and females. Women are culturally shaped into discourses of femininity and notions of being 'the good woman', and to view themselves in relation to men. Men are placed in the centre of the universe and women are marginal and have meaning when they are fulfilling roles that are significant for men, as mother, as partner, as daughter. Although roles in society are changing gender roles continue to be strongly influenced by external sources, particularly the family, media, religion and culture.

The male and female biological differences become socially and culturally value-based viewing the attributes of females as inferior to that of males. Sabbatini (1997) argued that this leads to the formation of gender identity, which is one of the concerns in discussing gender as biologically determined. The perceived superiority of male qualities results in the perceived superiority/inferiority and the subsequent dominance and abuse of females. Male attributes are viewed as desirable and seen as the norm while female attributes are viewed as less desirable, and even considered undesirable. Patriarchy is based on and promotes the male biological sex as superior and preferred. Gender role is then constructed and preserved to meet the needs and purposes of the dominant group, namely men in society. Gender roles in a patriarchal society subsequently give rise to gender inequality, favouring the male with respect to all available resources in society (WHO, 2013), and granting him power, privilege and influence in society (Sewpaul, 2013b). Gender privilege in society becomes based on inherent male/female differences, which should be acknowledged as variety and complementary rather than as superior/inferior.

Gender, as politically and as socially constructed, also materialises in the processes of identity formation. Dominelli (2002a) argued that identity construction is closely linked to physical attributes and, more precisely, *differences* in physical attributes namely physical sex differences. An *evaluation* of the *differences* in keeping with the dominant discourse becomes included in the definition of the differences. This contributes to, and perpetuates the male-female, superiority-inferiority discourse. The differences are then expressed as degeneration

rather than mere differences which in turn impacts social stratification leading to the creation and sustenance of oppression and dominance (Dominelli, 2002a). Social hierarchies are not biologically determined, inevitable, or unchangeable, but gender, like other social categories, is socially constructed for certain purposes and with specific societal consequences (Sewpaul, 2013a). The justification-function of any discourse is important in order to influence and gain acceptance by lesser-privileged groups who subsequently do their part in the maintenance of the social hierarchy. Convincing disadvantaged groups to accept discourses that justify social inequality and their lower position is the basis for the continuation of status quo (Dominelli, 2002a). This is where culture and socialisation plays a very important role. Through socialisation and culture "identities are created, negotiated, recreated and renegotiated" and the formation and maintenance of identity depends on "creating and maintaining differences" (Dominelli, 2002a, p.41)**.** By making men believe that they are superior and women believe that men are superior, the superior/inferior status quo is perpetuated. The superior/inferior status quo leads to "inequality between women and men which afflicts and sometimes prematurely ends the lives of millions of women, and, in different ways, severely restricts the substantive freedoms that women enjoy" (Sen, 1999, p.9). Identities may be experienced as stable, giving a person a sense of continuity across time and location, but can change as social meanings vary from one situation to another. The constant construction and reconstruction of identities affirm gender identity, social orders and hierarchies.

Compliance and acceptance is a response to oppression and/or privilege. Women have been exposed to oppression to such an extent and for so long that they no longer see the oppression (Sewpaul, 2013a). Society readily blames women for the ills of society to the extent that victims internalise and own the problem. Women therefore see themselves as the reason for their circumstances and blame themselves where they cannot be the 'good mother' society demands of them. They take ownership of and carry the burden of society as was evident with participants in this study. This submergence of the consciousness is referred to as internalised oppression, which is crucial for the maintenance and perpetuation of dominance, social hierarchies, and for keeping the oppressed powerless and as victims (Freire, 1970). It creates feelings of inferiority, low self-esteem, powerlessness, resignation, and gratefulness for whatever 'good' comes their way (Phererson, 1986). Internalised oppression becomes

embedded in one's personality impacting one's personal identity, attitudes and subsequent behaviour without consideration of reality outside the self. Reality becomes distorted in accordance with one's internalised perception (Rieser, 1990).

In general women have come to accept an inferior status as a normal way of life that is, having internalised their oppression. Of note, none of the women in this study, as discussed in *Chapter Ten*, spoke about women's rights while the men spoke about both women's and men's rights. Some women were so overwhelmed with their circumstances and the abortion that they could not see beyond their present crisis. They had no demands for a better life for themselves. This makes it even more difficult to empower and motivate women with the intention of liberation. The enemy becomes women, who are the oppressed themselves. This in itself slows the process of liberation of women as articulated by Freire (1970/1993, p. 33): "One of the gravest obstacles to the achievement of liberation is that oppressive reality absorbs those within it and thereby acts to submerge human beings' consciousness." This makes it difficult to create an environment of justice and inequality for women. It is women themselves who need to arise because no one understands their oppression better than themselves (Freire, 1970). Women in South Africa women need to be empowered to do so. Women, in turn, need to empower other women, and to raise their daughters and sons into reconstructed social roles. While socio-political and cultural changes are essential, equally important is the consciousness-raising of women and men.

Meintjies et al. (2001) and Rieser (1990) spoke of layers of oppression that have been accumulated and internalised over time resulting in the perceptions of ourselves mirroring attitudes and actions toward us. Women are discriminated against from the very early years of their lives. As girls where they are raped or sexually abused, and often deprived of the education that boys are allowed. Violence and domination by men becomes a part of their adult life (Meintjies et al., 2001). In many cultures around the world there is a preference for sons for various cultural reasons, for example, to carry the name and tradition of the family, to work on the farms, to care for parents in their old age, to bring income for the family, for physical protection of the family, to undertake family rituals, and to avoid the cost of dowries which is needed for females in India. In many cultures females do not work outside the home

(Pallikadavath & Stones, 2006; Garg & Nath, 2008). The value placed on male offspring forces women to prefer male offspring and to abort female foetuses. Abortions for sex selection are common in India, China and South Korea. This is so widespread that it has affected the male/female ratios to alarming proportions (Saharso, 2003). The ethics of sex selective abortion is discussed in *Chapter Four*.

Of concern in this study is that male dominance and female submissiveness extends to sexual and reproductive dominance. Women are more vulnerable to physical and sexual violence. Men who have internalised patriarchal values consider women as inferior and as property over whom they have full control (Dickerson, 2013). Despite our so-called democracy the balance of power has not leveled out in all aspects of life. Physical and sexual violence continues at alarming proportions and is indicative of how men exert power over women. Sexual and other types of abuse against women were directly related to women becoming HIV-infected. Structural abuse is visible where medication for HIV does not timeously reach those affected because of inadequate funds being allocated, or because of misappropriation of funds even where adequate funds are received (van Niekerk, 2001). Even in so-called democratic societies gender inequality is prevalent, often in rather invisible ways. Women are not allowed to use contraceptives lest they become unfaithful to partners, and men refuse to use condoms (Walker & Gilbert, 2002; Maharaj, 2010). Women may experience violence because of the use of contraceptives (Stephenson, Baschieri, Clements, Hennink & Madise, 2007; Stephenson, Beke & Tshibangu, 2008). The low status given to women too affects contraceptive use (Williamson et al., 2009). Even where contraceptives are freely available a large percentage of pregnancies are unplanned and end with abortions (WHO, 2000; Naz & Begum, 2004) which is in part due to cultural factors, and the objection of partners to women's use of contraceptives (Stephenson et al., 2008; 2007). In African religion and culture a couple cannot choose not to have children because not having children is seen as a curse. From this perspective, Caldwell and Caldwell (1987) and Burke (1987) asserted that the use of contraceptives is considered as unnatural and sinful, and could result in harm to the woman and/or child in the "form of divine or ancestral punishment such as barrenness, sickness, or child death" (Caldwell & Caldwell, 1987, p. 424), or the woman's body may react negatively to the contraceptives causing bareness, or harm to the foetus. Women who use contraception are considered to be promiscuous (Patel &

Kooverjee, 2009). Marriage and childbearing are communal issues and children are considered to be very important in the continuance of the tribe. This gives women who cannot conceive a lower status in society and they were referred to in derogatory terms (Sewpaul, 1995). This value placed on fertility is linked to young women choosing not to use contraceptives, and to the high teenage pregnancy rate in KZN (Preston-Whyte, Zondi, Mavundla & Gumede, 1990). Culture is therefore powerful in impacting sexual attitudes and behaviour (Cage, 1998). While women are condemned for pre-marital or extra-marital sex, men are seen as 'macho' for these actions. Where paternity is denied women are left with the sole financial responsibility of raising the child. This is one of the ways in which unequal gender roles is being perpetuated (Cage, 1998; Varga, 2003). In cultures where these gender inequalities are perpetuated as traditional values the practice of sexual inequality continues.

Inequality of power exposes women to gender based violence. Meintjies et al. (2001) argued that the unequal power relations is perpetuated in culture, values and beliefs and promotes male superiority and female inferiority. Men believe that they have to dominate women to feel masculine or macho. To this end, violence against women is used as a means of initiation into a group. Rape, including gang rape is often such a means of initiation. Men are referred to as 'chicken' if they fail to do so. It is of concern that violence against women can demonstrate and confirm male power and honour. Meintjies et al. (2001) found that participants attributed male violence on females to the male need for power over women. They argued that patriarchal society allows and perpetuates this abuse of gender power through the social acceptance of violence, inequality of power, economic power, and the constructions of masculinity and femininity. Women are 'disciplined' by the male members of the family, the father, brother or uncle. The request for equality in society does not imply that women will choose not to become mothers. McDowell and Pringle (1992) argued that women in general do enjoy motherhood and that motherhood does present a source of joy. It is unfortunate that society does not value the role of motherhood (Altman, 2003) as expressed in the words of Sceats (2000, p. 11): "Mothers are overwhelmingly powerful but at the same time are socially and domestically disempowered by their nurturing, serving role." Motherhood subsequently becomes a source of oppression (McDowell & Pringle, 1992) which is the concern of feminists. Society perpetuates double standards: while the role of mother is highly valued, it also goes

unrecognised and trivalised. The discourses protect and promote patriarchy and power at the expense of the well-being of women (Shankar et al., 2013).

Institutionalised religion imposes ideological hegemony, prescribing certain values, beliefs, practices and prohibitions (Schneider, 2003). Hence, while the overtly stated main purpose of institutionalised religion is to bring about unity and harmony amongst people, it has the opposite effect of keeping people apart by creating negative stereotypes. It becomes exclusionary and tribal and turns to violence to protect its territories. From the international level to interpersonal relationships, institutionalised religion has been used as a means of social control, violence and disruption. Feminists critiqued and challenged the discourses of marriage and family as being patriarchal, legal, monogamous, and procreative with women having to serve the sexual needs of men, bear children, and care for the family. Feminists demanded freedom of women to enjoy a sexual life, without having to bear and care for children. This included the use of contraceptives which acknowledged women's sex drive without the need for reproduction. Women, like men, had a right to enjoy their sex lives rather than performing a duty in marriage (Simmons, 2003). McDowell and Pringle (1992) argued that it is not marriage and family that is the source of oppression but rather the oppressive features of patriarchy that dictate marriage and family life that does so. The historic and patriarchal view of women being the primary house-minder places all physical and emotional demands on women (Douchet, 2000). Women who appreciate the role of mothers and homemakers will benefit from being treated as persons who have made the choice to do so. The family has different meanings at different times and to different people, and, as a social construct, the family is rapidly changing to accommodate a change in relationships. Single parent families are fast becoming a norm (Bourdieu, 1996).

There are no official statistics available on abortion, both legal and illegal, and poverty in South Africa. We do, however, need to look beyond poverty as the presenting reason to gender inequality, abuse, and the underlying reasons for abortion. Girls and boys are reared into particular masculinities and femininities that perpetuate the dominant discourses (Burman, 1995). Women are being abused by men and prevented from using contraceptives, and younger females are being taken advantage by older men who provide for them materially (Martin,

Coyle, Gomez, Carvajal & Kirby, 2000). Women who have repeat abortion were likely to be victims of physical abuse, sexual abuse or coercion (Fisher et al., 2005). Identity is not static but is continually constructed and reconstructed (Dominelli, 2002a). The constant construction and reconstruction of identities indicate that identities have the capacity for change: there are possibilities and opportunities for deconstructing aspects related to oppression and/or privilege, and to reconstruct alternative identities, discourses and social orders. This does give hope to the creation of a society where all are seen as, and treated as equal. While contraceptives are being made increasingly available to women globally as advocated by various women's rights and advocacy groups, the danger and harmfulness of some of the contraceptives are ignored. Women are kept ignorant of the effects of the contraceptives on their bodies, while they are being encouraged to utilise them (Smith, 2005). More effort must be placed on improving the circumstances of women in holistic ways than on focusing on contraceptives only.

The impact of broader socioeconomic factors namely broken or dysfunctional homes, absence of or poor role models, family and/or community violence, lack of community social and recreational resources, inadequate life-skills, and the high rates of crime demand intervention programmes that are holistic, comprehensive and widespread. Children born within a stable family, and where both parents are present have greater chances for stable lives (Bhana & Bachoo, 2011). Where women were not on contraceptive, and were sexually active it was due to limited, or lack of knowledge of contraceptives (Williamson et al., 2009) and fear of side-effects (Khanal, 2010). Programmes need to take into consideration the religious, cultural and social context of the groups being serviced (Ahmed, Flisher, Mathews, Mukoma & Jansen, 2009). Social hierarchies do exist, and the concern is how these hierarchies impact each other and subsequently impact women. This will inform programmes attempting to address the needs of women.

Abortion is just one of several symptoms of the difficulties faced by women. In many parts of South Africa women are not able to easily access resources, resources are either inadequate or service delivery poor. Even where these are adequate, women are victims of physical, emotional and/or sexual abuse, which might prevent their use. The reduction of poverty and maternal mortality, and the achieving of gender equality, is amongst the Millennium

Development Goals (MDGs) where all citizens are acknowledged and respected (Irigaray, 1993). South Africa does have a huge task ahead if it has to achieve these goals by 2015 as stipulated.

5.4 Consequences of abortion

This section focuses on the psychological, emotional and social consequences of abortion. The physical consequences of abortion are discussed under Chapter Three – *Medical Aspects*.

5.4.1 Psychological and emotional consequences of abortion

There is conflicting literature with respect to the consequences of abortion. While it is argued that women are relieved (Arthur & Harold, 1966; Petchesky, 1990; Kero, Hogberg & Lalos, 2004), others argue that women are traumatised by the event (De Puy & Dovich, 1997; Andrews & Boyle, 2003; Faure & Loxton, 2003). In debating the effects of abortion pro-choice groups persist in their claims that there are no effects to the abortion experience (Jagnayak, 2005) while the pro-life groups claim otherwise. Both positive and negative effects were found by the American Psychological Association (Burmell & Norfleet, 1987; Olivier & Bloem, 2004; APA, 2006). The ambiguous reaction is indicative of the complexity of the abortion experience. Although a feeling of relief is the typical reaction (Lemkau, 1988), the psychological and emotional complications are more common than the physical complications (discussed in Chapter Three) ranging from seven percent to 41% (Mcall & Wilson, 1987). Certain risk factors, however, are said to predispose individuals to these complications (Reardon, 2004). Moral and religious values of women led to feelings of regret and remorse (Bennett, 2001; Fielding, Edmunds & Schaff, 2002; Trybulski, 2005). It is argued that psychological effects of abortion cannot be overcome and that this has long-term implications for the well-being of women because they are unable to forgive themselves for what they had done (Conteh, 2008; Shahadah, 2010).

Amidst the abortion debate the psychological well-being of women is not considered. There is no acknowledgement that she may have struggled over her decision or felt bereaved, or that

the event may have left her with pain. Thus, abortion remains a significant personal experience that is not publically recognised, socially sanctioned or openly shared in the way a divorce, the death of a loved one or a miscarriage might be. De Puy and Dovitch (1997) argued that women's experiences, including their emotions are totally ignored forcing them to bury their feelings into their memories without coming to terms with it. The extent of the consequences depends on one's coping capacity, the reason for the abortion, one's beliefs about abortion, the support system available at the time, and the availability and quality of pre-abortion counseling (Coyle, Coleman & Rue, 2010).

Although the symptoms may not be immediate (Dykes, Slade, & Haywood, 2011), it may appear at any stage of life (Adanu & Tweneboah, 2004) and affects those with childhood trauma more adversely (Rue et al., 2004; Jagnayak, 2005; Coleman, Coyle, Shuping & Rue, 2008). While women, a year later felt that they would not have decided differently, they wished that they were not forced by circumstances to make such a decision (Kero & Lalos, 2000). They regularly, at least once a week, thought about the abortion and felt guilty and sad as was found by Adanu and Tweneboah (2004). While the ending of an unplanned pregnancy was welcomed, the abortion experience did cause anxiety, grief, guilt, despair and anger. These researchers argued that although guilt was felt on different levels by the individual women, guilt nevertheless existed. The role that society plays impacts women's lives from the decision-making process to the stigmatisation after the abortion. Guilt is experienced 'internally' leading to self-destructive behaviour or women just feeling awful about themselves. It is argued that negative experiences become hidden in one's subconscious memory where they remain inactive. A trigger brings them into remembrance, at different times and in different situations, affecting one's moods and social interaction (Major et al., 2000; Trybulski, 2006). This may continue in the long-term for several months or even years (Fergusson, Horwood & Boden, 2009; Dykes et al., 2011).

The context of abortion varies from one woman to another, so do the reactions and responses to the experience. One's attitudes, views and opinions of abortion predicted the subsequent response to it (Kishida, 2001). Women are more at risk for negative post-abortion reactions during adolescence, where there is coercion in any form, lack of social support, a history of

violence, strong religious views, prior emotional or psychological problems (Broen, Moum, Bodtker & Ekeberg, 2005; Steinberg & Russo, 2008), or prior abortion(s) (Steinberg & Russo, 2008). A conflicted decision arises from internal and external issues, personal difficulty in making the decision, being pressured or coerced (Broen et al., 2005; National Collaborating Centre for Mental Health (NCCMH), 2011), and/or making the decision based on inadequate/incorrect information. Other predisposing factors include unresolved trauma, low self-image, history of sexual abuse or sexual assault, lack of psychological coping mechanisms, assuming personal blame for the pregnancy, avoidance and denial prior to the abortion, ambivalence about the abortion, not wanting the abortion, partner not aware of the abortion, or having developed a relationship with the unborn (Goodwin & Ogden, 2007), uncertainty, and the absence of, or inadequate pre-abortion counseling (Major, et al., 2000; Kells, 2009; Vukelić et al., 2010).

The lack of social support, outside the family network, also affected how women coped with their abortions (Stotland, 2001). This included the attitude of service providers (Varkey, 2000). Broen et al. (2005) found that the non-support of friends also affected the psychological ability to recover afterwards, and the subsequent psychological responses. Where the spouse or partner is involved in making or supporting the decision, women are able to cope more adequately after the abortion. Not having the spouse/partner support in the decision leads to emotional problems thereafter. A poor or unstable relationship with the partner had a negative influence of the woman's ability to cope (Stotland, 2001), with violence in the relationship having led to a greater risk for post-traumatic stress disorder (PTSD) (Steinberg & Russo, 2008). The absence of pre- and post-abortion care affects post-abortion reactions and recovery (Coleman, Coyle & Rue, 2010; Vukelić et al., 2010).

While adolescents were at a greater risk for post-abortion reaction (Mentula, Niinimäki, Suhonen, Hemminki, Gissler & Heikinheimo, 2003; Major et al., 2000) religious faith, cultural teachings, regular sporting activities, high parental support, high partner support (Lorincz et al., 2001), and social support (Bradshaw & Slade, 2003) were identified as protecting teenagers from engaging in sexual activity and therefore from falling pregnant.

5.4.2 Social relationships

As is expected with situations incurring ethical dilemmas, social relationships were found to be impacted in the short term. Many women were found to withdraw from others by avoiding family and friends, especially people with babies or young children, and avoiding baby celebrations (Bradshaw & Shade, 2003; Coleman, Rue & Spence, 2007). The abortion anniversary or would-be-birthday of the aborted foetus triggered episodes of depression, sickness and/or isolation. Subsequent relationships and marriages for both men and women were also affected (Bradshaw & Shade, 2003; Reardon, 2004; Coleman & Rue, 2009; Ely, Flaherty & Cuddeback, 2010; Papworth, 2011). Those with single abortions were found to be more at risk for abusing or overindulging their subsequent children, or experienced difficulty in bonding with their children compared to those who had multiple abortions (Coleman, Maxey, Rue & Coyle, 2005; Coleman et al., 2008). Those with multiple abortions on the other hand, were less likely to marry, owing to mistrust issues in relationships (Reardon, 2004; Coleman & Rue, 2009; Ely et al., 2010).

5.4.3 Consequences for men

The limited research available on men and abortion indicate that abortion presents emotional and psychological consequences for men as well (Trybulski, 2005; Coyle, 2006). As part of a patriarchal society, men have the responsibility of providing materially for their families and protecting them from physical harm. The dominant discourse of fatherhood, in a situation where a man is not able to intervene, makes him feel helpless, anxious and guilty. Where the man did not want the abortion it is not unusual for him to feel a sense of loss, grief, sadness, pain, rage, and anger (Condon & Hazard, 2001; Coyle, 2006; Williams, 2006). Men generally do not express their grief, pain, sense of loss or other emotions because of discourse of man being ‘strong’. He may deny his pain and isolate himself giving the impression that he is strong, or unaffected. Many men disguise their pain or sadness, or attempt to ignore the pain by becoming fully involved in other tasks. The impact of abortion on them may remain unresolved for many years.

Possible relationship issues may be due to different grieving styles, or where one partner feels that the other doesn't care or is unaffected by what had taken place. Relationship issues may include social and sexual issues (Condon & Hazard, 2001; Myburgh, Gmeiner & van Wyk, 2001b; Naziri, 2007; Coyle, 2007b; Coleman, Rue, Spence & Coyle, 2008) where men may feel inadequate in handling the partner's emotions or pain (Condon & Hazard, 2001). This may be more intense for men where they had demanded the abortion, and accompanied by guilt both for the abortion and for the emotions of their partners. Effects listed by Coyle (2006) included "inability to communicate with one's partner about the experience, risk taking behaviors including suicidal behaviour, addictions, obsessive thoughts of the lost child, nightmares of someone/something vulnerable being threatened and being unable to protect it, desire for another child and subsequent behaviour to try to achieve that goal" which may lead to sexual compulsions including rape (Coyle, 2006, p.2). Research is not available as to the long-term effects of abortion on men. Research into pre-abortion counseling for the long-term adult men whose partners had abortions during their adolescence, indicated they experienced more distress than men who became fathers during adolescence (Coyle et al., 2010). Whether they agree with the abortion decision or not, or have requested the abortion, it is argued, men are affected (Kero & Lalos, 2000, 2004) and display various emotions (Coyle, 2007a) but do not express it (Williams, 2006). Where they had not agreed with the decision they were more deeply affected (Reich & Brindis, 2006; Naziri, 2007).

Men, too, can be considered victims of coercion where they are told that they have no voice in the abortion decision**.** In South Africa the Natural Fathers of Children Born out of Wedlock Act of 1997 was passed giving natural fathers (unmarried) the right to access, custody or guardianship of children (Morrell & Richter, 2006), excluding the unborn. The dominant discourse of men being caretaker and protector of their partners and children is challenged when a man is not able to protect his unborn. Despite the many fathers who do abandon their responsibilities there are many fathers who do assume responsibility for their children, with some fathers assuming full and sometimes sole responsibility for their children. Many fathers too are single parents. Fathers have become physically and emotionally nurturing (Wall & Arnold, 2007). In some primitive societies men psychologically identify with their wives by experiencing symptoms of pregnancy. Men in Western culture too may have this experience.

Hormonal changes are identified in men whose wives were pregnant. The estrogen level increases while the testosterone level decreases, making him less aggressive and sexually excited but more relational and helpful. When the hormones later readjust, the testosterone returns to its original levels. This is referred to as the *Couvade syndrome* (Laplante, 1989) where men are affected by the pregnancy experience.

5.5 Pre- and post-abortion care

The feminist ethic of care views 'care' as an activity which includes everything that we do to maintain, continue, and repair our 'world' so that we could live it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, sustaining web (Fisher & Tronto, 1990, p. 40). This definition of care includes several elements. Fisher and Tronto (1990) asserted that caring for another has a human element and involves action. It is not just a mental or academic process, presented in well-written reports, but activity to positively impact the daily experiences of those we claim to care about. *Caring about* – is a mental process and highly theoretical. As referred to earlier, Tronto (2001) argued that c*are,* and the *taking care of* involves action. It involves flexible standards and principles which include those of the carer but should also be determined by the values and lifestyle of those being helped. Caring should be based on people living their lives as well as possible. Fisher and Tronto (1990, p. 41) asserted that caring involves "ability factors" namely "time, material resources, knowledge, and skill". *Taking care of* is therefore also based on *power.* The carer needs resources, which are provided by those in power who *care about* with no related action. Caregiving also involves hands-on knowledge of the persons being assisted – culture, changing needs, and meeting those being helped on their level (Fisher & Tronto, 1990). To this end, in providing care for women seeking abortion those important in her life should be included to ensure that she has a support structure. By leaving men out especially where they do accompany women as is the practice (Beenhakker, Becker, Hires, Targiana, Blumenthal & Huggins, 2003), indicates that women are not attended to on their level of need. Abortion is provided as an isolated service rather than within the context of feminist care.

The service provider is an ingredient in the feministic ethic of care. There has to, however, be a balance between a distant and uninvolved professionalism to which women may have difficulty relating to, and the friendly-helper to whom women in pain may easily relate to but assume is not competent enough to address their needs. Expressions of care, which are a part of social work values, provide a necessary relationship enhancer which aids in the application of scientific knowledge. Care and expertise supplement each other and work together to achieve the goal of empowerment. Dybicz (2012) asserted that those in receipt of services describe the social worker as a friend and value this aspect of the relationship most highly in their receipt of services.

It is argued that most women seeking abortions welcome non-judgemental, empathic counseling (Hodson & Seber, 2002; Handy, 2011) and should not be denied quality, skilled, pre-abortion care (Steinberg, 1989), which can also serve to eliminate coercion (Needle & Walker, 2007; Kjelsvik, 2010).

Considering the psychological impact of moral and religious values (Bennett, 2001; Fielding, Edmunds & Schaff, 2002; Trybulski, 2005), and that psychological effects cannot be overcome in the short-term (Conteh, 2008; Shahadah**,** 2010), Fielding and Schaff (2010) asserted that post-abortion care should focus on the expression of emotions, working through the emotions, working though religious and spiritual dilemmas, building a supportive network, cognitive restructuring, and referral to a community organisation for ongoing care and empowerment. Skilled post-abortion care can provide women the opportunity to understand their particular circumstances and work towards empowering themselves and others (Boyd & Fales, 1983).

Women need holistic care and support. Good medical care reduces maternal mortality rates (Hogan, Foreman, Naghav, Ahn, Wang, Makela, Lopez, Lozano & Murray, 2010). Education, economic upliftment of women, and access to resources and development also contributes to the well-being of women (Klasen, 2002). Post-abortion care may also focus on both attitudes to sexual behaviour and to sexual behaviour practices with the goal of effecting individual change (Fasubaa & Ojo, 2004). Mullaly (1997) argued the need for changes in structure in order to facilitate and enhance individual change.

This chapter reviewed the various psychosocial considerations that impact the abortion decision focusing on woman-focused, other-focused, material-related reasons, the status of adoption in South Africa, and the dominant discourses on motherhood and fatherhood. It reviewed the structural determinants of the oppression of women, the consequences of abortion, as well as pre- and post-abortion care. From the literature reviewed, it can be concluded that the abortion decision is a complex one come the women affected. The research methods designed and employed to gather the data for this study is discussed in the next chapter.

CHAPTER SIX

RESEARCH METHODOLOGY

6.1 Introduction

A scientific method of acquiring knowledge involves a particular way of going about the process (Yegidis & Weinbach, 2002), and a particular way of thinking about and investigating assumptions about the world (De Vos, 2003). It 'refers to the ideas, rules, techniques and approaches that the scientific community uses' (Neuman, 2011, p. 8).

This chapter describes the research methodology used in this study and deals with the research questions, design and methods; the sampling strategy; methods of data analysis; ethical considerations; reliability and validity; and the challenges and limitations of the study. The strengths of the study are incorporated into the various sections.

6.2 Research questions

The following key questions are addressed in this study:

- How is the abortion decision made?
- How do current contextual realities affect the decision-making?
- What role do religious beliefs, value systems and cultural values play?
- How is right and wrong negotiated within the context of religious and cultural expectations?
- What does motherhood mean to those who abort?
- What does fatherhood mean to men whose partners abort?
- What support systems/structures are available?
- What is the potential impact of dominant discourses of motherhood and fatherhood on the abortion decision and

- What are the consequences of abortion?

6.3 Research method and design

The research design is a 'plan or blueprint' of how the researcher plans on undertaking the study (Mouton, 2001 p. 55). Methods of obtaining data can be either qualitative or quantitative, or a combination of both. The particular scientific method chosen will depend on the study being undertaken. While the natural sciences use experiments to allow the researcher to investigate or find explanations for natural phenomena in a carefully controlled environment, the social sciences deal mainly with finding explanations for social phenomena and human actions. Social science research centers on two activities namely the obtaining and interpreting of data. It permits the acquiring of in-depth knowledge of social phenomena despite possible constraints (Bless & Higson-Smith, 2006). The social sciences 'involves people and their beliefs, behaviour, interaction, institutions, and so forth' (Neuman, 2011, p. 15) finding explanations for social issues and happenings.

There are several considerations when deciding on research methodology. Qualitative research methods can be used to explore new grounds or obtain more information, where there is a need for flexibility, or it could provide the basis for a wider quantitative study. The research problems in qualitative studies are presented as open-ended questions (Strauss & Corbin, 1990). The findings can be presented on its own or together with quantitative data (Patton, 2002). The qualitative research method is about the qualities of a phenomenon rather than the quantity, moving beyond measurement to understanding and in-depth inquiry (Henning, van Rensburg & Smit, 2004). While statistical research cannot research the effects of interaction in social settings, qualitative research can study the complex, dynamic, and interactive social world. Qualitative research methods "attempt to gain access to personal, subjective experience" (Sullivan 2001, p. 49), which cannot be accessed through quantitative research. Qualitative and quantitative analysis therefore produce different types of knowledge. Of importance in this study, is that qualitative research

provided an opportunity to interact with, and to collect data directly from the participants, as they experienced and reflected on their reality.

