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An assessment of abortion seeking behaviours and preferences in rural communities of the Eastern Cape, South Africa: Research Report

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Critical Studies in Sexualities and Reproduction, Rhodes University

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Thank you very much.

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CHW	Community health worker
CTOP Act	The South African Choice on Termination of Pregnancy Act (No. 92 of 1996)
CSSR	Critical Studies in Sexualities and Reproduction
DoH	Department of Health
DCE	Discrete Choice Experiment
LMP	Last menstrual period
GP	General practitioner
MS	Marie Stopes
MSI	Marie Stopes International
MSSA	Marie Stopes South Africa
NGO	Non-governmental organisation
SADHS	South African Demographic and Health Survey
VCAT	Value clarification and attitude transformation
WIP	Willingness to pay

Executive summary

The South African *Choice on Termination of Pregnancy Act (No. 92 of 1996)* as amended in the *Choice on Termination of Pregnancy Amendment Act No.1 of 2008* (henceforth CTOP Act) permits abortion on the request of a womxn[1] in the first trimester and on various grounds thereafter. It was hailed as transformative in terms of reproductive health and rights. Despite this promise and some progress in implementation, many challenges persist, resulting in a lack of services, particularly in rural areas of the country. In light of this, Marie Stopes South Africa (MSSA) aims to extend its service provision, including safe abortion, post abortion care and family planning, to communities living in rural areas of the Eastern Cape Province without easy access to services in the urban hubs of Port Elizabeth and East London.

This research study, entitled *An Assessment of Abortion Seeking Behaviours and Preferences in Rural Communities of the Eastern Cape, South Africa*, was initiated by MSSA in focusing their service delivery in rural areas, and was conducted by the Critical Studies in Sexualities and Reproduction (CSSR) research unit of Rhodes University. In this report, we present the findings of the study.

The following research questions guided the study:

1. What understandings of problematic/unwanted pregnancies, abortion, abortion legislation, and abortion services are evident in rural mxn's and womxn's accounts?
2. What are the reported barriers to, and facilitators of, access to abortion services among rural populations in the Eastern Cape, and how are these affected by social, psychographic, geographical or economic factors
3. What are womxn's perceptions of safety and quality of abortion services among different types of providers?
4. What are womxn's preferences for facility, location, provider type, information channels and costs when accessing abortion services in the Eastern Cape?

This study used a mixed method approach, with qualitative data collection forming the foundation of the quantitative component. Qualitative data collection consisted of individual key stakeholder interviews; the quantitative aspect was a Discrete Choice Experiment (DCE). Questions 1 to 3 are answered primarily through the qualitative component while question 4 draws from the quantitative component. A thorough literature review and the qualitative data informed the foundation of the quantitative component. The study ran for fourteen months from February 2019 until March 2020 and was divided into five phases: the initiation phase, the qualitative data capture phase, the quantitative data capture phase, the data analysis phase, and the write-up phase.

A thorough literature review of research on abortion services conducted in South Africa was done to inform the study overall, but in particular the DCE instrument, as well as to compare findings with those of other studies. This review is contained in section 2 of the report. As abortion is a sensitive topic, we sought methodological guidance from the studies discussed in the literature review.

The DCE methodology allows researchers to investigate how people in a particular context rate selected attributes of a service by asking them to state their preference for different hypothetical alternatives. Each

1 We use the term "womxn" and "mxn" in acknowledgement of the fact that people of diverse gender identification may need abortion services. We do not distinguish between the plural and singular forms; this can be gleaned by the context of the sentence.

alternative is described by attributes, and responses are used to infer the value placed on each attribute. It allows for the calculation of participants' trade-offs between attributes. A review of studies using DCE methodologies in relation to reproductive healthcare preferences was undertaken in order to hone our study methodology, particularly in relation to sample size, developing the DCE questionnaire, and analysing the results. The review is contained in section 3.

The study population was individuals living in rural Eastern Cape communities. Three sites were selected based on the Municipal Demarcation Board's classifications: B3 defines local municipalities with small towns, but with no large town as core; the B4 category is made up of local municipalities which are mainly rural with communal tenure and with, at most, one or two small towns. Site 3 is a B3 local municipality in the western part of the province so as to cover commercial farm workers. The other two sites fall under B4 local municipalities. Site 2 consists of a large rural zone surrounding a small town. There is a clinic in town and a hospital in a neighbouring town. Site 1 consists of four villages in a remote municipality. There are no health services in the area, but two clinics in neighbouring villages.

In each site we conducted in-depth interviews with 20 individuals between the ages of 18 and 45. Of the sixty participants across all sites, six were mxn. Participants were treated as key informants, reflecting not only on their own understandings but also those of the community within which they live. DCE questionnaires (Appendix 10) were administered to 616 participants across the three sites (207, 209, and 200 respectively). The average age at the time of data collection was 29.3 years old; 82% (n=496) were womxn and 18% (n=112) were mxn. The qualitative data were analysed using thematic analysis. Quantitative data were analysed using descriptive statistics and regression analysis. Ethical clearance was obtained through the Rhodes University Ethical Standards Committee (RUESC) as well as the MSI Ethics Research Committee.

An expert panel was consulted throughout the research process. The expert panel provided specialised input at every stage of the research. This panel consisted of members of the research team, MSSA, MSI, statisticians, and members of the partner organisations in each site. In order to increase the study's validity, research capacity, data delivery and ethical practice, a partnership was formed with a local organisation in each site. These partnerships contributed towards the study's effectiveness by ensuring the appropriateness of our approach, embedding the research in the community, and facilitating communication with the community.

This report provides detailed information about the research and is meant for use by other researchers. Its structure outlines each component of the research in detail. A shorter form of the report, for use by policy makers, practice implementers and healthcare providers, may be accessed here. The latter report draws from this executive summary. It integrates the findings and provides concrete recommendations for consideration in MSSA's introduction of services in rural areas of the Eastern Cape.

Key findings

The findings of this study have implications have implications for (1) planning services; and (2) implementing services. Participants' preferences in seeking an abortion have relevance for planning and are presented first. These are divided into the following service attributes: facility type, services offered, types of abortion offered, travel requirements to attend the facility, cost requirements, and opening times of the facility. The data also provided significant insights that will be useful in implementing services in these areas. These include: participants' knowledge of abortion laws, procedures and facilities; community attitudes and understandings of abortion; barriers to having an abortion; and the abortion decision-making process. Understanding these dynamics would be useful for healthcare practitioners in providing contextually relevant services. These findings are presented second.

Findings and recommendations relevant to planning

The quantitative data revealed that all of the factors asked about in relation to abortion services play a role in participants' preferences – facility type, location, price and opening hours. This suggests that these factors need to be balanced in terms of MS planning their service delivery in rural areas of the Eastern Cape.

Preferences for facility type

Qualitative data revealed that confidentiality was especially important to womxn seeking abortions. Being able to present at a facility in which the purpose of the visit was unclear or, alternatively, where the person's presence would not be known to community members was seen as crucial.

With this in mind, five possibilities for MS clinic designs were decided on and included in the DCE: MS clinic in a government hospital or clinic; stand-alone MS clinic; MS mobile clinic; MS clinic in a pharmacy; and MS clinic partnered with a traditional healer.

The pooled DCE data show that the most preferred option is a MS clinic in a government facility followed closely by a MS mobile clinic. Differences in preferences across sites were, however, observed. Participants in site 1, the remote rural site, expressed a strong preference for an MS clinic in a government facility. In site 2, the less isolated communal tenure site, a MS clinic in a pharmacy was preferred over a MS clinic in a government facility. In fact, the MS clinic in a government facility was the least preferred option in site 2, although preferences for other options (except the pharmacy) were not significantly different from the government facility option. Site 3, the commercial farming area, is most similar to the pooled data although the mobile clinic is slightly preferred over the MS clinic in a government facility.

The differences can be explained by participants' experiences with the current healthcare contexts of the three communities. The qualitative data show that in site 2 there are major confidentiality issues with nurses in local clinics, explaining why the MS clinic in a clinic or hospital is the least preferred. In site 3, a mobile clinic provides most of the health care people receive. The preference of site 3 participants for the mobile clinic speaks to their satisfaction with this form of health care provision, although the current mobile clinic does not provide abortions.

The least preferred option was the MS clinic partnered with a traditional healer. This is also explained by the qualitative data which show that when it comes to abortions, traditional healers are not trusted. Albeit preferred by the mxn, standalone clinics were not a preferred option overall.

Recommendations:

> Given the diversity of responses across the sites, it may be of benefit to open clinics in different forms depending on the type of rural area in which the clinics will be located. In other words a catchment area approach should be taken.

> Contingent upon the number of clinics MSSA wishes to open, combinations of clinics in government facilities, mobile clinics and clinics within pharmacies may be considered.

> Stand-alone clinics should be avoided.

> Confidentiality is a key issue to consider in planning a facility. Mechanisms to ensure are listed below:

(a) There should be no obvious external indication concerning the particular service being offered, such as seating arrangements in waiting rooms, or different services being provided in different rooms. The waiting room should not be immediately visible when the door of the facility is opened and patients inside the building should not be visible from outside through windows.

(b) Locating a clinic next to other facilities that draw people might help womxn escape scrutiny. The entrance to the clinic should not, however, be located where people congregate or sit around outside. In other words, womxn should not be visible entering the clinic.

Preferences in terms of services

Three options of services offered by facility were included in the DCE: abortions only, abortions and contraceptive services, and abortions and other health services such as STI testing, cervical cancer screening, etc. Other than revealing the demand for particular combinations of services, this attribute indicates whether participants believe that womxn would be willing to visit a clinic that offers abortions only (which may have implications in terms of confidentiality). The data show that there is a strong preference for abortion to be offered with other health services. This was true across the three sites.

Recommendations:

> Whatever type of clinic (mobile, in a government facility etc.) is decided upon, it is clear that the clinic should not be viewed as an abortion only clinic, but that a range of services should be offered. The most robust finding across all sites was the strong preference for abortion to be offered alongside other health services. This finding dovetails with the qualitative findings regarding confidentiality. Locating clinics within government facilities or a pharmacy would assist with this.

> If mobile clinics are used as well, or if clinics are located within villages, then offering some non-reproductive health services alongside sexual and reproductive services should be considered.

> Given the shortage of second trimester facilities, and the increased possibility of womxn accessing unsafe abortion past 12 weeks gestation, offering both first and second trimester abortion is strongly recommended.

Preferences in abortion type offered by facility

Three options for abortion type were included in the DCE: medication abortion (up to 9 weeks pregnant) surgical abortion (between 9 and 20 weeks pregnant) and both medication and surgical abortion. The data show that medication abortion is preferred over surgical abortion. Disaggregation by site produces a different picture, however. Although medication abortion is preferred over other options in site 3, the differences in preferences is not statistically significant. This means that in site 3, providing medication, surgical or both types of abortion may be acceptable. In site 1, however, participants expressed a strong preference for medication abortion over both types as well as surgical abortion. In site 2, medication abortion was strongly preferred over surgical abortion, and preferred (but not as strongly) over both types. These results indicate the requirement for some nuance in relation to type of abortion provided across different types of rural settings. While the reason for the strong preference for medication abortion in sites 1 and 2 was not probed in this research, it is possible that this preference is related to the strong need for confidentiality in these sites, with medication abortion obviating the possibility of a longer clinic stay.

Recommendations:

> It is clear that clinics should stock and offer medication abortion.

> Obviously, the appropriate type of abortion procedure is frequently determined by medical criteria, including gestational date. On this basis, both surgical and medication abortions should be available.

> Nevertheless, data show that where medication abortion and surgical abortion are offered to a particular client, medication abortion will probably be chosen. This may have implications in terms of the training of providers and the stocking of clinics with abortion commodities. It also suggests that were only medication abortions provided (e.g. in mobile clinics), these services would be used and appreciated.

Preferences in travel requirements to attend facility

The qualitative data revealed an ambivalence about traveling for an abortion. On the one hand, the costs of travelling are clearly a barrier to accessing an abortion. Hospitals are usually in the nearest city or large town, but even clinics located in rural areas are sometimes hard to access. The issue of distance was especially prominent in site 1. On the other hand, participants expressed the need to travel far in order to maintain confidentiality.

Travel requirement preferences were presented in the DCE as follows: facility is in my village/community/township, facility is in a nearby village/community/township, facility is in the nearest town, and facility is in the nearest city. The pooled DCE data show a preference for a facility located within participants' village followed by a facility located in the nearest city. The difference between the two options is statistically insignificant. The overall preference for own village and nearest city seems to talk to the two major factors identified in the qualitative data – own village reduces cost and distance, while nearest city provides the possibility of anonymity and reduced possibilities of breaches of confidentiality.

Disaggregation by site reveals that sites 1 and 3 follow the pattern of the pooled data, with preferences for

facilities in their village or in the nearest city (site 3 has a slight preference for location in the nearest city over participants' village). Site 2's results show no statistical differences between the various options, with a slight preference for location in the nearest town. The fact that site 2 differs in the expression of location preference from the other two sites may have to do with its relative proximity to a small town and a major city.

Recommendation:

> Combined, these results point to the possibility of a catchment area approach to the provision of services in rural areas. Those rural areas close to towns or cities may be serviced by facilities in towns or cities, while those further afield may need services within their own village as well, probably in the form of mobile clinics of clinics partnered with local NGOs.

> Rural villages in the Eastern Cape are spread over hundreds of square kilometres; servicing these areas might require unconventional approaches. These could include, for example, home visits by community health workers, and telephonic consultations. It could also include finding ways to limit the number of visits womxn living in remote communities need to make to the clinic.

Preferences in cost requirements to attend facility

Rural areas are often resource poor. Indeed, of the DCE participants, only a quarter were employed and more than half of all the participants reported a monthly household income of between R0 and a R1000.

Distance is obviously connected to the question of costs. To travel is expensive and distant travel may require accommodation. In government termination of pregnancy clinics abortions are free, so travel costs are the only expense. Willingness to pay for an abortion was presented in the DCE as four options: abortion with no cost, R500, R800, R1400. These prices did not include transport costs. As expected, the preferred option is a no cost abortion. When it comes to paying for an abortion, pooled data showed that participants preferred to pay R500 followed closely by R1400. This pattern is consistent across mxn and womxn participants. Participants in sites 1 and 2 indicated a preference to pay R500, R1400 and R800, in that order. Participants in site 3 expressed a preference to pay R800, R1400 and R500, in that order. This may indicate that site 3 participants anticipate quality services to be provided with a higher price.

Recommendations:

> Given the low resources in these communities, no payment will obviously be people's first choice. As such, it is recommended that MS looks at ways to subsidise their rural clinics to increase usage.

> If payment is required, R500 seems to be the most acceptable. Several participants stated in the interviews that community members would be willing to pay for an abortion if they knew that it would be conducted in a professional, pain-free manner, and that it would be confidential.

> Nevertheless, it is recommended that costs are kept as low as possible, given the fact that some womxn will incur expense travelling from remote villages or farms.

> MS should also consider finding ways to provide free contraceptive services and free pregnancy tests, if possible. Early pregnancy detection could assist with womxn presenting in the first 12 weeks of gestation, which significantly reduces costs for womxn. Partnering with local NGOs and training their community healthcare workers in assisting womxn with pregnancy detection could also potentially reduce costs. Information on accessing pregnancy testing should also be widely disseminated.

> MS will also need to put protocols in place to deal with situations where desperate and vulnerable womxn arrive to the clinic needing an abortion but are unable to pay.

Preferences in opening times of facility

The options for opening times included possibilities for: extended hours within the working week, normal office hours but with the addition of Saturday, and a combination of the above. Pooled data revealed a strong preference for extended hours during the week, followed by a more-or-less equally strong preference for normal office hours Monday to Saturday. Interestingly, the combination of both (Saturday and extended hours)

was not favoured. This may have to do with participants' appreciation of the logistical difficulties in keeping facilities open for such a length of time as well as the fact that such an arrangement is unlikely. Although male and female participants differ slightly in their preferences, both prefer facilities to operate outside of week office hours, whether through extension into the evening or to Saturday. In site 1, the extension of hours to Saturday is more prominent. Walking is the most prominent form of local travelling in site 1 and this preference might indicate that participants are taking into consideration the need to travel during daylight. In site 2 and 3 where travelling is most often in the form of taxi and car trips there is more of a preference for extended hours during the week.

Recommendation:

In the trade-off of providing extended evening hours during the week or extended hours over weekends, the latter is recommended. This will ensure that womxn in both far-flung rural areas, and ones closer by, may access services outside of normal weekday operating hours. Alternatively, if a dual catchment area approach is taken, as suggested above, hours could be adjusted to suit the type of clinic. Clinics in towns or cities could operate with extended evening hours, while clinics in villages (mobile or in conjunction with local NGOs) could operate on Saturdays. Given the fact that rural villages mostly lack street lighting, extended evening hours are not feasible within these locations.

Findings and recommendations for implementation

Findings suggest that in implementing services, MSSA should address information provision, counselling and training so as to: enhance knowledge of abortion and abortion services; engage with community attitudes to unplanned pregnancies and abortion, as well as gender norms; address barriers to womxn accessing services; and provide contextually relevant assistance in reproductive decision-making. These are addressed below.