Characteristics of qualitative research are intertwined and reinforce each other. These include the use of the natural setting to obtain the data and the researcher as the instrument of data collection. The researcher attempts to observe, describe and interpret settings as they are. To this end, qualitative research generally uses inductive data analysis, and produce descriptive research reports using the voice of the participants in the write-up. The research design, therefore, ought to be open and flexible to allow exploration. Qualitative research is suited to investigating complex and sensitive issues and provides a better understanding of the lived experiences of people. It is best suited for research that is intended to gain details and insights into feelings and thought processes (Strauss & Corbin, 2008) where the researcher is able to research subjective, personal opinions (Mehra, 2002). Qualitative research involves the researcher interacting with people in their environment to understand them and their experiences (Merriam, 2002; Strauss & Corbin, 2008).

The particular design of a qualitative study depends, amongst other considerations, on the purpose of the inquiry and what information will be most useful. There is no accessible information on women's account of the psychosocial, ethical and religious considerations of abortion in South Africa. Taking into consideration the nature of my study I chose a qualitative method based on an interpretivist, feminist design. A qualitative method is necessary when one is 'concerned with understanding the meanings which people attach to phenomena (actions, decisions, beliefs, values etc.) within their social worlds' (Ritchie & Lewis, 2003, p.3). This study sought to understand the psychosocial, ethical and religious considerations of abortion in relation to specific themes which made qualitative research the appropriate option.

Knowledge is constructed both by what is observed and people's accounts, with the researcher utilising various sources for data. Interpretivist approaches to research attempt to understand the human world with the researcher being interested in the participants' views of the phenomenon under study taking into consideration both their background and

their experiences (Creswell, 2003). People's understanding of their experiences is influenced by and interacts with social contexts. This provides rich data for qualitative research. In contrast, positivism attempts to understand human behaviour through experiment, observation and reason and explains behaviour in a scientifically descriptive way.

Qualitative, interpretivist research allows for unstructured observation, open interviewing, idiographic descriptions, and qualitative data analysis. The study adopted a feminist research design which is committed to understand and take seriously the experiences of women (Hesse-Biber, 2013). The aim of the study was to provide an interpretation and critical analysis of the experiences of women and men. This design best suited the research questions.

The theoretical framework influences the perspective from which the phenomenon is studied and the data analysed and interpreted. The theoretical framework is in turn influenced by and must have synergy with the chosen research paradigm. It is the choice of paradigm that sets down the intent, motivation and expectations for the research. Feminist research lends itself to qualitative methods. Feminist research is based on 'an awareness that the subjective experience of women differs from a positivist perspective' which is based on a male orientation of being objective, logical, task orientated, and instrumental (Hesse-Biber, 2013). The generalisations of research, based on the experience of men, are extended to all people ignoring gender. Gender is the central topic in feminist research, not only within the research, but also within the reality that women ascribe to themselves (Hesse-Biber, 2013). The researcher studies how women make sense of the way gender constructs their world as women. It is important for women to relay their stories from their personal experience and social reality which is shaped by their experiences and understanding. Feminist research gives women the opportunity to voice their personal interpretation of their reality. Women's interpretation of their reality is central to feminist research, although feminist research allows both women and men the opportunity to express themselves.

The literature review was done prior to commencement of the data gathering as it provided information to understand the topic of research more in-depth (Shank, 2002), and continued throughout the data collection, data processing and data analysis.

6.4 Sampling

A population or universe comprises 'all the possible cases the researcher is interested in studying' (Sullivan, 2001, p. 187), each member of which is an element. To define a population, a researcher specifies the unit being sampled by defining their specific characteristics that is being studied. The only characteristic taken into consideration for this study is women and men who were involved in abortions, and abortion service providers from the Durban metropolitan area. The population for this study is men, women, and service providers from the Durban metropolitan area who were involved in abortions post 1997, that is, after the legalising of abortion in South Africa.

There are two main types of sampling designs namely probability and non-probability sampling. In probability sampling, the sampling is based on the random selection with each element having an equal chance of selection in the sample. It is a controlled procedure where each element in the population is given a known non-zero chance of selection. In probability sampling any part of the population of study can be chosen to represent the population (Cooper & Schindler, 2003). Non-probability sampling is nonrandom and subjective. Not just any part of the population of study is chosen to represent the population. The sample is chosen according to certain criteria. There are four non-probability sampling designs, namely, quota sampling, convenience, accidental, judgemental or purposive sampling, dimensional and snowball sampling that are commonly used in qualitative research (Sullivan, 2001; Cohen, Manion & Morrison, 2011).

Purposive sampling is sometimes referred to as haphazard, accidental, or convenience sampling. It is one of one the more popular forms of sampling where the sample is selected because it is accessible to the researcher or because it is easy to recruit. Purposive sampling is the easiest and cheapest form of sampling, and it is least time consuming (Castillo, 2009).

Purposive sampling is not based on probability.

Research sometimes requires that the sample to be chosen to meet the purpose and the needs of the research of the study (Cohen et al., 2011). Purposive sampling ensures that elements relevant to the research design will be included. The target population and unit of analysis is otherwise difficult-to-reach. In this study, it was impossible to identify women and men upfront to include in the interviews. Only with willing consent and voluntary participation were the interviews conducted. Since no registry exists to establish the population from which I could obtain names and draw a random sample, I used non-probability sampling: purposive/convenience, theoretical sampling for the various categories. Abortion service providers were chosen to link the researcher to the sample of primary participants. I also used the media (newspapers and radio) to recruit participants. Two abortion service centres were identified in the Durban metropolitan area. Permission was obtained from the Department of Health (Appendice B), the hospital (Appendice C), and the Head Office of the Non-governmental organisation (NGO) (Appendice D) to undertake the study. I was allowed access to the facilities and to both the women and their health professionals. The disadvantage with purposive/convenience sampling is that the sample becomes self-selective. The women, men and service providers who participated represented specific views. Where the sample is self-selective the researcher is not in a position to anticipate or ensure a sample that is reflective of the population.

Theoretical sampling is similar to purposeful sampling and is often used synonymously. It allows for the development of concepts and the deepening of the understanding of experiences of participants who are selected to answer the key research questions. The researcher continues interviewing more participants until all the key research questions have been adequately answered (Strauss & Corbin, 2008). Theoretical sampling therefore allows for flexibility in that the sampling is not pre-determined. The process continues throughout the study. This is in keeping with the flexibility needed in qualitative research to allow for exploration as was the aim of the study (Lincoln & Guba, 2000). According to Merriam (2002) the criteria used for sampling should contain the purpose of the study. In this study the criteria were:

- Women and men in the Durban metropolitan area who were involved in the termination of pregnancy post 1997, that is since the legalisation of abortion in South Africa. I did however get one male participant whose sister had had an abortion;
- Health professionals (doctors and nurses) from the Durban metropolitan area;
- A willingness to participate in the study; and
- Those included in the sample to be over 18 years of age.

The service centres included a hospital and a non-governmental organisation (NGO). I visited the Centers on an ongoing basis over a six month period. I addressed potential participants and obtained the names and contact details of those who indicated willingness to participate in the study. I also used the media (newspapers and radio) to especially target male participants. Those who responded to the media advertisement and were willing to participate in the research contacted me telephonically. The limitation with the voluntary participation is that despite working with both a hospital and a NGO my sample was self-selective and eventually consisted primarily of students and Black women. This, however, is in keeping with the racial demographics of KZN, and the population of persons seeking the service at both service centres that I visited. Those who responded to my article or message in the community radio were White and Indian men from middle socio-economic class. The article reached over 40 000 readers while the radio station reached approximately 100 000 listeners.

The number of participants interviewed for the study was determined by their willingness to participate in the study. On finding that no new data was being accessed, I did not attempt to recruit new participants. This is referred to as theoretical saturation (Strauss & Corbin, 2008). A total of 15 women, one doctor and eight nurses were interviewed face-to-face, five men were interviewed telephonically, and eleven doctors completed questionnaires, as they did not have time for interviews. I approached the doctor-in-charge in the gynecological ward in the hospital to participate in the study. She expressed her willingness but indicated that the staff had to set aside time for interviews. She offered to

discuss the study with them and inform me of the group's decision. The following week the doctor-in-charge informed me that the group was willing to participate in the study but would not sit in for interviews. They were willing to complete a questionnaire at a meeting which I was allowed to address.

I did experience difficulty securing both the women and men participants. During the period of recruitment, between June and November, 2012, at the two service centres I obtained names and contact details of approximately 100 women and five men who were willing to participate in the study. Those interested were given the opportunity to personally enter their details into my book. I provided my telephone number to allow them to identify me on their cellphones when I contacted them a month later. Between one and two months later I telephoned each of them to set up appointments. At the time of telephonically setting up the appointments most participants refused to speak to me: some slammed the telephone on me, some asked me to call them another day or time and then ignored my calls, some set appointments but did not keep them, while others politely told me that they did not wish to talk about what had happened. As with the study by Astbury-Ward (2008), I found that women were reluctant to participate in abortion research. Most women conceal their abortion because of shame or fear of the reaction of family and friends. It is for this reason that many eligible women do not claim from their medical insurers for the treatment (Trybulski, 2005). With pregnancy being socially constructed as a woman's responsibility, men were reluctant to participate in discussions concerning reproductive issues as is found by Sewpaul (1995), and confirmed in my efforts to recruit male participants.

6.5 Data collection

Qualitative, interpretivist research allows the researcher use of any of the qualitative methods of research e.g. questionnaires, interviews, direct observation. The qualitative methods that were employed for this study were in-depth interviews with the aid of loosely-structured interview guides (Appendices E, F, G, and H), observation and a questionnaire (Appendice I).

I undertook the fieldwork between June and December, 2012 after obtaining written consent from the relevant departments. Obtaining consent from the relevant departments was in itself a time-consuming process. After receiving ethical clearance from the university I had to obtain permission from the local service providers to conduct the research at their centers. Before granting me permission they had to wait for their monthly meeting where such requests are considered. It took several months before this materialised as the committee at one of the centres had disbanded and I had to wait until another was formed. On obtaining consent from the local offices I was required to write to the head offices for permission. This was another period of waiting. The permission granted was then to be referred back to local centres with whom I had to set up meetings to discuss my research.

Sources of data can be either primary or secondary. A primary source of data will provide new or primary data. Primary data can be obtained through observations, interviews, with questionnaires, from letters and speeches (González, 2002). Where primary data which has been used for other purposes is interpreted and analysed, it becomes a secondary source of data. Primary data was used for this study. It was gathered by means of in-depth interviews with the aid of loosely-structured interview guides. Women, men and health professionals shared their stories. The 'how' of data collection is important to the interpretation and presentation of the data. In qualitative research the researcher not only collects data but is an instrument in collecting the data. Where participants become comfortable with the researcher and are confident about her/his trustworthiness they are able to share and important part of their lives. It is therefore important that the researcher separates the research and clinical roles (Rew et al., 1993; NIH, 2004). I interviewed the participants as a researcher although they were aware that I am a social worker. For further counseling I offered my services and referrals to other professional persons and organisations in their areas of abode.

Questionnaires were completed by service providers who were not able to participate in interviews on account of time constraints. Telephonic interviews were conducted with four

males whose partners had abortions, and one male whose sister had an abortion. Observation supplemented the data I obtained during the face-to-face interviews. The following data collection techniques were utilised in this study.

6.5.1 In-depth Interviews

In-depth interviewing is one of several methods of conducting research, allowing greater depth than any other method of data collection (Cohen et al., 2011). Interviews involve a face-to-face situation in which the researcher obtains information directly from the participants. Qualitative interviews can be structured or unstructured (Cohen et al., 2011) depending on the need for flexibility and on the research questions. In semi-structured interviews the researcher works with a list of the aspects and questions that need to be covered in the interview, while unstructured interviews are informal and 'explore the experience of people and the meaning they make of it' (De Vos, 2003, p. 298). I conducted semi-structured, in-depth face-to-face interviews with 15 women participants, eight nurses and one doctor. This allowed me to personally listen to their stories and understand their feelings. With permission from the participants, the interviews were audio-taped with a digital recorder.

A month after obtaining details of women who were willing to participate I contacted them to set up appointments. For those who were still interested to participate in the research I set an appointment on a date and at a time and venue convenient for them. The women chose the venue, the date and the time that was suitable to them. A venue chosen by them, away from family and community members provided a relaxed and comfortable setting in which they freely spoke about their lives. This did mean that I had to travel a distance to meet each of the participants. The difficulty with this arrangement was that I could not obtain venues that ensured privacy and quietness for the audio recording of the interviews. Where I did experience such difficulty, with the permission of the participant, we drove to the park or the beach where we did the interview in the car. Our time together did help them relax and to relate to me. The service providers (the one doctor and eight nurses) were

interviewed in their offices at a date and time chosen by them. This ensured that they were able to give me uninterrupted time for the interview.

The direct questions in the interview guides related to the participants' personal and family life and served as a means to get the participants to relax. I did not record the close ended questions but chatted with them casually enquiring about the present circumstances and finding something to talk about. This worked well as the participants were keen to talk about their families. This also helped them to relax during interview. Each interview began with me thanking the participant for volunteering for the study. Participants appeared to respond well to this introduction and sensed my sincerity in wanting to understand their experiences. I once again explained to them the purpose of the study, their right to participation and their right to withdraw at any stage, the need to audio-tape the interview and only with their consent (Appendice J). I demonstrated to them how the audio-recorder worked. Informed consent was obtained and none of the participants withdrew consent. Five female participants refused to consent to the interview being audio-recorded. This could probably be due to fear of possibly being identified at any stage despite my assurance of anonymity and confidentiality. I attempted to keep detailed notes of the interview and recorded the data immediately thereafter.

To keep the interviews free flowing I asked the women to relate the abortion decision and experience, and the health professionals as to what their views on abortion were. This also gave them an opportunity to ventilate as some of them have never spoken to anyone about it. The women spoke openly. A few struggled for English words to express their experiences and feelings. The interviews were guided by a few broad topics and I encouraged the participants to actively participate in the discussion. A semi-structured interview was used as it allowed me to obtain the desired information though questions and prompts while at the same time not curbing the information that respondents gave. It was open-ended allowing for the women and men to elaborate and explain their decision in their own words and understanding of their situation and experiences.

Active listening, prompts, nodding of head and questions were used to keep the discussion flowing. Prompts gave participants a chance to think more about the questions and provided the opportunity for more detailed responses. Prompts are not leading questions but serve to direct the interview and to provide reflection. It was used to draw out more detailed information. The interviews were free-flowing and I found that I did not have to use all the questions from the interview guides. The health professional continued talking with minimal prompts. It was probably cathartic for them. I reviewed the first few interviews, identified gaps, and included more questions in subsequent interviews in order to cover aspects not already covered.

My experience as a social worker facilitated the interviewing. Their being aware that I was a social worker and my having made them comfortable encouraged their sharing of their experiences and feelings. My social work experience enabled me to create a safe relaxed environment for their painful and uncomfortable feelings. With the women participants, we sat next to each other to promote a power balance. The participants were relaxed and spoke about their intimate experiences and innermost feelings. I was able to sense when the story became painful. I held their hands and allowed them to relax. The key to conducting fruitful interviews is the establishment of rapport with the participants, the creation of a non-judgemental environment, and the conveying of respect for, and interest in what the participants share (Fontana & Frey, 1994; Carley-Baxter, 2008). In the words of Waldrop (2004), "the opportunity to discuss a difficult experience with an interested and non-judgemental researcher can generate positive feelings and hope for change among those who feel disenfranchised" (p. 242).

The information volunteered by the participants covered a couple of questions at a time. There were instances of 'stop-go' where the participant offered only one-word answers. In such cases I had to become more vocal and use more prompts. My experience in interviewing did help in such instances as I attempted to obtain the information needed without becoming too direct. Some just went on and on talking as if grateful for the opportunity to express their feelings. This occurred with both the women and the health

professionals. As a social worker, I received the necessary training to conduct interviews while being consciously aware of my own prejudices, judgments and weaknesses. When information presented by the participants contradicted, or were not in line with my value system, I ensured that I did not appear shocked, or did not make any judgments. Since it is possible for any type of information to present itself during research such as this one, it is important that the researcher not pass judgment either through word or body language.
There was no preset time limit for the interviews although during the recruitment, participants were informed that the interview will be approximately an hour long. It depended on a large extent on how much time the participant needed. Each interview was approximately 45min to an hour in duration.

At the end of the recorded interview I spent time with the participants reflecting on the interview experience and the emotions it elicited. Most women participants were glad to have had the opportunity to talk to an unrelated person as they did not have an opportunity to discuss the abortion experience with anyone. I offered my services if and when they needed someone to talk to. I also offered to refer them to social workers in their area. Some went on talking even after the interview.

Amongst the important characteristics of feminist research is the use of reflexivity as discussed in *Chapter One*. Reflexivity is an understanding of the subjective experiences of the researcher and of the research process (Pillow, 2003), enabling the researcher to acknowledge her role and the circumstances of the research (Finlay & Gough, 2003). In my use of the *self* as an instrument in the data collection I had to be consciously aware of my perspective on abortion, and to prevent it from being reflected to the participants. I succeeded in remaining non-judgemental throughout my interaction with all participants. This is evidenced in the quality of the rich data I was able to obtain, and the good working relationship I had established with the service centres I had worked with. The experience was enriching for me both as a professional and as a person.

In terminating the interviews I thanked the participants. Each of the female participants was given R100 to cover transport costs, and a gift as token of appreciation. Horowitz, Ladden, and Moriarty (2002) suggested that to recruit vulnerable individuals is to provide appropriate reimbursement. Most women participants travelled a distance for the interview. The health professionals, both the doctor and nurses who participated, were each given a token of appreciation. These were offered at the end of the data collection with each participant so it did not influence participation.

6.5.2 Telephonic interviews

Telephonic interviews were considered and used in this study due to the anticipated and experienced difficulty in obtaining male participants in face-to-face interviews (Sewpaul, 1995). With pregnancy and abortion being socially constructed as women's responsibility, men are reluctant to participate in such discussions. Men who accompanied their partners to the service provider were approached to participate in the study. Only five showed an interest of which only one participated in the interviews. The other four responded to a media request.

The few men who indicated a willingness to participate in the study did not wish to participate in face-to-face interviews and chose to remain anonymous. They agreed to the option of a telephonic interview. Three had responded to an article I had placed in a community newspaper, one responded to a request I made through a community radio, and one responded to my appeal at the service centre. They did not wish to provide their personal details. The one I recruited from the Service Centre too did not wish to set a special date to meet with me. He chose the telephonic option which I offered due to his subsequent reluctance to participate in the study. The others recruited at the service centre later refused to participate. The telephonic interviews with the men could not be recorded.

6.5.3 Questionnaires

Although questionnaires were not planned for during the initial stage of this study, questionnaires were subsequently compiled for health professionals in anticipation of possible difficulties they may experience in setting aside time for an interview (Appendice I). The difficulty experienced by doctors with respect of time constraints led to the need for a questionnaire. The questionnaire comprised two sections: the one dealing with demographic data and the other covering the key research questions. The questionnaire developed for the nurses was not used since all the nurses from both the service centres participated in the interviews.

The doctors who were willing to participate met with me as a group. I explained to them the research in detail, its voluntary nature, and obtained their informed consent (Appendice K). The questionnaire was administered to eleven doctors at their group meeting and completed at the same time. I did appeal to them to complete the questionnaire in as much detail as possible as it was a substitute for the in-depth interview. Each of the doctors who attended the session completed the questionnaire and was given a token of appreciation and thanked for their participation.

6.5.4 The interview guide

Loosely structured interview guides (Appendices E, F, G, and H) were used to keep the interviews focused, to ensure that all the key questions were answered, and to minimise possible bias on my part, while at the same time allowing flexibility for me to probe where necessary. An interview guide comprises a list of the topics, or key research questions, or the information that is purposed from the interview. How the interviewer handles or phrases the questions at the time will depend on the participant's level of operation. Flexibility is necessary to allow to repeating, rephrasing, and clarifying questions where they are misunderstood. Flexibility was essential in this study because of the sensitive nature of the topic and the need for me as the researcher to be able to meet the participants at their level (Mason, 2002). The open-ended questions gave the participants the chance to answer in

her/his own way, using her/his words, and expressing her/his opinions or feelings, to expand, elaborate and clarify answers (Grinnel, 1997). Although the interviews proceeded around the set of predetermined open-ended questions from the interview guides, other questions, relating to the circumstances of the specific participant, emerged during the interview. The greatly flexible interview guides allowed for this.

6.5.5 Observation

To supplement the data obtained, I used observations during the interview. Observation may be useful in recording non-verbal data. Interviews allow the researcher to exercise active control over observation. Through observation the skilled researcher is able to pick up information that the participants do not share (Cohen et al., 2011). Observation together with interviews can provide more information than interviews alone (Patton, 2002). Skilled observation demands the identification of both verbal and nonverbal cues (Patton, 2002). Observation in this study involved the observing of participants' non-verbal behaviour in the context of the interview. Observations made during the interview were recorded immediately thereafter. I noted instances of changes in tone of voice, and other non-verbal behaviour that may have significance in the research results.

For approximately three months, I regularly sat in at both the general waiting room, and the procedure waiting room at one of the service centres. I spent time observing women as they awaited their turns to be called in for medication, and those who had already been administered the medication and were awaiting the procedure in the second waiting room. In the general waiting room, I observed single women, couples, and mothers coming in with their daughters. While waiting to be attended to or waiting for family members, those in the general waiting room did not converse with one another. The room was silent. Some took to playing with their cellphones or to just glaring about. There was total silence with a tense atmosphere. No one dared even move around to possibly protect their being identified or later recognised. In the second waiting room where the women were awaiting their procedure, there was also total silence. I addressed the women in this waiting room. They did not answer any questions I presented. Neither did any ask me questions

concerning the research. Their only response was the nodding or shaking of the head, and those who chose to write their contact details in my book, did so. They were also in intense physical pain after being medicated to initiate the abortion process.

During the transcribing of the data from the interviews, I reflected on what had transpired prior to, during, and immediately after the interview, and recorded these separately. This information was used in the analysis of the data and the discussion of the findings.

6.6 Ethical considerations

Ethics are 'norms and standards of behaviour that guide our moral choices in respect to our behaviour and our relationship with others' (Cooper & Schindler, 2002, p.116). In research, the goal of ethics is to ensure that those participating in the research are not harmed or suffer adverse effects. The researcher is obligated to be ethical even where the participants are not concerned about such issues and make no such demands (De Vos, 2003). Abortion is a highly sensitive topic. Hence careful consideration was given to ethical concerns. The study was approved by the Ethics Committee at the University of KwaZulu-Natal (Appendice A). Permission was obtained from the hospital (Appendice C), and from the KZN Department of Health (Appendice B) to conduct the research at the hospital, and from the Head Office of the NGO (Appendice D). The ethical principles of research namely do no harm, be open, honest, and careful (Shank, 2002) were observed. At the time of recruiting participants and once again immediately prior to the interview I provided the following information to the participants:

- The purpose of the study;
- A brief explanation of the benefits expected from the research;
- The time expected to be spent in the interview;
- That confidentiality of the information given during the interview will be maintained; their anonymity to be maintained at all times; and that pseudonyms would be used in the reporting of the data;

- That participation in the study was voluntary and that they had the right to withdraw from the research at any stage if they so desired;
- The interview will be audio recorded;
- I would be transcribing the interviews;
- Only my research supervisor will have access to the recordings; and
- Their willingness or refusal to participate in the study will in no way affect the services they receive from the service provider.

After briefing each participant about the study and before embarking on the interviews, I obtained *informed written consent* (Appendices J and K), which included permission to audio-tape the interview. "Informed consent arises from the subject's right to freedom and self-determination" (Cohen et al., 2007, p. 52). Informed consent is necessary for participants to have the information necessary to participate, and to willingly agree to participate. Participants may agree or refuse to participate at any time. Informed consent contributes to making participants feel in control. This in turn influences how they respond to questions. It also ensures that they do not feel obligated to participate, and reduces the chances of the research results being negatively influenced.

To protect the ethical rights of the participants, during the process of recruiting the sample, through the stage of obtaining their written consent, to the time of the interview, I clarified the purpose of the study to ensure that I did not mislead them with respect to their receiving direct personal benefits. The study did not entail any direct benefits for them. Informed consent has to be negotiated on an ongoing basis as informed consent is not static (Andrews, 2001). Ongoing informed consent is an important part of qualitative research. The dynamics constantly change and participants may change their minds when painful issues surface. Participants were therefore made aware that their verbal consent was ongoing and that they could withdraw from the study at any point. At the time of obtaining the participants' written consent to participate in the study, I discussed their expectations in order to clear any misunderstanding they might have had and once again informed them of their right to withdraw consent at any stage of the study. Participants were informed that

the transcripts, handwritten notes, and consent form will be labeled with a number and that a pseudonym would be used in the writing up of the report to ensure anonymity. Participants were again assured that all information would be kept confidential and locked in a safe place.

During the recruitment phase I obtained approximately 100 women voluntarily giving me their contact details. A month or two later when I contacted them to set up appointments, the majority refused to participate. Only 15 women of the 30 who set up appointments with me followed through with the appointments. None of the 15 participants, who followed through with the appointments set, withdrew from the study. Five of these participants, however, did not agree to the interviews being recorded. Their requests were respected and honored.

Confidentiality and anonymity are necessary to maintain respondents' rights. To ensure their anonymity at all times, the participants were asked to choose pseudonyms for the write-up of the research findings as discussed above. Information disclosed during the interviews was being treated confidentially. It was not discussed with anyone except with my research supervisor and presented in this report under pseudonyms.

The collection of data on sensitive topics can be painful to participants (Horowitz et al., 2002). I prepared the participants for this possibility and provided debriefing at the end of the interview. Where traumatic personal issues arose, I counseled with them and offered referrals to local social workers. A support group was not possible as the participants came from various residential areas and many of them had limited finance to access public transport.

To avoid exploitation of participants who voluntarily participated with no expected benefits, I gave each a token of appreciation (McDowell, 2001). For the women who had to travel for the appointment an amount of R100, over and above the token of appreciation, was given to cover expenses.

6.7 Recording of data

After each interview I personally transcribed the recordings which I cross checked by listening to the recording while reading the transcripts. I used the pseudonyms during the recording to ensure that the transcripts did not contain identifying details. I copied the recordings and then edited for use of language and for punctuation. Any observations made were included in the edited version of the transcripts. Five women did not consent to the audio recording of the interview. In these instances I did as much detailed recording as possible and updated same after the interview.

6.8 Data analysis

Qualitative data analysis involves the organising of data, breaking it into manageable units, synthesising it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others (Bogdan & Biklen, 2003). In analysing the data, I used critical discourse analysis (CDA) which is necessary for describing, interpreting, analysing, and critiquing social life as it is reflected in words, and to analyse written texts and spoken words to unveil sources of power, dominance, and inequality, and how these are maintained within social, economic, and political contexts (van Dijk, 1988; Luke, 1997). CDA focuses on social structures and the use of language to describe how existing structures impact the lives of women.

With CDA, the research begins with a research question within the chosen theoretical framework. Interviews are transcribed and deconstructed to identify discourses that speak to particular perspectives. Data analysis therefore began with the preparation of the data. With the interviews this meant transcribing the information so that I could use a transcript of the results. Once the data had been transcribed, it was processed to identify common patterns and themes. The raw data was then placed into categories which were then examined. The findings are presented in this report as suggested by Bogdan and Biklen (2003). By personally transcribing the interviews I became familiar which the content

which aided in the process of analysis. The transcripts were read for developing themes, and in relation to the study objectives, research questions and items covered in the interview guides. The themes were modified/replaced during the subsequent stages of analysis (Hoepfl, 1997), and once again examined. This process is referred to as *axial coding* (Strauss & Corbin, 1990). I then compared and combined the themes in different ways to relate to the purpose of my study utilising the data that related to the themes that emerged. The focus was on the data rather than the participants.

In discourse analysis the language used is analysed to understand peoples' interpretation of their experiences taking into consideration that cultural and linguistic resources affect their presentation (Fulcher, 2012). CDA views discourse as both socially constructed as well as socially conditioned. The interest of feminists is the relationship between language and oppression (Wilkinson & Kitzinger, 1995). There is a strong relationship between discourses and other social processes and structures. In Fairclough's (2009) dialectical-relational approach to CDA, the focus is on the analysis of structures and context in addition to language. While textual analysis is important, it is only a part of the discourse analysis. The focus is on how the language action is framed within a broader social order (Fairclough, 2009, p. 170). Critical social theory facilitates an understanding of the hidden structures and cultural dynamics that underlie social meanings and values. It is important that the hidden structures and inscriptions of social meanings among oppressed groups, such as females be understood. The objective of CDA is to understand what influences one's making sense of one's reality, how this occurs, and how it is perpetuated in the social environment (Henning et al., 2004). Feminists use discourse analysis to explore a variety of questions that relate to gender power (Wilkinson & Kitzinger, 1995). According to Alvesson and Sköldberg, (2009, p. 166):

> It is necessary to consider not only what participants mean, and how we can understand their conception of the world and their way of imparting meaning to themselves and their situations, but also the totality of which they are a part of.

Wodak and Meyer (2009) highlight language as an activity and social practice. An oral utterance is embedded in a discourse, and regarded as "a manifestation of social action which again is widely determined by social structure" (Wodak & Meyer, 2009, p. 6). Foucault (1982) argued that dominant discourses are inherently related to power, and that it is the power which creates, promotes and sustains the dominant discourses. The *critical* component of CDA is that it exposes inequality and power relations by analysing the discourse in the context of the participant's social world. It attempts to understand the nature of social power and dominance, how these are produced, and perpetuated (van Dijk, 1988; Humphries, 2008). CDA reflects the inequality existing at various levels and is committed to social change. This is consistent with the feminist theoretical framework.

As with the feminist research design, central to discourse analysis is *reflexivity* where the researcher acknowledges her own bias and position on the issue under study. The researcher's is only one interpretation of the text which will be in keeping with the aim of the study. The aims of research vary and hence the interpretation. The aim of one researcher may be to understand power relationships in a specific instance to bring about change; but another may be interested in an interaction or conversation just to understand it (Fulcher, 2012). Reflexivity therefore stresses accountability of the part of the researcher. The findings need to be both transparent and justified (Gill, 1995).

The analysis of the data was guided by the theoretical framework and the research questions of this study. By studying the narratives, the researcher looks for recurring themes that are collated. The narratives are cited where necessary (Fulcher, 2012). I used voice in the write-up of the processed data, that is, participant quotes that illustrate the themes being described, and linked the data that has been analysed to the conceptual framework. The voices of participants tell the story of the phenomenon under study. The data is presented in narrative form to provide the reader with a fine grained analysis of the findings. The processed data was compared to findings of similar studies. Conclusions and recommendations were then drawn from the processed data. Tables are used to provide an overview of demographic data. Although biographical data of the participants are presented in the analysis, the confidentiality of identity of the participants are guaranteed in that their

areas of residence or places of employment were not disclosed. The Durban Metropolitan area is extensive and participants could have represented any community from the stated Metropolitan area.

The research paradigm adopted in this study favours the researcher positioning the self to ownership of the writing. I therefore chose to write the report in the first person in accordance with the positioning and the use of the self in feminist research.

6.9 Validity and reliability

Validity and reliability is associated with a positivist paradigm. Qualitative research does not claim reliability and validity but reviews its research for credibility, transferability, dependability and confirmability (Lincoln and Guba, 2000; De Vos, 2005).

Credibility is equated to internal validity. Stating and clarifying the context of the study, the population, the sampling method, and clarifying the theoretical framework contribute to 'validity' in qualitative research (De Vos, 2005). My study met this criterion. My relationship with the participants in the face-to-face interviews provided genuine information about their experiences and their feelings. They related to me as a client would to a social worker. Two of the nurses even discussed their home experiences with me. To ensure validity in the use of the instruments for data collection, I included repeat questions, phrased differently, at different points of the interview guides; interviewed different sources of data namely women, men, nurses and doctors; recorded the interviews and personally transcribed the recordings verbatim. I attempted to secure the participation of the partners of the women participants who had supported the women through the decision-making. They however were not keen on participating. I made repeated attempts but was unsuccessful. Field engagement, observation and triangulation exercises, and peer review builds credibility (Lincoln & Guba, 2000). Triangulation improves credibility of research. I used multiple sources of data collection namely women who had abortions, men

whose partners of family members had abortions, and health professionals, both doctors and nurses.

Transferability relates to the generalising or applicability of the findings which is also referred to as external validity in positivist research. Qualitative research does not claim the characteristic of generalising its findings. Rather the value of the context and the quality of the data is emphasised (Durrheim & Wassenaar, 1999). Transferability is achieved in a detailed report to enable readers to make judgment on the findings and how it relates to existing research (Lincoln & Guba, 2000). Triangulating multiple sources of data also enhances a study's transferability (De Vos, 2005). Triangulation in this study involved my obtaining data from various sources, as discussed, and the data has been analysed in its context. The findings do to a large extent represent the experiences of women, men, doctors and nurses with regard to abortion.

Dependability is equated to reliability, which is the repeatability of a study (De Vos, 2005). Qualitative research does not claim reliability since reality is always changing. Dependability refers to the trustworthiness of the findings that is, whether the findings did occur as the researcher claims. This involves detailed documentation of data, research methods, participants' experiences and decisions made during a project, as well as its end product (Lincoln & Guba, 2000). The interviews were recorded and transcribed verbatim to ensure accuracy and reliability of the scripts. This study meets this criterion.

Confirmability refers to the ability of the findings of a study to be confirmed by another, or whether the data confirms the general findings (De Vos, 2005). It replaces the conventional criterion of neutrality or objectivity (Lincoln & Guba, 2000). Reflexivity involves a self-critical account of how the research is done. This ensures neutrality of the research by explaining exactly how the research was conducted and the role of the researcher made transparent. I took cognizance of my own views on the abortion debate and consciously prevented my personal views from interfering with both the data collection

and data analysis. Triangulation exercises provide neutrality of data. I therefore used various sources of data as discussed above.

This study and the data presented are in line with credibility, transferability, dependability and confirmability as suggested by Lincoln and Guba (2000), and De Vos (2005).

6.10 Challenges and limitations

Every research project is presented with challenges. Problems may relate to any aspect of the research (De Vos, 2003). Challenges may include the method used to collect data, the selection of respondents, or the way in which data is presented. Limited time, resources, and availability of participants are also challenges often experienced by researchers (Mouton, 2006). The very presence and characteristics of the researcher affects the findings of the research. The researcher therefore needs to be aware of potential challenges and the effects it may have on the quality and validity of the results. Challenges presented in this study included:

- This being qualitative study generalisations cannot be made to all women who seek abortion, men involved in abortions and health professionals who provide the service. Qualitative studies do not lend themselves to generalisations. The strength of qualitative research however is that the data is analysed in context;
- In qualitative research it is difficult to replicate the study or to apply to settings outside of the research environment as the researcher is the primary instrument of data collection. The data obtained can only be used for analysis in its context;
- Obtaining permission from hierarchal structures to conduct the study at local service centres was time consuming;

- Doctors were not able to participate in in-depth interviews due to time constraints. Questionnaires were substituted. This did not yield the rich data as the in-depth interviews did;
- The sample was self-selective. Hence it may not reflect the population; and
- Securing the sample was difficult; it took much time and effort. I did anticipate difficulty in securing the sample and therefore used the media.

6.11 Summary

A qualitative research paradigm with an interpretivist, feminist design was used as it provided in-depth information on the psychosocial, ethical and religious considerations in abortion. In-depth interviews were used to collect the data from the women, men, a doctor, and nurses while a questionnaire was used to obtain data from eleven of the doctors.

A convenience, theoretical sampling technique was chosen. Use was made of the media (two community radio stations and a community newspaper) and abortion service providers from the Durban area to obtain the sample. The population selected was women who had abortions, men whose partners had abortions, and abortion service providers, both nurses and doctors. Written consent was obtained from participants. Because of the very sensitive nature of the study, ethics was a matter of concern and was given high priority.

The interview recordings were personally transcribed and information from the interviews organised into relevant themes that arose. The data was processed, analysed and compared to findings of other studies on abortion. Conclusions were drawn from the processed data. Chapters Seven and Eight analyse and discuss the findings of the study. The abortion decision and the subsequent coping with the consequences are affected by various interrelated factors, which are discussed in *Chapter Seven*.

CHAPTER SEVEN

ANALYSIS AND DISCUSSION OF RESULTS

7.1 Introduction

In-depth interviews were conducted with 15 women and five men who volunteered to participate in the study. Twelve doctors and eight nurses also participated. The purpose of this study was to obtain answers to the following key research questions:

- How is the abortion decision made?
- How do current contextual realities affect the decision-making?
- What role do religious beliefs, value systems and cultural values play?
- How is right and wrong negotiated within the context of religious and cultural expectations?
- What does motherhood mean?
- What does fatherhood mean?
- What support systems/structures are available?
- What is the potential impact of dominant discourses of motherhood and fatherhood on the abortion decision and on the consequences of abortion?

The study is based on feminist theory, which takes seriously the experiences of women. The analysis and discussion of the results are therefore in line with the feminist theory. Feminist theory takes into consideration affective and emotional components, other aspects that affect participants as presented in the data, and pays attention to the environment and the everyday events of ordinary women in an effort to acknowledge their daily lives (Kirsch, 1999). Critical discourse analysis (CDA) was used to analyse the data. It involves the deconstruction and interpretation of the data. CDA analyses written texts and spoken words to unveil sources of power, dominance, and inequality, and how these are maintained within social, economic, and political contexts (van Dijk, 1988). CDA is necessary for

describing, interpreting, analysing, and critiquing social life reflected in words (Luke, 1997). Feminist theory uses reflexivity to analyse and reflect on the responses from participants (Fulcher, 2012) to ensure the objectivity of the researcher.

Chapters Seven and Eight discuss the profiles of the women and men, and the health professionals, and analyse the data obtained from them. I include my observations as part of the reflexive exercise and/or to note possible discrepancies between what was said and what actually transpired during the collection of the data. These two chapters are structured according to the themes that were identified in the data. Chapter Seven analyses Theme One which is the abortion decision, while Chapter Eight analyses the other three themes identified namely the demonisation of women, the dichotomy of pro-life and pro-choice arguments and the structural constraints. Chapter also includes recommendations made by participants and a summary of the findings.

7.2 Profile of participants

7.2.1 Profiles of the women

This section introduces each of the women, all of who participated in face-to-face in-depth interviews. It reports on the most salient of issues as narrated by the women. As far as possible, major social criteria and issues are covered for each one of them. Pseudonyms are used.

Zanele was a 27 year old African female who was a member of the Zionist religion. She had failed her matriculation examination and did not return to school. Zanele was casually employed on an on-and-off basis at a local supermarket. She was a single mother of two children, aged five and eight years for who she received Child Support grants. She had no contact with the children's fathers. The Child Support grants were her only regular means of income. Zanele shared her parental house with her two sisters in Inanda. Her parents were deceased. She contributed towards the electricity costs and took responsibility for the needs of her two children. Zanele was involved in a casual relationship, which ended when

she learnt that she was pregnant and informed the reputed father accordingly. He refused to assume responsibility for the pregnancy. Zanele was reluctant to have another baby without support from the father. She believed that he would have not taken responsibility for the child and would not have provided for the child's material needs. She therefore decided on an abortion, which was performed in June 2012. I Interviewed her two months later.

Zama was a 26 year old African female from Kwa-Mashu. She was a Catholic but did not observe her religion very closely. She was a single mother of a nine year old child. Zama had fallen pregnant with her first child while she was in matric and had the baby the following year. The relationship with the father of the child ended due to personal differences. The child was in the care of the paternal grandparents from just over a year old to allow Zama to complete her studies. Zama had regular contact with her daughter. Zama was studying towards a degree through UNISA. Both her parents were deceased and she lived in the house of her late grandparents with her younger brother who was also studying. They were living off the scholarships that she and her brother received for their studies. Zama was in a stable relationship and hoped to marry her boyfriend. She became involved in another relationship during a brief separation from her boyfriend. When she fell pregnant from the new relationship she felt that she did not wish to continue the relationship with him for the long term. She therefore did not wish to have a baby with someone who she had no plans marry. Besides having a baby, the timing would have affected her ability to complete her studies, which she very much wanted to do. She therefore decided on an abortion, which was performed in June 2012. I Interviewed her two months later. Zama was on the contraceptive pill but had not taken it regularly when she fell pregnant. She had relied more on the condom.

Anita was a 22 year old Indian mother of two children aged three and six years. She was divorced from their father. Anita had fallen pregnant while still at school, terminated her schooling and married the father of the child. Their second child was born after the marriage, which later ended in divorce because her husband had been unfaithful to her. When she had begun a relationship with her new partner her parents asked her to leave the

parental home. She did so, leaving the children behind in the care of the maternal grandparents. Anita did not share a cordial relationship with her parents since the commencement of her second relationship. She did however go over to fetch and return the children during the weekends. Anita was from a Christian background while her partner was a Muslim. Both Anita and her partner were employed. Anita contributed towards her children's care. Although she was in a stable relationship, Anita felt that she was not ready to have another baby while she was not in a position to care for her two older children. She was concerned that a pregnancy and another child might build resentment in her two children. Besides, her relationship with her parents needed to be healed so that she would be able to take a new baby to them. She did not want her new baby to be deprived of grandparents. She therefore decided on an abortion, which was performed in July 2012. I interviewed her a month later. Anita was on the contraceptive pill at the time she had fallen pregnant and did not know how she had forgotten to take it. After the abortion she had take the contraceptive injection.

Zentle was a 21 year old African, single female. She was a Christian (Pentecostal) from a close-knit family who were regular churchgoers. Zentle completed her matric in 2011 and intended to study in 2013. She lived with her mother and siblings in their own house in Phoenix. Zentle was not employed and was dependent on her mother for her everyday needs. She was in a steady relationship with her boyfriend and planned to marry after completing her studies and after both have secured jobs. At the time of the interview her boyfriend was paying *labola* (a Zulu tradition where the male pays an amount – in cash and kind - as specified by the female's parents, as a gesture of goodwill for their care of the young woman, and as a means of indicating the seriousness of the relationship which will culminate in marriage) to her parents. He did however recently lose his job and was unemployed. Zentle did not want to disappoint her family with her pregnancy especially when they wanted her to complete post-matric studies. Having a baby at that stage would have meant that her mother would have to provide for the baby as well. She therefore decided on an abortion, which was performed in July 2012. I Interviewed her two months later. Zentle was not on any contraceptive as she said that she had not planned on becoming sexually active. She subsequently was on the contraceptive injection.

Mphilo was a 26 year old African female. She came from a Catholic background but did not go to church. She was a single mother of three children aged one, four, and eight years. Her first partner, the father of her first child was deceased. The oldest child was with her parents on the farm. The parents received a foster grant for him. The second relationship failed although the father of the second child did visit the family and had made marriage arrangements. The third partner, the father of the third child refused to care for the child. Mphilo completed her matric and was unemployed. She was dependent on the Child Support grants she received for her two younger children and was attempting to secure employment. Mphilo lived with her sisters and contributed towards the household expenses. She was once again involved in a casual relationship with the father of her youngest child. When he learnt of the pregnancy he told her that he did not want to have anything to do with it. He did not provide for the baby they already had and would not provide for the new baby. Besides he was involved in a number of casual relationships and would not provide a stable home. She therefore decided on an abortion, which was performed in July 2012. I interviewed her a month later.

Ruth was a 33 year old African single mother of a six year old child. Her family was in the Eastern Cape and assumed responsibility of her child. Ruth was a Christian (Methodist). She came down to Kwa-Zulu Natal for job prospects. She rented a flat in Newlands. At the time of the interview, she was attempting to secure employment. She did not complete matric and was experiencing difficulty in securing a job. Her family provided for the rental and her basic needs while she was attempting to secure employment. Ruth was HIV positive. She met her boyfriend in Durban. He was aware of her HIV status. When he learnt of her pregnancy he did not contact her again. She did not wish to burden her family with another child as they had already assumed full responsibility for her first child. Her other concern was the transmission of HIV to her unborn child. She did not want the child to be HIV positive. She therefore decided on an abortion, which was performed in July 2012. I interviewed her a month later. Ruth was not on contraceptives at the time of falling pregnant. I discussed the need for contraceptives. She subsequently decided to discuss

ligation with the clinic staff when she goes in for a follow-up appointment for contraceptives.

Stembile was a 20 year old African single student. Neither Stembile nor her family observed any religious or cultural practices. She was the only child for her parents who attempted to give her the best school and tertiary education. She had completed her schooling in 'Model C' schools. Her parents had great dreams for her. Stembile did not want to disappoint them in any way. She was in a stable relationship and planned to marry after she and her boyfriend graduated from UNISA where she was studying for a BA in psychology and he was studying for a Commerce degree. Although her boyfriend was not keen on the abortion he accepted her decision because she was determined to complete her studies. She therefore decided on an abortion, which was performed in July 2012. I interviewed her almost three months later. Stembile was not on contraceptive as she had not planned on becoming sexually active. She subsequently went onto the contraceptive pill.

Phindle was a 26 year old African single mother of a nine year old. The father of the child abandoned her while she was pregnant. She was from the Eastern Cape and had come to Durban for job prospects. Her family provided for her daily expenses including the rental of a flat in Durban. She was a regular churchgoer (Pentecostal). Her child, for whom she received a Child Support grant, lived with her. Since she was not able to secure employment even in Durban she chose to study through the Department of Labour, which offered free courses. She hoped to open her own business next year. Phindle was in a casual relationship, which she did not see as long term. She did not wish to have a child and bind herself to someone who did not care for her. Neither did she wish to care for a second child without a father. She therefore decided on an abortion, which was performed in August 2012. I interviewed her a month later. Phindile did not take contraceptives. She previously was on the injection and observed that it had made her gain weight. After the abortion Phindile was on the three-month injection. Phindle did not consent to my audio-recording the interview.

Vani was a 22 year old Indian, Hindu female. She was the younger of two daughters. Her older sister was married and lived independently. She came from a close-knit and very religious family. Vani's parents were very protective of her. She kept her relationship with a Muslim boy a secret for two years until she fell pregnant. On learning of her pregnancy her parents were adamant that she would not marry out of the religion and culture. The relationship with the boyfriend had to be terminated and she was forced into having an abortion. Vani had no choice in the decision and was experiencing difficulty coming to terms with the abortion and the termination of her relationship. She had the abortion in October 2012. I Interviewed her two months later. At the time of the interview, she was not on contraceptive as she had not planned on becoming sexually active. The relationship was over so she saw no need to use contraception. Vani did not consent to my audio-recording the interview.

Afika was a 20 year old African student from the Eastern Cape. She was a Christian (Anglican) and came from a family of regular church-goers. She came to Durban to study at a local college. She shared a flat in Durban with four other students. Her parents provided for all her needs. Her father had made it very clear to her and her two younger sisters that he would not accept any of them falling pregnant out of wedlock. Afika was afraid of her father who physically abused them when they disobeyed. She was in a stable relationship and hoped to marry when she qualified. Her partner was employed. Although he did not initially agree to the abortion, on understanding her fears he accepted and supported her through it. She therefore decided on an abortion, which was performed in August 2012. I interviewed her a month later. Afika depended on the condom as a contraceptive. She had heard that the oral contraceptives affected the body. Subsequent to the abortion she was on the injection.

Cheryl was a 23 year old single white female. She came from a committed Christian (Anglican) family. She however went to church occasionally. Cheryl was studying and lived with her parents. Although she did hold a part-time job she was financially dependent on her parents. Cheryl was in a committed relationship. Her partner was also a student. She wanted to be able to complete her studies before marrying and having a family. She did not

inform her parents of the pregnancy, as she believed that they would have objected to the abortion. The abortion was performed in September 2012. I interviewed her a month later. She was not on contraceptive as she had not planned on becoming sexually active. Subsequent to the abortion she was on the contraceptive pill. Cheryl did not consent to my audio-recording the interview.

Nerissa was a 27 year old Indian, Hindu female who lived with her family. Although she was employed she was very much a part of a close Indian family and emotionally dependent on them. Nerissa was in a relationship with a married person. She could therefore not have the baby and decided on an abortion, which was performed in October 2012. I interviewed her a month later. The birth of a baby would have damaged her relationship with her family, and her partner's relationship with his wife. Nerissa has since terminated the relationship. She was on the contraceptive pill and had defaulted. She did not consent to my audio-recording the interview.

Brandy was a 22 year old single white female who lived with her boyfriend. The couple shared a flat with their close friends. They did not have any religious affiliation. Brandy was studying and held a part-time job, while her partner was employed. She was financially independent. Besides holding a part-time job she had taken a loan for her studies. Her parents were aware of the abortion. They had left the decision to her. Brandy wished to complete her studies before having children to care for. She therefore decided on an abortion, which was performed in August 2012. I interviewed her two months later. She was on the contraceptive pill and had defaulted. Brandy did not consent to my audio-recording the interview.

Anne was a 20 year old African student from Northern KZN. She was a Christian (Pentecostal) who attended church regularly. She came down to Durban to study fulltime at a residential campus. She shared a flat in Durban with three other students. Her parents provided for all her needs. Anne got caught in double relationships. Her boyfriend went to work away from Durban and did not maintain contact with her. She did not expect him to return and therefore entered another relationship. She became sexually involved with the

person. Her boyfriend then returned the same week and they had sex. Anne was not sure as to whom the father of the baby was. She did not wish to make either of the two responsible for the pregnancy. She did not inform anyone of the pregnancy. She therefore decided on an abortion, which was performed in August 2012. I interviewed her two months later. Anne was not on contraceptives at the time she had fallen pregnant. She subsequently was on the three month contraceptive injection.

Natalie was a 27 year old white, single mum of two children aged six years and ten months. Natalie was employed and owned a house she has inherited from her parents. The relationship with the father of the first child was a casual one. Natalie was living with the father of the second child. They planned to marry soon. Her partner was a Muslim Indian. Both Natalie and her partner did not follow any religious faith. Their baby was just under a year. Natalie felt that she would not be able to cope with two babies. In the long-term too she would not be able to provide financially for another child. She therefore decided on an abortion, which was performed in September 2012. I interviewed her two months later. Although she was on contraceptives she was not regular with it and had decided on a ligation.

7.2.2 Profiles of the men

As with the findings of other feminist researchers (Sewpaul, 1995) it was far more difficult to secure the participation of men. Issues regarding reproductive health are considered primarily women's issues that men tend to distance themselves from, and men tend to be reticent to talk about emotional issues (Barker & Das, 2004). The men, who were recruited via calls in the media, preferred to remain anonymous, participated through telephonic interviews and chose not to leave their contact details with me.

Raymond was a 35 year old single, Indian, Hindu doctor. He ran a well-established private practice of his own. He had not been married and had no children. He had planned to marry his partner and care for his child. They had shared a relationship for two years. When she had fallen pregnant her parents forbade her from seeing him and had planned an abortion.

He had been emotionally hurt by her family's decision to abort the foetus despite his repeated requests for them not to do so. He attempted to obtain legal help but that was a bit too late. At the time of the interview he was still emotionally distressed although the abortion had been performed some five years ago. Raymond claimed that fathers needed to be given some voice in such decisions.

Ahmad was a 25 year old single Indian, Muslim. He was employed. Because of the religious differences between himself and his partner her parents refused to allow them to marry. When they learnt of her pregnancy they took her in for an abortion without discussing it with him. His parents were unaware of the pregnancy or the abortion. He believed that his parents too would not have approved of the relationship due to religious differences but that they would not have demanded an abortion. Ahmad was hurt by both the abortion and the termination of the relationship, which occurred in August 2011.

Alfred was a 23 year old single African male who was studying full-time at a local college. He was financially dependent on his parents. Although he came from a Catholic background he did not have any religious affiliation. Alfred was in a stable relationship with another student. Since they were both studying they were not prepared for the responsibilities of parenthood. They did not inform their parents for fear of repercussion in respect to financial support. The abortion was performed in October 2012.

Suren was a 42 year old Indian Hindu educator. He was married and had two children aged twelve and nine. Suren had a 'stable' marriage and wanted to protect his marriage. He had an affair with another woman who fell pregnant. On learning of the pregnancy he helped his partner through with an abortion. They have since terminated the relationship. Suren supported her through it and ended as friends. They do not contact each other. It was five years since the abortion. Suren continued to have recurring thoughts about the abortion, especially since it was performed on his daughter's birthday.

Jared was a 37 year old father of two children aged seven and nine years. He was married. Jared was affected by the abortion his sister was forced into. He was experiencing difficulty

in coming to terms with it. His sister had fallen pregnant and was forced to have an abortion by her partner's parents. This was done without the knowledge of her parents. The family only learnt of the abortion after it was performed in 2007.

Health professionals were also included in this study. In-depth interviews were conducted with one doctor and eight nurses, while eleven doctors completed questionnaires due to their time constraints. Four of the nurses interviewed were directly involved in abortion while the other four were involved in the nursing care of women who have had abortions and had been hospitalised. Nurses who volunteered to perform first term abortions were given the necessary training and placed in governmental hospitals. The hospital where this research was conducted had just one trained nurse to perform first term abortions.

7.2.3 Profiles of the nurses

Sister Joy was a 32 year old African single mother of two children aged six and ten years. She was a professional nurse/midwife and was employed on a full-time basis in TOP. Sister Joy was a Christian (Church of the Nazarene) and attended church regularly.

Sister Sandy was a 39 year old Indian mother of one child aged ten. She was a Hindu but did not observe its religious practices. She was a professional nurse/midwife and was employed on a full-time basis in TOP.

Sister Pinky was a 39 year old single African mother of one child aged 15. She was a professional nurse/midwife and was employed on a full-time basis in TOP. Sister Pinky was a Christian and went to church regularly.

Sister Lungie was a 30 year old single African mother of one child aged eleven. She was an enrolled nurse and was employed on a full-time basis in a TOP clinic. She was fully involved in the counseling aspect. This involved her being with the women throughout the procedure. Sister Lungie was a Christian. She attended church occasionally.

Sister Pretty was a 26 year old single African mother of one child aged 6. She was a professional nurse and was employed on a full-time basis in a hospital setting. The sisters rotate between various wards in the hospital. Sister Pretty was, at the time of the study, attached to the gynecological ward. Sister Pretty was a Christian and attended church regularly.

Sister Theresa was a 24 year old single Coloured mother of one child aged four months. She was a professional nurse and was employed on a full-time basis in a hospital setting. The sisters rotate between various wards in the hospital. Sister Theresa was, at the time of the study, attached to the gynecological ward. She was a Christian and attended church regularly.

Sister Simone was a 34 year old Coloured mother of three children aged four months, nine and twelve years. She was a professional nurse and was employed on a full-time basis in a hospital setting. The sisters rotate between various wards in the hospital. Sister Simone was, at the time of the study, attached to the gynecological ward. Sister Simone was a Christian and attended church regularly.

Rani was a 57 year old Indian mother of two adult children. She was an enrolled nursing assistant on a full-time basis in a hospital setting. The nursing staff rotates between various wards in the hospital. Rani was, at the time of the study, attached to the gynecological ward. Rani was a Christian and attended church regularly.

7.2.4 Profiles of the doctors

Dr. Hoosen was a forty year old Indian Muslim doctor employed on a full-time basis as a TOP doctor. He was married with three children.

The following doctors were employed in a hospital setting. The doctors in hospital rotate between the various wards. These participants were, at the time of the study, attached to the gynecological ward.

Dr Des was a 35 year old, Black male, married with three children. He held the position of medical officer in the unit. He was a Christian.

Dr Raven was a 30 year old single, Indian, Hindu male.

Dr. Blessing was a single, Black male. He was a Christian.

Dr. Thulani was a 28 year old Black married male. He had no children. He was a Christian.

Dr. Hoosen was a 25 year old Indian Muslim female, married with no children.

Dr. Vanessa was a 34 year old Christian female, married with three children.

Dr Premi was a 39 year old Indian, Hindu female, married with three children. She holds the position of Medical Officer-Registrar.

Dr. Haseena was a 36 year old Indian Muslim married female with three children. She was a consultant in the unit.

Dr. Raesa was a 38 year old Indian Muslim female, married with one child. She was a consultant in the unit.

Dr. Lauren was a 25 year old single, Indian Hindu female. She was an intern at the hospital.

Dr. Jamie was a 28 year old Indian Hindu female, married with no children.

7.3 Analysis and discussion of results

7.3.1 Demographic data of all participants

Twenty participants constituted the primary sample for this study: fifteen women who had abortions and five men whose family members had abortions. The ages of the women participants are presented in Table 7.3.1.1 below.

Table 7.3.1.1 - Age of women who had abortions

Age	Numbers
19 – 20	3
21 – 25	6
26 – 30	5
30 – 35	1
Over 35	-
Total	**15**

The women's ages extended from 19 to 35 years with the majority belonging to the 21 to 25 year age group. With a total of nine women falling in the under 25 age group, this group represents 60% of the respondents. South Africa does not have available detailed statistics on abortion. The statistics as provided for 2009 by the Marie Stopes Clinic in South Africa indicated the following: 36% were in the 17 - 20 age group and 64% were in the 21 - 24 age group. The majority of participants in this study fell into the 21 - 25 and the 26 - 30 age categories. While the sample size was too small to draw any conclusions from, it is interesting to note that there were no women in the above 35 year age category in the Marie Stopes statistics. Yet, 40% in the current sample were over 26 years of age. Given the nature of the sampling and the voluntary nature of the participation, the study does not reflect the general population at the Marie Stopes Clinic. It is possible that teenagers and young adults

did not feel emotionally ready to share their experiences or felt threatened to talk about the abortion. The ages of the male participants are presented in Table 7.3.1.2 below.

Table 7.3.1.2 - Ages of men whose partners or family member had abortions

Age	Numbers
18 – 20	-
21 – 25	2
26 – 30	2
30 – 35	-
Over 35	1
Total	**5**

The ages of the male participants extended from 18 to 35 years. The marital status of both male and female participants is presented below in Table 7.3.1.3.

Table 7.3.1.3 – Participants' marital Status

	Single	Married	Divorced/separated	Cohabiting	Total
Women	13		-	2	**15**
Men	3	2	-	-	**5**
Total	**16**	**2**	**-**	**2**	**20**

Sixteen of the participants were single, while two were married and two were cohabiting. Both women who were cohabiting were living with their partners who were responsible for, and knew of the pregnancy, and had consented to the abortion. The number of children that the participants had is presented in Table 7.3.1.4.

Table 7.3.1.4 – Number of children that participants' had

	Have children	None	1 child	2 children	3 children
Women	7	8	3	3	1
Men	2	3		2	
Total	**9**	**11**	**3**	**5**	**1**

Nine participants had children of their own while eleven had none. Five had two children, with one having three children. The ethnic group of participants is presented in Table 7.3.1.5 below.

Table 7.3.1.5 - Ethnic group of participants

	African	Indian	White	Total
Women	9	3	3	**15**
Men	1	3	1	**5**
Total	**10**	**6**	**4**	**20**

In keeping with the demographics of South Africa, the majority of participants belonged to the African ethnic group. This was also an adequate reflection of the ethnic groups that used the service in the Durban metropolitan area. The level of formal education of participants is presented in Table 7.3.1.6.

Table 7.3.1.6 - Educational level of participants

Formal education	African		Indian		White	
	Female	Male	Female	Male	Female	Male
University Degree				1		1
Completed College			2			
Presently at University	3				2	
Presently at College	2	1				
Completed matric	2			2	1	
High School without matric	2		1			
Primary School	-	-	-	-	-	-
Total	9	1	3	3	3	1

All participants had completed their basic primary school education. Only three ot hem did not go ahead and complete their matriculation. Twelve participants have undertaken post-matric studies. Table 7.3.1.7 below presents the religious affiliation of participants.