Knowledge of abortion laws, procedures, and facilities

Knowledge of the legality of abortion was widespread among interview participants themselves, although many reported low or partial levels of knowledge about abortion laws among their fellow community members. Most respondents could identify: which type of abortion service provider was legal and which not; that legal abortion has a cut-off date; that an illegal abortion can be obtained after that date; and that there is a risk to having an illegal abortion. While most knew that abortion was legal in South Africa, they also indicated that it should not be, often drawing from religious metaphors to justify this belief.

Knowledge of the existence of abortion facilities was reportedly widespread. Participants indicated that most people know to go to clinics or hospitals to either procure an abortion or to receive trusted information. There was reportedly widespread knowledge about illegal abortion providers as well, but it was mentioned that they are not available in the communities that formed part of the study. "Backstreet" abortion providers were said to be only available in cities or large towns; respondents indicated that traditional healers who provide abortions are not widespread. Regardless, traditional healers were not seen as safe providers.

Respondents were asked where in the community people would be able to find information on what to do when someone wants an abortion. Most respondents mentioned people around you or from the nurses at the clinic. Clinics and hospitals were seen as the most reliable sources of knowledge. Pamphlets and posters were also sources of information on abortion services. Some respondents mentioned getting information from electronic sources such as radio or TV, as well as social networks, but these types of information sources were not nearly as important as nurses and health care workers.

The quantitative data showed that participants prefer traditional non-interactive media (pamphlets, posters, radio, and TV) followed by trusted others, including family, friends and home-based carers.

Recommendations:

> While knowledge seems to be reasonable in the communities forming part of this study, continued information provision and normalisation of abortion is important.

- In addition to making it clear that nurses and other healthcare workers are there to answer questions, information provision on the legalities of abortion, safe abortion provision, and details of where services can be accessed would be useful.
- With support from MSSA, community health workers could also assist with disseminating such information.
- Given the remoteness of many rural areas, MSSA could consider using local and community radio stations for marketing and public campaigns (in addition to pamphlets and posters). There are an estimated 15.4 million radio sets in South Africa, with community radio attracting almost 8.6 million listeners a week.
- MSSA could consider organising events within rural communities that raise awareness of the services they offer in South Africa and use these events to also share information on illegal abortion.

Community attitudes and understandings of abortion

Several questions in the interview probed community perceptions on topics related to abortion and the circumstances under which abortion may be acceptable. Many respondents viewed abortion as 'not right' or equated it with murder. Despite respondents' general negativity to abortion, respondents indicated that abortion was a disputed subject in the community. Circumstantial acceptance of abortion was mentioned by respondents, including for reasons of poverty, being unwed, violence in the home, and rape. Tolerance of abortion was espoused by some of the participants. Arguments for such tolerance included: the ideal of being non-judgemental, not understanding the person's situation, being forgiving of mistakes, and it is the womxn's choice.

Almost all participants spoke of the damage that an abortion does to the pregnant womxn, especially death and infertility This is a prominent topic among participants and the type of damage expected from an abortion is a cause of fear, especially the possibility of infertility. Most of these participants attributed this type of damage to illegal and informal types of abortion and understood legal abortion in public facilities to be safe.

Respondents indicated that womxn who had undergone an abortion would be judged by community members. Judgement would be passed for: not being responsible and using contraceptives, being selfish and not considering the "baby"', not looking after herself, not adhering to the tenets of womanhood (which include reproducing), being a "loose" womxn, and being irresponsible. The most common consequence of such judgement is that womxn who abort are gossiped about. This gossip is the social mechanism through which womxn are marked as inferior to the ideals of womanhood, and through which shame concerning the abortion is promoted.

There were several references to womxn voluntarily leaving the community or being sent away as a result of the stigma and shame of having an abortion. Womxn dealing with the shame accruing to abortion consisted, for the most part, of disguising the abortion (undergoing the procedure prior to the pregnancy being known or visible, pretending that the abortion was spontaneous) or leaving the community to avoid repercussions.

In our data, married womxn who abort were depicted as the most stigmatised. This is mainly, as the respondents noted, because having children in marriage is 'mandatory'. Willingly not having children within wedlock was depicted as shameful; involuntary infertility was also seen as sad or alternatively shameful. When not having children within marriage is associated with abortion, explanations must be sought. The stereotype of an adulteress was said to be attached to married womxn who abort. The "fallen womxn" stereotype was said to also accrue to unmarried womxn who are accused of having affairs with married mxn.

Most participants indicated that communities were in favour of abortion in the case of rape. Indeed, not only would stigma not accrue to womxn who terminate a pregnancy in the case of rape, active support and compassion may be provided. Three major justifications were provided for the necessity of an abortion in the case of rape: poor outcomes expected of children conceived by rape, in particular that a child of rape cannot be loved or will be disabled; the trauma of the rape and the child being a reminder of the event; and a father should always be known, which rapists may not be. The difficulty of explaining the lack of a father to

the resultant child was emphasised by participants.

There were, however, exceptions to this general sentiment. It is only in the case of rape by a stranger that abortion is seen as acceptable. If a womxn is raped by somebody she knows, then abortion is seen, according to respondents, as less acceptable. . Some respondents (especially in site 1) argued that a rape victim (in any circumstances) should not abort, or that families would convince her not to terminate the pregnancy. Worryingly, some respondents said that the community would judge a rape victim. In this they spoke to what is known as rape myths – the act of shifting the blame of rape from perpetrators to victims.

According to participants across the three sites, pregnancy amongst teenagers is generally viewed in a negative way. Issue is taken with the fact that pregnant teenagers might not end up completing school and that the teenager's parents or grandparents may have to care for the child. Young womxn who conceive are stigmatised. They are judged for: not taking sufficient care, being badly brought up, and being promiscuous. Some participants made connections between this kind of stigma and young people deciding, or being coerced, to terminate their pregnancy. Participants indicated that the parents of the teenager, especially the mother, are likely to make the decision on whether to abort or not. This obviously contradicts the CTOP Act, in which minors are empowered to make their own decisions regarding the outcome of a pregnancy.

According to some participants, wealthier womxn who terminate a pregnancy will be spared judgement as community members fear intimidation or welcome the possibility of currying favour with a person with resources. Although rich womxn are slightly less likely to be openly judged for having an abortion, they are criticised as they are able to financially take care of a child. The same logic is what, for the most part, lets poor or unemployed womxn off the hook for having an abortion. Although poverty was seen generally as an acceptable reason to terminate a pregnancy, some participants indicated that was not always an exemption from judgement. Some respondents indicated that when community members make assumptions about the reasons for an abortion, they do not factor poverty into the equation.

Recommendations:

Decreasing abortion stigma and normalising abortion as a standard reproductive health procedure is an important component of abortion service provision. This can take two forms. The first is community engagement in which the assumptions underpinning abortion stigma are unpacked. The second is through MSSA healthcare providers integrating such normalisation into their counselling and interactions with clients.

Specifically, findings suggest the following:

- The provisional acceptance and tolerance of abortion under certain circumstances represent inroads into normalising abortion; community campaigns and dialogues that stretch these attitudes may prove useful in undermining abortion stigma in these areas. Partnering with NGOs or local community groups, especially womxn's groups (where they are not anti-abortion) would be useful.
- Community campaigns that stress the safety of abortion performed at MSSA clinics could address fears of infertility and of negative health consequences attendant upon abortion.
- Counselling should acknowledge that womxn may face stigma associated with terminating a pregnancy. Healthcare providers should work with clients to build resilience through foregrounding de-stigmatising alternative stories, such as abortion being a common gynaecological service across the world.
- Womxn who are married appear to face particular stigma. Healthcare providers should be cognisant of this, and engage with these clients in a sensitive manner, particularly in relation to the cultural imperative for married womxn to bear children.
- It is concerning that rape myths persist and that womxn may still be judged for terminating a pregnancy after rape or forced to carry the pregnancy to term if the perpetrator is known. Community campaigns that undermine rape myths and that emphasise the right of womxn to decide the outcome of a pregnancy, no matter the circumstances, could assist here.
- Young pregnant womxn face particular challenges. Emphasising the right of minors to make their

own decisions is important, as is supporting young womxn in making an uncoerced decision regarding the outcome of the pregnancy. Where these womxn decide to continue with the pregnancy, liaison with the school to provide support in both the pre- and post-natal period is recommended.

> Findings regarding attitudes to rich or poor womxn having an abortion illustrate the contradictions that womxn may face. In working through counselling, healthcare providers should be cognisant of these complexities, and provide space for womxn to speak through their concerns with regard to community reactions.

> Community leaders, especially those connected to or part of non-profit organisations, are likely to support the challenging of conventional religious and traditional beliefs if this is couched in health terms, i.e. described as a contribution towards the overall health of the community.

Barriers to having an abortion

Participants mentioned confidentiality as the most prominent barrier that womxn in their community might face when they have decided to have an abortion. Desire for confidentiality was linked to stigma: womxn who have an abortion are at risk of being judged by the community to such as extent that they travel far to access services, even in cases where a closer facility is available.

The second most prominent barrier reported upon, ironically, was the distance to clinics. This presents a double bind. Womxn take a risk going to a local clinic in terms of confidentiality, but if they do not have money for travel, they might have to take this risk or forfeit their right to an abortion.

Many participants also spoke about fear of abortion and its potential consequences as a barrier. It is widely believed that abortion, especially an abortion performed under illegal circumstances, will lead to death, morbidity, or infertility. The occurrence of mortality or morbidity as a result of unsafe abortion tended to taint people's understanding of abortion in general.

Fear of hostility towards abortion at public health clinics or from those to whom womxn turn for advice was also mentioned. Health workers were often described as helpful, especially in certain areas, but some participants said that they would fear going to the hospital because of health workers' attitudes. Participants also spoke about abortion healthcare providers trying to persuade womxn not to have an abortion. While obtaining informed consent does require that healthcare providers explain procedures, research conducted in South Africa has shown that nurses may, indeed, try to dissuade particular people from having an abortion. This includes creating a hierarchy of deserving clients, being dismissive of repeat abortions, suggesting that abortion leads to negative consequences, moralising about abortion, and pushing womxn to consider adoption.

Another barrier is the conception partner's attitude or lack of support. Partners can be supportive of an abortion and provide the financial help a womxn needs to have an abortion, but they can also be a major barrier to a womxn's decision to have an abortion. Participants indicated that some womxn opt to abort without the knowledge of the partners out of fear that their partner would stop them or would terminate the relationship. A major consideration was partners shaming the womxn in public for having undergone an abortion, even if he agreed to the abortion. Given the high status in which fertility is held with the communities that formed part of this research, knowledge of an abortion can become a powerful weapon in a (former) partner's arsenal should he feel aggrieved with the womxn, or with her decision to terminate the pregnancy.

Traditional healers continue to play an important role in the lives of many Black people, including people living in rural communities. The qualitative data, however, show that traditional healers are not trusted by participants to provide safe abortions. They are seen as likely to charge people a great deal of money and to give people a concoction that does not work, costs them their lives, or renders them infertile. Traditional healers' concoctions have had an immense impact on the ideas that participants in the three rural areas have about abortion and have contributed not only to its stigma, but also fear of the procedure, particularly that it renders womxn infertile or could kill them.

Recommendations:

Successful service delivery goes hand-in-hand with overcoming barriers to womxn accessing the service. The findings suggest the following:

- Healthcare providers are generally trained in maintaining confidentiality. Research shows, however, that this principle is not always strictly upheld. Emphasis regarding the extreme importance of this in abortion service provision may prove fruitful.
- It is recommended that all employees working at the clinic or in outreach services understand the importance of not breaching confidentiality. Ideally, clinic workers should not be drawn from the local community. However, this may not always be feasible or possible, given the remoteness of some areas. Where they are drawn from the local community, additional emphasis should be placed on confidentiality, and the negative outcomes of breaches of confidentiality stressed. Value clarification around reproductive health issues in general, but also abortion, would be needed.
- Public campaigns that address any myths relating to the physical or psychological consequences of safe abortion provision may be necessary.
- Forming partnerships with local public health clinics to ensure smooth referral and that womxn are not discouraged from accessing services is essential. If this option is considered, values clarification workshops will need to be conducted with all staff at the referral clinics (research shows that nurses at referral clinics may actively try to persuade womxn against seeking an abortion).
- Training of healthcare providers should emphasise the right of all womxn to request an abortion, and that hierarchies of deservedness should not be subtly introduced into services.
- Given the key role played by conception partners, it may be useful for MSSA to partner with NGOs that work on issues of masculinities to address the gender dynamics underpinning partners potentially coercing womxn to make a particular decision regarding the outcome of the pregnancy (see discussion below as well).
- Given the importance of traditional healers in many rural communities, as well as the negativity participants voiced in relation to their handling of abortion, some engagement by MSSA would be necessary. It might be useful to engage with local healers about the importance of safe abortion procedures and the need for referral. This would need to be conducted sensitively, as the healers may be suspicious of MSSA taking business away from them.

The abortion decision-making process

The data show multiple reasons why womxn may decide on terminating their pregnancy. The most prominent reasons given were connected to the conception partner. It seems that unmarried womxn are vulnerable when an unplanned pregnancy occurs since, as the participants continually pointed out, mxn could simply deny the pregnancy, leave, or insist on the abortion. Generally, mxn were described in a negative way, but even more so when it came to the topic of support during pregnancy, especially outside of marriage. Multiple partnerships put womxn in even more of a vulnerable position since sexual partners are likely to deny a pregnancy or because they fear that knowledge of the infidelity might end their main relationship. Participants suggested the following outcomes in the case of pregnancy in the context of multiple partnerships, all of which may lead to a decision to terminate the pregnancy: fear of not knowing who the conception partner is, judgement from the community, pressure from the main partner's family, or from one of the partners. Proof of paternity was seen as paramount.

Abandonment was seen as most likely in the event of an unplanned pregnancy. In addition to physical abandonment, participants spoke about mxn being unable or unwilling to support the pregnancy and child financially. In some instances, participants spoke of a cultural phenomenon known as *ukwaliswa* or *ukubukuzana*. This phenomenon is where mxn leave temporarily during pregnancy because of pregnancy hormones or "mood" (often directly translated as the foetus does not want the father). Mxn may return once the baby is born. Womxn also fear that the conception partner will neglect her or withdraw support because she is pregnant. Not all discussions depicted partners in negative ways, however. Participants also indicated that womxn may seek to terminate their pregnancy if the relationship with the conception partner was casual or not strong.

Families, especially parents, can be important support structures to people living in rural areas. However, according to participants, families may be hostile in the context of unplanned pregnancies, and womxn may choose to have abortions out of fear of their response. Various reasons were provided for the families' disapproval of the pregnancy, including their being religious and fearing that shame will accrue to the family. There were also discussions by participants of how families actively coerce womxn into having an abortion.

According to participants, a major factor in the decision to abort is the womxn's fear that she cannot afford to take care of a child, or another child. The high levels of unemployment make this a distinct possibility for womxn living in rural areas. Family financial resources tend to be minimal, and the child support grant does little to alleviate the penury state of the family. The expenses incurred during pregnancy, and in looking after a child (particularly if there are other children) are seen as prohibitive in such contexts.

It was often stated that a teenager who conceives might choose to have an abortion. Families were reported to be involved in the decision-making process when the pregnant womxn is young. The association of education with better financial prospects within these communities, and the possibility of pregnancy disrupting schooling means that early timing of a pregnancy becomes a distinct factor in the decision to terminate a pregnancy.

Participants argued that abortion is only truly accepted in extreme circumstances such as rape. Despite this, several respondents said that simply not being ready to have a baby (or another baby) might be reason enough for an abortion. While the act of an abortion leaves a womxn open to judgment by community members, so does having an unplanned pregnancy, especially if the womxn is poor and/or unmarried. Some womxn therefore choose to secretly have abortions to avoid the stigma of an unplanned pregnancy.

Antenatal care clinics tend to be over-crowded and over-stretched in South Africa, despite significant efforts by the Department of Health to improve prenatal care in order to reduce maternal mortality and morbidity. In rural areas, this is exacerbated by the distance womxn must travel to reach public health clinics. Participants indicated that some womxn might choose an abortion over a pregnancy because even a pregnancy is a stressful and expensive process.

Research shows that that stigma and misinformation around HIV and HIV care may form a part of womxn's decision-making on abortion, as well as healthcare providers' interactions with HIV-positive womxn seeking abortion. Although HIV did not feature in the data, it is important that this is considered in service delivery.

Recommendations:

> The CTOP Act stipulates that non-mandatory counselling should be offered to womxn presenting for an abortion. Counselling guidelines developed by the CSSR make it clear that healthcare providers should not ask womxn to provide reasons for requesting an abortion. Nevertheless, should womxn engage in this kind of talk, the provider needs to be able to engage sensitively with the client. This requires being alert to the social dynamics that may underpin the decision-making process.

> This study has highlighted partner and family contexts as key spaces in which womxn's decision-making is undertaken. For example, participant discussion of paternity denial, partner abandonment, or partner coercion to terminate a pregnancy painted pictures of negative gender relations, with mxn being positioned as uncaring and irresponsible. Working through these dynamics with clients may prove beneficial to them, not only in being comfortable with their decision, but also in terms of emotional adjustment post the procedure.

> Generally speaking, womxn who present at a termination of pregnancy clinic have already made a decision. Indecision, which may lead to late access, generally occurs prior to this. Training community health workers in the listening skills required to assist womxn in making an autonomous decision may be useful.

> Research shows that providers may face stigma and stress in relation to their work. Peer support mechanisms (for example, regular debrief sessions that bring providers together) and the provision of a positive work environment would assist with this.

There is a real possibility for MS to make an important contribution to access to abortion care in South Africa by servicing rural areas. MS has up to now focused on urban populations, hoping to provide services to the largest number of people they can. Building rural facilities will be a challenge and, as the study has shown, will require some changes in the model of services MS have provided up to now. Apart from the specific aspects discussed in this report, MS should consider continuing their current bottom-up approach in setting up services and specifically focus on being developmental in the process.

The process of integrating a service into a rural community may take effort and time, including partnering with local groups and organisations. MS clinics in rural areas could become a vehicle for developing and sustaining constructive attitudes towards reproductive health and rights in rural parts of South Africa, and could, if MS adopts a developmental approach towards their service, contribute towards a broader agenda of womxn's equality and liberty.

Introduction

The CTOP Act (Act No. 92 of 1996), together with other health legislation, changed the landscape of reproductive health in South Africa in line with the post-apartheid government's commitment to reproductive health rights (Guttmacher et al., 1998). The decision to terminate a pregnancy within the first 12 weeks of gestation is placed with the pregnant womxn, with the grounds for granting an abortion thereafter being relatively open (including continuing pregnancy affecting the womxn socio-economically).

The CTOP Act (1996, p. 2) indicates that "the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised". Up to 12 weeks of gestation, professional midwives and registered nurses can provide the service and abortion can be performed at primary health facilities. A 2008 amendment allowed any health facility with a 24-hour maternity service to offer first-trimester abortion services without the ministerial permission that was previously required.

Despite the promise of the CTOP Act, and initial indications of its implementation leading to decreased maternal morbidity and mortality (Jewkes et al., 2002), several challenges have been noted. These include: staff at referral centres dissuading womxn from seeking abortions (Harries, Orner, et al., 2007); health service providers and facility managers citing conscientious objection to providing services (Trueman & Magwentshu, 2013); many designated facilities not functioning (Bateman, 2011); womxn not receiving the abortions that they requested (Gerdts et al., 2015); womxn seeking care outside of their residential area for fear of breaches of confidentiality (Harries, Orner, et al., 2007); stigma associated with abortion particularly for HIV+ womxn (Orner, Harries, et al., 2010); and lack of state-led information campaigns resulting in womxn not knowing their rights under the CTOP Act (Jewkes, Gumede, et al., 2005; C. Macleod et al., 2014; Moodley & Akinsooto, 2003). Because of poor or inaccessible legal services, many womxn continue to procure abortions from traditional healers (Jewkes, Gumede, et al., 2005) and from health professionals performing abortions without DoH designation (Moodley & Akinsooto, 2003) or use herbal infusions to self-abort (Constant, Grossman, et al., 2014).

Albertyn (2015) argues that the advances made initially with the promulgation of the Act have been pushed back as a result of a declining health system, pervasive stigma and normative resistance, a reduced non-governmental sector and unclear political will. The consequences of these challenges are felt most keenly by poor black womxn and womxn in rural areas, who are more likely to die from abortion related complications than their urban, white and wealthier counterparts (Orner, de Bruyn, et al., 2010). In addition to the barriers noted above, access in rural areas is hampered by large distances to facilities and the high costs of transport (Amnesty International, 2017).

Considering these concerns, MSSA wishes to offer appropriate information and service provision to rural populations in the Eastern Cape of South Africa. Currently MSSA only operates in seven of the nine South African provinces and has no presence in rural areas. The aim of this research is to assist MSSA to focus service delivery to overcome barriers to safe abortion care, reduce stigma and ensure access to appropriate service provision for rural populations. This is in line with Marie Stopes International's (MSI) strategy of increasing awareness of services or referral networks for safe abortion, expanding the number of safe points of access, and scaling safe abortion and post-abortion care with integrity (Marie Stopes International, 2018).

The duration of the project was fourteen months. The timeline was as follows:

Phase I: Initiation
February 2019 – July 2019

Phase II: Qualitative data collection
August 2019 – September 2019

Phase III: Quantitative data collection
October 2019 – December 2019

Phase IV: Data analysis
January 2020 – February 2020

Phase V: Write-up
February 2020 – May 2020

In this report we present an overview of current literature on abortion in South Africa. We outline the design and methodology used in the study, as well as an overview of the DCE methodology and its appropriateness for this study. We then present the findings from the qualitative and quantitative data. We finish off with recommendations and insights that were drawn from the data.

Literature review

Introduction

Abortion is a common and essential reproductive healthcare procedure. According to Sedgh et al. (2016), 35 abortions occurred annually per 1000 womxn aged 15–44 years worldwide in 2010–2014. As such, abortion is a common reproductive health procedure which should be safe and accessible. This was the intention of the CTOP Act which was promulgated in South Africa shortly after the first democratic elections. The CTOP Act recognises womxn as autonomous decision-makers regarding the outcome of their pregnancy within the first trimester of pregnancy. The grounds on which abortion may be performed in the second trimester are relatively broad, including for socio-economic reasons.

In this chapter, South African studies exploring the following are discussed: decision-making regarding the outcome of a pregnancy; knowledge and accessing information about abortion services; factors relating to service preferences; barriers to accessing abortion services; and experiences of womxn seeking abortion services. In the final section of the report we discuss specific recommendations from the review of literature.

Decision-making regarding abortion

The CTOP Act is clearly premised on a human rights framework, extending to every womxn "the right to choose whether to have an early, safe and legal termination of pregnancy" in the first trimester of pregnancy (1996, p. 1). The locus of decision-making shifts to the health service provider from the second trimester, with medical doctors making the decision based on the womxn's mental or physical health, risk of physical or mental foetal abnormalities, rape or incest, and the social and economic status of the womxn. Thus, the autonomy of decision-making accorded to the womxn is circumscribed by gestation date.

Given the time-based nature of the CTOP Act, and the dearth of services for second trimester abortions, early detection of pregnancy and accurate gestational dating are important. The method of discovering a pregnancy varies among South African womxn. Some womxn discover their pregnancy through signs such as tender breasts, having cravings for certain foods and nausea (Harries, Orner, et al., 2007). In other cases, pregnancy may be noticed through a missed period – the latter has been reported as very common amongst South African womxn, especially those in rural areas (Harries, Orner, et al., 2007). Confirmation of pregnancy is normally done by buying a pregnancy test from the pharmacy or going to a clinic to be tested by nurses. Some womxn consider waiting until the second or third month of a missed period before seeking pregnancy confirmation (Harries, Orner, et al., 2007). Morroni and Moodley (2006) found that when womxn can obtain a urine pregnancy test, gestational age at presentation for abortion decreases. They conclude that 'fast-track' urine pregnancy testing services should be established in public sector clinics.

Once pregnancy has been established, womxn learn their gestational age through various means. In a study by Gerdts et al.(2017) of womxn presenting for abortion, the majority of the womxn knew their gestational age based on their last missed period. Other womxn learned their gestational age through pregnancy tests (17%), ultrasound (10%), or other methods such as recognizing pregnancy symptoms, and manual assessment at a clinic or from an illegal provider.

Johnston et al. (2016) argue that the requirement for an ultrasound to establish gestational age among womxn seeking abortion can be a barrier to access. In their multi-centre cross-sectional study at four urban non-governmental reproductive health clinics in South Africa, they determined the accuracy of gestational age estimation using last menstrual period (LMP) assessed by community health care workers (CHWs). They conclude that if LMP recall is within 56 days, most womxn will be eligible for early medication abortion and that, therefore, LMP can be used as a substitute for ultrasound dating. They warn, however, that while such gestational age estimation is feasible, its implementation should meet womxn's privacy needs and address healthcare workers' concerns about managing any

procedural risk. Findings from Momberg et al's (2016) study indicate that an online gestational age calculator would be accurate and helpful and could potentially act as an enabler for womxn in accessing abortion within the first trimester. This depends, of course, on access to the internet or mobile data, which is much more of a challenge in rural areas than it is in urban ones.

Once pregnancy has been established, the abortion decision-making process is complex and embedded within overlapping power relations. While the reasons for abortion have been relatively widely studied (and are not repeated here), relatively little research has been conducted on the social dynamics involved in abortion decision-making, both internationally (Lie et al., 2008) and in South Africa (Mavuso, 2015).

Harries et al. (Harries, Orner, et al., 2007) argue that family, selected friends, community members and partners play a significant role in womxn's decisions about the outcome of a pregnancy. This influence may be direct (e.g. through conversations about the situation) or indirect (e.g. through the womxn, especially young or unmarried womxn, being too scared to reveal the pregnancy or her intention to terminate the pregnancy). Some womxn can discuss their decision to have an abortion with their conception partner, while others are afraid to do so for fear of being abandoned. Indeed, the decision to terminate a pregnancy must be seen in the context of gendered sexual and reproductive power relations (Sullivan et al., 2018). Womxn may lack decision-making power in sexual relationships, particularly in relation to negotiating condom or contraceptive use. Intimate heterosexual relationships may be characterised by violence, which may restrict access to services and treatment. Some womxn may not tell their partners of the pregnancy or the possibility of terminating the pregnancy for fear of a negative reaction (Sullivan et al., 2018), or because they do not expect support from them (Mdleleni-Bookholane, 2007). On the other hand, in a survey examining attitudes on abortion amongst female university students, Patel and Myeni (2008) found that a majority of participants felt that it was the father's right to prevent abortion. The authors of this study, however, indicate that the opposite could be the reality: conception partners insisting on pregnancy termination (Patel & Myeni, 2008).

Decision-making may be straightforward or may involve ambivalence and uncertainty. Indecision, according to Harries et al. (2007) is linked to changes in personal circumstances; emotional responses, including denial of the pregnancy; the stigma attached to abortion; and religious influences. For HIV-positive womxn, the decision may be complicated by fears of harming their health (e.g. a loss of blood during the procedure resulting in decreased CD4 counts) (Orner, de Bruyn, et al., 2010).

In a comparative study of South African and Zimbabwean womxn's narratives of the decision-making process regarding abortion, Chiweshe, Mavuso, & Macleod (2017) found that womxn felt obligated to justify their abortion decision in the interactive interview space. This indicates that the decision was not seen as ordinary or part of standard reproductive health care. The justificatory labour engaged in by womxn centred on relationships (lack of marriage, the imperative of good mothering, and unstable partner relationships) rather than reproductive health rights. This is in line with international literature, where researchers in the United States (Jones et al., 2007), the UK (Greene, 2006) and Kenya (Izugbaraa et al., 2011) found that womxn's reasons for abortion centre on a concern/consideration for others, and that prevailing discourses around motherhood and responsibility played an important role in the decision-making process. This is true for womxn living with HIV as well. Participants in Orner et al.'s study (2010) felt that their ability to make autonomous decisions regarding the outcome of a pregnancy was hampered by strong social expectations that dictate that womxn should bear children.

The CTOP Act requires the state to promote the provision of non-mandatory and non-directive counselling before and after a termination of pregnancy. According to the Act, this counselling should "at the least include sufficient information to assist a womxn to make an informed choice regarding the termination of her pregnancy" (1996, p. 3). This provision seems to constitute pregnant womxn as autonomous decision-makers. However, Vincent (2012, p. 126) argues that abortion counselling can "easily be founded on problematic assumptions about womxn, their bodies, their sexuality and their choices". One of the mechanisms, she points out, of such normative counselling is to create a hierarchy of deserving candidates for abortion, differentiating appropriate and acceptable reasons for requesting

abortion from inappropriate and unacceptable ones. Indeed, research indicates that, in spite of the CTOP Act, womxn are often not, in practice, treated as autonomous abortion decision-makers within abortion counselling services (Mavuso, 2018); and that providers do indeed differentiate between worthy and unworthy clients (Röhrs, 2017). Nurses' moral judgments in this regard are largely shaped by the circumstances of the pregnancy, the behaviour of the client, their understanding of their professional identity, and the circumstances of their work environments (Röhrs, 2012).

Knowledge and accessing information

The CTOP Act was promulgated to ensure that all womxn have the power to make decisions regarding a termination of pregnancy. For this to be a reality, accurate information about the various choices available is necessary to facilitate womxn's ability to choose what is best for them (Klugman & Varkey, 2001).

It appears, however, that information about abortion is not reaching many womxn. Knowledge about the CTOP Act was investigated in the first South African Demographic and Health Survey (SADHS) in 1998, soon after the passing of the Act. It was found, at that time, that only 53% of womxn knew about the law and that a pregnancy could be terminated legally during the first 12 weeks of gestation (Althaus, 2000). Knowledge was poorest among teenagers, womxn living in rural areas, those with less education and black womxn, especially those in the 45–49-year age range. Following this, a study was conducted in the Western Cape of womxn presenting at 26 public health clinics in an urban and a rural health district (Morroni et al., 2006). Thirty-two percent of the womxn did not know that abortion is legal in South Africa, with womxn presenting at rural clinics being significantly more likely to not know the legal status of abortion than womxn presenting at urban clinics. Of those who knew that abortion is legal, few had knowledge of the time restrictions involved (i.e. gestation restrictions). Age, level of education and employment status were not associated with knowledge.

Mwaba and Naidoo (2006) conducted a survey with undergraduate psychology students from a South African university, a population that would be expected to be relatively well informed. The results showed that 19% of the male students and 16% of the female students believed that abortion was illegal in South Africa. In terms of the various stipulations of the legislation, 28% of the male students and 23% of the female students believed that womxn under the age of 18 years could not have a legal abortion; 40% of the mxn and 42% of the womxn believed that a married womxn needed her husband's permission in order to have a legal abortion; and 67% of the mxn and 46% of the womxn believed that parental consent was required in order for a womxn under the age of 18 years to have a legal abortion.

In their study among Grade 11 leaners in the Buffalo City Municipality (located in the Eastern Cape), Macleod, Seutlwadi, and Steele (2014) found that there was little understanding of the abortion legislation amongst the learners - including knowledge concerning the legal status of abortion, the stipulations contained in the legislation and where services are provided. This is confirmed in a recent study by Ramiyad and Patel (2014) which explored South African adolescents' knowledge of abortion legislation and attitudes in Kwazulu-Natal. Although 80% of participants were aware of the legal status of abortion, they showed limited knowledge of specific aspects of the Act: only 10.7% were aware of the period of gestation when termination is allowed; 20.7% were aware of the different methods of abortion; 28.7% knew who is allowed to perform the procedure; and 29.3% were aware that it is a criminal offence to prevent or obstruct access to a legal abortion.

Sources of knowledge about abortion service provision vary according to the type of abortion sought. Most of the womxn who had accessed illegal abortions in Gerdts et al.'s (2017) study cited other community members and family members who had previously had an abortion as their source of information about informal sector abortion. Signs and flyers posted in public areas frequented by many people (such as taxi ranks) and offering illegal services (usually with the claim of being pain-free and safe) also served as an important source of information.

Print media, radio, television and internet searches are sources of information used to understand formal abortion services. Womxn may use the internet to search

for nearby clinics or clinics located in other towns. This can come with risks, however. For example, in Harries et al.'s (2015, p. 7) study, some womxn, after searching online for clinics that provided abortion, decided not to use the facilities because they had realized that they were illegal providers after "making initial telephonic contact or, in two instances, after visiting the provider".

Womxn in Sullivan et al.'s (2018) study indicated that they received little information regarding the type of abortion they were eligible for. Many womxn received incomplete information from referring clinics, and there were few personnel to answer questions. Generally, womxn confirm pregnancy at a primary care clinic, then receive an ultrasound in another facility, before proceeding to the abortion clinic, often walking between these clinics. Womxn may also receive misinformation on counselling sessions. Research conducted under the auspices of the CSSR shows how counsellors may present disputed or incorrect information (for example, that abortion increases the risk of breast cancer or inevitably leads to psychological problems).

While knowledge and information are necessary conditions for autonomous decision-making, they are not sufficient. For example, in Harries et al.'s (2007) study, all of the womxn were aware that abortions are legal in South Africa and of their right to seek an abortion. However, they did not necessarily consider it "right" in terms of their religious, personal or moral beliefs. Their findings indicate that where womxn do have knowledge about abortion legislation, other factors such as religion may still constrain them from seeking an abortion. It is to these issues that we turn to in the next section.