Table 7.3.1.7 - Religious affiliation of participants

Religious Group	Women	Men	Total
Muslim		1	1
Hindu	2	2	4
Anglican	2		2
Catholic	2		2
Methodist	1		1
Zionist	1		1
Pentecostal	3	1	4
No affiliation	4	1	5
Total	15	5	20

Participants represented all the major religious groups existent in South Africa. Five participants had no religious affiliation.

7.3.2 Demographic data of health professionals

Twenty health professionals participated in this study. The eight nurses were all females very much in keeping with the demographics of the nursing profession which is predominantly female in South Africa. There was an equal balance with the twelve doctors: six males and six females. The demographic details are presented in Tables. The gender of the health professionals is presented in Table 7.3.2.1 below.

Table 7.3.2.1 - Gender of the health professionals

	Male	**Female**	**Total**
Doctors	6	6	12
Nurses	-	8	8
Total	**6**	**14**	**20**

Fourteen female and six male health professionals participated in the study. The majority, namely eight of the female participants were nurses. With nursing being predominantly a ‘female’ profession, all nurses in the service centres that participated in the study, were females. The medical doctors equally represented both genders. The ages of the health professionals are presented in Table 7.3.2.2.

Table 7.3.2.2 - Ages of the health professionals

Age	Doctors	Nurses
21 - 25	2	1
26 - 30	3	2
30 - 35	6	2
35 - 40	1	2
Over 40	-	1
Total	**12**	**8**

The ages of the doctors ranged from 20 to under 40 years, while that of the nurses ranged from 20 to over 40 years. The two younger doctors were inters at the hospital. The marital status of health professionals is presented in Table 7.3.2.3.

Table 7.3.2.3 - Marital status of health professionals

	Single	Married	Divorced/separated	Cohabiting
Doctors	2	8	-	2
Nurses	4	4	-	-
Total	**6**	**12**	**-**	**2**

Four of the nurses were married and four were single. Eight of the twelve doctors were married, two were living in stable relationships, and two were single. Table 7.3.2.4 below presents the number of children that the health professionals had.

Table 7.3.2.4 – Number of children health professionals had

	Have Children	1 child	2 children	3 children	4 children
Doctors	6	1	1	3	1
Nurses	8	5	2	1	
Total	**14**	**6**	**3**	**4**	**1**

All eight nurses had children. Six of the doctors had children. Five of the health professionals had three children or more.

7.3.3 Thematic analysis of the data

This section is presented according to four broad themes that emerged during the analysis of the data namely: the abortion decision, the demonising of women, the pro-life/pro-choice dichotomy, and the structural constituents of women's choices. The first theme, that is, *the abortion decision* will be discussed in this section. The other three themes will be discussed in the subsequent chapter, *Chapter Eight.*

7.3.3.1 The abortion decision

The abortion decision is a complex and emotionally laden one as was found by Lakartidningen (2005) and expressed by Zama, *"It was a big decision"* and Nerissa *"It was a hurtful decision."* Nerissa indicated much pain in making the decision. It being a 'big' decision for Zama indicates the seriousness with which the decision was taken, and the complexity of the decision, where various psychosocial considerations impact the abortion decision. These are analysed in this section. Moral dilemmas and the context in which abortion is decided on vary with each person. Factors, both psychological and social, and their interrelatedness influence the decision (Lorincz et al., 2001). Several significant sub-themes related to psychosocial considerations in making the abortion decision, which emanated from the data, are discussed.

Abandonment/absent fathers

Within the social constructs of pregnancy, child-birth and child-care being women's responsibilities, many men in South Africa abandon their partners during pregnancy, leaving them to fend for themselves (Morrell & Richter, 2006). Zanele's story represents the experiences of other participants in this regard which confirms the findings of Morrell & Richter (2006):

> *When I found out that I was pregnant I called my boyfriend and told him about it. He didn't like it when I told him I was pregnant. He said that he didn't want anything to do with it. I said what I am supposed to do. He said that he doesn't know. We never spoke since the day that I told him that I was pregnant. He never came to me. Even to today. He does not know I did this. I don't want to see him no more.*

Zanele's partner asserted that "he didn't want anything to do with it" and that "he doesn't know" thus placing the responsibility for the pregnancy on Zanele, who was unemployed and poor. This discourse privileges men into abandoning their partners and evading responsibility leaving women to cope on their own. Women too have internalised this and have come to accept responsibility of falling pregnant and coping with the consequences of the decision to the extent that is has become, to use the metaphor, described by Sewpaul (2013a), 'inscribed in our blood'. Zanele's feelings of hurt and disappointment are palpable as she describes shifting from a position of having a boyfriend that she thought cared for her to being totally abandoned to the point of "we never spoke since the day" and being left to deal with the pregnancy alone.

When Ruth informed her partner that she was pregnant *"everything changed. He never phoned me, never did anything. I never saw or heard from him again."* In the case of Ruth too, the disclosure of the pregnancy "*changed everything,*" including his love for her. Ruth's partner too did not even telephone as a courtesy to check on her well-being. Do the men who abandon their women when they are pregnant really care for their partners? In keeping with the social and cultural pressure of being macho, men continue their sexual exploits of women leaving them to decide what to do with the pregnancy, or the subsequent birth of the child.

Men assume that it is up to women to decide what to do with pregnancies, or the subsequent birth and care of children. In Umlazi, south of Durban, only 7 000 from the 67 000 men ordered to pay maintenance towards the care of their children in 2002, complied. This

affects all socio-economic groups, and men from various social status in South Africa (Morrell & Richter, 2006), where they not only refuse to pay maintenance, but also refuse to acknowledge the existence of their children.

This leads to women having to assume sole responsibility, including financial responsibility for the family. In South Africa female-headed households are a common feature. Since women generally hold lower paid jobs than men this implies that even where women are employed in women-headed households, the family experiences financial hardship. More than finances are, however, needed in caring for a family and women are frequently left to carry the burden all on their own. Women have to take these realities into consideration when making a decision as to whether to continue with the pregnancy. Women who already had children and experienced hardship in providing for their existing families did not wish to have the experience repeat itself, nor have their present children suffer to a greater extent. Furthermore, raising children is no easy task. Babies grow up to become teenagers who, without adequate structure and care, can become teenagers-in-crisis with possible abuse of drugs and alcohol (Bhana & Bachoo, 2011).

Health professionals who witnessed the abandonment of women and children decided to perform abortion out of humanistic concerns for children and women. They were concerned by the many babies and children who are not just being abandoned by the fathers but by the mothers as well because of circumstances. Therefore health professionals too, considered abortion an act of responsibility by the woman, rather than allowing a child to suffer. They were concerned about babies that are being abandoned soon after birth, and about those babies being murdered by women because they are unable to care for their babies, as indicated by Dr Premi, "*Abortion is better than bringing babies into the world to be abused or neglected,"* and Dr. Hoosen: "*They require help. Or those people will deliver the baby and abandon them. That will be the end result. Like what is happening with cases in Soweto – they deliver in the toilet pit and walk away. So the end of the day the baby that comes full formed and does not get, at the end of the day, what is required from the parents."* Dr Hoosen made a decision to perform abortions by comparing abortion against the babies abandoned and decided that it was the 'better' choice from the two options.

It is an irony that in the face of the dominant discourse of men being protectors and providers of their families that men abandon their partners and children, and do not pay for child support; and that women are left to literally carry the baby. Child abandonment has become a feature in South Africa where 2,583 babies were abandoned in 2011, an increase of 36 % from 2010 (Chaykowski, 2013). Yet women are the ones, and not the men, who are demonised by society for the pro-abortions choices that they are often forced to make.

Still studying

Women who have the privilege of studying do not wish to forgo the opportunity. Coming from disadvantaged circumstances where women were deprived of even basic education, women focus on attempting to build a better future for themselves and their prospective families. Despite South Africa's transition to democracy many children are still deprived of basic education. Many young adults, who go on to complete matric, cannot afford to pursue tertiary education for various social and financial reasons. As mentioned earlier 25.5% of the country's labour force was unemployed as at September, 2012 (Statistics SA, 2012). Still a large portion of the SA population has very little if any formal schooling. Education is stratified as in all developing countries (Buchmann & Hannum, 2001). This makes it even more difficult for the lower-income group to secure employment (Iheduru, 2004; Du Toit, 2005) as was the situation with participants in this study. Where efforts were made by the democratic government to level the educational playing field, it is higher income groups of Blacks, which comprise a small percentage, who have benefitted. Therefore women, who do have the opportunity, wish to complete what they had embarked on, like Zama who said: *"I'm studying at the moment – a baby is just gonna you know… I place my studies first," and* Phindile who stated that, "*I am studying - It will hinder my present plans for making a future for myself and my son.* Stembile too, viewed her present circumstances as affecting her in the long-term: *"I am still studying. I did look at it in the long term, 19 and a baby and it would have been a big problem."* These participants considered their future and that of their present/future families in the long-term.

Education and economic upliftment of women are necessary not only for the improved lives of women but also for the well-being of families and for the economics of any country. When women are able to contribute for their own care and those of their children, they are in a position to rear their own children to provide for themselves. Hence women are able to break the intergenerational cycle of poverty. Education, economic upliftment of women, and access to resources and development may reduce fertility and child mortality, expand education and reduce poverty of the next generation. It contributes to the economic growth of the country by advancing the well-being of its participants (Klasen, 2002). Where women in this study chose to complete their studies, they did so to be able to participate in the open labour market. As citizens, they have made a responsible choice. They chose not to have children in the immediate, but when they were in a position to be able to take care of, and to provide for a child.

HIV Status

Being HIV positive is one of the considerations in the decision. Women who are HIV positive may choose not to have another child for fear of HIV transmission to the child, or of their own demise and the child being left an orphan, or that they may become too sick during the pregnancy (without the medication) and die leaving their existing children without a mother (ICW, 2008). This finding was confirmed with the concern of Ruth who stated that: "*I took the decision because I am positive. Sometimes your baby might be positive. That is why I had the abortion."* Ruth's main concern was that of her unborn – she did not want her baby to become HIV positive. This is the concern of many women who are HIV positive. Although there is medication available to prevent the mother-to-child transmission during pregnancy, many women are unaware of this. With the recent developments in medication for HIV there is now available in South Africa a single dose medication, antiretroviral prophylaxis, which can, during breastfeeding, be administered to either the mother or to the baby, and which has the same medicinal properties as previously administered medication (De Vincenzi, 2011). Although made aware of the medication by the clinic sister who subsequently referred her for the abortion, Ruth was reluctant to opt for medication. She had not heard of the medication or of its effects from other women,

and did wish to risk transmission of HIV to her unborn. She stated that '*I hear so many stories if you are positive'.* Abuse is visible where medication for HIV does not timeously reach those affected on the ground because of inadequate funds allocated for the treatment or because of misappropriation of funds on various levels where adequate funds are received (van Niekerk, 2001). Ruth's personal circumstances too, did not allow her to risk any possibility of her child contracting HIV.

Partner is married

Becoming pregnant by a married man is taboo from a moral point of view. Such a pregnancy has consequences for a range of people beside for the woman herself. Women therefore are forced to secrecy. The choice to abort is linked to the need to save herself and those close to her from shame and embarrassment. Nerissa took into consideration the man's family and their protection: *"He is married, and we are not married to each other. Only that mattered."* Nerissa was concerned about her partner, his marriage and his family life. With her partner being already in a marriage, it meant no future for Nerissa with him. Besides she would not have had the blessing of her parents. In considering all her relationships, Nerissa was forced to end the pregnancy. She chose her long-term relationship with her parents, and her partner being able to preserve his family life, over having a child out-of-wedlock with a partner who was already married. Nerissa placed the needs of others above her own.

Coercion

Women are often coerced, for various reasons to abort a pregnancy (McFarlane et al., 2002a; Reardon, 2002; Rue et. al., 2004). This was the situation with one participant in this study who had no choice but to succumb to her parents' decision although she very much wanted to continue with the pregnancy. The parents disapproved of the relationship with someone from another religion. According to Vani:

> *My parents insisted that I have the abortion. I did not want the abortion – my father forced me into it. He told me that I would have to leave the home and never enter his life again. My mum could not say anything. But I know that she supported him because she too was upset that I had a Muslim boyfriend. I did not choose the abortion – and my boyfriend wanted the baby. He is working and would have been able to support the baby. I am also working – we would have managed. My dad was very angry when my mother told him that I was pregnant. He became even angrier when I told him that my boyfriend was a Muslim. He did not even want to meet him. He just insisted that I have the abortion.*

Vani had no voice in a very personal decision that affected her body, her life, and her future. South Africa which is called a 'rainbow nation' is separated and divided along religious, class and ethnic lines. Whilst religion on the one hand calls for love, unity and oneness especially in an already historically divided society, and brings diverse peoples together, it also drives people apart. Religion can therefore be a source of disunity, conflict and discrimination as evident in the case of Vani. Individual cases are reflective of the broader dynamics of society (Hartmann et al., 2011). Vani's father became *'angry'* about the relationship. Ethnic and religious differences give rise to anger and different forms of violence one of which is coercion to abort against one's wishes. The father 'insisted' on an abortion. He did not even consider the level Vani was at, reflecting yet another instance of male domination. Vani chose to preserve her relationship with her parents by conceding to their demands instead of going ahead with the pregnancy. One of the male participants too, voiced how his sister was coerced by her boyfriend's parents to terminate the pregnancy. This she succumbed to without the knowledge of her parents or other close family members.

Small baby or too many children

The discourse of women being considered the primary child-minders and primary caretakers of the home, places both physical and emotional demands on women especially where women hold responsibility of outside jobs as well. The historic and patriarchal view of women being the primary house-minder (Douchet, 2000) has not changed sufficiently to accommodate women who hold outside jobs. Women therefore, over and above work responsibilities, still assume a large portion of the responsibility of the home. Having very young children or already having the desired number of children impacts the abortion decision. Radical feminists concern themselves with this uneven distribution of work (Enns, 207). With the major burden of family responsibility falling on women, it becomes difficult for them to cope. This stress and difficulty in coping with the present responsibilities contributes to the abortion decision as expressed by Natalie who was employed: *"My baby is ten months old – I fell pregnant too soon. There was really no option of having the baby."*

Relationships

Women need support through pregnancy, childbirth, and in caring for a child. Raising a child is both a huge responsibility and a demanding, enormous task. Although women may initially accept the pregnancy, a lack of social support may contribute towards the decision to end the pregnancy (Stotland, 2001; Jones et al., 2007). Where the relationships are casual, abusive, unstable, or financially unsupportive, women may resort to abortion to relieve themselves of the stress of the relationship (Nakano, et al., 2004). Four participants in this study had poor social relationships with the partners just prior to the abortion. Three were abandoned by their partners as discussed under *Abandonment.* Domestic violence and its severity is a predictor of abortion (Whitehead & Fanslow, 2005; Kaye et al., 2006).

Women were afraid of family members learning of the pregnancy. Amidst the possibility of rejection and/or violence a decision had to be made. In such instances abortion becomes not only an individual decision but also the only option for women. Women who experience

violence are afraid of exposing both themselves and those close to them to further acts of violence. They are forced to make decisions to protect themselves as was the case with Afika. Afika's narrative spoke of substance abuse and domestic violence that contributed to her decision to abort. She said:

> *My dad drinks a lot. We are three girls at home. I am the oldest. He usually says if one of us gets pregnant, he'll kill them or throw them away from home. When I thought of those things I just couldn't, I just couldn't keep my baby. And I thought of my mum. She would suffer for my consequences. While I was growing up my father used to hit me and my mum. I just couldn't, just couldn't allow that.*

Zentle and Zanele too were afraid of the reaction of their families to the pregnancy. Zentle stated that, '*I was scared that my mother will kill me', and* Zanele, '*If my sisters know they are going to kill me'.* The severity of the domestic violence too is related to abortion (Kaye et al., 2006). Both Zentle and Zanele used the word *'kill'* indicating the passion with which their families would react to them. They were afraid of the reaction.

Family and partner violence, as a structural constraint, is also a predictor of abortion (Whitehead & Fanslow, 2005; Kaye et al, 2006). The internalised, patriarchal values of society contribute to men treating women as inferior and as property over whom they have control. Females are attributed the status of children and have to 'listen' to the male (Dickerson, 2013). This was evident in the case of Zama:

> *He was emotionally abusive. He used to say 'you listen - you are a woman, you must know your place. When I am talking you must shut-up.' If a person is making you feel inferior then how can you share something with a person like that? So that's one thing that put me off about him - he doesn't want me to speak my mind. If I don't like something I can't say it because he's gonna tell me he's the man, I must listen to him so I don't have to say anything. If he says this or that, it is what he says or nothing at all. Sort of like controlling so I decided to get rid of him. So*

> *as soon as I got rid of the baby I got rid of him. So the relationship with him also affected my decision to abort.*

The gendered power imbalances are clear in the above, where Zama was expected to be passive and compliant. But Zama indicated that she did not wish to submit to a controlling partner, and that by terminating the pregnancy she could terminate all ties with him – '*get rid of him*.' She took control of her own life. Making a decision to abort was, for her a manifestation of her strength and agency, reflected in the power of her words: *"as soon as I got rid of the baby I got rid of him."*

Women who had negative and painful experiences with their previous or current partner in respect of caring for their children may fear a repeat of the past (Jones et al., 2007). Phindile, for example, stated that:

> *I have an eight year old son whose father abandoned both of us when the baby was born. I was left to be both a mother and father to the child. I have an unstable relationship with my partner. He visits me whenever he chooses to. He is never there when I need him for anything.*

Phindile was forced to play a double parental role, which became very demanding. Zama's past relationship also impacted her decision. She stated that: "*When I see my child (my daughter) I remember what I went through with the father. I didn't want this again."* Anita too was afraid of a repeat of the past experience. Although she was in a stable relationship, Anita carried the fear of the possibility of being abandoned yet again, proffering this to be one of the major factors in her abortion decision. Anita said:

> *I was previously married. My husband was having an affair. We separated after our first child. We later reconciled and had our second child. He did the same again and we got divorced. I had to go through so much. I cannot imagine what my children went through. I don't want to bring a child into this world now not being*

married and not having that grounding for three children because if he decides that he wants to leave one day and walk out what happens to me and the child?

After being hurt by her husband the first time, Anita attempted to reconcile with her husband. She was, however, once again hurt. The marriage ended in divorce. She expressed the pain that both she and her two young children had to subsequently endure. Anita did not wish a repeat of this with three young children having to endure pain. Anita carried the fear of the possibility of being abandoned once again when she said, "*if he decides that he wants to leave one day and walk out what happens to me and the child?"*

Anita experienced difficulties in her relationship with her parents and wanted this healed before having children in her new relationship. She stated that: "If *circumstances were different, if they accepted my relationship, if I had a good relationship with the family, I don't think that I would have even considered it. Because financially I could do it, emotionally I could do it because I have grown emotionally so much because of my two sons so it never would have been a problem. And I love children and I am used to having my two sons around."*

Support

The abortion decision is even more intense where there is the absence of support of their partners, close family members and/or friends. Women often cannot, and do not, confide, in their own family members, about the pregnancy or abortion as was evident with participants in this study. The secrecy of abortion is discussed later in this section under *Stigma*. The type of relationship one shares with friends and close family members, and the wider social network influences decisions of a personal nature (Baker et al., 2003). Zama had the support of a friend. She noted that *"I feel like if ever I need somebody to talk to, my best friend is always there for me and she will never judge me."* Not being judged was very important to Zama. She was glad to have found that in her friend. Zanele too was fortunate to have the support of a friend but wished that she also had the support of her family:

> *I shared this with my friend. My friend normally agrees with me in each and everything. She said that 'it is your decision I am not going to make any decision for you. If you thought about it, it's fine. I will not say anything. If you want to talk about it, it is fine'. She is supported me with the decision. My friend is still there for me. I was not free to go to anyone else. I wish that I did have the support of my sister. I wish that there were older people around who will give us more advice. If I had a mother I will go to her and ask her what I should do.*

Zanele too valued her friend's non-judgemental support of the decision she had made. The participants also appreciated the opportunity to share their stories in a safe, non-judgemental environment with me during the interviews. Negative attitudes of those around also have an adverse effect on the decision (Ekstrand et al., 2009). Mphilo was afraid that her family would reject her. She stated that: "*The people at my home they won't accept me with a 4th child. My sisters, even my mother and father at home. He (the present one) is the father of my third child and does not support me. They will be angry.* Although Mphilo knew that they will be angry with the pregnancy, she did understand their views and their subsequent feelings towards her pregnancy. Her continuing her relationship with a partner who did not accept responsibility for their child, who was one year old and still needed diapers and milk, would have upset them.

Stigma

There is great secrecy surrounding the pregnancy and the subsequent abortion decision, making the abortion decision a private one. Secrecy is maintained both with the pregnancy and the abortion (Engelbrecht, 2005). Male participants who had supported the abortion decision too did not disclose the pregnancy or the abortion. Secrecy of the abortion may be due to guilt arising from the belief that what is being done is morally wrong (Engelbrecht, 2005), an overwhelming sense of shame resulting from and stigma attached to, and/or the dominant discourses on pregnancy out-of-wedlock. The norms and values of the family and the community influence one's decision in personal issues (Baker et al., 2003; Ekstrand et al., 2009) and fear of family and societal reactions force many women not to disclose both

the pregnancy and the subsequent abortion as was evident with participants. Several participants mentioned that they would be 'gossiped' about in the community as represented by Zentle who stated that, '*people would start looking at you differently and start giving you different names. Labeling you and stuff like that'*. All participants in this study felt that what they did was wrong and wished that they did not need to do it. Their circumstances however dictated otherwise.

Social class or social standing of a family in the community affects individual family member's behaviour and choices (Anstee, 2009). Families concerned about their reputation in society are less accepting of their daughters' out-of-wedlock pregnancy. To protect their status in society, family members make demands that would enable this. Vani stated that: *My parents did not want other family members to know that I had a Muslim boyfriend.* The family's standing in the community impacted their decision as was with Nerissa *"My family's name is important to them. A pregnancy and a baby while I am unmarried will let them down" and* Zentle as well: *"My mother will be embarrassed by the church people."* Yet, there is the possibility that the same families would not be affected by their sons' out-of-wedlock pregnancies. Parents were found to be more accepting, if not encouraging, of their son's sexual interests than their daughter's (Leary & Snell, 1988). To protect their status in the community, Vani's parents coerced her into having an abortion: *My dad was very angry when my mother told him that I was pregnant. He just insisted that I have the abortion.* Objection from the family was the fear of Anita who said: "*The pregnancy would have driven my parents further away from me.* Abortion was used to protect the social status of the parents.

Participants noted that although organisations did exist in their communities they did not turn to them for help and support, or to discuss their feelings and concerns because, they believed, their issues would not be treated in a confidential manner. When members of the community do get to know about the abortion they gossip and pass funny and hurtful comments. A number of the participants feared gossip, as mentioned above. Gossip results from, and leads to further stigma. Stembile stated that: '*In communities like back home people would start looking at you differently and start giving you different names - so it not*

really easy being in a Zulu culture and having a person saying that I had an abortion'. While Stembile linked her experience to the Zulu culture, such stigma permeates the various racial, ethnic and language groups in South Africa. Zama did not wish to be judged by the people in the community and therefore felt that if she had to access support, it would be from those she did not know or would not meet in the community. She stated that, '*If I have to go to a support group I will go. But I don't want to go to where there are people I know – people who are gonna judge me. I'd rather go to people who are strangers where I can be free - not a person that's gonna tell me 4 or 5 years from that time 'hey you killed your baby'.* Zentle too did not wish to be judged. She stated that:

> *Some people can be judgemental - you can talk to them now but then in the future one mistake you do they tell you about all the bad things you've done. Some people can hide their real self from you – they can pretend to be nice but they are not.*

Many participants were reluctant to discuss their abortion because people gossiped about such matters. For most participants it was important what other people knew and thought about them. Zama was afraid of being labeled and judged by being told *'hey, you killed your baby'.* They therefore did everything they could to prevent neighbours and others from gossiping about them. Zama chose not to go to a support group even if one was available in the community, while Zentle stated that, *'I'm quite happy on how I made the decision (without involving others)."* The need for secrecy of the pregnancy and the abortion is indicative of the various levels that women are oppressed. While the different cultures and religious groups in South Africa highly value the birth of a child, a woman pregnant out of wedlock is frowned upon. This was voiced by Nerissa who stated that *"He is married, and we are not married to each other. Only that mattered."* The dominant discourse in society is that children are a blessing but within the context of marriage. Children born out-of-wedlock are referred to as 'illegitimate', often described by the derogatory term 'bastards' (Merriam-Webster Online, 2013). Social stigma is so powerful that it was extremely difficult obtaining participants for the study. Participants did not reveal the pregnancy or abortion to anyone except to the partner where they were still in a relationship, and participants could not share their post-abortion experiences with anyone.

It is ironic that while childbirth and children are celebrated in all cultures in South Africa (Hinduism's Online Lexicon, 2002; Hilton, 2007; Mwenye, 2010; Every Culture, 2012) there is such enormous stigma attached to pregnancy out of wedlock. The dominant discourses on what constitutes the ideal (generally conceptualised as the Western nuclear, two-parent family) needs to be challenged, deconstructed and reconstructed, as discussed under Recommendations, to allow every child born to be a wanted, loved child. Children should not be equated with fear and shame.

Health professionals too, maintain secrecy because of societal discourses, as made explicit by the voice of Sister Sandy:

> *My family, although a close-knit family, does not know. They do not know what I do. I have not told them. Even my child does not know. My husband knows and he supports me. In time I would let my daughter know what I do. I would tell her that I am working at an abortion clinic. And I will explain to her the reason why I have chosen to be here. She is still very young for me to tell her now. I think about this all the time. In time maybe I will do education and admin and get out of here so there will be no need to tell her. I think about all that. That is my dilemma - to tell my child. Being a girl as well …*

Unlike Dr Hoosen who was able to separate his professional life from his personal life, Sister Sandy was unable to do so. In commenting about our efforts to maintain neutrality and the separation from the professional and the personal self. Bauman (1993) makes the following poignant comment:

> [...] it does not always feel like that at all; not all stains incurred on the job – 'in the course of the role performance' – stay on the work clothes alone. Sometimes we have the unsavoury feeling of some of the mud spilling on our body, or the fatigues sticking to our skin too tight for comfort; they cannot be easily peeled off and left behind the locker [...] Away from mere 'role playing',

> we are indeed 'ourselves', and thus we and we alone are responsible for our deeds (p. 19).

For Sister Sandy it was not just a job; she seemed to experience shame and embarrassment so much so that she considered opting out: "*My family, although a close-knit family, does not know. They do not know what I do. I have not told them"* and that "maybe I will do education and admin and get out." Yet Sister Sandy had volunteered to be trained for the job after witnessing many young women suffer complications from unsafe abortions. The job however, did affect her to the extent that she stated: "*That is my dilemma - to tell my child. Being a girl as well…"* Her possible fear could be that her daughter, *"Being a girl as well," when* learning of her mother's job, may interpret it as permission for abortion being granted to her. Sister Sandy's situation is indicative of the inherent dilemmas in moral reasoning. It is easier to make moral decisions when one is not directly affected by the decision, or when the consequences are distal. As discussed earlier, where the dilemma is personal, decision-making is approached differently (Jaffee & Hyde, 2000; Haviv & Leman, 2002; Juuvari, 2006).

One nurse reported that she felt isolated and that other nurses did not readily socialise with her. She had to make the effort to integrate into the group or was completely left out. She occasionally heard negative comments made in passing about her job. This is in keeping with the findings of WHO (2010) where health professionals who performed abortions are frowned upon by colleagues.

Religious and cultural values

The overwhelming discourse in South Africa, determined by history, context, religion, culture and medical evidence, is a pro-natalistic one. Commitment to a particular set of values guides both the process of the decision-making and the implementation of the decision (Hinman, 2013). The norms and values of the community also influence one's decision in personal issues (Baker et al., 2003; Ekstrand et al., 2009).

In providing the values and principles for life religion does, in a rather direct way, act as a source of reasoning especially in moral and ethical issues, and indirectly controls social behaviour. The extent to which religion affects one's attitude and stand on moral issues depends on one's adherence to religious values and teachings. Certain religious denominations that have strong pro-life commitment are the most likely to disapprove of abortion (Elm et al., 2001; Anstee, 2009) compared to groups, which do not emphatically state their views. Zanele stated that: *"They say that a child is a gift from God so whenever God feels like giving you a gift you must accept that gift."* But Zanele's circumstances led her to choose to abort even against her religious prescription that *"a child is a gift from God."* Anne felt like a *"murderer"* because of the discourse of her religious teaching. She voiced that, "*In terms of my religion I think that I am a murderer – that's what I'm thinking. My religion teaches that I killed someone- my flesh and blood. I killed my baby. That is affecting me."* Anne judged her action by her religious teaching and considered herself a *'murderer'.*

Many of the participants, although aware of their religious teachings, allowed their circumstances to supersede their religious and cultural values, or as in the case of Vani, coerced into it. Vani stated that: *Hinduism is against abortion – a child is a creation of God and has a purpose. He may be a reincarnation of someone close to us. My parents shouldn't have made me do something that is wrong in God's eyes.* Her religious belief in reincarnation got Vani to consider the possibility of the unborn child being the '*reincarnation of someone close to us'.* This impacted her acceptance and recovery. She viewed her parents' coercion as having "*made me do something that is wrong in God's eyes."* Ruth, on the other hand, coped with making the decision by not considering her religious teaching: "*I did not consider my religion when I made the decision. It would have made it hard if I considered my religion."*

The discussion of religious values did arise during the interview. Despite the extent of their adherence to their religious values, some women were forced by circumstances to choose abortion. Knowing, understanding and accepting their religious values with respect to abortion contributed to making the abortion decision a painful one. In this study religion

was considered in the abortion decision by both the women and men participants. For some health professionals, religious values were the most influential, as indicated by Dr Haseena: "*I am one hundred percent committed to my religion and its teaching. I only agree to abortions in exceptional cases – the mothers' health and severe foetal abnormality" and* Sister Simone: "*Abortion is about taking the life of somebody (medical). Our religious teaching is that it is incorrect that you take the life of somebody. In the case when you do an abortion it's the taking of the life of a foetus."* Those who were committed to their religious teachings and experienced difficulty in separating their religious teachings and values from their everyday lives opted not to perform abortions. Only a small percentage of doctors and nurses are willing to perform abortions. For them the decision is a complex one in that various interrelated factors were taken into account. The twelve doctors who participated in the study equally represented the three major religions in KZN namely Islam (4), Christianity (4), and Hinduism (4). The nurses were predominately Christian (7) with one nurse being Hindu. There was no representative amongst the nurses from Islam. Those who chose to perform abortions did so despite their religious teachings. Dr Hoosen was able to separate the two. He said, "*I am equally committed to my job and to my religion. I don't associate religion with my job, or my job with my religion. I separate the two. They are two different entities. The job is just like me performing a tonsillectomy or any other op (operation). Between religion and work, I have no dilemma. They are entirely two different entities."* Unlike Sister Sandy, Dr Hoosen viewed abortion like any other medical procedure. This allowed him to view his task as being just a *'job'.* Other health professionals felt that there was a need from the perspective of women and abandoned children, and that they therefore had to do it as voiced by Sister Pinky: "*I do understand that it is against the religion but if we don't do it who will?"* Sister Pinky saw the need for abortion despite her religious views and wanted to help women. Sister Joy stated that: "*My view is that if it is a sin, rather commit a sin yourself than putting other people to sin against their child."* Sister Joy did not wish that women should go ahead and have the child and *'sin against it'* by not being able to care for it. Abortion was the lesser sin in hew view.