Factors involved in womxn seeking abortion

There is significant evidence of illegal and unsafe abortion taking place in South Africa, despite the liberal abortion legislation. Evidence comes from police bringing human tissue to hospitals for determination of whether it is a foetus (Meel & Kaswa, 2009), foetuses being abandoned (du Toit-Prinsloo et al., 2016), womxn who access second trimester abortions in a formal setting admitting to having attempted self-induction (Constant, Grossman, et al., 2014), womxn presenting at hospital with an incomplete abortion (Jewkes, Rees, et al., 2005), and the fact that 24% of maternal deaths with a preventable cause were the result of unsafe abortion in the years 2014-2016 (Department of Health (South Africa), 2017). Research (Constant, Grossman, et al., 2014; Gerdts et al., 2017; Jewkes, Rees, et al., 2005) documents a wide range of methods used to induce an abortion informally. Womxn may ingest a widely available herbal product called Stametta (a cure-all product consisting of aloe, ascorbic acid and magnesium sulphate), tablets (often, but not always, Misoprostol) bought from unlicensed providers, traditional medicine, "Dutch" medicine, contraceptive pills, painkillers, flu medicine, castor oil, vinegar, laxatives, methylated spirits, quinine, salt, sugar, abrasive material such as steel wool, excessive amounts of alcohol, household cleaning products, or a combination of the above. Womxn indicate that these medications or remedies may be provided or suggested by a range of people, including unlicensed general practitioners, nurses, pharmacies, local 'muti' shops, illegal abortion providers, traditional healers, priests, sisters or mothers. Abortion may also be induced by mechanical means such as inserting a sharp object (stick, pencil) into the uterus, heavy massage, or another person sitting on the stomach.

Reasons for accessing informal services provided by womxn include: experiencing barriers to legal service use; gestation being too late to access legal termination of pregnancy services; it being a 'natural' way to deal with an unwanted pregnancy; lack of knowledge of the law, or of a legal facility; and fear of rude staff or breaches of confidentiality (Jewkes, Rees, et al., 2005). The advent of abortion medication has increased the prevalence of informal sector abortions (Gerdts et al., 2017). In addition, womxn living with HIV, in a country with a high incidence and prevalence of HIV, report being actively dissuaded from accessing formal abortions, and may therefore opt for informal services (de Bruyn, 2006).

Gerdts et al. (2017) found that some womxn prefer to procure an abortion from traditional healers. Various reasons for this have been documented. For example, Mokwena and Van Wyk (2013) found that teenagers may prefer to get 'out of the trouble' associated with the pregnancy by consulting a traditional healer rather than the clinic staff at government hospitals and clinics. In the case of older womxn, it was also found that they feared that their neighbours would laugh at them

for being pregnant when their daughters were already considered old enough to be pregnant (Mokwena & van Wyk, 2013). Seeking abortion from traditional healers in such a context was believed to provide them with some confidentiality and privacy about their pregnancy.

Lack of access to second trimester abortions may force womxn to seek illegal abortions. For example, in the rural clinics of KwaZulu-Natal, Limpopo and Mpumalanga, it was found that the nurses were not offering any second trimester termination of pregnancy services, resulting in some womxn opting for an abortion outside of designated health facilities (Grossman et al., 2011). Harries et al. (2012) show that service providers tend to be resistant to the second trimester dilation and evacuation (D&E) procedure, mainly because it means more active provider involvement. Medication abortion is preferred. The participants in their study also indicated that there was a lack of infrastructure, physical space and personnel to respond to the demands for second trimester abortion, sometimes resulting in fragmented or poor quality of care (Harries et al., 2012).

The variety seen in accessing abortions is not unusual to South Africa. In studies conducted in Africa (including Kenya, Ethiopia and Ghana), it was found that womxn sought abortions through public hospitals, private hospitals, traditional healers, traditional birth attendants, and unregistered providers including elderly womxn and family members (Belay & Sendo, 2016; Penfold et al., 2018). In addition, international literature shows that the preferences of womxn seeking abortion are determined by many factors including safety, the quality of the service, walking distance, availability of funds, privacy and confidentiality, the type of procedures offered by a facility, cleanliness, staff competency, positive attitudes of staff, speed of service, the possibility of obtaining family planning afterwards, and fear of traditional medicines or providers (de Cruppé & Geraedts, 2017; Penfold et al., 2018). This means that the choice of providers may be influenced by more than one factor.

Barriers to accessing abortion

Significant barriers to accessing formal abortion services have been highlighted in the literature, including: active dissuasion from others; conscientious objection on the part of service providers; a dearth of functioning facilities; lack of management support of facilities; fear of breaches of confidentiality; costs; and stigma. Each of these factors is discussed further below.

Staff at referral centres may try to dissuade womxn from seeking abortions, despite it being illegal according to the CTOP Act (Harries, Orner, et al., 2007). This has consequences for womxn, some of whom have reported inappropriate referrals and being sent from one facility to another before being seen (Bateman, 2011). Value clarification and attitude transformation (VCAT) workshops were held by IPAS with traditional healers, traditional leaders, midwives, members of faith-based organisations, municipal councillors and health facility managers in order to reduce such dissuasion (Mitchell et al., 2005; Turner et al., 2008). Following the VCAT workshops, participants reported more behaviours supportive of the law and more compassion for womxn seeking abortions than prior to the workshops. However, with the withdrawal of IPAS from South Africa in the mid-2010s (returning only recently), these workshops have not been held on a regular basis.

Health service providers and facility managers may cite conscientious objection to providing abortion services. This features as a major obstacle to the provision of abortion services, resulting in many designated facilities not functioning (Bateman, 2011). Conscientious objection regarding abortion has been debated rigorously in the international literature (Harris et al., 2016). We shall not repeat the complex arguments here, except to indicate that some have re-named the action as dishonourable disobedience (Fiala & Arthur, 2014). While the CTOP Act is silent about the right to conscientious objection, Section 15 of the South African Constitution implicitly accommodates conscientious objection to abortion (Ngwena, 2004). Amnesty International (2017) identified the South African government's failure to regulate conscientious objection as a key factor in its assessment of the barriers to safe and legal abortion in the country. Harries et al.'s (2014) research shows that there is a general lack of understanding among health professionals concerning the circumstances in which they may invoke their right to refuse to provide or assist in abortion services, and few guidelines or systems are currently in place to guide them.

A major barrier to womxn accessing safe abortion in South Africa is that service provision is often extremely limited. Research shows that a significant number of

womxn do not receive the abortion care that they requested (Gerdts et al., 2014). There are frequently long queues at facilities (Trueman & Magwentshu, 2013), and womxn often have to endure significant waiting periods for an appointment as clinics are fully booked (Constant, de Tolly, et al., 2014). This is exacerbated in rural areas, where geographical distance from a legal service provider may also constitute a barrier (Gerdts et al., 2014). Travelling long distances may be hindered by lack of available transport, finances and other factors.

While clinics may close or open depending on resources and the filling of posts, there is a dearth of functioning clinics. Earlier in this decade, it was reported that only 57% of the designated clinics were functional (Bateman, 2011), and fewer than one third of trained health service providers actually provided the service (Trueman & Magwentshu, 2013). Services in functioning facilities are fragmented according to the willingness of the health service providers to be involved in the various aspects of abortion care (Harries et al., 2009). Facility, departmental and government officials are viewed as lacking the political will to implement the CTOP Act (Trueman & Magwentshu, 2013). Such lack of management support may result in a failure to provide the necessary infrastructure, equipment, supplies and supervision (Sibuyi, 2004).

Provision of abortion services in South Africa is uneven across socioeconomic status and location. Poor womxn and womxn in rural areas are more likely to die from abortion-related complications than wealthier womxn and womxn living in urban areas. Notably, womxn living in urban centres and wealthier womxn can access services through private providers (e.g. private practice GPs or MS). Indeed, it has been argued that poor womxn are no better off in terms of abortion service provision than they were before the CTOP Act (Trueman & Magwentshu, 2013), and that the distribution of termination of pregnancy health services is unjust (Gerdts et al., 2017).

Womxn seeking abortion experience a myriad of problems in the Eastern Cape Province, many of which are associated with having to wait long hours before they can get an abortion (Dickson et al., 2003). In most cases, womxn end up postponing their abortion until the second trimester, while others may resort to unsafe illegal abortion (Dickson et al., 2003). Dickson-Tetteh and Billings'(2002) study showed that waiting times varied considerably: from 13% of womxn waiting less than 24 hours to 4% waiting more than 21 days from the time they sought an abortion to the time they had the procedure.

Termination of pregnancy services are free in the public sector, although womxn still incur the costs of transport, time off work or arranging childcare while they visit the facility. In a study by Lince-Deroche et al. (2017), womxn incurred a median cost of US$9.99 (R190.00) for the abortion, which usually required two facility visits. Many had to pay for transportation, a pregnancy test, sanitary pads or pain medication. Particularly in rural areas, transport is a factor that adds to the cost of a procedure. In areas where people are mostly unemployed and generally depend on subsistence farming, small businesses, social grants or stipends sent by relatives working elsewhere, reserving family resources for transport can be prohibitive. Even if rural pregnant womxn can travel to hospitals in a different location to get an abortion, they are not guaranteed to be served on the day they visit the hospital, thus often needing to make another trip. Nevertheless, despite the costs, negative perceptions of public sector facilities have led some womxn to present at private sector facilities. This not only has financial implications but may also mean a delay in accessing the service as womxn have to save enough money first (Constant, Grossman, et al., 2014).

Even though abortion is legal in South Africa, it is still stigmatized and, as indicated by womxn in one study, not a subject discussed openly in their communities (Constant, de Tolly, et al., 2014). Overall public support for abortion in South Africa is low, with few people approving of abortion on request or for social and economic reasons. There is, however, some support for abortion in the case of rape, incest and danger to womxn's health (Mosley et al., 2017; Mwaba & Naidoo, 2006). A survey amongst university students found that female students had more positive attitudes to the autonomy of womxn in abortion decision-making and in making abortion accessible than male students (Patel & Kooverjee, 2009). Indeed, the gendered aspect of public understandings of abortion has been highlighted in several studies (Feltham-King & Macleod, 2015; C. Macleod & Hansjee, 2013).

For HIV-positive womxn, stigma adheres not only to an abortion, but also, contradictorily, to the pregnancy itself. Interestingly, however, womxn in Orner et al.'s (2010) study indicated that abortion was more stigmatised than HIV/AIDS. This may be as a result of the activist work conducted by groups such as the Treatment Action Campaign.

Young womxn may also be subject to more stigma than older womxn. Research shows that young womxn struggle to trust anybody in relation to abortion, feel that their decision is judged, and indicate that attitudes to abortion enforce secrecy (Geldenhuys & de Lange, 2001). They experience shame, embarrassment and guilt about having an abortion (Mojapelo-Batka & Schoeman, 2003).

Stigma has implications in terms of womxn accessing services. Some womxn are reluctant to visit health care providers or clinics within their communities for fear of being recognized and ostracized. Shaming may come not only from community members, but also from health service providers. Research shows that womxn fear breaches of confidentiality and privacy by healthcare providers and may therefore seek abortion care outside of their residential areas, thereby adding significantly to the cost of procuring an abortion (Harries, Orner, et al., 2007). Within the actual healthcare sessions, providers may impose their own religious beliefs during counselling or consultation (Harries, Orner, et al., 2007; Mavuso, 2018). Hodes (2016, p. 86) argues that "the personal politics of many healthcare workers in South Africa are profoundly at odds with the legal commitment and the public health imperative to provide comprehensive reproductive healthcare, including abortion". For example, Harries et al. (2007) found that many womxn spoke of instances where staff were not only rude and hostile, but also attempted to dissuade them from having an abortion, resulting in them obtaining an abortion at another facility (Harries, Orner, et al., 2007).

While womxn experience significant stigma in terms of abortion, health professionals who do offer the service may also face negativity. Research indicates that stigma toward abortion health service providers manifests as name-calling, harassment and intimidation (Potgieter & Andrews, 2012; Sibuyi, 2004).

Experiences of womxn seeking abortion in South Africa

The process of seeking abortion among South African womxn has been explained as strenuous and challenging, especially among teenagers, unmarried womxn and those who are not working (Harries, Orner, et al., 2007). Long waiting times and initially being denied an abortion may delay womxn in seeking their abortion and may cause feelings of distraught and distress, particularly for those who are already beyond 20 weeks and for whom pregnancy options narrow considerably as a result (Constant, Grossman, et al., 2014).

The general lack of information available on abortion procedures may have negative effects on womxn's experiences in the process of seeking or having an abortion. Womxn in one study spoke about being "scared and afraid", not knowing what to expect in terms of the procedure and anticipating pain (e.g. one womxn described having "sleepless nights" weighing all the possibilities) (Harries, Cooper, et al., 2007, p. 28).

Another experience faced by womxn seeking abortion involves having to walk long distances in search of hospitals and clinics which offer abortion services. In their study, Dickson et al. (2003, p. 280) identified the Eastern Cape Province as one of the provinces with a high number (41%) of womxn of reproductive age not living within 50 km or within 100 km of facilities offering services for first- and second trimester induced abortions.

Additionally, a study by Kaswa et al. (2018, p. 4) found that having to travel to other towns or cities in search of abortion services is costly not only financially, but also emotionally. For unemployed womxn living in poor socioeconomic conditions, having to travel far may involve having to make childcare arrangements, finding the money, and the emotional strain of travelling to an unfamiliar place during an already difficult time. The emotional and logistical strains of travelling such long distances may, thus, motivate some womxn to seek abortion from informal providers operating within walking distance.

Methodology

Studies seeking to explore womxn's abortion seeking behaviours and preferences have employed various strategies and methods regarding recruitment, method of data collection, persons responsible for data collection, and method of data analysis. Given the stigmatised status of abortion, methodological decisions need careful reflection. In this section, we briefly summarise methodological discussions of abortion research reported in the literature and we discuss the implications for the methodology used in the present study.

A social scientific, mixed-methods approach was used in this research: a qualitative component consisting of individual, key informant interviews and a quantitative discrete choice experiment (DCE). The literature review and qualitative study formed the foundation for the DCE. Given that DCEs have not, to our knowledge been used in studying abortion seeking behaviours and preferences, we turned to other studies for guidance. Our review of health service related DCE studies highlighted questions around developing and analysing the DCE. We present these methodological discussions, as well as the decisions we made as a result of this reading.

Methodological discussions on abortion research

As abortion is a sensitive topic, we sought methodological guidance from the studies discussed in the literature review. In the following, we outline the methodological challenges and/or limitations highlighted in the papers. We focus on those studies from the literature review that spoke to how and why womxn sought abortion services and which foregrounded methodological issues encountered in the research. There are eight such studies which we discuss below.

Of the eight studies in the literature review that explored or were related to abortion seeking behaviours and preferences, six studies were conducted in South Africa, with one of these being a multi-country study that was also conducted in Colombia, Nepal and Tunisia (Gerdts et al., 2014). The remaining two studies were conducted in Kenya (Penfold et al., 2018) and India (Kalyanwala et al., 2012). Of the six conducted in South Africa, all took place in Cape Town in the Western Cape province except for one study (Jewkes, Gumede, et al., 2005) which was conducted in Johannesburg, Gauteng. All studies employed purposive sampling to recruit participants, with one specifically employing respondent-driven sampling (Gerdts et al., 2017). Except for Harries et al.'s (2014) study among abortion providers, hospital managers and policy influencers, participants were womxn who had sought an abortion. In most of the studies the sample comprised womxn who had sought an abortion from formal service providers (Constant, de Tolly, et al., 2014; Constant, Grossman, et al., 2014; Gerdts et al., 2014; Harries, Orner, et al., 2007; Penfold et al., 2018), with two studies recruiting womxn who had sought an abortion from outside of formal public or private abortion facilities (Gerdts et al., 2017; Jewkes, Gumede, et al., 2005).

Across the eight studies, the number of participants recruited ranged from 22 to 311. In four studies, surveys or questionnaires were used to collect data and data were analysed using descriptive statistics (Constant, Grossman, et al., 2014; Gerdts et al., 2014; Jewkes, Gumede, et al., 2005). The remaining studies collected data using semi-structured, one-on-one interviews which were analysed using thematic analysis (Harries, Orner, et al., 2007; Kalyanwala et al., 2012; Penfold et al., 2018) or a grounded theory approach (Harries, Orner, et al., 2007). In two studies, data were collected by the study researchers (Gerdts et al., 2017; Jewkes, Gumede, et al., 2005) while the remaining studies employed trained assistants, fieldworkers or investigators to collect data. Two studies specified that data were collected by female persons (Gerdts et al., 2017; Penfold et al., 2018) while the rest of the studies did not specify or include information on the sex of the persons collecting data.