Zama was aware of her cultural teachings. She voiced that:

> *In the Zulu culture sometimes these things come back to haunt you, and then when you go to a prophet, he will tell you this is what happened. And it's worse if it's from the father's side. If the father's side has very strong ancestors then the effect is very powerful. So those are things that we have to take into consideration as well. So the reason why I decided to tell him was because if ever you know something like that happens like if maybe he has to go through something and then he must know what happened – that's why I decided to be honest.*

She subsequently disclosed the pregnancy and the abortion to her partner. One of the male participants noted the cultural requirements in the case of death. Alfred stated that: '*The Zulu culture asks for a ritual after a child is aborted. Maybe later in life we will do the ceremony if it has to bring peace to us and to the child'.*

These participants made their decisions concerning their dilemmas according to feminist relational ethics. While they did consider the good of others involved, the decision was eventually dictated by their realities which included the future of their unborn as was the finding of Pergert & Lutzen (2012). As discussed earlier, *relational ethics* is interrelated with circumstances and a caring relationship. It emphasises both emotions as well as reasons. Relational ethics therefore also involves the context in which one comes to reflect on, think about and decide on one's obligations and responsibilities to self and other.

Constructs of parenthood

The dominant discourses of motherhood and fatherhood impacts the abortion decision, and acceptance thereof. Where women and men felt strongly about their role as parents, making the decision became more difficult both during the decision-making and the post-abortion phase. The female body undergoes hormonal changes during pregnancy that accompany implantation. Following implantation numerous biological changes occur in both the foetus

and the mother, which continues throughout the duration of the pregnancy (Warner & Rosenberg, 2007) which was experienced by Anita:

> *I think that it is one of the greatest things in the world - the pregnancy, the birthing process - you can never change. It is a bonding time. From the time that I found that I was pregnant I automatically grew an emotional attachment. From my previous experiences I found that the body automatically just adjusts and you start bonding with the baby that you don't even know, you don't ever see. Automatically you start bonding, you start having feelings, your morning sickness, and everything plays a role.*

Anita experienced emotional bonding and feelings towards the unborn. Despite the natural bonding during pregnancy, motherhood is seen as taking on a huge responsibility as voiced by almost all female participants in this study and expressed by Mphilo, and Zanele:

> *Mphilo: Being a mother means many things – there is something - it is a big step because it is too hard to be a mother especially a single mother because all the responsibility it's for you your own. We have to do everything for the children, even if sick, or hungry, for clothes, school. I go and see to the school. It is also financial.*

Mphilo was a mother and understood the complexity of the mother role. '*Being a mother means many things'* from her experience, and '*it is too hard'*. Mphilo had been experiencing a difficult time as a mother. She was solely dependent on a CSG and could not provide for all her children's needs. Beside the financial aspects, mothers are required "*to do everything for the children, even if sick, or hungry, for clothes, school."* Zanele too experienced motherhood as being '*hard'. She stated that: "Sometimes I enjoy being a mother – not always - because it is hard. I am not working and it is hard to provide for them. It's good to have children, playing with them, hugging them, seeing them run around. It is not good when they come to you and say 'mummy, I'm hungry' and you don't know what to give them. I know that I am not a good mother because I am not educated, and I do not have a good job. Being a good mother means having a good job, getting a good salary,*

taking good care of them, when they need something you are there for them. I think that being a mother takes a lot of your time." Zanele too was dependent on a CSG and experienced having nothing to give to her children when they were hungry. This caused her much pain especially where she viewed her role as being a *'good mother'* and providing for their needs. Women have internalised this discourse of being 'everything' for their children. Any shortcoming in this regard renders them 'not good mothers' in their own view. These participants wanted to care for their children and be 'good mothers' as viewed by society. They had internalised the constructs of society regarding 'good mothers' to the extent that they measured themselves as failing to be 'good mothers'. They solely shouldered the responsibility of caring for children and blamed themselves for not being able to adequately provide for their children. Zanele blamed herself for not being educated and not having a good job. These women took on both responsibility and blame – the burdens of societal oppression. Anita, however, was fortunate in that she had the support of her parents during her experience of motherhood. She stated that:

> *I was a young mother. It (motherhood) changed my life. Without support of my family throughout the entire experience I don't think that I would be where I am today and the mother that I am without them. I coped as a mother at that age with my family's support. The greatest demand of motherhood is financial. And emotionally it is a strain especially being a young mother because you are also experiencing your own changes in life because you are still changing until you are probably 25. You yourself are emotionally adjusting to everything around you, the people around you. Basically you are getting your mindset correct. So being a mother and dealing with all of that at the same time is quite challenging. It is very demanding – so many different roles cause you a still a child. A part of you is still a child - you still want to experience everything in life and a part of you is being a mother you still have the emotional attachment to your child.*

Anita was able to identify her own needs as a person over and above her role as mother, and how these needs make the role of motherhood even more '*challenging'* and *'demanding'*. Anita was a very young mother who had her first child during adolescence.

Her experience sheds light on the even more intense complexities of adolescent motherhood. An adolescent is still a child with her own emotional needs and, as a mother, has the demands of meeting the physical and emotional needs of a baby.

Women make decisions based on an ethic of care and responsibility (Gilligan, 1982) while taking into account their relationships and obligations to others, including the unborn (Cannold, 1998; Finer et al., 2005; Jones et al., 2007), as was evident with these participants. Jones et al. (2007) found that women did not want to continue the pregnancy to term while developing a strong emotional bond with the unborn only to have to give it up in adoption. One participant stated that she did not wish to consider adoption as an alternative to abortion because she felt that a full-term pregnancy will develop an emotional attachment between herself and the baby and that it would be emotionally traumatic to give-up the child. Mphilo stated that *"You can't have a baby to give to someone (became emotional). It's too hard to part with your child - to have the pain. So, so…it's too hard. So I decided to do the abortion."* Mphilo experienced pain just pondering the thought of continuing the pregnancy, having a baby and giving it away in adoption.

In view of the complexities of motherhood some participants were not ready for motherhood. The discourse of motherhood where women are seen as being responsible for the care of children, affected participants' decision-making as voiced by Cheryl. *"Being a mother means that I will have to place the child's needs first. He will be dependent of me for everything. I cannot be a mother right now. I complete my degree in a year and want to finish it."* Zama voiced that she was not in a position to assume motherhood responsibilities: "*I wanted that baby, but I realise that I was not ready yet at that time."* Participants who were studying wished to complete their studies in order to secure good jobs to provide a good life for their future families as voiced by Stembile: "*I had to choose between having a standstill in life looking after a baby or focusing on working on something that will in future help me and the babies I would have in future."* Having a baby at this stage in her life meant that Stembile would have to forfeit a good future. Therefore, taking their circumstances into account in making the abortion decision may be considered an act

of responsibility as a mother as was the finding of Boonstra et al. (2006) where 74% of the women in their study cited responsibility as the reason for the abortion.

A new fatherhood is emerging where men are becoming increasingly more involved in the lives of their children (Plantin, 2003; Johansson & Klinth, 2008). Despite the findings of Morrel and Richter (2006) that the majority of fathers in South Africa do not accept responsibility for their children, the overwhelming majority of men in South Africa aged 18 to 32 years did indicate a desire to be good fathers (Morrel & Richter, 2006). The male participants in this study viewed the role of father as providing for all the needs of their children. Suren stated that, '*Fathers must be there for their children. They must be there and be involved in raising them. Or else children grow up to be delinquent'.* The physical presence of a father was seen as a necessity in '*raising'* the children and producing well-behaved children. Jared saw the role of father as "*to train them for the life ahead and to guide them spiritually."* One participant very much looked forward to the fatherhood role. Raymond stated that *"I very much looked forward to being a father. Fatherhood means to me that I am there for my child. I must meet all his physical and emotional needs. To love him and give him whatever opportunity I am able to afford. I have nieces and nephews whom I am very close to and so much wanted to be a father."* Fathers are considered important as also meeting the emotional needs of children. One of the female participants voiced that her partner looked forward to being a father. To this end he provided the necessary medical care. Zama stated that:

> *He took me to the (private) doctor. They did a scan, they did everything. He seemed very excited about the baby. He seemed very, very excited about the baby. The doctor told him when the baby is due and everything, what I need to do, you know basically everything, the next date I have to see him and all of that. I have a child but he doesn't have a child. So he was excited about the pregnancy.*

Men who were supportive of their partners understood and accepted the concerns of their partners and consented to the abortion although they were initially against the abortion and even very much wanted to have the baby. Five female participants in this study indicated

that their partners did not want the abortion but agreed to it on their request. This is exemplified in the statement of Anita who stated that, "*He wanted to have the baby - he wanted to go through with having the baby."* The male participants' perception of the fatherhood role did affect their acceptance of the abortion. Suren stated that:

> *Fathers must be there for their children. They must be there and be involved in raising them. Or else children grow up to be delinquent. I am close to my children and attend to all their needs. I know that is not what a father should do (abortion). My job is to care for my child. Here I asked to abort my child. I could not be there for this child. Unfortunately I had too much to lose with my mistake. I stood to lose my family (my wife and children) and my parents. They are very close to my family. They care for my children on a daily basis.*

Suren made the abortion decision on the basis of his concern for the well-being of his present family. While these participants expressed care and concern, this study did not exclude the possibility of respondent bias. Men who voluntarily came forward to participate in this study may have been prompted by their views on fatherhood to do so. Considering the statistics on child abandonment presented in this report, it can be inferred that the majority on fathers in South Africa do not subscribe to the views held by these male participants.

Abortion: a time bound decision

The abortion decision is time-constrained in that the decision has to be made within a short space of time. This makes the abortion decision a 'crisis' decision. Time is of essence. Limited time is available to ponder an intense, complex ethical issue and arrive at a decision as soon as possible. This therefore pressurises women to make a hurried, though critical decision as best exemplified in the voice of Zama:

> *The thing is when you have to make a decision – and this termination is not like we say oh we gonna give you eight months to think about it you know – it's urgent.*

> *Every day depends. I had my termination when I was eleven to twelve weeks and some people have termination at twenty weeks. Like I'm thinking in 20 weeks that should be a baby cause you like 17 weeks it's like half pregnancy that time already. Of course I think that at 20 weeks the baby starts kicking already and you felt the baby kick which means that's a baby.*

I was so panicky and thinking oh my gosh I am pregnant, I'm going to school, what am I going to do, this man – you know it was so much in my head and I just I just thought of one solution - what am I going to do to make all these problems go away and the only thing that came to my mind that time was termination. When you fall pregnant, when you least expect it, you panic. Like you start thinking oh my God I am pregnant you know and eighty percent of the time you don't think about the other things – the only thing you think about at that time is what can I do to make this go away? That's what you think about. You don't think about what's gonna happen after its gone away – how's this gonna … how am I get back to normal – how am I gonna fix it once it goes away. The only thing you think about at that time is how am I gonna solve this problem

Amidst all the complications at hand, Zama viewed abortion at that time as a quick-fix solution where **'***all these problems go away'.* She had to focus on the present and '*eighty percent of the time you don't think about the other things'.* There was no time to consider the future and '*about what's gonna happen after it's gone away'.* The decision was *'urgent'.*

The urgency of the decision, as so aptly articulated by Zama, has implications for the rights of fathers to their unborn. While some men articulate a desire to be involved in the planning and decision-making, the reality of time constraints do not permit this. This is particularly so when men oppose their partner's choice of termination of pregnancy, and where protracted court battles may preclude women from terminating a pregnancy within medically and legally permissible time limits.

Poverty and unemployment

Poverty and unemployment directly impact the abortion decision. Despite being employed, Natalie's financial situation did not allow the responsibilities for another child. She stated that: *In making the decision we mainly looked at finances because our finances are not that great at the moment and we got two children. We can't afford to have another one.*

The voices of these women were in keeping with the material conditions of motherhood where the decisions to abort were made on the basis of inadequate finances to provide for the child as was the finding of Williams and Shames (2004). Women are concerned about how they would provide for the new child and decide that it is in the best interests of their present and future child that they terminate the pregnancy. Poverty plays a critical role in the decision as observed by Sister Pretty: "*Poverty - Poverty I can say is the main cause – that's my opinion."* Poverty and unemployment are discussed under the theme *Structural Constraints* in *Chapter Eight*.

Although participants considered their religious and cultural values they placed their immediate circumstances as priority. Despite the conflict between the head and the heart, the sheer determination of the women was to keep their resolve to abort in the face of fear, guilt, and shame as made explicit in the voice of Anita:.

> *I had to weigh the situation. I was weighing in the situation in my mind and I had to look at reality. I kept telling myself you can't think with your heart. You need to think with your mind, you need to think with a clear mind and you need to think about reality. Yes the main focus was that you keep your heart out of this. You cannot think with your heart. You gotta think with your head. Throughout all of that it was emotional for me because I kept telling myself you cannot let your heart come into the way. You know you just got to allow your mind make the decision to look at reality. That is most important.*

Health professionals' major reasons for providing abortion services

Health professionals were also concerned with the many deaths they had witnessed amongst women, leaving many children subsequently orphaned as was also found by the Population Action International (2010). Sister Pinky represented the concerns of the other health professionals when she stated that:

> *If they go to backstreet they may die. If they have say 5 kids thy will be leaving the five kids without a mother. These kids are going to grow up without a mother, without someone to look after them. There are kids, lots of kids, let alone the ones that you see here in town. They are growing alone because the mother died trying to terminate (illegally). There are kids everywhere because somebody went out to terminate (illegally).*

The devastating effect of illegal abortion is the reason why abortion is said to have been legalised in South Africa as in many other African countries (Jewkes et al., 2002). Sister Joy stated that, "*To me it means being responsible for your own life"* rather than seeking an illegal abortion. This was a concern of other health professionals as well as expressed by Sister Pinky:

> *I feel helping out someone is the best because if they go to backstreet they may die. If they have five kids they will be leaving the five kids without a mother. These kids are going to grow up without a mother, without someone to look after them. I said myself that if I can be able to help these people to make a right decision - If they want to terminate let it be in a safe way so that in future they might save their lives and also later have other children, or save their lives. It is happening whether we like it or we don't. It is happening. It is better if somebody is being helped the correct way than somebody doing it illegally and then end up dying. We are from the locations and the rural areas. We see worst things happening there. And there are kids, lots of kids, let alone the ones that you see here in town. They are growing*

alone because the mother died trying to terminate. There are kids everywhere because somebody went out to terminate.

The many young girls seeking illegal abortions were also a concern that affected the decision-making of health professionals:

Sister Sandy: *When I saw these young girls dying from having all these metal instruments inserted I decided that when abortion becomes legal I don't mind helping out. Girls as young as 14 and 15 years old were dying. This touched me. I felt the pain of the mothers who came there.*

Sister Sandy had made a personal decision on wishing to help young girls even before abortion had been legalised in South Africa. This was based on her seeing and understanding the pain of the parents of young girls who were hurt or even killed because of illegal abortion. Sister Joy observed that when women circumstances drove them to end a pregnancy, they would do so under any circumstances. This does indicate the pain and desperation faced by many women in this country:

Sister Joy*: We used to have these women coming with babies in a bucket. I see that if a woman wants to terminate, it doesn't matter if the law says that it is 20 weeks she will find means to take that baby out of the uterus even if it means that it is going to kill her. This 15 year old teenager comes with her mum, she was on a stretcher. The mum does not know that the child tried to do something. She does not know that the child was pregnant. She does not know why she was sent to the gynae department. The child had stomach cramps. I was assessing the child. The child was, my goodness, was almost fully dilated. She was approximately 24-25 weeks. I ask the mother if she told her she was pregnant. The mother almost died – she collapsed. Being a midwife was about saving lives. Was it the mums or the baby's? But if you are going to lose them both then I'm not doing what I am supposed to be doing. If a teenager comes in at 18 with previous cesareans X 3 and*

she was in for TL (tubular ligation) that means I am not doing what I am supposed to be doing. What was that? Where the future for those kids? How old are they?

Mothers of these young girls were not aware that their daughters were in relationships and that they were subsequently pregnant. Even where mothers are physically present in the home, they may not be able to monitor their children appropriately and to protect them from harm. Young girls and boys are forced to travel and/or walk long distances to access quality, or even basic schooling, and sometimes even for the basic necessity of water for the family. Where young girls fall victims under such circumstances, it speaks ill of a society that is instrumental in exposing them to such danger. Although health professionals who have decided to perform abortions did experience their own personal issues with the abortion, as discussed in *Chapter Eight*, and had made sacrifices in this regard and had made their decision from the perspective of the need of women. From their experiences backstreet abortion is equivalent to death, while legal abortion is equivalent to safe abortion. Sister Joy noted that she *"loved babies"* as a way of explaining that she has nothing against the foetus but that the woman's circumstance demanded her concern and priority care. Health professionals experienced first-hand the pain and suffering to women who had to undergo backstreet abortions. Since their service is limited to medical care, the health professional felt that they had to do something within their means to help these young women. Those who chose to perform abortions did so despite their medical and religious views. They did so to help women, to prevent the death of women from illegal abortions as made explicit in the statement by Sister Pinky: "*I feel helping out someone is the best because if they go to backstreet they may die."* Unfortunately their help is limited to the medical setting and relates just to the health of women. If these health professionals could make personal sacrifices to help women, there is no excuse for our country not to ensure that women are safe and secure outside the medical environment. The deciding factor for all health professionals in this study who chose to perform abortions was the issue of women being hurt and even killed by illegal abortion, and children having to be left without a mother. Health professionals were confronted regularly with women coming in ill as a consequence of illegal abortion. They negotiated between their pro-natalistic religious and cultural values and the circumstances of women and children who are abandoned or neglected.

Health professionals who chose to perform abortions only in exceptional circumstances also did so out of concern for women and the unborn as stated by Dr Haseena: "*I do not accept abortion unless for mothers health (and severe foetal abnormality). I approve of abortions only in exceptional cases – mothers health and severe foetal abnormality."* Despite their personal views and decision not to perform abortions, health professionals were still concerned about the circumstances of women who seek illegal abortions and thereafter come to hospital for emergency treatment. They therefore did not condemn the health professionals who decided and did perform abortions in the hospital settings where they were employed.

Summary

The women and health professionals considered their religious and cultural values in making the decision. The women participants placed their immediate circumstances as priority, while the health professionals made the decision to perform abortions from the perspective of the needs of women as they had witnessed. The male participants, with the exception of one who was a part of the abortion decision, felt aggrieved and betrayed for being left out of the decision. This however is not indicative of the male population in South Africa where large numbers of families are being abandoned each year.

CHAPTER EIGHT

ANALYSIS AND DISCUSSION OF RESULTS

8.1 Introduction

This chapter continues from the previous chapter, *Chapter Seven*, with the thematic analysis, analysing the subsequent three themes namely the demonising of women, the pro-life/pro-choice dichotomy, and the structural factors that contribute to the oppression of women. The recommendations made by participants are also discussed and carried into the next chapter under *Recommendations.*

8.1.1 Demonisation of Women

Women are expected to sacrifice their own needs to ensure that those of the family, including the extended family are met. This discourse is internalised by women to the extent that they assume the full burden of responsibility for their families, without appreciating the external barriers that might impact on those responsibilities. This is exemplified by the statement made by Zentle: "*Motherhood means being responsible, taking care of other people, being there for other people, supporting them, loving them unconditionally. Need to support them financially and stuff. Others include everyone in the family – extended family – don't have to choose."* While women are expected to play such a pivotal role in the family and society, they are readily demonised when they fall short of society's demands and expectations. Being pregnant and having a child out of wedlock is demonised even by culture. Children born out-of-wedlock are referred to as 'illegitimate', often described by the derogatory term 'bastards' (Merriam-Webster Online, 2013). Participants reported that community members judged women who had 'illegitimate' children or abortions and that they were concerned about being looked down upon and called hurtful names. They therefore could not access support from local community organisations. Men on the other hand, are considered as being 'macho' when

they have different sexual partners and impregnate different women (Preston-Whyte et al., 1990).

Women are expected to assume responsibility in the sexual relationship. They have to ensure that they are on contraceptives despite the side-effects these may have on their bodies. If by default they fall pregnant, they are required to take responsibility for the consequences, namely, end the pregnancy or assume total responsibility of the baby as is the prevailing situation in South Africa where a great percentage of men abandon their pregnant partners. Zama and Natalie were on the Pill when they fell pregnant. Zama stated that, "*I was on the Pill and I do not know what happened. I may have defaulted,*" while Natalie stated that *"I do take precautions but not fully – 'I do not follow through enough with those things – contraception."* Both Zama and Natalie had taken responsibility to prevent a pregnancy but had fallen pregnant. Where women decide against abortion and do continue the pregnancy and have the child out-of-wedlock, they are still frowned upon, while at the same time being left to assume sole financial responsibility of the child. It is not easy to raise a child as a single parent. When a woman's circumstances force her not to continue with the pregnancy, she is demonised for such a decision. Where women do end the pregnancy they consider themselves murderers, a discourse that women internalise as seen in the narratives of Zama who stated that, *"To some people once you terminate there is no difference between you and a murderer,"* and of Anne who stated that, *"I think that I am a murderer."* Women bear both the physical and psychological consequences alone. Whatever the choice made in this situation the woman would be labeled. The women considered themselves 'murderers' in the face of the pronatalistic view held by society. Contraceptive failure accounts for a number of unplanned pregnancies. Participants reported that they used contraceptives at the time of falling pregnant. The condom, the pill, and the loop were amongst the contraceptives that were reported to have failed.

> *Mphilo: I was on the loop after the third baby because the injection is not good. It is bad for me. So I was put on the loop – I think it's safe for me – but it didn't work for me. And when I went to the clinic – the clinic they told me I was pregnant. It was still there but was moving down – that's what happened.*

Mphilo had given much thought to contraceptives in articulating that "*the injection is not good. It is bad for me. So I was put on the loop – I think it's safe for me."* The contraceptive recommended to her by the clinic failed leaving her pregnant. Despite her effort to prevent a pregnancy she is demonised for falling pregnant out-of-wedlock. Afrika and Nerissa used the condom but had fallen pregnant when it ruptured. Afika stated that: "*I knew that I could get pregnant without contraceptives – we used a condom and then it burst. That's how I got pregnant," while* Nerissa said that "*He always used a condom so I was fine. But I fell pregnant."* The condom is widely publicised as being the solution to unplanned pregnancy and HIV. This can present a false sense of security to people who subsequently depend solely on the condom and still fall pregnant. Despite not being responsible for the failure of the contraceptive, women are demonised for falling pregnant and accused for using abortion as a contraceptive measure by health professionals. Dr Hoosen stated that, *"People are just too lazy to use contraceptives – they are using this as a last resort. If they had taken family planning they would not have ended up here. We accept failed contraceptives – maybe 1-3%,"* while Sister Simone stated that, *"People are opting to use the termination of pregnancy as contraception instead of using the contraception as a preventative measure of pregnancy."* This contrasts with what the participants reported. None had chosen abortion as a contraceptive measure. Where participants were sexually active, they were on contraceptives. Those who were not on contraceptives were not sexually active at the time. The sexual encounter was not anticipated and not planned. Where women were not on contraceptives, and were sexually active, it was due to limited, or lack of, knowledge of contraceptives (Williamson et al., 2009) and/or fear of its side-effects (Khanal, 2010). Contraceptives do have side-effects, some to the extent that they had to be removed from the market and it is the women who have to live with the effects (Smith, 2005). Women are afraid of the side-effects as was the situation with Phindile who said that, "*I did not take contraceptives. Previously I was on the injection and it made me fat. Everyone was saying that my body was filled with water. I did not like that."* Because of her experience with contraceptives and the effect it had on her body, Phindile had chosen not to use contraceptives because of the fear of the negative effects on her body. Afika too was afraid of the negative effects: Afika: "*I wasn't on contraceptives because I heard people say that*

when you go for an injection you get fat." Health professionals indicated that women had inadequate and incorrect information on contraceptives. Sister Sandy voiced that:

> *Women in general hear about the myths of contraception from peers, family, and friends. They say that the depo makes them put on weight, you bleed too much, don't get your period, and so on. They go with what others say. They do not go to the clinic and find out for themselves about the various contraceptives. They rely solely on the information obtained from those around them. There is no information from a professional. I do not know whether poverty plays a role now because there are clinics everywhere. I think it is just being misinformed, not having the information.*

Behind the non-use of contraceptive, at times, is the demand and threat by men who consider women on contraceptives as promiscuous (Patel & Kooverjee, 2009). But it is the women, who do not use contraceptives that are readily accused and demonised by society when they fall pregnant. The role of men in preventing the use of contraceptives, or themselves not using contraceptives is not given any consideration.

8.1.2 Dichotomy of pro-life and pro-choice arguments

Debates around abortion generally centre on the pro-life/pro-choice dichotomy. With all the major religions promoting life and valuing childbirth and children, South Africans generally adopt a pronatalistic view. It is this pronatalism and the value of the sanctity of life that underscores the pro-life position (Smith, 2005), which is widely held in South Africa despite abortion being legalised. The majority of South Africans do not approve of abortion on demand, and a very small minority is in favour of abortion under particular circumstances (HSRC, 2004). There is a presumption that if one is pro-life, one cannot or will not make a pro-abortion decision. The results of this study challenge this view. While it may seem a paradox, all of the women expressed decidedly pro-life views, even as they chose abortion. None of the women spoke of the unborn in objectified pro-choice, language of 'the foetus' or 'the embryo'. They talked about the unborn in endearing and humanising

terms like ‘my baby’ or ‘my child’ and during the course of the interviews, the women cumulatively made forty-five references to the unborn as ‘baby’. One of the women, Anita talked about, ‘*bonding with the baby that you don’t even know, you don’t ever see.’*

The women’s pro-life stances can be seen by them taking on the dominant pro-life discourses about those who opt for abortion being sinners and murderers, as articulated by Afika who said: “*I know that I have killed an innocent child,”* and Zama who referred to her “*decision of terminating the baby,”* adding that *“there is no difference between me and a murderer.”* Anne adds to the chorus of women’s self-imposed judgment and conscience with: “*I think that I am a murderer – that’s what I’m thinking*.” Had their circumstances been ideal, without the financial constraints, abandonment or fear of abandonment, threats of violence and fear of societal reactions and judgments on falling pregnant outside of marriage, these women might not have opted for abortion. The paradox of being pro-life while opting to abort made the abortion decision all the more difficult for the participants, and they had to bear the burden of guilt and responsibility for taking a life.

Life is not as simplified as these two compartmentalised groups. Women do not live in a vacuum. Many factors and pressures come into play. That is the reality of life. Life is complex and the decisions made in life are complex. Hence the reasoning too used in decision-making is complex. Women are caught in this complex life where they are forced to make choices against what they believe as is evident in this study. All participants in this study viewed the unborn as a ‘baby’ and not a ‘foetus’ whilst some of the women humanised the unborn to the extent that they wanted to fulfill cultural rituals to appease the ancestors and allow the spirit of the unborn to rest in peace. Zama equated the loss of the inborn to that of family members when she articulated that:

> *In our Zulu culture, when you lose a baby, when you lose your mother, when you lose your spouse, you know you need to go for a cleansing ceremony. … whether you are only three weeks pregnant or six weeks pregnant at the end of the day that was gonna be a human being and a part of your family. So you need to go for a cleansing……it depends on how strong the ancestors are. And*

> *it's worse if it's from the father's side. If the father's side has very strong ancestors then the effect is very it's very powerful.*

Mphilo stated that: "…*in our culture we are not allowed to do this. And when we do it, we believe that it's a person at the end of the day. It grows up. When it grows up it will come back - need something to buy like clothes for him for her, and a name. … maybe after five years when she or he'd grow, come back to me on a dream and say 'my mother I want my name – I don't know my name, my mother I'm not wearing anything'. Then I'm gonna tell them (my parents) that no-one was there and I got to do these things."*

Their decision to abort however was dictated by the circumstances, which were directly related to the oppression and discrimination women face in society. Although these women held onto pro-life views, they made choices that said otherwise. If women are truly free they will be able to make choices that are not constrained by societal discourses and practices as advocated by radical feminists. Right now, while women do make the choice to abort, the choices are, more often than not, constrained ones as reactions to structural factors such as unemployment and poverty, partner rejection and abandonment, and the fear, stigma and shame of being pregnant and unmarried (The Revolution, 1868, as cited in Feminists for Life, 2004, p. 1; Lewis, 2011). If pro-natalism and pro-choice are the preferred options as reflected in popular daily discourse, especially those of religious doctrines, then societal discourse around parenthood within the institution of marriage will have to be challenged and de-constructed so that women do not opt for abortion out of fear and shame.