Table 1: A breakdown of the studies in the review of methodology

Reference	Aim	Site	Data collection method	Data analysis method
Constant, de Tolly, Harries, & Myer (2014)	Establish whether womxn having a medication abortion could self-assess whether their abortion was complete using an automated, interactive questionnaire on their mobile phones (part of randomized controlled trial)	2 NGO and 2 public sector abortion facilities in Cape Town metropole, South Africa	Structured questionnaire and self-assessment questionnaire implemented via mobile phone with abortion seekers. Interviews with providers	Descriptive statistics and unstructured supplementary service data (USSD) system log files for abortion seekers
Constant, Grossman, Lince & Harries (2014)	Explore prevalence and methods of and factors related to unsuccessful attempts at self-induction of abortion by womxn presenting without complications and seeking second-trimester abortion at public health facilities	4 public health facilities, Western Cape, South Africa	Structured questionnaires	Stata (version 12, College Station, TX, USA).
Gerdts, DePiñeres, Hajri Harries, Hossain, Puri, … Foster (2014)	Assess sociodemographic characteristics of legal abortion seekers, as well as the frequency and reasons that womxn are denied abortion care	2 clinics in each of four cities: Kathmandu, Nepal; Cape Town, South Africa; Tunis, Tunisia; and Bogota, Colombia	Questionnaires	Descriptive statistics

Reference	Aim	Site	Data collection method	Data analysis method
Gerdts, Raifman, Daskilewicz, Momberg, Roberts & Harries (2017)	Investigate reasons for attempting self-induction, methods used, complications, and sources of information about informal sector abortion, and tests a specific recruitment method which could lead to improved estimates of informal sector abortion prevalence among an at-risk population	Cape Town, South Africa	Face-to-face questionnaires	Descriptive statistics, using Stata 13 (College Station, Texas)
Harries, Cooper, Strebel & Colvin (2014)	Explore how providers in South Africa make sense of, or understand, conscientious objection in terms of refusing to provide abortion care services and the consequent impact on abortion access	Western Cape, South Africa	In-depth interviews	Thematic analysis
Harries, Orner, Gabriel, & Mitchell (2007)	Understand reasons why womxn delay seeking an abortion until the second trimester	1 public sector tertiary hospital and 2 NGO health care facilities in the greater Cape Town area, South Africa	In-depth interviews	Grounded theory approach
Jewkes, Gumede, Westaway, Dickson, Brown & Rees (2005)	Explore why South African womxn still abort outside designated services where there is substantial legal service provision	3 hospitals in Gauteng, South Africa	An interviewer-administered questionnaire with open and closed questions was completed	Descriptive statistics were generated in Stata 6.0; open-ended questions analysed using content analysis
Kalyanwala, Jejeebhoy, Zavier & Kumar (2012)	Understand experiences of unmarried abortion-seekers in India	NGO abortion clinics in Bihar and Jharkhand, India	Surveys in-depth interviews	Descriptive statistics Atlas Ti5 (interview analysis)

Reference	Aim	Site	Data collection method	Data analysis method
Penfold, Wendot, Nafula, & Footman (2018)	Explore pathways, decision-making, experiences and preferences of womxn receiving safe abortion and post-abortion family planning (PAFP) at private clinics	6 private clinics, Western Region, Kenya	Semi-structured interviews	Descriptive thematic analysis

The methodological challenges reported by the studies tended to centre on the generalisability of the results, which was hindered by a small sample size (Gerdts et al., 2017) or a homogenous sample whether by geographical region (Harries, Orner, et al., 2007; Kalyanwala et al., 2012), participants' access to resources (Harries et al., 2014; Harries, Orner, et al., 2007), pregnancy trimester (Constant, de Tolly, et al., 2014), or type of healthcare provider (Penfold et al., 2018).

Various other methodological challenges are reported by the studies. Firstly, Penfold et al. (2018) discuss how the use of one-on-one interviews, instead of focus group discussions, may have limited the extent to which community views on abortion and delays seeking abortion services could have been obtained. Secondly, Harries et al. (2007) note that participants in their study may have experienced difficulty in discussing abortion as a result of the stigma attached to it. Lastly, in Gerdts et al.'s (2017) study, which used respondent driven sampling, participants received a monetary reimbursement of R100 for participating in the study and a further R50 for each participant they managed to recruit. Gerdts et al. (2017) note that the recruitment strategy and monetary reimbursement may have meant that participants' ability to refuse participation was compromised by the monetary incentive.

Discrete choice experiments: a brief methodological discussion

The Discrete Choice Experiment design has been used in several areas, including consumer products, customer services, and health care services. This methodology allows researchers to investigate how people in a particular context rate selected attributes of a service by asking them to state their preference for different hypothetical alternatives (de Bekker-Grob, 2009). Each alternative is described by attributes, and responses are used to infer the value placed on each attribute. It allows for the calculation of participants' trade-offs between attributes. This technique is useful where there is an intention to extend or alter services (or provide new ones where the current services do not yet exist). Regarding health services, studies have been conducted both from the perspective of prospective and practising service providers, such as nursing and medical students' intentions to provide health services in rural areas (M. Kruk et al., 2010), and potential users of health services.

Data collection for the methodological review proceeded using the search terms "discrete choice experiment", "discrete choice experiment in healthcare" and "discrete choice experiment abortion" in Google Scholar. The search was not restricted to a particular time period. To select articles to review, we looked at the title and then abstract of articles to assess whether the articles reported on DCE research on sexual and reproductive healthcare preferences. Although articles from higher-income countries were included, we focused specifically on articles reporting on DCE research in lower-income countries, given the context of the study. A total of eight articles were included in the review. Although more could have been included, the articles were included because of their direct relevance to the study which meant they would be useful for gaining an understanding of the DCE methodologies which have been used in relation to reproductive healthcare preferences (particularly in the African region), and could therefore inform the methodology to use for the study. Information included in the review were the context of the study, sample size, method(s)

used to develop the DCE questionnaire, methods used to analyse the DCE results, and any methodological challenges reported by the studies.

In the following, we present a brief discussion of a small sample of eight studies employing DCE designs, focusing only on studies that have sought to understand participants' preferences and priorities in relation to the use of health care services. Topics explored in the studies include preferences for family planning service providers (Michaels-Igbokwe et al., 2015), obstetric care (M. Kruk et al., 2010), places of delivery (M. Kruk et al., 2009a), quality care of public health facilities (Honda et al., 2015), management of first trimester miscarriage (Petrou & McIntosh, 2009), interventions for early detection of breast cancer (Kohler et al., 2017), new HIV prevention technologies (Terris-Prestholt et al., 2013) and patients' priorities for patient-centred care in primary care consultations (Cheraghi-Sohi et al., 2008).

In their systematic review, Clark et al. (2014) found that studies employing a DCE design have been conducted in a number of higher, middle and lower-income countries, with this design being increasingly used in middle and lower-income countries in the last ten years. Because of their relevance to the proposed study, of focus in this discussion are studies conducted in lower-income settings. Thus, of those we discuss here, only two were conducted in a higher-income country, England (Cheraghi-Sohi et al., 2008; Petrou & McIntosh, 2009), while the remaining studies were conducted in lower-income countries, namely, Ethiopia (M. Kruk et al., 2010), Malawi (Kohler et al., 2015; Michaels-Igbokwe et al., 2015), South Africa (Honda et al., 2015; Terris-Prestholt et al., 2013) and Tanzania (M. Kruk et al., 2009b).

Sample sizes varied greatly, with a range of 213 participants (Kohler et al., 2017) to 1203 participants (M. Kruk et al., 2009b). Only three studies had sample sizes below 700 (Kohler et al., 2017; Michaels-Igbokwe et al., 2015; Petrou & McIntosh, 2009). Those with larger sample sizes compared sub-groups which needed to be accounted for in the sample size (Cheraghi-Sohi et al., 2008; Honda et al., 2015), or were population-based studies (M. Kruk et al., 2009b, 2010; Terris-Prestholt et al., 2013). This variation in sample size appears to be determined by the goals of the studies, specific DCE design chosen, and/or flexibility around sample size calculations (Cheraghi-Sohi et al., 2008; M. Kruk et al., 2010). Clark et al.'s (2014) review does not discuss trends in sample size.

Studies have differed in their approach to developing attributes and levels for the DCE. Most of those reviewed developed attributes and levels from a review of the literature and qualitative interviews. One study, however, by Petrou and McIntosh (2009), did not use qualitative interviews and therefore developed attributes based on a review of the literature and expert advice. Several of the studies, including Petrou and McIntosh's study, highlight the importance and usefulness of using qualitative interviews to inform the development and design of the DCE as doing so allows for the selection of attributes that are locally specific and relevant to the sample. Although useful, qualitative interviews may produce long lists of attributes. In two studies, therefore, workshops were used to reduce the long list of attributes developed from the qualitative interviews.

The number attributes and levels, number of choice tasks, and use of pictorial representations vary across DCE surveys. For the number of attributes, six was the most common (Cheraghi-Sohi et al., 2008; M. Kruk et al., 2009b, 2010; Michaels-Igbokwe et al., 2015; Petrou & McIntosh, 2009), followed by five attributes (Kohler et al., 2017; Terris-Prestholt et al., 2013) and only one study used seven attributes (Honda et al., 2015). In Clark et al.'s (2014) review, six attributes were also the most used. Differences further emerge in the number of levels assigned to the attributes. For example, a combination of two 4-level and four 2-level attributes were used in studies by Cheraghi-Sohi et al. (2008) and Michaels-Igbokwe et al. (2015), while in Kohler et al.'s (2017) study two attributes were assigned 2 levels, two were assigned 3 levels, and one was assigned 5 levels. Trends across studies suggest that in the past three decades, studies have typically asked participants to complete between nine and 16 choice tasks (Clark et al., 2014). Most of the studies discussed here cohere around five to eight choice tasks, with three having 12 and 13 (Petrou & McIntosh, 2009), 16 (Cheraghi-Sohi et al., 2008) and 20 (Honda et al., 2015) choice tasks. Interestingly, pictorial representations were incorporated in the DCE surveys conducted in lower-income settings, to attend to the possibility of participants having low literacy levels and/or low formal education.

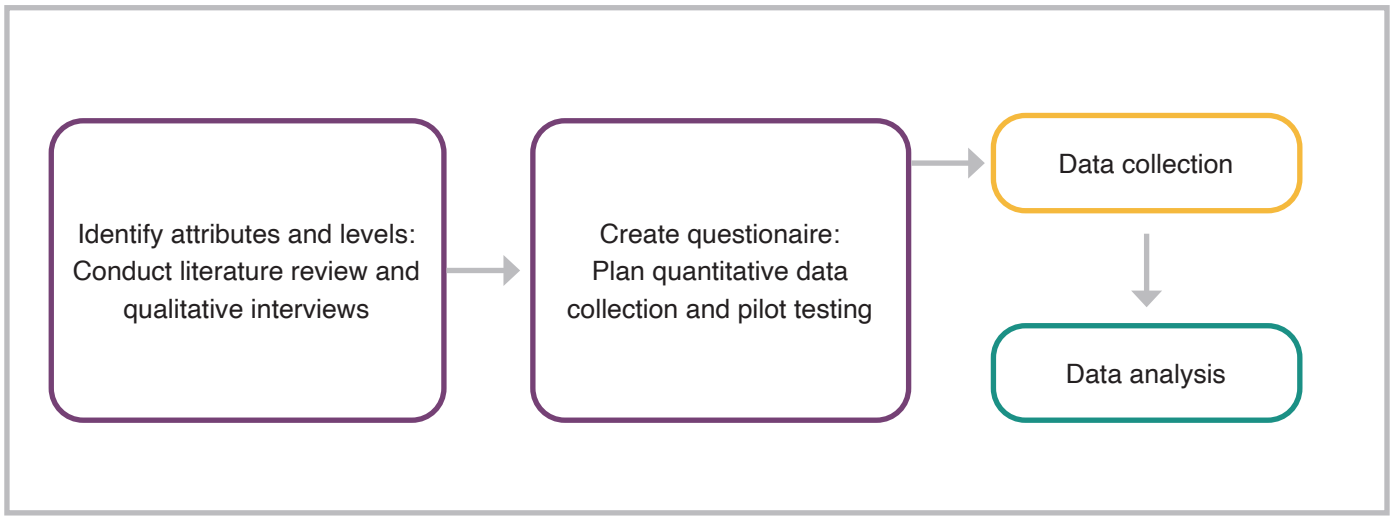
To analyse the DCE results, probit models (Cheraghi-Sohi et al., 2008; Michaels-Igbokwe et al., 2015; Petrou & McIntosh, 2009), logit models (Honda et al., 2015; Kohler et al., 2017; Terris-Prestholt et al., 2013) and a Hierarchical Bayesian module found in the Sawtooth software (Kohler et al., 2017; M. Kruk et al., 2009b, 2010) were used. This is similar to trends in Clark et al.'s (2014) review where probit models were favoured in older decades, with logit models being increasingly used, especially since 2009. To achieve validity of responses, the studies employed various tests for:

- consistency, where the same alternatives (Cheraghi-Sohi et al., 2008) or a superior attribute (Petrou & McIntosh, 2009) were presented in the choice tasks;
- lexicographic preferences to assess those unwilling to make trade-offs (Cheraghi-Sohi et al., 2008);
- predictive validity assessed using software simulations (M. Kruk et al., 2009b, 2010; Michaels-Igbokwe et al., 2015) or 'holdout' questions (Honda et al., 2015);
- theoretical validity (Honda et al., 2015); and
- debriefing sessions with those who administered the DCE surveys to determine if the results resonated with interviewers' perceptions of participants' views during data collection (Honda et al., 2015).

Other studies did not report on the use and results of validity tests (Kohler et al., 2017; Terris-Prestholt et al., 2013).

Study design and methodology

Figure 1: Diagram of study design



Site sampling

The Eastern Cape is a large province formed from two former homelands (Ciskei and Transkei), and the eastern section of the former Cape Province.

- The average household income from pensions, social insurance and family allowances in the Eastern Cape is R13 260. (National average is R11 378) (Statistics South Africa, 2017)
- The Black African population group which made up our entire sample is the largest population group in the province (6,1 million of the 6,8 million) (Statistics South Africa, 2017)
- In South African traditional areas there is a tendency towards a higher number of female headed households (52% female), in rural formal areas such as in some of site 2 and site 3 household heads tend to be male (32% female). The Living Conditions Survey of 2014/2015 shows that Black Africans in the Eastern Cape consisted of 2,78 million male-headed households and 3.3 million female-headed households. National data shows that female-headed households tend to have almost 30% less household income than male-headed households and female heads of households tend to rely more on pensions, social insurance and family allowances and income from individuals (Statistics South Africa, 2017).

Rural populations consist of people living on commercial farms (mainly in the western part of the province), on communal tenure land in the former homeland areas, and in villages. Given this diversity, three sites were selected based on the Municipal Demarcation Board's classifications: B3 defines local municipalities with small towns, but with no large town as core; the B4 category is made up of local municipalities which are mainly rural with communal tenure and with, at most, one or two small towns.

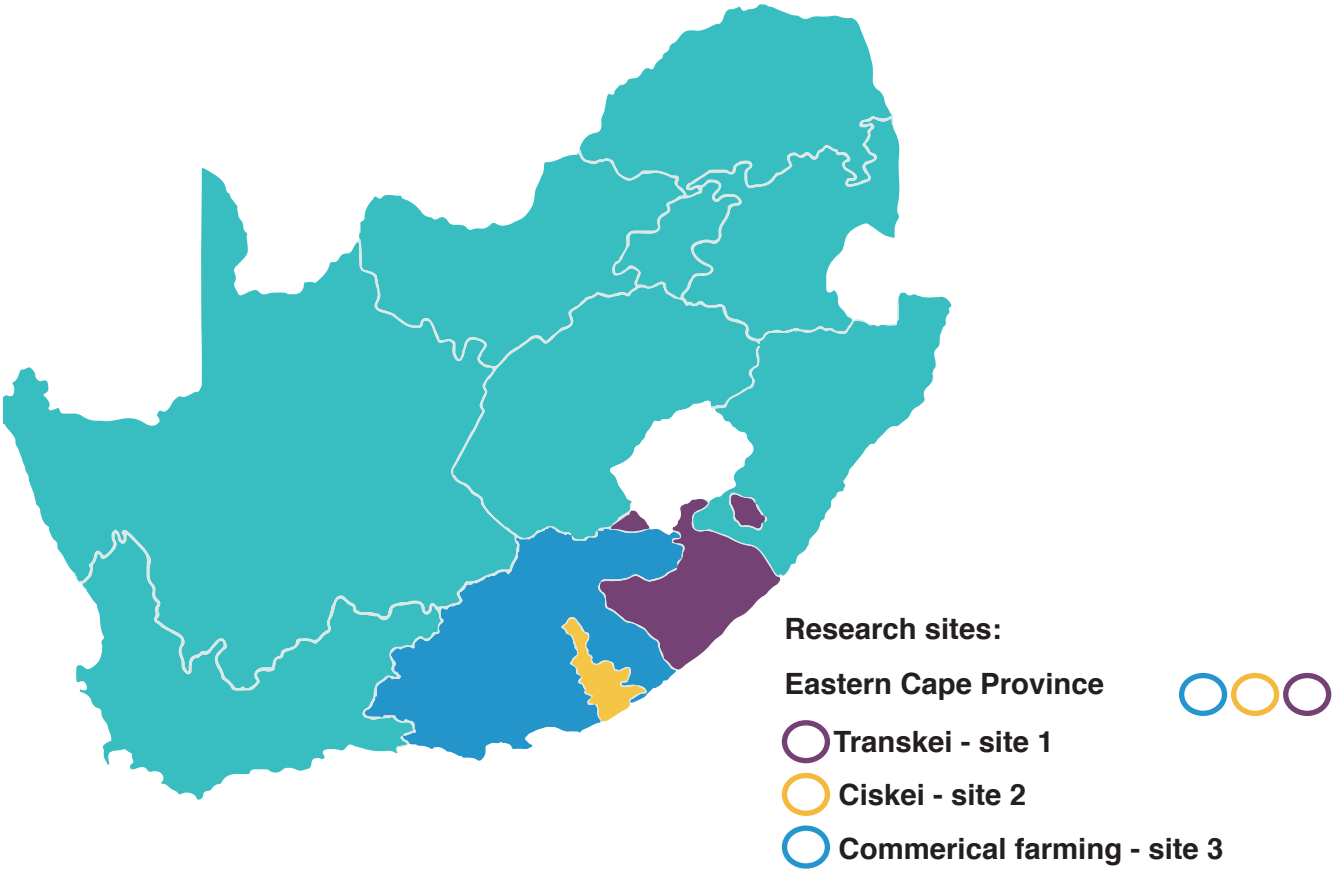
Site 3 is a B3 local municipality in the western part of the province so as to cover commercial farm workers. The most suitable site for the research was selected with the help of our research partner, an NGO which operates across the western part of the province.

The other two sites fall under B4 local municipalities. Site 2 consists of a large rural zone surrounding a small town. An estimated 2000 people live around the town. There is a clinic in town and a hospital in a neighbouring town. The local NGO provides basic health services through their home-based carers. Site 1 consists of four villages in a remote municipality that has only three small towns. An estimated 6000 people live in these four villages. Apart from the NGO health point in one of the villages which employs a nurse and provides basic primary health care services, there are no health services in the area. There are two clinics in neighbouring villages, and two hospitals in distant towns. Abortion services are provided by hospitals. Clinics provide information and referrals.

Figure 2: Map of the municipalities in the Eastern Cape province of South Africa[1]

1 Adapted from Htonl based on File:Map of the Eastern Cape with municipalities blank (2016).svg, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=55874316

Figure 3: Map of the former homelands in the Eastern Cape province of South Africa



Twenty people were interviewed in each site; sixty interviews were conducted in total. 200 questionnaires were planned to be done in each site (600 in total), in the end 629 were conducted, although 13 were removed from the sample for the regression analysis due to missing values in the main variable of interest. Purposive and snowball sampling were employed for the qualitative data collection, and cluster sampling for the quantitative data collection. Sampling was effected with the help of our NGO partners in each site. Participants were selected to fit the purpose of potentially needing reproductive health and abortion services in the area, viz. be (1) of reproductive age (between 18 and 45), and (2) a permanent resident of the area. Diversity of participants was sought along the following lines: gender, age, and reproductive status (see later discussion of sample demography).

Remuneration and tokens of appreciation

The NGO partners were remunerated and accordingly made the services of their home-based carers and chosen panel members available for the study. In consultation with the partners, the NGOs were paid a lump sum and the individual members helping with the study were not remunerated individually. The given rationale for this is that the financial benefit of being part of the study contributes to the entire working budget that keeps the NGOs running.

All participants were given a token of appreciation. During the qualitative phase, the token of appreciation took the form of airtime or data. During the quantitative phase, the token of appreciation was an OK stores voucher. The type of token was suggested

by expert panel members working for the partner organisations. All participants had the right to withdraw from the study at any point until the analysis was completed (February 2020) without being penalised or disadvantaged in any way or needing to provide a reason for withdrawing and were informed of this right. If a participant wanted to withdraw after the interview or questionnaire had been completed, they could phone the lead researcher whose details were provided on the information sheet or they could let the NGO know who would in turn let the lead researcher know. The NGOs are very accessible to their communities, either directly or through their home-based carers.

Qualitative component

Given the sensitive nature of reproductive health issues, including abortion, individual rather than focus group interviews were conducted with 60 people (20 from each site). Participants were treated as key informants, reflecting not only on their own understandings but also those of the community within which they live. Data were collected through semi-structured, open-ended questions and narrative-inducing interviews. Interview times varied but were mostly between 30 minutes and an hour long. These kinds of interviews have the advantage of ensuring that the participants' perspectives and understandings are heard (Scheibelhofer, 2008). Interview questions elicited data on:

- participants' reports of communities' understandings of problematic/unwanted pregnancies, abortion, abortion legislation, and abortion services,
- the barriers to, and facilitators of, access to abortion services,
- perceptions of safety and quality of current abortion services, and
- recommendations for new or improved services.

Pilot study

A pilot study to test the draft interview guide was conducted once ethical clearance was obtained. This consisted of four interviews in site 2. The four participants were recruited by the site 2 health programme coordinator (also the expert panel member). Site 2 was chosen because of its accessibility. Information from the pilot study fed back into the review of the instrument as well as the training of fieldworkers. A feedback discussion with these individuals was used to make the necessary alterations. These included some changes in the images. The final draft of the interview guide (see appendix 1) was refined through inspection by the expert panel (see section of quality assurance). The interview guide and consent forms were translated into isiXhosa (see appendix 2) through a rigorous back translation process (Bucholtz, 2007; Chen & Boore, 2010).

Recruitment

In each site, the NGO partner identified and approached 20 participants based on the selection criteria (locals, a range of ages within reproductive age, 6 mxn and the rest womxn). For two of the partners in Sites 1 and 2, this was effected through their home-based carers (also known as community health workers). These home-based carers are NGO employees who have been drawn from the local community and are trusted by community members. One of the specific requirements was that the NGO select participants in a non-biased manner and according to the inclusion criteria. Of the 20 participants in each site, two were mxn.

Home-based carers were given the relevant training in how to administer the instrument. For the NGO partner that works with farm workers (Site 3), recruitment was affected through their programme facilitator. The facilitators work regularly with farm workers (e.g. through workshops).

The NGO-employed home-based carers and facilitator described the study to the chosen individuals using an information sheet (see appendices 3 and 4) and asked if the individual would like to participate. Since many of the participants were likely to be illiterate, the information was also described verbally and the home-based carer made sure the potential participant understood the study, their role in the study, and their rights as a participant. The fact that the participant may withdraw at any point until the analysis phase without having to give a reason and that their identity will be kept confidential were emphasised. Home-based carers and the facilitator were specifically asked to make sure that any potential recruit or participant understands that their choice to participate or not participate in the study will have no effect whatsoever on the subsequent care or

services they receive from the NGO. The NGOs agreed that there would be no coercion from their part on participants or non-participants.

The home-based carers were given a short course in research ethics and a workshop in the aims of the study as well as their role in it. A specific aspect of this training included home-based carers being clear about their different role as research facilitator and carer. They were required to explain their roles as recruiter for the study in detail and that this did not impinge on their role as home-based carer. The home-based carers and facilitator approached community members until enough participants had been recruited. Participants were given an option of being interviewed at their homes or at a neutral space such as a local NGO office which, in each site, was hired for the occasion.

Fieldworker training

The fieldworkers for the qualitative phase were drawn from the Rhodes University postgraduate student population and were thoroughly trained. Where possible, fieldworkers with prior knowledge of doing fieldwork in rural areas were recruited. The fieldworkers were chosen based on their past experience in interviewing in rural areas and level of previous training and not according to their sex. According to our NGO expert panel members, the sex of the fieldworker would not impact the quality of the responses. Many of the home-based carers are male and there were no reported incidence where community members did not want to speak with or be cared for by a male home-based carer. Since many of the fieldworkers were recruited from the Rhodes University Anthropology department, they already had some previous experience and training. Fieldworkers were required to have a non-judgmental stance towards abortion and speak fluent isiXhosa and English. Each fieldworker was required to do an online ethics course before commencement of training. Each fieldworker (as well as all researchers, translators, transcribers, etc.) signed a confidentiality agreement (see appendices 5 and 6) in line with the ethics protocol. Each fieldworker was inducted in the goals and aims of the study, the administration of the instruments as well as the ethical considerations.

Data collection

In Sites 1 and 2, home-based carers played an important role in the collection of data. Home-based carers, known as community health workers in Site 1, are the main providers of health services in these areas. They go from house to house on a daily basis and provide basic primary health care related services to the residents. These include activities such as taking blood pressure or blood sugar levels, distributing medicine, discussing health related issues and giving health promotion advice. The NGOs suggested the involvement of the home-based carers as a means of collecting data as a way to integrate the study into the community since, they believe, the home-based carers are trusted members of the community. The home-based carers, having been recruited from the local community, act as a connection between the functioning of the NGO and the residents in the community. In sites 1 and 2 the trained fieldworkers each joined a home-based carer who took them to the houses of the recruited participants or interviewed them at the NGO offices.

The home-based carer was asked to remain outside the house during the consent process so that the participant did not feel pressured to participate if they had changed their mind. While the home-based carers were told specifically not to pressure any community member into partaking in the study, the possibility existed that existing power dynamics between the NGO and community members inadvertently produced this risk. The fieldworker was trained to be sensitive to the potential risk and discuss the possibility of pressure with the participant, giving them enough space to withdraw without the home-based carer knowing why.

Since home-based carers go from house to house all the time in Sites 1 and 2, the data collection process did not seem out of the ordinary in the community. In Site 3 the NGO could only provide a list of identified individuals and instead the fieldworkers went on their own to these identified individuals' houses and interviewed participants. Each participant was again provided with the information of the study and was given the opportunity to withdraw.

Where the participant chose to partake, they were asked to sign a consent form (see appendices 7 and 8). Even though some participants could not read or write, they were nonetheless able to write their own names or sign. Using a thumbprint system will have caused additional ethical issues since the taking of biometric information in South Africa is historically fraught.

Interviews were conducted in participants' preferred language (isiXhosa or English). The NGO partner expert panel members indicated that no other language is spoken by the residents in the three communities and isiXhosa is the most likely language to be chosen by the participants.

Interviews were audio recorded with the permission of participants. At the end of each day of fieldwork, fieldworkers turned over all data and consent forms to the lead researcher who stored the data in a password protected folder. The lead researcher ensured at the end of each day that all confidential data had been handed over and secured and ensured that all data had been adequately deleted from any digital platform used to collect data and consent forms. Consent forms were scanned once the lead researcher was back at the office. The scans were secured in a password protected folder by the lead researcher. No participant asked to withdraw from the study, so re-identification of participants' data was not necessary. The hard copies of the consent forms were destroyed via shredding.

Transcription and translation of the interviews took place after the fieldwork was completed. To ensure rigor in this process, the audio data was transcribed first and then translated into English by a speaker fluent in isiXhosa and English. All transcribers and translators involved in the study signed the confidentiality agreement and the lead researcher ensured that all data were handed over and secured, and then subsequently deleted from the transcribers' and translators' computers.

Analysis

The qualitative data were analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis enables an understanding of patterns across a data set. These patterns are participants' shared meanings and understandings of a phenomenon or social practice.

This method of data analysis is useful for its flexibility and for its accessibility in terms of disseminating research results. The analysis was conducted in the following stages, reiteratively as opposed to linearly:

1. Familiarization with the data (repeated listening of audio data and reading of transcriptions).
2. Initial coding (labelling and organizing the data into succinct features based on descriptions and interpretations of the data). Two researchers did the initial coding for the DCE independently and then discussed and agreed the themes together to minimise bias. Thematic analysis for the final report was done by the lead researcher.
3. Generating themes from the codes (identifying patterned responses by revisiting the codes and searching for similarity and linkages).
4. Reviewing potential themes (checking the themes against codes and data extracts to ensure that the themes reflect the data, which involves discarding any codes or themes, redrawing boundaries of themes).
5. Defining and naming themes (themes need to be clear, distinct and coherent).

The analysis started off with a set of themes attached to questions in the semi-structured interview guide. These themes are as follows:

- Attitudes towards abortion
- Barriers to accessing abortion
- The abortion decision-making process
- Involvement in the abortion decision-making process
- Knowledge on abortion laws, procedures and facilities
- Preferences in choosing an abortion provider

Additional themes were identified in the process of analysis. These are as follows:

- References to stigma
- References to government services
- References to NGO services
- References to support

- Myths and stereotypes attached to abortion

The data provided by the qualitative component, along with the literature review, expert panel input, and researcher discussion, formed the basis of the quantitative component.

Quantitative component

The quantitative part of the research consisted of a discrete choice experiment (DCE) conducted in each of the three sites.

This study component drew on the ISPOR Task Force's suggestions for good research practices regarding conjoint analysis, which includes DCEs (Bridges et al., 2011). Their suggested systematic process includes a 10-item checklist covering the following:

1. The production of a well-defined research question delineating what the study will attempt to measure.
2. Identifying the relevant attributes and assigning levels (within a realistic range) for each of these attributes (e.g. if travel time to a clinic is incorporated as an attribute, then levels may include a short, medium and long travel time).
3. Construction tasks, i.e., the ways through which the attributes are presented to the respondents.
4. Choosing and producing an experimental design.
5. Choosing a preference elicitation method.
6. Producing the instrument.
7. Producing a data-collection plan.
8. Doing statistical analyses.
9. Writing up the results and conclusions.
10. Producing a study presentation.

Producing the DCE

The question that the DCE answered was: 'What are womxn's preferences for facility, location, provider type, information channels and costs when accessing abortion services in the Eastern Cape?'

The following aspects were identified as potential attributes during the literature review, qualitative data, input from expert panel, and researcher discussions:

- Transport and travel
- Type of abortion facility (public, private, informal, etc.)
- Confidentiality
- Willingness to pay
- Health provider attitude
- Information channels
- Availability of service/quality
- Type of provider

After some discussion, the expert panel decided the DCE levels for facility type would be limited to MS services since the research informed MS in extending its services to rural communities in the Eastern Cape. The following attribute levels were decided on:

1. MS clinic in a government hospital or clinic
2. Stand-alone MS clinic
3. MS mobile clinic
4. A MS clinic in a pharmacy
5. A MS clinic partnered with a traditional health practice

MS also wanted to know what type of abortion procedure people would prefer and thus the levels for type of abortion services were decided to be the following:

1. Medication abortion (up to 9 weeks pregnant)
2. Surgical abortion (between 9 and 20 weeks pregnant)
3. Both medical and surgical abortion (up to 20 weeks pregnant)

The qualitative data revealed that it is possible that womxn would prefer the anonymity that is, at least partially, provided by the fact that a facility do not provide abortions only. Thus, the following levels were identified for services offered:

1. Abortions only
2. Abortions and contraceptive services
3. Abortions and other health services such as STI testing, cervical cancer screening, etc.

Travel was divided into the following levels for easy comprehension and application across the three sites. This question is intricately connected to the desire for confidentiality. Not only does it indicate how far people are willing to travel, but also how likely they are to avoid clinics that are close by. The following levels were attached to the location attribute:

1. In my village/community/township
2. In a nearby village/community/township
3. In the nearest town
4. In the nearest city

The prices of abortions were put forward by MSSA to reflect reality. An option of 'free service' was added to give individuals the option to state whether community members were likely unwilling to pay.

1. Service is free (excluding transport)
2. R 500 (excluding transport)
3. R 800 (excluding transport)
4. R 1 400 (excluding transport)

Finally, the opening times were set at the following levels:

1. The service is available Monday to Friday, 8:30 - 16:30
2. The service is available Monday to Friday, 08:30 to 22:00
3. The service is available Monday to Saturday, 8:30 - 16:30
4. The service is available Monday to Saturday, 8:30 – 22:00

The following supplemental questions were chosen:

1. What is your sex?
2. What is your age?
3. Are you employed?
4. Do you live/work in a rural area?
5. What is your average household income per month?
6. What is your attitude towards abortion?

These questions were presented as multiple choice. This information was used to conduct subgroup analysis and to see how preferences differ according to these factors.

Images were produced for the attributes and their levels by a graphic designer (see appendix 16). The chosen tasks were piloted in order to ensure that they are not too complex or lengthy. The DCE was piloted in site 2. Through a process of cognitive interviewing, the pilot study participants were asked to comment on the instrument and to provide feedback on its comprehensibility, the suitability of the attributes, and number of choice sets. The pilot went well and based on the input, various changes were made. Some of the images were changed to be in line with community understandings; the form was reformulated into a single answer sheet (see appendix 9) and the fieldworkers were provided with one task sheet (see appendix 10). This task sheet was laminated and bound for ease of use and endurance.

Sampling

The DCE instrument was deployed in the three sites. The sample size of a DCE is dependent on a variety of aspects associated with the study, including the specific hypothesis to be tested. While even small sample sizes may still produce meaningful data, it does tend to prevent the detection of small effects (de Bekker-Grob et al., 2015). Literature indicates a tendency to consider very low sample sizes feasible and functional. De Bekker-Grob et al. (2015) indicated in their review of DCE studies that 32% of studies had sample sizes smaller than 100 respondents, 23% had sample sizes larger than 600 respondents and 9% had sample sizes larger than 1000 respondents. Since the study did not have limitations due to stringent eligibility criteria, which often constrains other health-related research studies, we were able to have as large a sample size as the study budget allowed for. Our anticipated sample size was 600 participants, although we ended up with a few more (629; however, 13 were removed from the sample for the regression analysis due to missing values in the main variable of interest). This ensured sufficient statistical power to detect a difference in preferences. Participants were identified using the same processes described in the qualitative data collection stage.