From the pro-choice stance, women are seen as having total control of their own bodies on a very individualistic level rooted in a liberal, individualistic view of democracy; it does not consider how women's choices are constrained by structural factors namely the social, economic, and political conditions (Patchesky, 1990; Smith, 2005; Fried, 2008). Pro-choice assumes that all women who choose abortion are pro-choice and cannot be pro-life. Initially the term 'rights' rather than 'choice' was used. While the term 'rights' is understood as benefits owed to all regardless of access to special resources, the term 'choice' relates to

possession of resources. This implies that those with more resources have more choices. Therefore ‘choice’ works against women who are already marginalised in society, and specifically women from the lower socio-economic groups, and does not reflect the reproductive experiences and needs of women (Smith, 2005). It victimises the poor and the disabled women without addressing the conditions that gave rise to a woman having to make this decision in the first place. This leads to the limited view of leaders, and private health professionals for example Planned Parenthood that claim to be pro-choice. They do not address the real concerns and needs of women (Smith, 2005).

Smith (2005) argues that with the ‘choice’ paradigm, women continue to be oppressed, for example, with the use of abortion in instances of foetal disabilities. Woman’s choice, in this instance, lends itself to the discourse where children with disabilities are viewed as lesser citizens, and where society does not subsequently provide adequate resources to women who may want to have their babies. This choice undermines efforts made to challenge such discourses and to change economic policies that contribute to the poor care of children with disabilities (Smith, 2005). The ‘choice’ perspective also detracts attention from the harmful side-effects of contraceptives to focusing on the ‘choice’ of various contraceptives, and from inadequate and incorrect information on contraceptives to the lack of the availability of contraceptives.

8.1.3 Structural constraints

Women are constantly subject to structural conditions that impose constrained choices (Foucault, 1982). While women are the central figures of the home, they face multiple sources of oppression and abuse. The intersectionality of the various structures of oppression makes the impact of oppression on women so much stronger and at the same time so very difficult for them to understand and fight their way out of it. The structural constraints discussed are economic constraints, patriarchy, poor quality reproductive health care service, and lack of pre-abortion and post-abortion care.

Economic constraints

Financial circumstances have a marked influence on the abortion decision (Baker et al., 2003). As discussed earlier, South Africa has an unemployment rate, which is considered to be amongst the highest in the world (Kingdom & Knight, 2004), namely 25.5% as at September 2012 (Statistics SA, 2012). This reflects a narrow definition of unemployment. With the inclusion of discouraged work seekers, this percentage rises to approximately 36% (Vavi, 2012). The country's unemployment is in keeping with the country's racial history and racial demographics where the lower-income, mainly Blacks and mainly women are affected (Trading Economics, 2012), particularly under conditions of neoliberal capitalism (Sewpaul, 2013b). The proportionately high Black population means that that group is most affected by the economic downturn in South Africa (Mlatsheni & Rospabe, 2002). Efforts by the democratic government to level the economic playing field, benefits a small percentage, and mainly the higher income groups of Blacks. The stratified education (Buchmann & Hannum, 2001) contributes to the difficulty being experienced by the lower socio-economic groups to secure employment.

Some of the women in this study were struggling against the odds to secure an education and a better future. A premature and unplanned pregnancy would have negatively impacted their aspirations. Phindile stated that, '*I am studying - It will hinder my present plans for making a future for me and my son'.* Participants considered their future and that of their present/future families. When women are able to contribute to their care and those of their children, they are in a position to raise independent children, and help to break the intergenerational cycle of poverty. Education, economic upliftment of women, and access to resources and development may reduce fertility and the rate of abortions, child mortality, expand education and reduce intergenerational poverty, and contribute to the economic growth of the country by advancing the well-being of its participants (Klasen, 2002). Participants who chose to complete their studies, wished to participate in the open labour market. They did, as citizens, make a responsible choice. They chose to have children when the timing was right and the circumstances more conducive to caring for a baby without depending on financial assistance from others.

When women, especially those who single-handedly manage their households are affected, families are indeed affected. Children and the elderly suffer as well. Poverty in turn leads to various forms of abuse of women where women and young girls in many instances resort to using sex to obtain material resources for the family or for themselves. Women who subsequently fall pregnant are unable to provide for the babies and resort to abandoning the baby or the child at a later stage. Women therefore reason that it is more ethical to end the pregnancy than continuing the pregnancy and abandoning the child. Health professionals too, as discussed above, viewed abortion as the more acceptable option. With the countries high rate of unemployment women are mostly affected. Five of the women participants in this study were unemployed, while six were students. Amongst the unemployed in the country, women form the larger group namely 60% of the unemployed population (Mlatsheni & Rospabe, 2002; Trading Economics, 2012). Combined with their being left destitute because of death or abandonment with a family to support, women in South Africa are experiencing a difficult time. Even where there are employment opportunities women are discriminated against as men are given preference (Mlatsheni & Rospabe, 2002) often on the grounds that they have a family to support. In reality however it is the women who are left with a family to support.

With the ever-increasing cost of living in South Africa and the limited work opportunities those who are dependent of the Child Support Grant (CSG) as well as those who are employed and receive a below average income experience extreme difficulty in making ends meet. Although the Child Support Grants do help in contributing towards the provision of the basics, women are experiencing extreme difficulty in providing single-handedly for their children. Under circumstances of dire need, abortion becomes a viable option for many women (Abortion Rights Coalition of Canada, 2006). This is reflected in the voices of Zanele:

> *I am dependent on the Child Support grants. It is hard to provide for the children' and* Mphilo: *I receive Child Support grants. The father never gives me any support. The third child (which is his) is very small – one year and six months. She*

> *still drinks milk. How am I gonna get money to feed them because I cannot breastfeed – I have a problem –and cannot breastfed. So how am I gonna manage? It's too hard to bring another child when you do not have enough support for her or for him. I have a casual job at the local supermarket sometimes.*

Zanele's and Mphilo's sole income was the Child Support Grants (CSG). Although Phindile was able to manage with the income she received from her parents and the CSG, she was not able to take on the expenses of a baby. She stated that: "*I do not have the financial resources to provide for another child. Babies are very expensive."*

Poor quality reproductive health care services

Reproductive health care services include family planning services. Sister Joy observed that women were being abused at service-provision level.

> *It will be advisable if our government promotes family planning in a manner that makes it comfortable for all to obtain contraceptives. Some clinics make it uncomfortable for the sexually active young person to go onto contraceptives. Many providing the service are not comfortable with the service and cause many to default by the way they treat the person. Many providing the service are very old and given the job because they are too old to move around. They do not counsel, or give any advice. The service has to be restructured.*

Sister Sandy too was concerned with the services offered to young people at the clinic. She stated that, *"But the problem is also at the clinic. The sisters at the clinic do not want to give the young girls contraceptives. They are told that they are too young to have sex and that they must wait. They are not waiting. The girls need to be counselled about the side-effects of the contraceptives on the bodies in the long term but not deprived from the service. This will prevent them from coming for abortions."*

Although the lack of access to contraceptives is more of a feature in the rural areas, it is the rural areas that make up the greater percentage of the South African population. Coming from urban and sub-urban areas, none of the participants in this study had difficulty with accessing contraceptives. It was instead the lack of correct information on contraceptive use and the information received from others on the effects of contraceptives that resulted in some of the participants' pregnancies. Society has to accept responsibility for not providing adequate information to women and for not providing guidance to young men. The social and political structures in society do not provide adequate information on the availability of contraceptives and the range of contraceptives available for women and for men as well. Neither do the social and political structures in society educate and encourage men to use contraceptives to prevent unwanted pregnancy. Ruth was not even aware of ligation. She asked *"What's a ligation?"* Other participants had been misinformed about contraceptives. Default on contraceptive use arises from the lack of adequate information on the use of contraceptives. If women do not know how contraceptives work they will not understand the need to use them regularly and properly.

Patriarchy

Although gender roles in society are changing, they are still very strongly influenced by culture. Male dominance and female submissiveness extends to sexual and reproductive dominance (Maharaj, 2010) and many women experience violence that extends to even the use of contraceptives (Stephenson et al., 2007; 2008). These findings were confirmed in this study where health professionals witnessed the consequence of the physical and sexual violence in the form of battered, pregnant women who were not only prevented from using contraceptives, but are even forced to abort the pregnancy. Culture plays an enormous role as a determinant of male/female behaviour.

> Sister Lungie: *Men in our culture - whatever they say they want it to go. 'whatever I say goes'. And most of them they do not believe in contraception. But at the end of the day sometimes they will say you are pregnant – not married – say that it is*

your baby. I'm not involved. Do whatever you want to do with it. The poor women end up here. Maybe no money, they're at school.

Sister Sandy: *The main reasons for abortion are with the Black women - the men are the dominating people – they don't want to condomise, they don't want the women to be taking prevention. The belief prevails that if you do fall pregnant you can go and terminate.*

Sister Theresa: *It boils back to beliefs I feel because the traditional beliefs of some of some of our patients where they don't believe in contraception. And also that's the reason why the HIV/AIDS rate is so high in our province specifically. KZN got the highest HIV rates. I think that it goes back to the traditional ways: not believing in contraception. Well, when it comes to culture, in certain cultures they feel that the man is superior so the women feel that they must respect them so they won't do contraceptive, they won't do this. They won't do that.*

Culture as observed by health professionals in this study, plays a vital role in the abuse and dehumanisation of women. I spoke to several community leaders from the local Zulu community. They stated that women in the local churches do encourage young girls to use contraceptives because young men tend to force young women into having sexual intercourse with them. If the young women do, in such instances, fall pregnant the community stands by them and assists with the material needs of the child. Senior women from the culture do address young girls and encourage them on keeping their virginity. Where young women are encouraged not to take contraceptives, it was based solely on the many negative effects contraceptives have on the body.

Young men refuse to use condoms and demand that 'their women' do not use contraceptives as it is indicative that the woman does not 'love' him enough to have his baby. But, as voiced earlier by Sister Lungie, "*at the end of the day they will say that it is your baby. I'm not involved. Do whatever you want to do with it. The poor women end up*

here. Maybe no money, they're at school." The role of culture in affecting contraceptive usage needs to be addressed.

Lack of pre-abortion care

Health professionals were generally concerned with the common occurrence of repeat abortion as was the findings of Cohen (2007).They were of the view that they are, despite their ethical, medical and religious dilemmas, performing abortions or nursing women who have abortions only to see them come in once again. Some women were observed to come in several times. If women are forced into repeat abortions despite the effects of abortion as reported by them, it indicates the need for post-abortion care which addresses the needs of women and the reasons as to their choice of abortion. Women returning to the same abusive, deprived environment will at some stage be in need of an abortion once again.

The concern of these health professionals were purely from a medical view. They were concerned that women were having repeated abortions and consequently damaging their bodies. While some of the health professionals viewed the repeat abortions from a medical stance, they were also concerned about the circumstances of women that force them into having repeat abortions. They understood how women were being abused by men and prevented from using contraceptives, and younger females were being taken advantage by older men who provide for them materially as was found by Martin et al. (2000). They were of the view that **w**omen who have repeat abortion were likely to be victims of physical abuse, sexual abuse or coercion as was found by Fisher et al., (2005). This emphasises the need for pre-abortion care and post-abortion care in empowering women and in reducing repeat abortion. These health professionals did make recommendation which are discussed later in this chapter, and included in the recommendations in *Chapter Nine.*

Only two participants received counseling from the health professionals prior to and/or after the abortion. One was referred to a psychiatrist by the doctor of the clinic she had been attending for many years, and who had referred her to the NGO for the abortion. The only preparation participants received from the nurses who set the appointment for them, and

had taken consent from them related to the expected physical discomfort during, and immediately after, the procedure. There was no discussion as to their reasons for the decision, concerns, fears, or post-abortion circumstances. Women who just made an individual, complex, emotionally-laden decision are once again ignored by services that were said to be put in place to attend to the needs of women. Yet another form of structural abuse! Just attending to the symptom of possibly a host of other psychosocial problems while at the same time ignoring the feelings and concerns possibly faced at that time is not a form of 'caring for women'. As stated by Sister Joy:

> *Hopefully in the future we will have a social worker who can work with the screening. Because some of them - maybe 5 to 10% - do it because of the boyfriend. In those cases I feel a bit guilty if she takes the cytotec or does the procedure because somebody says so. I try but there was nothing I can do. In counseling I cannot take an hour to counsel one person. Those are the disadvantages. We need to look at people individually. We cannot say that we are limited by time.*

This may have also assisted Vani who was coerced by her parents into having the abortion. Vani understood it as *'When my parents took me to the abortion clinic they did not get involved in our family problems."* The participant who received some counseling prior to and subsequent to the abortion seemed to have coped better than the other participants. Zentle stated that:

> *We are going for some counseling together at the local clinic. After we decided I went to the clinic, told them about it, they did some counseling, and they gave me two days to think about it. I went back home, thought about it, talked to him again, and then I went back to the clinic, and they referred me to that clinic where I did the abortion. They (the first clinic) told me the consequences of doing it – that I might not have a child in future, umm… the guilty consciousness that I'm gonna live with. The counseling is helping. We go in, we talk about things that affect us in life, our relationship, how we're working through this whole thing. It's a support group.*

Zentle was in a stable relationship and had the support of her partner. He too participated in the counseling and support group with her. Having his support allowed her to share and discuss her feelings about the abortion. Needle and Walker (2007) asserted that pre-abortion counseling can help good decision-making. It ensures that the decision is solely the woman's, that her decision is 100% certain despite all the options available to her, assessment of her decision-making and coping skills, and work through her feelings about the abortion to minimise the post-abortion effects.

Participants, in retrospect, indicated the need for pre-abortion counseling. Pre-abortion care is vital in addressing concerns, fears, feelings, reasons for the abortion decision, how the decision was arrived at, the various options available and to explain the abortion procedure (Kells, 2009). This service should be provided at the time women first approach the service centre for assistance. At the time of coming in for the procedure, women cannot discuss their circumstances or their decisions. Time will not allow this. Engaging in a dialogue with anyone at this time may only serve to complicate their thoughts. Women awaiting the abortion were so stressed that they did not even talk to one another. This reinforces the need for support and care before they go in for the abortion as was found by Hodson and Seber (2002). As discussed earlier, the women awaiting the procedure refused to converse with me in this regard. The majority of those who did respond with the shake or nod of the head indicated that they did not see the need for counseling prior to the abortion. They may have interpreted counseling as being an attempt to detract from a very difficult decision that they had made.

Since they did not speak to me I was unable to clarify their views as to whether they did not wish to receive any form of counseling on that particular day, or did it also refer to counseling at the time of seeking the abortion. Neither did I query their views concerning the need for post-abortion care. One of the participants however, did during the interview, voice that she intentionally avoided thinking with her heart, and used her head in making the decision. Pre-abortion care in her situation would have helped her work through the pros and cons of her decision.

Another observation was that when women went into the service centres their partners are not considered although they were present. Men are left out of the abortion decision-making process in South Africa as with other countries. A pilot study in a Baltimore City clinic by Beenhakker et al., (2003) indicated that many men accompanied their partners to the service centres but were not included in the service provision to their partners. On the basis of their accompanying their partners it is suggested that men be involved in pre-abortion care and encouraged to accompany and participate in post-abortion care (Beenhakker et al., 2003). Alfred had the experience of being ignored although he was present at the clinic. "*I supported her and went with her for the abortion. They did not call me in or talk to me."* While focusing on the interests of women it is imperative to include their own personal support persons. This strengthens the support for the women. By ignoring those close to them, real concern for women is not being displayed. The female participants too mentioned that their partners were left sitting in the waiting room. Representing what other participants as well voiced by Cheryl, *"My boyfriend waited for me on both days. He was not called in for the interview."* Where men do show an interest and stand by their spouses or partners they too need to be offered support and counseling. By dealing with the issues affecting the supportive partners as well, women will receive quality support and care from them. In the long term it is both for the woman's wellbeing and that of her partner that he, if interested, be offered the necessary counseling and support (Plantin, 2003; Johansson & Klinth, 2008).

Women in this study were administered the three-month injection by the health professionals. This is routine procedure where they did not have a choice. No counseling was offered in this respect. In my telephonic follow-up discussion with them approximately a year later, half of the women were no longer on contraceptives because they were not in relationships and subsequently did not see the need to. Counseling helps to change both attitudes to sexual behaviour and to sexual behaviour practices. Contributory factors to the change in behaviour included knowledge of contraception which was previously lacking, and easy access to contraceptives which was also previously difficult (Fasubaa & Ojo, 2004).

Pre-abortion care should focus on the present status of the woman, not on the long-term post-abortion plans unless these are directly related and would impact the present. Although the women in the room awaiting the procedure refused to talk to me and those who responded mainly indicated that they did not think that pre-abortion counseling was necessary, Handy (2011) found that most women seeking abortions welcomed non-judgemental, empathic counseling. In retrospect, all participants indicated that they should have been offered pre-abortion counseling because they were subsequently more rational about the experience. Prior to the abortion, the participants were in an emotional, painful state, rendering them unable to assess their own need to talk to a professional they had just met, about the situation. Pre-abortion care offered within the context of the service will be seen as part of the services available and provide an opportunity, before the scheduling of the appointment, for women to discuss their fears and concerns. Sitting in the waiting room awaiting an emotional procedure is no time to talk to anyone, even to those who were in the same predicament as was with the situation with these women. Pre-abortion care should be a part of the process of setting up the appointment for the procedure and not just prior to the procedure when women are in an emotional and anxious state and do not wish anyone to defocus their decision. Furthermore time would not allow postponement or delay of the decision. Women should however not be denied the choice, at the time of approaching the service provider, and the opportunity to discuss their concerns with a professional counselor available to them for the purpose. Generally, just one or two sessions may be sufficient unless otherwise dictated by the circumstances and/or requested by the woman (Steinberg, 1989). Women need pre- and post-abortion care where their circumstances could be addressed and they are referred, after the abortion, to appropriate community programmes that empower women to improve their circumstances. Women can become instruments of change with the appropriate support structures. Society owes women that much to empower themselves to improve their circumstances in life. Corbett (2010) asserts that the PrimaHealth Independent Practice Association (IPA) 1991 strategic planning document encourages post-abortion care and family planning services to become an integral part of health care services. This is viewed as action to improve the health status of women, and prevent further unwanted pregnancies. To this end a total reproductive health care package is required in the provision of quality abortion care (Corbett, 2010; AGI, 2013).

Women with unplanned pregnancies are exposed to further abuse. The private services available do not focus on their needs as women, but rather solely on profit. The service provision is seen as a business opportunity as was found by Rosenberg (1997) and as best exemplified in the voice of Sis Joy who stated that, *"It's a pity that it's all about money now. It is all about money. This is not why I chose to perform abortions. I chose to give back to women who cannot really, really afford to have a child and who really need help. Sometimes you get these people coming in to terminate for the fourth time just because they can afford. While others who need it, but cannot afford to, cannot access abortion. Time is money, and money is the focus. When you dealing with a person in crisis you do not look at those things. We need to look at people individually. We cannot say that we are limited by time."* Abortions at NGOs in South Africa cost between R1900 and R3200 depending on the stage of pregnancy. Rather they are seen in monetary terms. With more women seeking abortion the incoming revenue for private service providers is ensured. This concern was voiced by Sister Joy:

> *Some of them – maybe 5% to 10% do it because of the boyfriend. In those cases I feel a bit guilty if she takes the cytotec or does the procedure because somebody says so. I try but there is nothing I can do. In counseling I cannot take more than an hour to counsel just one person. Those are the disadvantages. Time is money, and money is the focus. When you're dealing with a person in crisis you do not look at those things. We need to look at people individually. We cannot say that we are limited by time.*

I spent time between June and December 2012 at the organisations which participated in the study. My observation was that despite the TOP Act allowing for abortion on demand up to twelve weeks and restricted access between twelve and 20 weeks, this was not being observed in practice: women have unrestricted access to abortion up to 20 weeks. Nurses were overloaded with no time to invest in the women. All they saw was 'another termination'. The women were left alone with their feelings and apprehensions both before and after the abortion which was indeed treated as 'any other medical procedure'.

Health professionals voiced concern that despite abortion being legalised to supposedly protect women backstreet abortions continues. Sister Simone: "*I don't think that legalising abortion was the right move. Illegal abortions continue."* Reasons for this are not known. It is believed that women try to abort at home to prevent others getting to know of the pregnancy, and doctors and pharmacies are providing medication to commence the abortion without providing the full medical care. This is another form of abuse by those who wish only to make money from the pain of women without rendering adequate services.

Although health professionals saw the need for and chose to offer the service, they nevertheless were concerned about the addressing of other important issues to improve the circumstances of women. They felt that abortion in itself did not solve the problems experienced by women as evidenced by the many repeat abortions they have witnessed. This is made most explicit in a statement by Sister Lungie: *"There should be more than the Act to help women."* Health professionals acknowledge their concerns of the possible long-term physical effects of abortions on women. To this end they raised several concerns with respect to women, men, and abortion. The concern of health professionals, from their observation during their medical service provision in just one geographical area, highlights the extent of the abuse of females of all ages. It is surprising that our government has not really felt the impact across the province, and the entire country! Or, one wonders, is anyone really concerned?

Research indicates that women do experience various effects after abortion (Mojapelo-Batka & Schoeman 2003; Trybulski, 2005; Major, Appelbaum, Beckman, Dutton, Russo & West, 2008; Vukelić et al., 2010). On having no alternative but to opt for abortion, women once again are left to bear the consequences of the abortion alone. Participants reported various physical, psychological, social and spiritual effects three months after the abortion. Where the pregnancy and abortion was kept secret, the women were left to cope with the effects all alone. The secrecy of the abortion implies that women cannot share the experience and the feelings that may accompany it both during and after the abortion. This in itself leads to personal trauma in struggling to make sense and come to terms with the action. Participants who did disclose the abortion did so only to their partners who

supported the decision and the participant through the procedure. Although they also experienced pain and hurt after the abortion, those who were able to share with their partners or concerned others did not feel totally responsible for the abortion. One participant, Phindile, shared the decision with her sister. Although her sister does not live in close physical proximity to her, she does main regular contact with her to offer support. This has helped her to cope with the decision as it relieved her of carrying the 'burden' alone. Participants who did not share the decision with anyone seem to have been more affected and welcomed the opportunity the interview offered them to confide in an unrelated professional person. This is exemplified in the words of Jared: *"This affected me for years. And still does. That's why I chose to share this story. This is most therapeutic for me. My talking to you too is therapeutic."*

Post-abortion care therefore needs to be holistic, addressing all needs of women with the sole purpose of empowering women to rise above their circumstances.

8.1.4 Concluding Remarks

Participants' decision to abort was dictated by the circumstances, which were directly related to the oppression and discrimination women face in society. Although these women held onto pro-life views, they made choices that said otherwise. If these women had the support of those around them, and the financial means to provide for a baby, they might have chosen differently in keeping with their pro-life values. Radical feminists assert that if the needs of women were met by society, women would not be forced to choose abortion (The Revolution, 1868, as cited in Feminists for Life, 2004, p. 1; Lewis, 2011). Their choice would truly be a free one, and not constrained by societal discourses and practices. The results of this study indicate that while women do make the choice to abort, the choices are, more often than not, constrained ones in response to structural factors such as unemployment and poverty, partner rejection and abandonment, as well as the fear, stigma and shame of being pregnant and unmarried. From a radical feminist perspective, having to choose abortion is an indictment on society. While women have a right to safe and legal reproductive health choices, including abortion, it is up to society to ensure that societal

conditions support women's choices. Structural oppressions and limitations, which force women into decisions that may go against their moral frame of reference, must be confronted, challenged and eliminated. If pronatalism and pro-choice are the preferred options as reflected in popular daily discourse, especially those of religious doctrines, then societal discourse around pregnancy and childbirth within the institution of marriage will have to be challenged and de-constructed so that women, who fall pregnant outside of marriage, do not opt for abortion out of fear and shame.

8.2 Recommendations from participants

8.2.1 Counseling

Participants, in retrospect, saw the need for and recommended that counseling be provided both prior to and after the abortion, as represented by Zama:

> *There should be counseling before and after the abortion because the feelings you have before are different from the feelings that you have after. Especially before (the abortion). Maybe the person who's counseling you can manage to change your mind. Maybe you are making the biggest mistake of your life.*

After the abortion Zama was able to reflect on her feelings at that time (which was desperation) and her feelings after the abortion. Before the abortion she may not even have seen the need for such services. But looking back she considers the need for such support. Others saw the need to talk to someone as stated by Zanele *"it's best if you know it you tell someone she is the right person to talk to - someone who will not tell anyone."* One of the male participants, Jared whose sister was coerced into having an abortion stated that:

> *They should counsel all women coming in for abortions. Many do abortions because of pressure from others. They should also explain exactly how abortion is done, the stage of development of a particular pregnancy and give the choice of the women in keeping with the constitution. But women must be told.*

Jared saw pre-abortion counseling as providing information, and ascertaining that the decision is truly the woman's. This constitutes *informed consent*. Female participants, in retrospect, also expressed the need for counseling. While some specified when the counseling is necessary, that is, before or after the abortion, others were general in their recommendation. Mphilo referred to post-abortion counseling when she stated that:

> *Counseling is important. It's important for every problem you have. You need someone to talk to someone because it eats you, you become thin, the people wonder what happened to you maybe you got a problem you don't have someone to talk. You must be able to talk to someone you trust. Maybe when I tell you, you never go to tell someone. Maybe I tell my friends and they go and tell my neighbours. It's right to get someone to trust - like a counsellor.*

Mphilo was affected by her action and needed to share her pain. She however could not find anyone to trust and bore the consequences all alone. Stembile specifically referred to counseling after the abortion when she stated that:

> *I do think that there should be counseling afterwards. You would really need counseling because it's very emotional. I am walking around in that area. It just doesn't make me feel comfortable. It makes me think back to the day I was there. So I think like they must have a way of separating you from being there and the life after the abortion stuff. When I walk there I think that this is the place where it all happened - and it's not too far from where I live.*

Although Stembile shared the decision and was able to have post-abortion discussions with her partner, she too needed post-abortion professional care. Anita saw the need for pre- and post-abortion counseling:

> *Someone who comes in alone needs to be informed. You can't just come there and fill out an indemnity form and you race through the procedure - walk in and out. I*

feel that should offer counseling where you sit down and speak to the patient, give them an entire procedure from beginning to end, and all the information. Let them sleep on it and decide this is what I want to go through. It makes it easier to handle the consequences.

Anita viewed pre-abortion counseling as including support and information. Anita had seen a psychiatrist after the abortion because of depression and nightmares. Participants appreciated the research interview as a therapeutic opportunity because they had no one to confide in as represented by Nerissa: *"Now that I have broken up with the boyfriend I have no one to speak to. I would not go to any organisation – no one must know what happened to me. But I do need someone to speak to. I cannot share this with anyone. This is why I agreed to the interview. I actually took time off from work to come to you."* Others were, after the interview, grateful for the opportunity to talk about their experiences with someone who understood and cared as expressed by Mphilo. "*It is important for me today because I think I'll be OK because I talked to someone about everything. I had pain inside - even when I'm sitting I'm thinking – maybe sometimes when I am watching I'm not watching – I'm just watching. I'm thinking….. So I like to talk with you."*

Health professionals too acknowledged the need for counseling for participants. Concerned about the limited time and attention that is afforded to women who come in for abortion, and repeat abortion, Sister Joy stated that: "*When you're dealing with a person in crisis you do not look at those things. We need to look at people individually."* The concern again reflects the need for pre-abortion care for women who come in for abortion because of their needs. Having a professional attend to them prior to setting-up the appointment will give women an opportunity to work through their feelings and the options they have available to them. This might in the long term reduce the repeat abortions.

8.2.2 Reach out to women to reduce unwanted pregnancies

Nurses personally witnessed the impact of partner violence in the lives of women. Since they are not able to render the necessary services and the hospital social worker only attends

to the women during their stay in hospital, the nurses recommended that much more be done for women. Women seem to have internalised and accepted their 'inferior' status and allow men to abuse them. To this end the nurses recommended that:

> Sister Lungie: *We need to find out still what really needs to be done on a serious note to bring a change to this. There should be more than the Act to help women.*

> Sister Theresa: *it's up to them (women) to value their own lives really. Women need to be empowered to be responsible and not to always look at the man to be superior.*

What was observed by the nurses was that women did not have adequate knowledge of contraceptives, some were ill informed, and some did not see the need for contraceptives while others were bullied into not using contraceptives. Men were in control of these women's lives to the extent that they were not able to make decisions concerning their own lives. The health professionals recommended that women become financially self-sufficient and take control of their lives. This will prevent men from abusing them. Sister Pretty stated that, "*I think that empowering woman to do things like baking – things that make them self-sufficient. Poverty, I can say, is the main cause – that's my opinion."*

The abuse of women on various levels calls for holistic action by the government. The health professionals viewed schools as the starting point as represented by Sister Sandy:

> *I think that education programmes must start at school. We do not want to promote promiscuity, we do not want to promote kids having sex early but it is happening. Kids are having sex early. I have had 13, 14 and 15 year olds coming here. In the past when I stared we did not have many teenagers coming in. they were mainly 18, 19 and many were in their 20s. Now it is increasing from all geographic areas. We need to introduce sex education in the schools. They need to be told about family planning. We cannot only speak about the condom. Many have told me that they are using the condom and that the condom is breaking. So how is a woman or girl protected? If they choose to have sex they must go on contraceptives. Even without*

the mother knowing they can go to the clinic. If the girl does not want her mother to know she can leave the card at the clinic. We will have to start giving them from the schools. Distributing the condom at schools is a good idea. I know because I am working at the TOP clinic. Everybody out there in the community is saying that It is a bad thing but I thing that it is a good thing. You are not promoting anything because the children are having sex anyway. They are not going to listen to you.