Demographic and socio-economic characteristics of the sampled participants are shown in Table 2. More

than eighty percent of the final sample are womxn (n=496) while approximately 18% are mxn (n=112). The average age at the time of data collection was 29.3 years old, CI=(28.7, 30.0), and no statistically significant differences were observed in the average age between male and female participants (28.1 versus 29.6 years old for mxn and womxn respectively, p-value=0.142). More than 20 per cent of the study subjects live and work in a rural area, while two thirds of them only live in a rural area. Only a quarter of the sample are employed with no statistically significant differences in employment status between mxn and womxn. Monthly income is rather low with more than half of the participants (56%) reporting income R0-1000 and only three per cent earning more than R5000 a month.

Table 2: Demographic characteristics of the sample for the DCE

Variable	N	Estimate (%)	95% CI	Missing (N)
Sex				8
Female	496	82	(78, 85)	
Male	112	18	(15, 22)	
Site				
Site 1	207	34	(30, 37)	
Site 2	209	34	(30, 38)	
Site 3	200	32	(29, 36)	
in rural area				6
Live...	421	69	(65, 73)	
Live and work	130	21	(18, 25)	
Work	21	3	(2, 5)	
None	38	6	(4, 8)	
Employed				7
Yes	144	24	(20, 27)	
No	465	76	(73, 80)	
Income				26
R0-1000	328	56	(52, 60)	

Variable	N	Estimate (%)	95% CI	Missing (N)
R1000-2000	179	30	(27, 34)	
R2000-5000	63	11	(8, 13)	
R5000+	20	3	(2, 5)	

Data collection

In sites 1 and 2 the home-based carers were the fieldworkers and in site 3 we brought in our own fieldworkers. They attended a training workshop in executing the questionnaire as well as in the ethics of fieldwork. Fieldworkers were aided with a comprehensive fieldwork guide (see appendix 15). All fieldworkers signed confidentiality agreements (see appendix 5) and all participants signed consent forms (see appendices 11 and 12) and were given information sheets (see appendices 13 and 14). The fieldworkers verbally provided the information in the information sheet to the participants before commencing with administering the questionnaire.

Data analysis

The analysis of the quantitative data was done by a statistician and consisted of two parts, descriptive analysis of the characteristics of sampled participants and inferential analysis through hypothesis testing and regression models. More specifically, regression analysis allows us to assess the participants preferences for a specific level of attribute and how strong this preference is. Regressions were applied to the pooled sample that includes all participants together and by sex and site in order to explore differences in preferences. The most common methodology used for analysing data from DCE is multinomial regression (MNL) that enables us exploring the associations between the attributes and participants' preferences. The data manipulation, cleaning and statistical analyses were all conducted in R and package mlogit was employed for the MNL regressions.(Croissant, 2019; R Core Team, n.d.)

Quality assurance

The credibility and trustworthiness of the research output was ensured throughout the project through the following processes:

- An expert panel was consulted throughout the research process. This panel consisted of members of the research team, MSSA, relevant NGOs, and community members. Input was sought on data collection methods and research instruments.
- The credibility of the qualitative portion of the study was ascertained through an ongoing, process-understanding of validity (Walsh & Downe, 2006).
- The interview guide was piloted prior to data collection and interviewers were thoroughly trained.
- During the analysis stages of the research, credibility was ensured through a rigorous and transparent translation process, detailed descriptions of the analytical process, and evidence provided for interpretations made (use of data extracts). The relevance and transferability of the results are ensured by linking the analysis to relevant literature and studies conducted in similar contexts and addressing limitations and weaknesses of the study.

Validity of the quantitative aspect were ensured through several processes.

- It was important that there was no conceptual overlap between attributes. To effect this, clear unambiguous definitions were developed and checked by the expert panel.
- A pilot study was conducted in one area. Through a process of cognitive interviewing, the pilot study participants were asked to comment on the instrument and to provide feedback on its comprehensibility, the suitability of the attributes, and number of choice sets.
- Fieldworkers were thoroughly trained and assisted participants in understanding the tasks throughout.

Two researchers did the initial coding for the DCE independently and then discussed and agreed the themes together to minimise bias. The final analysis was done by the lead researcher.

The DCE studies reviewed earlier outline various methodological challenges and limitations, including generalisability of the study results (Cheraghi-Sohi et al., 2008; Honda et al., 2015; Kohler et al., 2017), ensuring that important and relevant attributes are included (M. Kruk et al., 2009b, 2010; Petrou & McIntosh, 2009), and keeping up with advancements in DCE methodology (Petrou & McIntosh, 2009; Terris-Prestholt et al., 2013). Each of these is dealt with below.

Firstly, this study attempted to achieve a sample that is diverse and representative of rural communities living in the Eastern Cape, by recruiting participants from one B3 municipality and two B4 municipalities. However, generalisability of abortion service preferences may only be applicable to communities from similar municipality categories. Secondly, the study's incorporation of semi-structured interviews with key informants, stakeholder input in the design of the DCE and pilot-testing of the DCE ensured that relevant attributes were included in the DCE. This is particularly important given the need to ensure that the process of completing the DCE survey is not made long and cumbersome for participants. Thirdly, given the possibility that the abortion services that may be implemented following the results of the study will require payment from users, and given the relative poverty of the Eastern Cape region, a 'willingness to pay' attribute was included in the DCE. For this information to be useful, however, correct estimations of the cost of services was necessary.

Ethics

Ethical clearance was obtained through the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee as well as the MSI Ethics Research Committee.

In order to reduce the risk of an emotional response and reduce the effect of stigma, individual rather than focus group interviews were conducted, and participants were treated as key informants rather than being expected to reflect on their personal experiences. The interview guide did not include personalised questions and only required general reflection. Interviews were conducted at a venue convenient to the participant that provided comfort and privacy. Neutral venues were negotiated with the NGOs. In the process of recruiting, home-based carers gave potential participants a choice of venue as well as advice on which venue might be most appropriate to the participant's context. Fieldworkers and home-based carers were trained to deal with an emotional response and participants who requested it were to be provided with an emergency counselling call number and given additional airtime. However, these actions were not necessary as no participants required referral.

While the topic of abortion has not reached the politically controversial and divisive stage in South Africa as it has in the United States of America, there are some religious organisations that are against abortion. Although social attitudes to abortion, pre-marital sex and unmarried womxn becoming pregnant/giving birth in the communities in which we did our research were not known, previous research in the former Transkei has shown that abortion is viewed as culturally inappropriate.(Feltham-King & Macleod, 2020) We had ascertained from our expert panel members living in the rural communities in which we were doing fieldwork that individuals who obtain abortions are often gossiped about, but that there is no hostility towards them and that they did not foresee any issues arising around the research. These local contributors believed that the participants might like to be part of a research study, especially one that could contribute positively to the reproductive health of the community. Regardless, the privacy and confidentiality of all participants were taken seriously throughout the entire study. Every effort was made so that participation remained confidential, as detailed below.

Since abortion may be a sensitive topic, participants might have felt uncomfortable if other members of the community knew they were being interviewed. The communities in Sites 1 and 2 are close-knit. To obviate any potential fall-out, fieldworkers were teamed up with home-based carers. These carers are constantly moving from house to house, so the process of gathering data did not look out of the ordinary. These home-based carers are known to and trusted within the local community. The home-based carers were asked to sign a confidentiality agreement and they were made to

understand that this includes keeping the information of participants private including the discussions with the fieldworker. Before each interview, the fieldworker gave the participant the choice to have the home-based carer in the room with them or not.

Furthermore, the information provided to the community reiterated that participants are key informants and not being interviewed because they have any direct connection to the abortion procedure. The information sheet, which participants could keep, was altered to say, 'Research study on reproductive choice', which is less divisive than a title that includes the words 'abortion seeking behaviours'. Despite this change, participants were told that they are being questioned on abortion services as detailed in the consent form text (see appendix 7), which the fieldworkers reviewed with each participant. Interview participants were recruited as key informants and were not required to divulge personal information on any procedures they have ever undertaken.

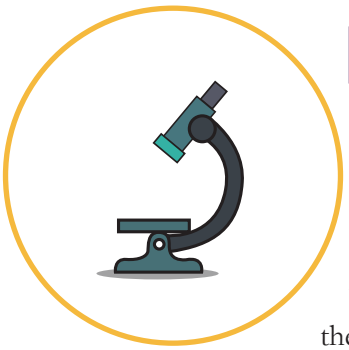
There is a risk during any study that the identity and confidential data of participants or other members of the community will be seen by members not on the research team. Several countermeasures were put in place to reduce this risk. All data were anonymised from the start and only the lead researcher is able to re-identify data (via a numbering system connected to the consent forms) and only for the purpose of withdrawal at the request of participants (a right we afforded them as stated on the information sheet and consent form). During the qualitative stage, fieldworkers were trained not to ask for or write down any confidential information that could give away the identity of the participant or any other community member. The audio data is being kept in a password protected folder by the lead researcher. All individuals handling the data – including the researchers, fieldworkers, transcribers and translators – have signed a confidentiality agreement outlining their duty to not disseminate any information in the data to anyone who is not on the research team. Once the data were transcribed and translated, all identifiers were redacted from the transcriptions, and the audio files were destroyed. The redacted and anonymised data will continue to be stored in a password protected folder. The consent forms were scanned by the lead researcher and kept in a password protected folder. The hard copies were destroyed via shredding.

There is a risk that the information is not captured, transferred and stored securely. Several countermeasures were put in place to reduce this risk. The lead researcher remained in close contact with all fieldworkers while they were collecting the data. All data were handed over at the end of the fieldwork day. The lead researcher immediately transferred all the data to a secure password protected folder. Any other individuals handling the data were required to sign a confidentiality agreement in which they agreed not to distribute any of the data to anyone who is not on the research team. Translators and transcribers were not allowed to keep any data after they handed the finished product back to the research team. The lead researcher reminded the translators and transcribers to delete all data from their computers once they handed it over. The research team went through the qualitative data in detail in order to ensure that no information is present that identified the participants or other community members. The anonymised data will be stored by the CSSR on a secure server for five years, after which it will be destroyed.

There is a risk that participants will feel discomfort or embarrassment talking about a sensitive topic such as abortion. However, participants were thoroughly informed about the topic of the interview before they gave consent to be interviewed or to fill in the questionnaire. They were not surprised by any of the questions. Participants were also informed that they could stop the interview/questionnaire at any point without needing to give a reason. The study did not gather any information about individual medical experiences and fieldworkers were trained to avoid such personal questions.

There is a risk that participants who have been promised confidentiality may disclose information that identify a threat to the health, welfare and safety of someone, in which the researcher is legally required to pass this information on to an appropriate individual or agency. This risk is understood as the limit of confidentiality and fieldworkers were trained to identify this risk and act appropriately. The clause is also inserted in the consent form and described in the information sheet. As such, participants knew that researchers are legally required to pass on such information. No such event occurred.

The quantitative stage did not involve taking data that might identify the participants or any other community members, except for the consent forms. The consent forms were digitised and are being kept in a password protected folder. No-one except the core research team has access to the consent forms. The consent forms were kept for as long as participants can withdraw from the research. All gathered data and the consent forms will be collected by the lead researcher at the end of each fieldwork day and kept safe until they can be digitised and captured.



Findings

Qualitative findings

The main themes surfaced in the interviews are knowledge, attitudes, preferences, barriers, and decision-making processes. Other specific topics were also identified, such as the impact and quality of government services, the functioning of local NGOs, myths and stereotypes about abortion, suggestions on type of support services that could be provided to womxn who abort, and a rich and broad engagement with the stigma involved in abortion in rural areas. The following keys are used to identify the interviews: BI001 - BI020 represent participants in the interviews conducted in site 1, the rural site that consists of homesteads dotted along several valleys, HB001 - HB020 participants in site 2, homesteads dotted around a small town, and SV001 - SV023 participants in site 3, an agricultural region where people live in small townships in and around commercial farms, and often work on these farms. We start off by discussing findings pertaining to research question 1 on understandings of problematic/unwanted pregnancies, abortion, abortion legislation, and abortion services in these communities. We then discuss the reported barriers to access to abortion in these communities (research question 2) including findings on the abortion decision-making process, and finally the preferences for abortion services (research question 4). Research question 3 on perceptions of safety makes an appearance in each of these sections.

Knowledge on abortion laws, procedures and facilities

a) Abortion laws

Knowledge of the legality of abortion was widespread among respondents, although many of them reported low levels of knowledge about abortion laws among their fellow community members. Most respondents could identify which type of abortion service provider was legal and which not.

The illegal way of doing an abortion is doing it yourself by just drinking something. The legal way is going to the clinic. (BI013)

No, they could get an abortion anytime because, their bodies belong to them. (BI016)

It is legal because it is now being talked about in the news and in the papers that doing an abortion is legal. (HB009)

They know that it is now legal to terminate a pregnancy. I mean people have rights to abort their pregnancies should they not want to keep the baby. (HB013)

They believe that there is legal abortion because they are scared of illegal one because they are warned that when you are going for an illegal abortion, when you die there are no pay outs but when you go for a legal one you have a right for a pay-out. (SV011)

They believe that it is their right to abort. They also believe that it is illegal to have an abortion in other places or providers other than in health care facilities because you'll encounter difficulties, and no one will know you have a problem... Because you might buy someone to help you abort illegally. That is not right by the law. Someone will offer money and ask for a fast way of abortion and that is not right, you have to follow the rules of the law to get to where you want. (SV013)

That which is unlawful, sister, is the one written on papers where a person will write and say they can perform an abortion and leave their number. You cannot trust that one, rather go to a doctor. (SV023)

In these extracts legal abortion is contrasted with illegal abortion, which participants refer to as self-induction and procuring an abortion from an informal provider. The rights of womxn to an abortion is spoken about as is the means of obtaining the knowledge (newspapers and the radio).

In contrast, some key informants indicated lack of knowledge amongst community members. The major differentiation made between those in the know and those with little knowledge was based on age.

People have vast knowledge about pregnancy prevention, but very little when it comes to abortion. I realised that abortion can never happen properly without medical assistance. (HB016)

Others know but there aren't many people who know, and others simply just do not care. (SV003)

I think… yes, we do know that we have a right to terminate pregnancy, is that correct? … but I think older people don't know that. We, young people, know that. (BI015)

The reference to pregnancy prevention speaks to the concerted family planning programme instituted by the South African government during apartheid, which continues today. Contraception is well-known in communities, but, suggests one participant, abortion is not.

Some key informants indicated that while knowledge of the legality of abortion was good, many did not understand the nuances of the legislation.

They know the laws created by the government, but they still need help because they do not know [understand] them fully. (BI017)

To be honest, the youth is very knowledgeable about abortion, but fifty percent of them do not know the relevant information. They do not know that they the right to have an abortion and that no one can say no, and that it is actually legal for them to terminate a pregnancy. It would be ideal if someone could give them full information about where they can go and other options, to inform them that it is their right and it is legal. (HB003)

These claims are in line with research conducted amongst learners in the Eastern Cape. This study found that participants' knowledge of the various elements of the Act were lacking.(Macleod et al., 2014)

Three months of pregnancy was often given as the cut-off date for a legal abortion, but sometimes earlier ('before the bones are formed' (HB018)).

They do the abortion process if you're at least 2 months pregnant if you are 3 months, they can't…. (BI009)

If you've been pregnant for a long time, I think when pregnancy is more than months, they do not allow you to abort, but if you're 3 or below months pregnant then they help you abort. (BI015)

Therefore, you need to have 3 months or below, even if you are 3 months with 2 days extra, you cannot because now the baby is developing, and it is starting to be more like a person as it is developing. So, if you are 3 months or less, you can get an abortion, but if you have an abortion after the 3 months period you will be at risk of losing your life because you can get it done but you might also die right away. (HB019)

A few respondents believed abortion is illegal or said their community members might believe it to be illegal.

They do as they please, but the law does not state that it is lawful. (BI016)

No that has never been legal, well, we don't know it is as legal as the olden day people. If it is legal these days I do not know. (BI020)

Oh a lady…Yes she can hide that…she can hide it because it is said that it is legal but not really…not really, she can hide it because most of the time an abortion is seen to be a bad thing, and again to some it is unbelievable that it is legal, some still have the idea that you can be arrested for it. (HB012)

Some thought abortion was illegal and that it should be legalised.

I would say it should be made legal because we live in a time where people are being raped. We live in a time where womxn are raped on the streets. Sometimes womxn are raped at home by a relative. Children are raped at a young age maybe by their uncles and would be quiet about it until the family notices that they are pregnant. (SV014)

As seen above, belief that abortion is illegal was associated either with womxn "doing it anyway" or with arguments for it to be legalised (e.g. there is a lot of rape).

Several respondents knew abortion was legal, but believed it should not be, or reported that their community members did not support it being legal.