Sister Sandy experienced the intensity of the problem in seeing many young girls, dressed in school clothes, coming in for abortion and without being accompanied by an adult. A distribution of contraceptives, however, would not solve an issue deeply entrenched in the dominant discourses of society and in the structural abuse of women. Sister Simone saw the need to begin the educational programmes at school, but included the role of the home when she stated that, "*I think that it starts at home basically. I know I speak to my daughter. I am very open with her and I always tell her that - you need to be careful."* Sister Simone's view was that the educational programmes at school should be conducted by health professionals who will be able to provide first-hand information. She stated that:

I always feel that the nurses need to go to the schools –educate them, teach them. I hope they do cause its nice for the young girls and boys to know that we come from there, we see the patients that are sick. We're trying to prevent them from ending up in this situation. Most of the time it is between 17 and 25 year olds that you find coming in with the TOPs. So it's that school. Now they're getting younger. You get the 13 year old, 14 year old, or 15 year olds coming in. I think that it would be a very, very good idea telling them the stories and that you have to look after yourself.

The concern for the plight of women goes beyond the legislation as voiced in the heartfelt concerns expressed by health professionals. The male participants also showed concern for women and the youth as represented by Raymond:

People need to know what abortion is all about. How it affects the woman's body and mind, affects relationships, and affects men as well, especially when they want

> *the child as badly as I did. People need to see and understand pregnancy from a medical view. Then they will understand what they are actually doing.*

Raymond viewed the inclusion of men and the provision of adequate, appropriate information as being vital in the abortion decision. Jared also voiced the need of women to be empowered to make informed decisions. He stated that:

> *They should counsel all women coming in for abortions. Many do abortions because of pressure from others. They should also explain exactly how abortion is done, the stage of development of a particular pregnancy and give the choice of the women. This is what the Constitution says. But women must be told. There should be programmes for women as well to teach them to stand up for themselves and not to be pushed around by others and have regrets for the rest of their lives. No matter what the constitution says it is the woman alone who has to live with the effects of what she has done. Men get away. There should be programmes for youth as well - both boys and girls – because all need to know about life before making big decisions.*

Alfred voiced concern for young people who are not aware of the reality of relationships, pregnancy, and abortion. He recommended outreach programmes to schools and colleges. He stated that there should be "counseling *at schools/colleges. Tell young people what abortion is, and how it affects the person. I don't know if this will remain with me forever. What will happen if our relationship breaks up?"*

8.2.3 Age of consent

Health professionals had witnessed many schoolgirls coming in for abortion without their parents or guardians. They were concerned that children are growing up in an adult environment where they too, have to be recipients of abortion services. Sister Theresa stated that, *"It is sad – the legalising of abortion. It's sad to think that's the way children are growing up now."* The health professionals were concerned that girls as young as twelve

were allowed to access abortions but needed their parents to go to theatre if any complications arose from the abortion, or for other medical emergencies. Sister Simone stated that:

> *I don't think that legalising abortion was the right move. I don't think that, taking into account that it's legalised from the age of twelve - it's still twelve I think - that a child doesn't have to tell her mother that she's coming for an abortion and she can give consent but if she complicates and she needs to go to theatre then we have to get the mother's consent because now this is the story. Legally you have to be of a certain age to go to theatre and you're considered a minor. I don't think ……. for me it's a little, I don't know – it doesn't make sense. It doesn't make sense. It's become fairly, I am shocked at the amount of young girls I see coming in here every day – shocked, shocked, shocked, shocked, shocked! You get those coming for TOPs.*

8.2.4 The rights of men

The male participants were concerned about their own rights and focused on their lack of opportunity to voice themselves. Raymond voiced the concerns of the male participants. *"Men must be consulted in issues with respect to their children - even the unborn unless of course a man has abandoned his family. A court must listen to both sides and make a decision."*

8.2.5 Concluding Remarks

The aim of feminism is a society where men and women are treated as equal and allowed to use available opportunity to rise to their full potential as human beings (Crown, 2005). It should be noted than none of the women spoke about women's rights while the men did so. Women were so overwhelmed with their circumstances and the abortion that they could not see beyond their present crisis. They made no demands for a better life. Women have been exposed to oppression to such an extent and for so long that they no longer see the

oppression as articulated by Freire (1970/1993, p. 330): "One of the gravest obstacles to the achievement of liberation is that oppressive reality absorbs those within it and thereby acts to submerge human beings' consciousness."

Internalised oppression is the basis for the maintenance and perpetuation of social hierarchies. Women have internalised their oppression to the extent that they have come to accept their structural oppression as a way of life. This internalisation of oppression leads to the development of low self-esteem, humiliation, and self-hatred that is evidenced in the attitudes and behaviour of those who are oppressed. The view of the oppressor is accepted as unchallenged truth. ''So often do [the oppressed] hear that they are good for nothing, know nothing, and are incapable of learning anything—that they are sick, lazy, and unproductive—that in the end they become convinced of their own unfitness" (Freire, p. 49).

8.3 Summary of findings

This study describes the psychosocial, ethical, and religious considerations of abortion. The findings, discussed in Chapters Seven and Eight, are in line with the underlying assumptions of the study.

The abortion decision is a complex one involving psychosocial, ethical and religious considerations. The contextual realities affecting the decision were financial circumstances, family relationships namely relationships with either the partner or the parents, and the extent of financial dependence on parents. Relational ethics rather than principled ethics guided the understanding of the abortion decision. The guilt experienced was over-ridden by psychosocial contextual realities at the critical moments of making the decision to abort.

Despite their pro-life views, participants prioritised their personal circumstances. The religious and cultural values and beliefs adhered to did lead to guilt and anxiety concerning the abortion. For the female participants the expectations of motherhood also contributed to the decision to abort. Those who had children wanted to ensure that their children had a

better life. Those who were not yet mothers wanted their future children to have a secure future, which they would be able to provide only if they completed their education. For the male participants the abortions done without their consent challenged their role as fathers, as men who want to provide for and care for their children. The participant had a family whom he wanted to protect.

The abortion decision is ultimately a woman's decision. Where participants had the support of their partners, the partners had supported the decision but did not contribute to the decision-making. Women are more intimately involved in making the abortion decision than men, as child bearing and child rearing are seen to be primarily the responsibility of women. The support systems available to the women did affect the decision-making and the ability to cope with the consequences of the decision. Those who did not have anyone to share their decision with experienced greater difficulty coping with the pain of the decision.

The decision produced guilt for women who might experience higher levels of guilt than men as the decision challenges the taken-for-granted assumption of the 'motherhood instinct', and society's expectation that women protect their unborn. Two male participants were involved in the abortion decision. They seemed to have coped with the decision because it was their own compared to the male participants whose partners chose abortion despite their objections. They experienced guilt in not being able to protect their unborn as is expected by society.

Health professionals too were faced with ethical dilemmas. They were divided on their views on abortion. Those who were totally against abortion and refused to perform abortions did not discriminate against those who felt otherwise. The need witnessed for abortion over-rode their ethical concerns. Those who chose to perform abortions tried to isolate their personal values from professional principles that focus on the need of the patient. They saw the need for legal abortions amidst the number of women who come in as a consequence of back-street abortions. They did however feel that since the legalisation of abortion, there has been an increase in abortions and repeat abortions. This did present,

to even those health professionals who have decided to perform abortions to assist women, an ethical dilemma. Most health professionals in this study voiced their concern for women and their having to succumb to various forms of structural abuse. Women are abused by family, spouses/partners, and once again by the system who in the name of meeting their needs set up thriving businesses without improving the lot for women. Women are not seen as persons in need. They are seen as 'another termination'. Therefore no time of professional care is invested in them. Women are not offered pre- and/or post-abortion care, or referred to any services or community organisation to improve their circumstances.

CHAPTER NINE

CONCLUSIONS AND RECOMMENDATIONS

9.1 Introduction

This study was designed to explore the psychosocial, ethical and religious considerations of the abortion decision. It adopted a qualitative, interpretivist paradigm and a feminist research design, which is committed to understanding the experiences of women and the gendered power relationships and discourses (Hesse-Biber, 2013) in a predominantly patriarchal society. Critical discourse analysis (CDA) was used in the analysis and discussion of the data. CDA focuses on social structures and the use of language to describe how existing structures impact the lives of women. Fifteen in-depth interviews were conducted with the aid of a loosely-structured interview guide. The sample was accessed via purposive sampling in a specialist abortion clinic and a governmental hospital, with entry facilitated by the health professionals. The interviews were recorded with permission from the participants, and transcribed verbatim. The data were coded, categorised and built into major themes. All ethical considerations, as discussed in *Chapter One* were adhered to.

This chapter discusses the major findings of the study with reference to the key objectives, and provides some recommendations. The major findings of this study corroborate the underlying assumptions of this study as outlined in the methodology in *Chapter One* of this report, with the exception of the assumption that, H*ealth professionals too are faced with ethical dilemmas. However legal imperatives over-ride their ethical concerns***.** Nurses, however, who had to care for the women and had to deliver live foetuses, did allow legal and employer obligations to over-ride their ethical concerns. The doctors were not faced with this dilemma.

9.2 The research

The following were the objectives of this study all of which were achieved:

- To ascertain how the abortion decision is made;
- To explore how current contextual realities affect the abortion decision;
- To explore the role that religious beliefs, personal value systems and cultural values play in the abortion decision;
- To explore how right and wrong is negotiated among men and women within the context of religious and cultural expectations;
- To analyse whether women and men experience abortion differently;
- To analyse the meaning of motherhood and fatherhood to those who decide on abortion;
- To ascertain what support systems/structures are available to people who decide on abortion;
- To analyse the potential impact of dominant discourses on motherhood and fatherhood on the abortion decision; and
- To explore the possible consequences of abortion

9.3 Major conclusions

Based on the findings of this study, major conclusions are presented under four broad headings namely the abortion decision, structural constraints on women's choices, challenge to the pro-life/pro-choice dichotomy, and the dominant discourses of motherhood and fatherhood.

9.3.1 The abortion decision

As with the study by Lakartidningen (2005), this study concluded that the abortion decision is a complex and emotionally laden one. The complexity of the decision is due to various psychosocial factors as was asserted by Loriencz et al. (2001). From a psychological

perspective, the aftermath of the decision is traumatic. While none of the participants reported symptoms of clinical depression, they reported experiencing guilt, a sense of shame, and that they had violated moral, ethical and religious codes. From a personal perspective, they felt uncomfortable with the decision they made although they had no regrets in having made the decision. While participants did not report on-going disrupted relationships, they reported intensified feelings of sadness, and chose to isolate themselves as a way of dealing with their feelings soon after the abortion. The primary driving factors were financial constraints, unemployment, abandonment by partners, and fear and shame in view of familial and societal judgments and rejection of pregnancy outside of marriage. Abortion is therefore, not a straight, clear-cut decision. Life is complex, and so are the decisions in life. If life was simple and straightforward, and all human beings were exposed to the same opportunities, women would not have to consider such painful decisions (The Revolution, 1868, as cited in Feminists for Life, 2004, p. 1; Lewis, 2011).

Feminist relational ethics and social constructs of motherhood impacted the abortion decision**.** The narratives spoke of the women's acute awareness of the responsibilities of motherhood and the obligations that they have towards children and other significant others in their lives as was the findings of Cannold (1998), Finer et al. (2005) and Jones et al., (2007). Those who already had children enjoyed being parents. They felt a natural bond with the unborn and experienced a sense of loss after the abortion. They expressed the view that in carrying a child to full term pregnancy and giving birth, they would develop an emotional attachment to the baby, which would make giving-up the child for adoption traumatic, a finding that concurs with the findings of Jones et al. (2007).

While religious and cultural teachings were considered both prior to and after the abortion, participants negotiated the ethical dilemmas engendered. These were negotiated by prioritising their immediate needs, and the needs of their families. The adherence to religious and cultural values did, however, affect their coping with the abortion as was found by Bennett (2001), Fielding and Schaff (2002), and Trybulski (2005).

The medical professionals who participated in this study had chosen to perform abortions

as was found by Mhlanga (2003). Factors influencing the decision to perform abortions included personal experiences of women being injured or dying as a result of backstreet abortions, personal experiences of having seen children left orphans and on the streets because their mothers died as a result of backstreet abortions, and personal experiences of babies and small children being abandoned because women were not able to care for them. Humanistic concerns overrode the religious and moral concerns of health professionals. Medical professionals who worked in the hospital ward where abortions were performed and who chose not to perform abortions did not condemn those who did. They too viewed abortion from the perspective of women's needs but were not willing to perform abortions themselves. They were able to exercise the right to conscientious objection on the grounds of their religious and ethical values. The legal imperatives were not mentioned by any of the doctors who chose to perform abortions. Nurses who performed first trimester abortions had a choice in being trained to do so. The legal imperatives were mentioned by the nurses who had chosen not to be trained to perform abortions but were required to nurse women prior to, during and after the abortion which included the delivering of the live foetuses during the abortion process. These findings are consistent with those of Hannah (2005) and Pera & Van Tonder (2005).

9.3.2 Challenge to the pro-life/pro-choice dichotomy

Pronatalism and the value of the sanctity of life underscore the pro-life position (Smith, 2005). The presumption is that if one is pro-life, one cannot or will not make a pro-abortion decision. The data from this study challenge this dichotomy. While it may seem a paradox, all of the women expressed decidedly pro-life views, even as they chose abortion. Life is not as simplified as these two compartmentalised groups. Many factors and pressures come into play, making life, the decisions made in life, and the reasoning used in decision-making, complex. Women are caught in this extremely complex life where they are forced to make choices against what they believe, as is evident in this study. The narratives speak of the dominant pro-life discourses as women referred to themselves as sinners and murderers. As discussed in *Chapter Eight*, none of the women spoke of the unborn in objectified pro-choice language of 'the foetus' or 'the embryo'. They talked about the

unborn in endearing, humanising pro-life terms like ‘my baby’ or ‘my child’ and during the course of the interviews, the women cumulatively made forty-five references to the unborn as ‘baby’.

Had their circumstances been ideal, without the financial constraints, abandonment or fear of abandonment, threats of violence and fear of societal reactions and judgments on falling pregnant outside of marriage, these women might not have opted for abortion. The paradox of being pro-life while opting to abort made the abortion decision all the more difficult for the participants, and they had to bear the burden of guilt and responsibility for taking a life. Some of the women humanised the unborn to the extent that they wanted to fulfill cultural rituals to appease the ancestors and allow the spirit of the aborted to rest in peace, equating the loss to that of family members. If these women had the support of those around them, and the financial means to provide for a baby, they might have chosen differently in keeping with their pro-life values as was the finding of The Revolution (1868) as cited in Feminists for Life (2004, p. 1) and Lewis (2011). Their choice would then truly be a free one, and not constrained by societal discourses and practices. The narratives of the women speak to the fact that the women did not choose abortions simply because they had a right to such choice. There were grim life circumstances that pushed them into making the decision, thus rendering their choice a constrained one, a finding that challenges the pro-life/pro-choice dichotomy (Smith, 2005).

Pro-choice advocates a liberal feminist perspective, emphasising the freedom of choice of women (Smith, 2005). From a liberal feminist pro-choice stance, women are seen as having total control of their own bodies and decisions are reduced to the level of the individual. Liberal feminist pro-choice stance does not consider how women’s choices might be constrained by structural factors. It ignores the realities of women and the need to improve the circumstances of women (Patchesky, 1990; Smith, 2005; Fried, 2008). Abortion is a conditioned choice.

None of the participants viewed it a ‘right’ but rather a painful, emotional decision that presented many dilemmas, and subsequently led to them labeling themselves as ‘bad,’

‘criminal,’ ‘sinful,’ and ‘wrong.’ Although from a principled point of view they viewed abortion as wrong, from the relational ethics point of view, namely, the relationship with their parents, the care of their present children, the future of the unborn, other family members who may be affected, they considered abortion the more appropriate choice that did not compromise others in their lives. This is in keeping with feminist ethics that explain how women use relational ethics to make complex moral decisions (Cannold, 1998; Finer et al., 2005; Jones et al., 2007).

Both the pro-life and pro-choice stances inherently exclude the experiences of most women. While these two groups claim to be on opposite sides, they are actually very similar with the focus on whether women should or should not have a right to abortion without focusing on the economic, political, and social circumstances that force women to make such a choice. Neither group focuses on empowering women to improve their circumstances so that they may not be forced to make such a choice (Smith, 2005).

In the abstract it is easier to make judgments of right and wrong. Contact with participants helped me humanise the context of abortion. In the relational context of being with women, getting to know them, and hearing their narratives it is harder just to label behaviour/actions as right and wrong. Similarly, the pro-life and pro-choice groups need to humanise their views by getting into contact with women and men and understanding their circumstances (Smith, 2005). The pro-life/pro-choice perspectives should not be viewed as dichotomous, but interrelated.

9.3.3 Structural constraints on women’s choices

It cannot be claimed that women in our democratic society exercise free will as they are constantly subject to structural conditions that impose constrained choices (Foucault, 1982). One of the recurring themes in the narratives of the women was financial hardship combined, in some cases, with abandonment by their partners on learning about their pregnancies. The abandonment of women and children were corroborated by health professionals who noted that abandonment of women and children as the reason for their

decision to perform legal abortions. One of the major push factors towards abortion is financial constraints and women's concerns about their inability to provide adequately for the child as was found by Williams and Shames (2004). Within the social constructs of pregnancy, child-birth and child-care being women's responsibilities, many men in South Africa abandon their partners during pregnancy, leaving them to fend for themselves which confirms the findings of Morrell and Richter (2006). This discourse privileges men into abandoning their partners and evading responsibility, leaving women to cope on their own. Women too have internalised this and have come to accept responsibility for falling pregnant and coping with the consequences of the decision. Men assume that it is up to women to decide what to do with pregnancies, or the subsequent birth and care of children (Morrell & Richter, 2006). This leads to women having to assume total responsibility for the family, which has become a common feature in South African households.

Unemployment, poverty, child neglect and child abandonment are linked. The impact of neoliberalism in post-apartheid South Africa, denies millions of people the right to decent work, and is a notable contribution to growing inequality (Sewpaul, 2013b). Some of the women in this study reasoned that it was more ethical to end the pregnancy than continue the pregnancy and abandon the child because of poverty, a practice that is widespread in South Africa (Morrell & Richter, 2006). Those who experienced hardship in providing for their existing families did not wish to repeat this, and they did not want their present children to suffer even more.

The internalised, patriarchal values of society contribute to men treating women as inferior and as property over whom they have total control. Men demand that their partners do not use contraceptives, while they do not share in the responsibility for preventing unwanted pregnancies. This emerged from the narratives of health professionals. From a patriarchal perspective, contraception is considered 'women's business.' The primary participants did not even mention the role or responsibility of their partners in this regard. They have come to internalise the responsibility as being theirs alone as asserted by Freire (1970), Phererson (1986), Rieser (1990) and Sewpaul (2013a). As with the finding of Kaye et al., (2006) and Whitehead and Fanslow (2005), family and partner violence, as a structural constraint, is

also a predictor of abortion. One of the push factors towards abortion was that women with painful experiences in their previous or current relationship feared a repeat of the past, a finding consistent with that of Jones et al., (2007).

What also emerged from the narratives of the primary participants and the health professionals is the lack of holistic sexuality education. Health professionals observed that women had minimal information of contraceptives, their rights and responsibilities in relationships, how pregnancy and abortion affects their bodies, and the extent of the abuse of young women by older men in keeping with the findings of Martin et al. (2000). The primary participants maintained secrecy of their relationships and the subsequent pregnancies. With life orientation available from grade one at schools, the concern is the quality of the content and approach of the programme. The youth need to be taught the importance of family and formal community structures in protecting them from all forms of abuse.

The need for post-abortion care emerged from the narratives of the women who had no guidance or support after the abortion, and no help in improving their circumstances. These conclusions find support in the literature (Wood & Tully, 2006; Corbett, 2010). Participants returned to the very circumstances that dictated their choice to abort. This was corroborated by health professionals who were aware that women have abortions against their choice but they, as health professionals, do not have the time to attend to the needs of women. They were also concerned about the abuse of women and the rate of repeat abortions as was the finding of Cohen (2007). The narratives also indicated that participants had little or no knowledge of the TOP Act. While some knew that abortion is legal and therefore sought the service, others were told so when they were referred for the service. Pre- and post-abortion care moves beyond the need for just counseling of any sort. The feminist ethic of care demands that women receive holistic care prior to and after abortion to empower them to reconstruct their personal environments.

9.3.4 Dominant discourses of motherhood and fatherhood

Popular pronatalism contributes to motherhood being revered and rarefied, but only within designated circumstances, namely, at the right age, and in an increasingly consumerist society at the right time, and within the context of marriage. Pronatalism and the motherhood mandate, where every women is supposed to *want to be* a mother (Gillespie, 2003) irrespective of her life circumstances, contributed to guilt and an internalisation of society's judgments about one's moral badness as was asserted by Engelbrecht (2005). Yet, at the same time there was an overwhelming sense of shame on account of the stigma attached to out-of-wedlock pregnancies that pushed participants into the abortion decision. The social status and reputation of the family in the community, where issues are gossiped about, had to be protected as was the finding of Anstee (2009). Thus participants were placed in a double bind, being condemned for falling pregnant out of wedlock and for making the decision to abort. Shame, guilt and fear of family and societal reactions contributed to the participants not disclosing both the pregnancy and the abortion. As pregnancy occurred outside ideal circumstances, secrecy was maintained both about the pregnancy and the abortion, making the abortion decision was a private one as was found by Engelbrecht (2005).

Responsibility for sex, pregnancy and children were seen as 'women's tasks' where the men involved avoided such responsibility as was found by Maharaj (2010). Women and men are socialised into these roles and strive to fulfill the gender role expectation of society. In Freirian language (Freire, 1970), the women internalised societal oppression and failed to see how external structural constraints imposed limitations on access to resources such as jobs and education, and on the mothering role. The participants believed that they have to be 'everything' to their children, even where they were denied gainful employment and the support of their partners. The participants solely shouldered the responsibility of caring for children and blamed themselves for not being able to adequately provide for them. The awareness of the complexities of the social demands of motherhood influenced participants' decision-making.

With women being considered the primary child-minders and caretakers of the home, the physical and emotional demands of the family were placed on participants despite their jobs outside the home. The historic view of women being the primary house-minder (Douchet, 2000) has not changed sufficiently to accommodate women who hold outside jobs. The participants therefore, over and above work responsibilities, assumed a large portion of the responsibility of the home. Stress and difficulty experienced in coping with the present responsibilities also contributed to the abortion decision.

The discourse on fatherhood impacted the reactions of the male participants to their partners'/family member's abortion. Where participants wished to have the baby and assume responsibility as fathers, the discourse of male as protector of the family led to feelings of anger with regard to them not being allowed to protect their unborn in keeping with the findings of Condon and Hazard (2001), Coyle (2006), and Williams (2006). This however is not common practice in South Africa where the discourse of non-involved father prevails. Men in South Africa were found to become biological fathers without involvement in the lives of their children (Morrell, 2006).

Summary

As reflected in the discussion of the major conclusions, all the objectives of the study have been achieved. The underlying assumptions were collaborated except one, namely, *health professionals too are faced with ethical dilemmas. However legal imperatives over-ride their ethical concerns.* This assumption was applicable only to the nurses who had chosen not to perform abortions but were, nevertheless, required to care for women who had abortions. Their dilemma included the delivering of life foetuses.

Radical feminism has contributed to social work's understanding of the structural dimensions of women's lives, and how dominant social constructions of motherhood, pregnancy and marriage have contributed to women's reproductive health decisions (Sewpaul, 1995). Adopting a principled approach towards justice, the participants constructed their choices as bad, sinful and murderous, and in doing so saw themselves as

immoral, sinners and murderers. Yet, feminist relational thinking superseded this principled moral reasoning, as they allowed the needs of others, primarily concerns about provision for the unborn child, their responsibility towards existing children, and the need to protect their reputation and the reputation of their families, to take precedence over the pain and suffering that the abortion decision brought. The structural conditions and the dominant societal discourses that uphold pronatalism, but only within certain defined situations as discussed above, are an indictment on society. If the reproductive health choices have to be made freely, safely and legally available to women, women must be granted true freedom to exercise reproductive choices. Stemming the incidence of abortions depends on society's ability to provide structural conditions, conducive enough to render women's choices to be truly free. This means ensuring women's access to education and gainful employment, challenging dominant gender-roles that place an inordinate responsibility on women for child-bearing and child rearing, and getting men to take on the responsibilities of fatherhood. It also means challenging the double standards of a society that reveres motherhood and children, but condemns women for falling pregnant in less than socially determined ideal circumstances, and more importantly a society that ostracises and labels children as 'unwanted bastards'. The most felicitous start to life, after all, is being born a wanted and loved child.

9.4 Recommendations

Healy (2008) asserted that social workers have made an impact in the key provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). The rights that are identified in the Universal Declaration of Human Rights (UDHR) are the basic human needs for survival and development, and social works mission and values as a profession fall in line with that of human rights (Healy, 2008). This places social work in an ideal position to address women's circumstances and abortion more clearly and specifically. Healy (2008) identifies several strengths of social work which needs to be utilised to promote the care of women. Social workers understand how meaningless legislated rights are to the well-being of

women. Where women have to go without adequate food, shelter and health care and expose their children to same, the best of legislation has no meaning. At the same time, women from all socio-economic groups are affected where there is no legislation to enforce their well-being. Social workers are, therefore, in the best strategic position to represent the needs of women. Social workers understand and are committed to both cultural diversity and individual needs, and are committed to action. This places them in a unique position to impact women's issues holistically (Healy, 2008).

Arising from the findings of this study and the suggestions made by participants, the following recommendations are made: policy implementation, education for life, reframing dominant discourses, addressing structural constraints, and empowering women and men. In making the foregoing recommendations it is presumed that government has established structures that are able to attend to the needs of all women and men. If not, it would be wise to invest in such structures in all communities to ensure a better quality of life for all the country's citizens. This is in line with true democracy and the demands of feminism. Considering that women are oppressed by various structures in society, recommendations are made with respect to all structures at micro, mezzo, and macro levels. As expressed by Dominelli (nd. p. 69) "The challenge remains as to how best to support women's struggle for gender equality - by supporting women and women's issues or by improving the position of all people in the hope that women's specific concerns will be addressed as a by-product." The recommendations of the participants and the health professionals are included in my recommendations.

9.4.1 Policy implementation

South Africa has phenomenal policies and legislation of world-class standards. The policies in themselves cannot be faulted. The poor implementation of the policies and legislation, and the accompanying inefficient service delivery demands governmental intervention. Access to information itself is insufficient in impacting the lives of women. The existing legislation needs to be implemented and effected simultaneously, at multiple levels, to make a constructive change for women. Policies must be redesigned towards reducing the

incidence of abortions by making socio-economic and cultural conditions more conducive to women's well-being. The Departments of Women, Children and Disability, Education, Health, Social Development need to plan, design and implement strategic inter-sectoral programmes that will effect change for women and children. The Departments of Social Development and of Women, Children and Disability need to work together towards creating sheltered jobs for youth and women who receive grants, and meaningful, structured programmes for women, youth and children. This could include income-generating opportunities in the communities which enable them to still be available for their children or grandchildren. Grandmothers have historically been a strong support to their children and their grandchildren and need to be supported in their contribution to society. To this end the various departments need to corroborate their efforts and involve the various community-based organisatons, religious and cultural organisations, as well as social and sporting groups in the design, implementation and evaluation of programmes. The programmes should be socio-culturally sensitive as recommended for HIV education programmes (Holtgrave, Qualls, Curran, Valdiserri, Guinan & Parra, 1995), and should be implemented in close proximity to women's places of residence by personnel qualified. All existing programmes in a particular community need to be coordinated in order to make a greater impact and to ensure that those in rural areas and those who have not received much formal education are also reached.

The implementation of the TOP Act needs to be addressed on a national level with reference to its implementation, the quality of pre- and post-abortion care including counseling, referrals, informed consent, and services to women after the abortion (Varkey, 2000). There is a need to maintain statistics on women who had abortions including geographic location, level of education, racial/ethnic groups, employment status/income, economic groups, reasons for abortion, number of abortions, and use of contraceptives. This will aid in strategic planning as in the case with other needs (United Nations, 1979). Where there is a need for abortion it must be provided safely, legally and with skilled pre-abortion counseling to enable women to make fully informed decisions. Post-abortion care, too, becomes a necessity in reducing the incidence of repeat abortions.

9.4.2 Education for life

Education is liberating. To this end education should develop persons who are able to critically evaluate their circumstances, are sufficiently empowered to impact change in their personal environments, and have sufficient vision to make positive decisions that contribute towards a better life for themselves and their future families.

Although knowledge alone will not change behaviour, knowledge is power. The best prevention of unwanted pregnancies at school level is the empowerment of all children through education. For the school and other institutions of education to achieve their task of empowering young people it is important that the Department of Education provide quality basic education that focuses on developing citizens who respect one another. What a child learns during the early years plays a profound role in shaping later values and behaviour (Sylvia & Wiltshire, 1993).

Education is important for responsible living in preventing unwanted pregnancies and exposure to sexually transmitted infections (STIs), including HIV/AIDS. Children and adolescents are not ready for the physical, emotional, and psychological consequences of sex. The main aim in education should therefore be to guide learners toward abstinence and toward practicing sexual relationships only within a monogamous adult relationship. To this end, the promotion of responsible sexual behaviour, improvement of young people's socio-economic status and reduction of their vulnerability to sexual and other forms of exploitation is imperative (van Rooyen & Louw, 1994). There is a need for holistic sexuality education programmes, and access to accurate information (Jacob et al., 1989). This needs to be enhanced through the promotion of an environment that facilitates the healthy development of both learners and the school staff. A school environment that promotes mutual respect, caring, sharing, self-efficacy, self-esteem, and self-motivation should be cultivated.

Both girls and boys need to be empowered. Boys become men. The kind of men they become impacts the quality of life of women, themselves and society at large. It is therefore

imperative that boys are educated to appreciate the importance of being involved, caring and supportive husbands and fathers. To this end, the format of teaching sexuality education programmes needs to be reviewed. There is a need to balance the discourse on rights with that of responsibilities. Responsibility for one's self and for others ensures a good life for all. Teaching values and self-control, promoting sporting and recreational activities, and promoting healthy living will stimulate attitudinal and behavioural changes such as delaying of sexual activity until one is physically and emotionally mature, and economically independent to deal with the consequences of sex. A comprehensive sexuality education programme needs to be part of the whole school curriculum (Kirby, 2002). It needs to promote changing attitudes to sex, communication among learners and significant others such as parents and educators around sex, networking with community resources with regard to sexuality education and services, partnerships among family, religious organisations, school, media, business and other community groups, and recreational activity. The programme should teach assertive behaviour, values, self-talk, self-control, effective and efficient social skills, and decision-making skills especially in crisis situations (Deshler, Schumaker & Lenz, 1981), and teach male and female learners to respect themselves and to respect each other. The programme should enable identification and the accessing of community resources, identification and the changing of negative or destructive thoughts, and problem-solving. It should build skills that foster positive self-concept, higher levels of self-efficacy, coping with peer pressure, initiating and maintaining relationships, identifying and controlling their feelings, and identifying when they are being taken advantage of. It should teach and encourage abstinence from sex or the delaying of the onset of their sexual debut, and communication with parents and other significant adults in their lives. To this end the school needs to provide a forum to discuss their sexuality, correct information as to the consequences of sex and abortion, role models which are exceptionally important to young people, opportunity to systematically use the basic skills that are required in problem-solving situations, information on available family planning methods from which they will be able to draw during all stages of life, and opportunities to be actively involved at school (Advocates for Youth, 2008). Children are becoming sexually active at an early age either by choice, need, or abuse. The family, cultural beliefs and socio-economic status often predisposes young girls to abuse by older

men (Martin et al., 2000). Sexuality education must therefore, be specifically addressed in the context of the cultural and traditional norms and values of the communities it is presented in.

It may be necessary to screen and train educators who are suitable for sexuality education programmes because educators become role models to the children they serve. The Department of Education needs to provide ongoing training for and monitoring of educators, especially those who are responsible for sexuality education of children (Howard-Barr, Rienzo, Morgan Pigg Jr. & James, 2005). Ongoing support services for educators ensure that their needs are met and they are empowered to serve the children in their care. To this end, the Department of Education also needs to provide structured resource networks within the communities and within the Department of Education itself to afford educators access when needed. Provision needs to be made for a school social worker and a school psychologist to be attached to every school or to a cluster of schools within close physical proximity to each other. The school social worker and school psychologist can develop caring relationships with learners thereby enhancing the programme. Furthermore, these professionals will also be able to network with parents, community organisations and departmental resources (Dupper, 2003).

It is recommended that all stakeholders be involved in sexuality education. An interactive model, structured by educators, social workers, parents, religious and community groups and learners to meet the needs of learners, is strongly recommended. A participatory approach in designing and implementing life-skills programmes at schools ensures that learners, educators, parents and the community are involved. This leads to ownership of and participation in the programme. Such collaborative efforts would give impetus to the school's sexuality education programme (Dupper, 2003).

The designing of community health education programmes, with sexuality programmes in the education sector, should be undertaken with socio-cultural sensitivity to the culture and values of the community being served, while, at the same time, addressing the cultural

values that promote abuse of women. As discussed above, various community and religious groups also need to be involved from the outset.

Abortion services offered by hospitals and clinics should include comprehensive, non-discriminatory and non-judgemental *pre- and post-abortion care* which is discussed later in this section. It is recommended that professionally trained social workers be attached to abortion service providers making pre- and post-abortion care accessible to women. Social workers can empower women through individual and group therapy, family counseling and community liaison services. Stabilising and building relationships with families; building, strengthening, and encouraging families; and networking with the communities will provide greater insight into the realities of women as well as help establish links for women with their community resources (Klasen, 2002; Wood &Tully, 2006).

The provision of health services needs to be improved and extended to include educational programmes with respect to contraceptives, prevention of STIs, pregnancy, childbirth, childcare, abortion and the TOP Act and made available to all women. Contraceptive providers at clinics need to counsel especially young women with regard to the consequences of early and promiscuous sexual activity. Where necessary, women in abusive circumstances need to be referred to appropriate community resources. School programmes on health care, sex and contraceptives can be undertaken in community services outreach programmes covering contraceptives, the consequences of sex, pregnancy, STIs, and abortion (Advocates for Youth, 2008).

Factors identified as protecting young persons from engaging in sexual activity and hence from falling pregnant include high parental support, social support, religious faith, regular sporting activities, and culture (Loriencz et al., 2001; Bradshaw & Slade, 2003). To decrease the rate of unplanned pregnancies the involvement of other *role-players* is imperative. Parents are the primary influence in children's lives. Together with the family, both the immediate and the extended family, the parents are important role models for the child. The majority of young people make their decisions about sex according to their family standards. Parent involvement and responsibility in sexuality education activities at school

and the community is therefore necessary (Kirby, 2002). The sustainability of programmes will, in this way, extend from the school to the home.

Community-based organisations include, amongst others, NGOs, welfare organisations, religious, cultural, youth, social and sporting groups. Young people join community-based organisations because of sport, recreation or community service. These organisations could be multi-dimensional and extend themselves in providing young people with a sense of belonging, social support, and responsibility for themselves and for others, self-esteem through personal achievement, personal satisfaction and public recognition, decision-making, alternatives to risky behaviour, and provide meaningful, structured programmes in sexuality education. Community based organisations can also provide support, information and practical assistance to schools in sexuality education programmes (Shumow, 2009).

Both culture and religion play a significant role in the life of individuals. In a country with diverse cultures and religions, building on and strengthening the positives from different groups is a key to changing behaviour. Bringing on board the religious and cultural groups is a means of constructively reaching out to make a difference. But the various cultural and religious groups cannot be expected to teach their followers values that contradict their teaching. To this end, policies must be sensitive to the cultural and religious values and thereby gain the support of the various groups. These groups can then be used to teach adherence to religious and cultural values that result in the protection of the individual, the family, and society. Through socialisation and culture "identities are created, negotiated, recreated and renegotiated" and the formation and maintenance of identity depends on "creating and maintaining differences" (Dominelli, 2002a, p.41). Cultural issues that need to be addressed by the leaders of various groups include the role of women in the home, in relationships and in society; and the education of men concerning their attitude towards and treatment of women. Unequal gender relationships that have their roots in religion and culture are difficult to change with just educational programmes. It demands a new mindset and needs to be addressed while children are still very young.

Sporting groups are in an advantageous position in terms of impacting young people with

regard to the many pressures that are present during adolescence, well before they reach adolescence (Gísladóttir, Matthíasdóttir, Kristjánsdóttir, 2013). Membership to community sporting groups is voluntary and very attractive to the young person who not only enjoys the physical action, team play, and competition, but also has the energy for sport. Members develop a sense of belonging to the group, loyalty to their trainers, and often are willing to go out of their ways to please them. The trainer/coach does become a very important person and needs to utilise his unique position to positively impact the young people that come to her/him.

Existing women's groups in the communities need to focus on building self-esteem, empowering women with basic education and skills to become self-supporting, parenting skills to raise their sons to respect and care for women and to ensure that their daughters receive adequate education, and skills which address the basic issue of the attitude of men. Women need to value themselves as independent, unique persons with their own needs (Meintjies et al., 2001). Men's groups play a vital role in teaching men to respect women and to treat them as equals. Men can be taught and trained, in a familiar setup, to become responsible husbands and fathers. Many men need to be re-trained into these roles. Men's groups which may take the form of sporting, religious, or social groups may be utilised to teach child-minding skills. Parenting programmes for both women and men need to address the parenting of boys and girls who are generally socialised into particular masculinities and femininities that perpetuate the dominant discourses (Burman, 1995).

The conflicting messages received at school, from public figures, culture, and especially the media need to be addressed. Role models are extremely important. Public figures need to be *worthy role models*. Having several sexual partners and not using contraceptives only teaches young people to do likewise. The majority of young people watch television each day. Television subsequently provides an important, available and effective medium to reach and to make a positive impact on them. Correct information needs to be disseminated at all times. Beside introducing more educational and life-skills programmes, government needs to be proactive in visiting the type and quality of the programmes that young people are exposed to on a daily basis. (L'Engle, Brown & Kenneavy, 2004). There is an urgent

need for ongoing wholesome programmes especially in respect of sexuality education, and the potential role of culture in promoting the abuse of women, pre-marital and unprotected sex, non-use of contraceptives, and multiple sex partners in a society where HIV is beyond control. Programmes like the Soapies, which are aired on all channels during peak viewing time do nothing to instill wholesome values on impressionable people.

To maximise impact of community programmes, all efforts in the community should be coordinated. Both vertical and horizontal networking is vital if programmes are to be successful. It is important that all stakeholders plan constructive, sustainable programmes that would have an impact on all community members. Most importantly all institutions, organisations, and groups need to speak with one voice which can be heard and remembered by all: a voice which promotes quality life for all.

9.4.3 Reframing dominant discourses

Patriarchy has promoted oppression, male aggression, violence against, and the abuse of women (Meintjies et al., 2001). The discourse on patriarchy and masculinity needs to be deconstructed and both men and women need to be re-socialised to value the inherent differences. This lends itself to the elimination of all forms of violence and abuse in society, and to men accepting and living with women as no different to them (Sathiparsad, 2008). In reframing dominant discourses both women and men need to be guided into understanding how these discourses protect and promote patriarchy and power at the expense of the well-being of women (Sewpaul, 2013; Shankar et al., 2013). To this end, leaders of religious groups, cultural groups, community groups, and victims of abuse can play a crucial role in educating society and effecting change by generating alternate discourses that eliminates violence and promotes equality for all. Empowering women, as discussed later in this section, to resist oppressive discourses is urgent and calls for a holistic approach that combines interventions on all levels. Women will more readily seek help with their oppressive circumstances when they are assured a change in their circumstances (Shankar et al., 2013).

Dominant discourses however, do not necessarily function totally to the detriment of the well-being of women and the well-being of society. Marriage and family life has long been a foundation to a stable society. And marriage together with the family is highly valued by all the religious groups. The discourses of marriage, family, and pregnancy can be perceived as dual-purposed: perceived as protecting women and also hurting women. In deinstitutionalising marriage, men may more frequently abandon women because they have made no commitment to them. More women may be left pregnant and alone, and more children left fatherless. Fathering children and not participating financially or socially in their lives may become the norm. The promotion of marriage may protect women and provide a home for children. It is the discourse of the role of women within these institutions that have led to the inequality and abuse of women. While family life needs to be reinforced and strengthened, these discourses need to be addressed to ensure that women are valued members of the family and of society with equal opportunities to participate in and contribute to a democratic society. Aspects of those discourses, which negatively impact the quality of life for any member of society, need to be deconstructed, and reconstructed in a complex, multicultural society. Discourses, which serve to improve the quality of life for all, need to be protected and reinforced to ensure a safe life for all. Institutions that promote stable family life should be strengthened for indeed the family is the foundation of society. The role of women in the home should be viewed and respected as invaluable rather than women being treated as sources of unpaid and as inferior (Altman, 2003).

Discourses, to establish credibility and acceptance by all, need to be consistent with the values attached to circumstances, issues and events. Society needs to be consistent in its expectations of all members of society. Sexual exploitation, multiple sexual partners and unprotected sex is unacceptable and counter-productive for both women and men. Both women and men should receive negative sanctions for this. Where cultural and religious groups promote the value of life, all life, including that of the unborn, conceived out-of-wedlock, should be valued. All children should be equally cared for and not stigmatised. Understanding and acknowledging differences in a multi-cultural, multi-religious society like South Africa is paramount. The various groups in society need to find common ground

(Sen, 2006), despite the differences, to work together to identify and eradicate practices in social class, religion and culture that perpetuate abuse and violence towards women, and other oppressed groups in society. Foucault (1982) views communication as the key to deconstructing and reconstructing dominant discourses. Men need to be re-socialised into their roles. Programmes like Men as Partners (Peacock & Levack, 2004), and the Fatherhood project (HSRC) in South Africa that work towards re-socialising men into appropriate gender role of husband and father should be supported, promoted and extended into all communities.

9.4.4 Addressing structural constraints

The needs of women go far beyond pregnancy and abortion. Women's lives are shaped by socio-economic and cultural realities. In keeping women central to feminist studies, feminism attempts to alter social institutions and situations which discriminate against women (Wadsworth, 2002). In addressing the abortion debate the real issues namely the inequality and abuse of woman in society is overlooked (Smith, 2005). Coupled with legislation, there needs to be structural changes at every level from attending to women's basic needs to empowering them to improve their circumstances.

Abortion has been legalised because of the prevalence of unsafe abortions. Yet there are countless bogus doctors in every province who are performing illegal abortions and hurting women (Khumalo, 2009), and private legal abortion providers prey on the circumstances of women by making abortion a money-making venture (Rosenberg, 1997). In keeping with the goal of protecting women, all illegal abortion providers need to be removed and legal service providers need to provide the service within a holistic plan of treatment. Health workers need to be adequately trained and allowed sufficient time to counsel and educate women to reduce the frequency of forced abortions and repeat abortions. This is in keeping with the demands of feminism.

The TOP Act, 92 of 1996 provides for the right to information but the right to counseling before the procedure is non-mandatory. It should be made mandatory for abortion service

providers to provide pre- and post-abortion counseling, and that women should be allowed to access this service on a voluntary basis (Hodson & Seber, 2002; Handy, 2011). The option not to receive counseling should be the prerogative of women and not that of providers of the service (Steinberg, 1989). In instances where men show an interest by accompanying women to the abortion clinic, they need to be encouraged in their actions and involved in the whole process. This helps to allay their fears and concerns and enables them to offer adequate support to their partners. It is encouraging to note that men, although a small number, are becoming involved in the lives of their partners (Plantin, 2003; Johansson & Klinth, 2008).

Democracy in South Africa with its claim of economic development has not significantly impacted the circumstances of the majority women. Poverty and unemployment is still widespread. Real freedom is seen within the context of social, economic, political, health and civil rights. Therefore development demands the eradication of all forms of oppression namely poverty, lack of employment, the practice of nepotism, and inadequate medical, educational, social, and community facilities, inequality and systematic abuse. True freedom needs the removal of social circumstances that impinge the rights of women (Sen, 1999).The government needs to provide wider access to decent jobs where citizens can earn an income and provide for their families. This can be achieved by limiting cheap imports and supporting local production. Contrary to what is commonly said, most people want to work and are not content living off a grant (Sewpaul, 2013). To this end citizens need to be equipped with skills and on-job training to make them employable. Given the current high rates of poverty, inequality and structural unemployment; and the fact that many households, some 65% of those employed, earn below a living wage, a basic income grant (BIG) is recommended in promoting socio-economic equality (Du Toit, 2005; Sewpaul, 2005, 2013; Triegaardt, 2006).

While women have a right to safe and legal reproductive health choices, including abortion, it is up to society to ensure that societal conditions support women's choices (Smith, 2005). Structural oppressions and limitations, which force women into decisions that may go against their moral frame of reference, must be confronted, challenged and eliminated. If

pronatalism and pro-choice are the preferred options as reflected in popular daily discourse, especially those of religious doctrines, then societal discourse around pregnancy and childbirth within the institution of marriage will have to be challenged and de-constructed so that women, who fall pregnant outside of marriage, do not opt for abortion out of fear and shame.

9.4.5 Empowering women and men

Feminism views women as being interconnected (Hesse-Biber, 2013). By empowering men it would ensure that men understand, accept, and care for women as equal partners in life. Empowering women entails the empowering of the masses of women, and not just the few elite, to ensure that women are in a position to rise above their deprived, abusive circumstances to carve a future for themselves and hence for their present or future families.

The promotion of family planning to enable women and men to avoid unwanted pregnancy is important in improving women's health. This, in turn, will achieve one of the Millennium Development Goals, namely, *improving women's reproductive health*. This however goes beyond ensuring that women have access to safe and effective methods of fertility control. Addressing cultural views on contraception, ongoing education, better and appropriate education and health facilities, and social services will empower women to become self-sufficient and to generally avoid situations of unwanted pregnancies WHO (2008).

Women and men firstly need correct information on contraceptives, including the condom (Cohen, 2007). The condom, widely publicised as being the solution to unplanned pregnancy and HIV, can present a false sense of security. Participants fell pregnant when condoms failed. In empowering women and men, they need to be fully informed about the various contraceptives and how they work, the procedure of abortion and what is actually being aborted. People are led to believe that 'it's only a blob of tissue' whilst health professional confirmed otherwise (Smith & Davis, 1980). Women also need to be informed on the possible effects of abortion, both physically and psychologically, and on accessing legitimate abortion providers.

As emerged from the narratives of the health professionals, formal education is necessary to empower women to understand and implement their rights, and to provide necessary skills training to enable them to earn an income of their own, either by working from home or securing employment outside the home.

The family is critical for the well-being of children, society at large, and for the country. Fathers are an essential component of the family (Mkhize, 2006). Gender education will assist in the addressing of women's needs holistically and in the long term. As evident with the Men as Partners (MAP) and the Fatherhood programmes in South Africa, men can change their views and demands on women even where cultural influences are strong (Peacock & Levack, 2004; Maharaj, 2010). These programmes that work towards re-socialising men into appropriate gender roles of husband and father should be supported, promoted and extended into all communities. Simultaneously cultural values that negatively affect the rights of women need to be addressed. Some cultures, which favour male offspring, namely countries such as India, China and South Korea, have used the opportunity of legalised abortion to abort female foetuses. Care must be taken to ensure that such a practice does not take place in our democracy.

The Millennium Development Goals (MDGs) have been set to achieve gender equality. To this end, policy and practice need to focus on assisting women who are living with various forms of violence in their lives, and in poverty (WHO, 2008). Women who are aware of their rights and have the appropriate resources to obtain assistance will be able to make their own decisions. Men too need to be educated as to what their rights and responsibilities are. Forcing a woman to have an abortion is no quick-fix to a man's problem of not wishing to, or refusing to accept responsibility for the consequences of his actions.

Both pre- and post-abortion care can be tools of empowerment. Pre-abortion care should provide care and support through the decision and the procedure, provide correct, full information about what it to be expected with abortion (Walker, 2000; Kells, 2009), and to ensure that the decision is that of the woman without any form of coercion (Kjelsvik, 2010). Post-abortion care should extend beyond seeking to help a woman to come to terms with

the abortion. Although it must provide support through the recovery, more importantly it must provide longer-term empowerment, guidance, and support for women to become self-sufficient (APA Task Force, 2008). Women can be empowered to work together as women with common circumstances to create larger changes (Boyd & Fales, 1983). In working through their feelings after the abortion**,** the Freireian strategy of critical reflection of the self and reflective thinking helps women externalise the experience by understanding where the idea came from, and how their own circumstances influenced the decision. In reflective learning, the abortion decision and the circumstances leading to the decision are explored. This enables women to understand themselves and forms the basis for learning from one's experience, personal growth with a changed perspective of the self (Boyd & Fales, 1983).

In attempting to make necessary structural changes, oppression and its internalisation has to be understood and considered (Mullally, 1997). Feminism identifies the processes by which women are dominated and makes them aware of the broader structures that led to their domination. Wood and Tully (2006, p.21) identified four main tactics for structural practitioners: 1) connecting people to needed resources, 2) changing social structures, where feasible, 3) helping service users negotiate problematic situations and 4) deconstructing sociopolitical discourse to reveal the relationship with individual struggles. Feminism also connects women to others with similar problems. A group with women who experience similar problems of disempowerment might mean a referral to an established skills/empowerment group. Such groups should also focus on advocacy for the needs of women on a community level and national level. Social work emphasises personal self-awareness. Self-awareness needs to be accompanied by political awareness, and awareness of the one's own way of handling power and powerlessness (Moreau, 1979; Sewpaul, 2013). There may be need for changes in structures to facilitate and enhance individual change (Mullaly, 1997). The therapist should therefore link women to appropriate resources, work on changing social structures even if this means mobilising the people affected, teaching and empowering women to act in conflicting situations, and deconstructing discourses to enable women to understand their circumstances (Wood & Tully, 2006).

Holistic abortion services must include referrals to post-rape services, information on sexual and reproductive health and rights, information on gender-based violence, immediate support services, identification of community support services, and referral to relevant community support services for ongoing support. Mutual referrals between abortion and other service providers, namely sexual and reproductive health services, community support and intervention organisations are needed for women to fully benefit (ICW, 2008). To render the necessary services in keeping with human rights, the services need to be provided by trained personnel (WHO, 2006), comprising a multidisciplinary team that looks at the woman in her total environment and makes proper referrals to empower her to rise above her circumstances. Reproductive health care programmes should not unwittingly contribute further to gender inequalities (Maharaj, 2010).

Structural forces do not operate independently of human agency (Mullaly, 2010; Sewpaul, 2013). Changing the political and economic system without at the same time changing *individuals* would be as meaningless as changing ourselves in a vacuum without simultaneously trying to make congruent changes in the social, political and economic structure (Moreau, 1979). It is therefore important to instill a sense of individual responsibility for one's actions. Unwanted pregnancy is the main reason for abortion, accounting for the major percentage of legal and illegal abortions. Amidst the emotional abortion debate individual agency should not be overlooked. Human beings are not passive victims of circumstances, and are called upon to make responsible decisions with respect to their behaviour in life. Taking responsibility for one's actions is the foundation of a healthy, democratic society. When one makes a decision, one chooses with the decision, its accompanying consequences (Halpern, Bates, Mulgan & Aldridge with Beales & Heathfield, 2004). Individual responsibility in sexual behaviour implies consideration of one's actions, making constructive decisions, and protecting others from one's own impulsive or moment-of-passion behaviour. For those who have children and cannot afford more children, sterilisation may be an option offered after an abortion. This will prevent further abuse of a woman's' body and mind, as was the concern of health professionals, with yet another pregnancy and another abortion.

9.4.6 Concluding remarks

"Demanding equality, as women, is an erroneous expression of a real issue" (Irigaray, 1993, p. 21) and the question is "equality to what?" McDowell and Pringle (1992) argued as to whether equality implies that women have to conform to masculine standards or the reverse? In demanding equality, where does this take women? Women have, to varying degrees, secured employment and become financially independent. This however has, to a large extent, freed men from financial responsibility while adding another dimension of responsibility to women over and above their home-maker responsibility. Therefore 'safeguards' have to be built to ensure that women are not exposed to a form of 'secondary' abuse.

In South Africa, the majority, including men, is living in poverty, which is unacceptable. The country's citizens need to be treated as human beings with a basic quality of life and the opportunity to work themselves to whatever level they chose or are able to achieve. All citizens need access to the country's wealth. Within that context women and men should be treated equally in terms of accessing the resources. Bond (2004, p.3) observed that "The reality is that South Africa has witnessed the replacement of racial apartheid with what is increasingly referred to as class apartheid - systemic underdevelopment and segregation of the oppressed majority through structured economic, political, legal, and cultural practices."

Knowledge and information on its own cannot change behaviour. To this end the various interrelated factors must be taken into account namely gender inequality, cultural and religious values, economic circumstances, and the social and physical environment. Gaps exist between the objectives of policies, legislation and governmental programmes and their actual impact on people's lives. This cannot be solved in isolation. In a society where all members respect others from the different groups, male/female domination and violence will fade away (McDowell & Pringle, 1992). What is needed is a multi-dimensional approach to empower women to prevent unwanted pregnancies resulting mainly from abuse. A bottoms-up approach is vital where women's needs are addressed at grassroots

level upwards. Only when women, the masses of women, are free from all forms of oppression and abuse, and able to raise themselves to achieve their potential, will the playing field be leveled. Only then will women be able to enact their individual rights. Only then will there be no need for 'women rights', only 'human rights' for all members of our democratic country to equally enjoy the country's wealth (Bunch, 1990). The country, in turn, will benefit from leveling the playing field. This will positively impact children's health, family circumstances, household equity, fertility decline, and ultimately the country's economic growth (Kabeer, 1999).

While there are specific policies and specialized governmental departments to attend to the various needs of people, in utilising a holistic approach in meeting the needs of women, it is imperative that the various departments in government collaborate their planning and service implementation to increase efficiency and to ensure speedy, quality service delivery (WHO, 2013).

9.5 Implications for further research

This was a small scale study within designated contexts. To gain a broader understanding of the phenomenon, the study could be extended to a national one.

Several areas with respect to women, men and abortion need to be researched, namely, the long term effects of abortion, both physical and psychological; what happens to women after abortion – both legal and illegal abortion; what difference does the access to legal abortion make in women's' lives; what programmes do religious and cultural institutions have in place to empower their followers; contextual factors that lead to non-use of contraceptives; the role of culture in promoting sexual abuse of women and non-use of contraceptives; how to assist women at risk; adequate statistics being maintained on reasons why women have abortion in South Africa, the number of repeat abortion, the economic status of the women, the racial groups, the religious groups, and the different geographic areas women come from. These will provide for a fuller understanding of, and the initiation and implementation of more appropriate programmes. A review of literature indicated that

most global statistics and research on illegal abortion has been conducted in third world countries. There are limitations in applying knowledge from that context to a different one in South Africa which has made great transition since 1994. Here, contraceptives are freely available and easily accessible, and legal abortion is provided through referrals.

There is a need for extensive research on how best to meet the needs of women in both rural and urban areas which will subsequently result in the development of improved policies and practices, and its implementation on all levels.

9.6 Summary and conclusion

This study adopted a feminist research design, which is committed to understanding the experiences of women and the gendered power relationships and discourses (Hesse-Biber, 2013) in a predominantly patriarchal society. Critical discourse analysis (CDA), which focuses on social structures and the use of language (Fairclough, 2009) to describe how existing structures impact the lives of women, was used both in the analysis and the discussion of the data. Critical discourse analysis permitted an understanding of the discourses that shaped the lives of participants.

The findings expose current dominant discourses, religious and cultural beliefs and practices of patriarchy and male superiority, and how these impact the lives of women. The findings are in keeping with previous studies that in oppressive patriarchy women come to internalise and submit to unequal treatment and violence. Considering the exceptionally high rates of family violence in South Africa, strategies are needed on the individual, family, community and national level as a matter of urgency. This will be a concrete means of empowering women to cope with inequality and violence (Shankar et al., 2013). All role players must be involved in the drawing up of the programmes which need to take into account the religious, cultural and ethical differences, the urban-rural factors, and flexibility to adapt the educational material (Ndeki et al., 1995).

In addressing the circumstances of women one needs to go beyond the pro-life/pro-choice debate. The needs of women go far beyond pregnancy and abortion. Women's lives are shaped by social and cultural realities. Reproductive rights need to be seen in conjunction with socio-economic and cultural rights, not in isolation. This calls for the needs of women to be addressed holistically (Sewpaul, 1995; Smith, 2005). Particular discourses that contribute to the oppression of women and which promote gender inequality and violence need to be deconstructed and reconstructed within the broader cultural, social and religious constructs to ensure that all members of society are treated equally as human beings. Women need to be given the opportunities, and allowed to excel as persons in their own rights. Only then will their choices, whatever these may be, truly reflect the rights of women. Prior to the leveling of the playing field, any rights, even if legislated, cannot be considered 'rights' amidst the dominant, disadvantaging discourses.

Arising from the findings of this study and the suggestions made by the participants, it is recommended that women and men receive pre-abortion and post-abortion care where the rights of men and women are addressed; the abortion decision reviewed to eliminate any form of coercion; that government on the various levels educate and empower women to be able to become self-sufficient; and that men be educated to respect the decision of women with respect to sex and contraceptives. Sexuality education needs to begin early in a young person's life and presented in a holistic manner taking into consideration the values and culture of the community. The mass media can play a key role particularly in not promoting promiscuous behaviour and in both creating and maintaining general awareness of sexual responsibility.

The TOP Act has led to an increase in illegal abortions, as observed by the health professionals in this study, resulting in the subsequent increase in abortion-related complications for women. This demands urgent attention on the part of the South African police in order to protect women. Education, improved environmental circumstances and medical care will prevent maternal deaths especially in the rural areas. Women need care and support. In the developed world, the decline in maternal mortality rates is due to improvement of medical services (Hogan et al., 2010).

Feminists argue that if women are granted equality and freedom there will be no need for abortion. The aim of feminism is a society where men and women are treated as equal and allowed to use available opportunity to rise to their full potential as human beings (Crown, 2005). True freedom means that there is liberty for all, where men assume responsibility for their children and receive support in their efforts to do so.

I commenced this study from the perspective of the pro-life end of the spectrum. This research has enriched me in that it has made me aware of the extent to which women are oppressed in society. Through my dialogical encounters with women, I realized that the abortion decision was an extremely painful one and that although they adhered to a pro-life position, they had no option but to terminate their pregnancies, which impacted them psychologically, emotionally and spiritually. The pro-life feminist movement views abortion as institutionalised violence against women and children. It is seen as yet another act of male-domination. They advocate that the circumstances of women be elevated to the level that they do not even have to consider abortion as an alternative irrespective whether it is legal or not (Matthews-green, 2000; Pollitt, 2005). Women are hurting and have to, over and above their pain, make painful decisions the consequences of which they have to bear alone. Is this democracy? To those who hold on solely to the rights of women to abortion, the concern is whether they really care for the well-being of women. To those who claim that they are, the challenge is that they attempt to understand the pain of such a decision and help uplift women to prevent them having to claim such a 'right.' To those who hold on solely to the rights of the unborn, the concern is whether they really care about the unborn. To those who claim that they are, the challenge is that they work towards improving the lives and status of women. We need to understand how poverty and sexual inequality are perpetuated through culture, religion, and education. Having better choices will make a profound difference in a woman's life. Both the oppressors (privileged) and the oppressed must identify their respective roles in the dehumanisation process and work towards structural changes, and everyone must do their part (Freire, 1970). The time to act is now! To conclude, I quote the following that support my views.

We have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now - right now.
(Former president of South Africa, Dr Nelson Mandela)

Sweeter even than to have had the joy of caring for children of my own has it been to me to help bring about a better state of things for mothers generally, so that their unborn little ones could not be willed away from them.
(Susan Anthony as cited in Matthews-green, 2000 p. 2)

No woman enjoys having a pregnancy terminated. Therefore, as a society, we should strive to prevent by caring. I shall be the happiest person, if, one day, even in the presence of the Choice on Termination of Pregnancy Act, no woman feels compelled to terminate her pregnancy!
(Former Minister of Health, Dr Dlamini-Zuma as cited in Mhlanga, 2003, p. 126)