People understand abortion laws in South Africa, that abortions are welcome. People understand that the abortion law in South Africa is not welcome because it is written in the Bible, it says increase family members, it does not want abortion, but the South African law allows for abortion. (HB001)

They do understand. They know that a person has the right to do an abortion when she wants to go through the right channels. And then other people, then, you can see that they have that thing that you can't do an abortion because the child is a blessing from God… others have that thing that the decision maybe you took is wrong for you because you have killed a blessing. (HB004)

I don't think there are cases, there is no such thing as an argument about whether or not your abortion is legal but it is just a thought that they shouldn't abort, it is not about the legalities, it is about their opinion that you shouldn't abort. (HB009)

In my opinion, it is legal only according to government laws. But in my opinion, I view it as an illegal practise. (HB015)

Yes, even though they may know abortion laws, they will never consider it as legal, they know what is wrong and right. (SV002)

Participants draw a distinction here between the legal and moral status of abortion. Drawing from religious metaphors, HB001 and HB004 differentiate between the law and what is "right".

b) Abortion facilities

Knowledge of the existence of abortion facilities was reportedly widespread. Participants indicated that most people know to go to clinics or hospitals to either procure an abortion or to receive the right information.

No, there is no other option except going to the hospital. (BI002)

She can go to the clinic, she can go to the hospital or to a private doctor if she has the money, if she can afford in that place in government that can provide appropriate care for someone (HB005)

It was mentioned a few times that one could go to a private doctor (some people, it was indicated, do not believe public facilities do abortions). Who these private doctors are is not made clear (e.g. whether they are MS)?

There was reportedly widespread knowledge about illegal abortion providers as well, but it was mentioned that they were not available in the communities that formed part of the study. "Backstreet" abortion providers were said to be only available in cities or large towns, and traditional healers who provided abortions were not widespread. Regardless, traditional healers were not seen as safe providers. Resultantly, people may self-induce.

There are other places, but you find that they are not legal. Because people say you can't go to a place when you don't know if maybe that person is a qualified doctor or qualified nurse. So, the best place you can go is government places, clinics, public clinics. (HB005)

No sister, there are no other places that I know of. Some people say they go to the hospital, I don't know, but hospitals are very far from here, you can find it at [nearest city] and [nearby town]… the traditional ways are available, but not in this community. Even those that use such things they go to the township at [an area some distance away]. (SV002)

We end up knowing those who secretly went to have an abortion the traditional way and they also end up being a burden when there's complications, having to be taken to hospitals. (BI015)

I can just say we do need to have abortions here in this community but not the traditional one because it is not right. The clinical one is the right one because they do it effectively and your safety is ensured. I support it. (BI015)

Yes, others abort by themselves in their houses. They also know herbs from the forest; they therefore drink those to abort… We recommend places for each other. For instance, you recommend the one you once went to. (BI009)

Knowledge of the existence of facilities that provide legal services was not the same as knowing where they are located.

What I can say is that we hear that there is a place that conducts abortions for a person who does not want her pregnancy even though we do not know where these places are located (BI001)

There's a place for abortion at [closest city], apparently, there's another one here in [this area], but I don't know where it is (BI009)

Knowledge of the legal status of abortion and that abortion providers exist must obviously be supplemented with knowledge of the location of services for womxn to access abortion.

c) Abortion procedures

Key informants differentiated between abortions performed in legal termination of pregnancy facilities and those self-induced or performed illegally. General knowledge within communities of legal abortion procedures were reported to be quite low. In the extracts below respondents provide some accurate and some inaccurate information.

I just hear people speak about somebody who has done an abortion. You hear that the person has taken some pills that resulted in an abortion. I don't even know what kind of pills those are or where they may have gotten them. (BI007)

The law I know is that before the doctor assists you with abortion you have to fill in and sign a form acknowledging that you are going ahead with abortion and you have heard risks involved. They, therefore, numb you with an injection so you don't feel pain. There is a machine that they switch on, it counts, as you are fast asleep, it cuts itself when it is time for you to wake up. If the machine doesn't go off at the right time, you die. These are some of the risks involved and then if you are still sure you want to abort, they help you and receive their money. (BI009)

They believe when you explain your condition to them. Some say you must take the baby out and kill it by yourself. For example, if you mislead the abortion providers about how far along you are; maybe because you too were misled by an inaccurate pregnancy test. You then abort a baby that is alive, they then say kill him/her yourself and then you kill him/her. (BI009)

I explained this before that if you are pregnant and you do not want to keep the baby, you abort or go to the hospital. You can also go to the pharmacy and get an abortion pill. It is better to go to the hospital than to self-abort because at the hospital, they can at least put you on an IV drip after the abortion and they clean your womb. (BI010)

When you get an abortion there are procedures you go through to clean your womb, you'll go to the hospital and clean your womb. (BI016)

Participants shared details of illegal and self-induced methods, sometimes going into graphic detail.

If you drink a concoction to abort the pregnancy you might bump into a lot of problems. If I take a mixture and don't get cleaned, I might get sick. Some pharmacies give abortion pills for R1000 to sort out "my problem". I might lose strength on this bed without anyone to help after taking this pill because I do not want anyone to know what I have done. After the abortion has happened, I'll take the dead foetus, dig a grave and bury it. Or I can just throw it on the road. Then dogs can pick pieces of it apart and come to the people with it. (BI010)

It's the healers that can make traditional medicine and carry out abortion… I do not know the details about how the process works but it is a risk. (HB001)

So, people don't have the necessary knowledge of what to do, instead they listen to others as they suggest pearls of pseudo-wisdom. They will say eat steelwool, orocrush etc., and all these things will leave me damaged. I must just go to the hospital. They don't have such knowledge. I was also ignorant before my friend went for the abortion at the hospital. Another example is one of my other friends who once told me that she was pregnant and drank flagel. Do you know flagel? Flagel is a pill that is used to clean the womb. She said she drank flagels, and I know how smelly flagels are. One tablet emits a very strong smell, how much more when you drink a packet? Some other people would say things that they think would work, never having seen it being done. One would just think that such and such a thing could damage the pregnancy. And it ends up being ineffective. It leaves you with some damage. (HB016)

Some, my sister, I hear, what you need to do is when you want to abort and you might not be able to go to the clinic or the hospital you must take a bottle of old brown and toilet paper or take newspaper and boil it and take that boiled newspaper and drink it and take a bucket that you normally use to pee on, undress and sit on it and all will come out (abortion complete). (SV003)

These findings mirror those of Macleod, Seutlwadi and Steele (2014) conducted in the Eastern Cape. Respondents in that study, as is evidenced above, reported knowledge of a wide range of products supposedly used to self-induce.

d) Information sources on where to access abortion services

Respondents were asked where in the community they would be able to find information on what to do when someone wants an abortion. Most respondents mentioned that either you can get information from people around you or from the nurses at the clinic. Clinics and hospitals were seen as the most reliable sources of knowledge.

In this community I haven't heard about anyone who has terminated a pregnancy. It is only when you go to the clinic because you are sick and you hear that pregnancies are terminated if a person does not want their pregnancy. Perhaps the nurses teach you about when a person does not want to be pregnant and they find themselves to be pregnant, that is to say they inform them about terminating an unwanted pregnancy so that person would be the one to meet the nurses. (BI001)

We have information; we get it from each other, from people who have gone to certain abortion facilities. (BI009)

Living here, I think someone would have to ask around about the place in [distant city] that assists in having an abortion because, honestly, having an abortion the traditional way is not safe. (BI015)

She went to consult her mother's cousin who was working at the hospital at the time to arrange for her to get abortion. (HB004)

Most womxn in the community do not have much knowledge about the options at their disposal in cases of unwanted pregnancies. Normally people would get such information from the health clinics, or from a known mid-wife in the community who is against abortion. (HB010)

Yes, because we tell each other lies. We tell you to drink such and such. We possess little knowledge which tends to be dangerous. I think the clinic will set you on the right track. I never heard that the local clinic conducts abortions. What I know is the hospital in town. But I would suggest that one starts making enquiries at the local clinic. Maybe when you realise that you are pregnant you can indicate to the nursing sister that you do not want the baby. What can I do to come out of this situation? (HB016)

I think it's something they hear maybe someone else had done it and survived. Or maybe someone else had used something and they came out okay. I think they just hear it around. (HB018)

Others mentioned receiving information about abortion providers from pamphlets or posters. It is unclear whether these pamphlets were advertising legal or illegal services.

She got these pamphlets that's says here is a place you can do abortion here. (HB005)

It's the ones that are not legal. They are on every poster in town. If someone doesn't want to go to the public clinic, they will call that number that's on the poster and get the information. (HB006)

One respondent said she would opt to speak to the local NGO and suggested that the funders of the research could look into providing the necessary information.

Now that we work together with Marie Stopes I think Marie Stopes can give us the full details about where a person can go to get help if they become pregnant without planning it… Also, [the health programme manager at the NGO] with us here helps us a lot when we are pregnant, I think a person can talk to her if she no longer wants the pregnancy. (HB012)

Electronic sources, while not prominent, were also mentioned.

We have no such assistance here. We are informed only by the radio and television that one can terminate a pregnancy if they go to a place that offers that service. Without them we would not know. (SV004)

You do it as you have heard through hearsay; you ask from others as to how to do abortion and now that there is Facebook, you ask there, and you get an answer. You choose from the options mentioned, you go to the clinic and buy those tablets, or you drink that coffee. (SV016)

I hear on social networks, but the best people are the nurses in clinics. Social networks such as Google are the ways of white people but the best information comes from nurses. (HB014)

The response from respondent HB014 speaks to the trust that some community members put in nurses. The "ways of white people" are viewed either with suspicion or as something out of reach (it is not clear which applies in the above quote).

Community attitudes and understandings of abortion

Several questions in the instrument probed community perceptions on topics related to abortion and the circumstances under which it may be acceptable. In analysing community attitudes towards abortion the following themes emerged: General statements include that abortion is 'not right', that abortion is murder, that an abortion might mean potentially killing a child with a bright future, that abortion has physical and mental consequences, including infertility. Many participants argued that community members hold different beliefs on abortion and there were situations in which abortion should be legal. There were also discussions on how communities should consider being less judgmental and aim to understand womxn's situations. We present them here:

a) General stated community perceptions of abortion and womxn who abort

There are many statements in the dataset of abortion simply not being 'right'.

When I see people who get pregnant for a long period of time with a living human being in them, then at the end you find out that they did an abortion -that is not right. (BI005)

A lot of people do not accept it that is why a lot of people end up secretly going to get an abortion because they will be stigmatised because they went to get an abortion. It's not acceptable. (HB001)

There is no such thing as an argument about whether or not your abortion is legal. It is just thought that they shouldn't abort. It is not about the legalities; it is about their opinion that you shouldn't abort. (HB009)

The unacceptability of abortion rested, for the most part, on religious beliefs, in which abortion is equated with murder.

People have different faiths and beliefs. We believe aborting a child is killing an innocent soul. (HB004)

Whether you are married or not, keep the baby. Don't terminate the pregnancy; that is a sin. (SV001)

Yes, for example in the church they emphasise a lot about abortion. My pastor even tells you that you are leaving a trail of dead bodies of children that you have aborted. Some churches do not continuously preach about that. (HB002)

Yes, they feel differently about it. Some people do not like the idea of abortion, especially here in the rural areas, due to religious reasons and the belief that is a gift from God and could even be a president one day. (HB003)

Children with a potentially bright future were mentioned frequently in opposing abortion.

They (the community) feel bad about it. It worries them. Because that child that they have aborted could have been their only child, or they were going to become a teacher, or they were going to become a person who helps a lot of people. (BI007)

The issue is that abortions are not good. Maybe you are aborting a future lawyer or nurse or whatever and you don't know what the future had in store for that child. (BI010)

And if you abort you will never know if that child was going to be the right one out of the ones you did not abort. (HB004)

Damage caused to self or others was also mentioned. Damage was spoken about in general terms, but also in relation to infertility, psychological and social fall-out.

The people who have abortions should be arrested [laughing]… People who have abortions should just be arrested and locked away. They are doing a lot of damage to themselves. (BI007)

Maybe I could be aborting my last child and I won't be able to conceive in the future when I want a child. My only chance at being a parent I lost when I threw the baby away. (BI010)

When they come back with the belly, we ask what happened and they tell us then. We ask, "Why were you trying to get an abortion? You don't get abortions. It's a gift from God. Where will you get another child?" because we grew up being told if you get an abortion you won't be able to have children again. And you will go to hell all on your own wrongdoings. (BI016)

The people who get abortions, in my opinion getting an abortion should not be important [should not be done]. Because having an abortion when you are young is also going to affect you mentally. Your body is going to tell that something is missing. (BI016)

Abortions are witchcraft because you end someone's life, and then you're left living your own. (BI009)

The fear of infertility, as referred to above, loomed large, including in cases of rape (which was seen, in many instances as an acceptable reason to obtain an abortion), the decision to not terminate the pregnancy was seen as premised on the possibility of not being able to conceive in future.

Then to get out of such a situation she will think the easiest way is to abort the pregnancy. However, some would keep the baby because of the fear of infertility in the future and end up adopting and doing other things. (HB004)

So, a womxn may have an abortion because she was raped and did not want a child, you understand? But mostly, you must understand what she wants because as I said, some complications may arise during an abortion. Not only that, but she may want to abort a child only to find out later that it was her one and only child and would never have another one. (HB015)

Despite respondents' general negativity to abortion, respondents indicated that abortion was a disputed subject in the community, The answer to the question whether all members of the community believed the same way in terms of abortion was always no. Different people had different opinions.

Others encourage you to get an abortion, others discourage that because they don't like it when you terminate a soul. (BI009)

They say it is okay to have an abortion if you are only one month pregnant and below. (BI009)

They have different views because one says you are playing with death when you terminate while others say it's not a problem. (BI017)

They know that a person has the right to do an abortion when she wants to go through the right channels and then other people then you can see that they have that thing that you can't do an abortion because the child is a blessing from God when you are going to have a baby others have that thing that the decision maybe you took is wrong for you because you have killed a blessing. (HB005)

Provisional acceptance of abortion (i.e. when performed on particular grounds) was mentioned by respondents, including for reasons of poverty, being unwed, violence in the home, and rape.

[Abortion is acceptable in] circumstances where someone is poor, and they do not know what they will do with the baby. (HB002)

What can I say, I think they are treated differently? When you're married you must have a child but when you're not married, having a child is not right. This where I think the abortion is needed (BI015)

As I said, what if this is your last chance at having a child? It doesn't matter the reason but what matters you are aborting a child. We do know though that people do things for different reasons. Some abort because at home their father beats them every time they leave the house and threaten them with "the day you get pregnant, you will know me." So, a girl will see no other solution but to abort. (BI010)

Yes. We spoke about rape. So, it could be legal in that case. I would like it to be legal in that case, but it still requires the pregnant womxn to decide whether she wants to an abortion or not. (HB015)

Participant HB015 talks above about rape being a legitimate reason for abortion, but intimates that it is not a simple decision. Indeed, rape featured strongly in the discussions, with some complex reasoning surfacing. This is discussed further below.

Tolerance of abortion was espoused by some of the participants. Arguments for such tolerance included: the ideal of being non-judgemental, not understanding the person's situation, being forgiving of mistakes, and it is the womxn's choice.

A person terminates a pregnancy because of their situation which they understand. I don't think it's legal, it's just situations are different. (BI017)

I think the community needs to stop being judgemental, as we all are not perfect in life, we make mistakes and learn from them. Everyone has his/her own mistakes so we should not judge. (HB004)

There are some who do understand that it might have been certain circumstances that influenced someone to go and get an abortion. (HB003)

Yes, the community would look at her in a bad way, but it is none of their business, because a decision is made by the person and it's her liking. (HB012)

Statements such as that made by HB012 were few and far between. Although the language of rights is not used here, the implication is that womxn should be allowed to make their own decisions about their bodies. The lack of traction of a rights-based discourse in the talk of womxn presenting for abortion in the Eastern Cape is commented upon in Chiweshe, Mavuso and Macleod (2017).

b) References to abortion stigma

Kumar, Hessini and Mitchell (2009, p. 628), in a seminal paper on abortion stigma, indicate that such stigma, rather than being universal, is a constructed and reproduced locally through various pathways. They define abortion stigma as "a negative attribute ascribed to womxn who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womxnhood".

Some respondents indicated that abortion is visible in the community, and that, thus, there was no escape from judgement, except through clandestine behaviour.

Having an abortion is wrong, because we can physically tell that something is wrong or missing from looking at,

looking at you. Even if you went behind everyone's back and got an abortion we can tell, and we can see what you have done. Nothing good comes from having an abortion. (BI016)

If your partner did not want you to have an abortion, the community will look at you in a negative way. That is why I say it is better when you have an early abortion, then it cannot be seen, and the community has not seen you because the community always has a lot to say. (HB003)

Respondents indicated that womxn who had undergone an abortion would be judged by community members. Judgement would be passed for: not being responsible and using contraceptives, being selfish and not considering the "baby"", not looking after herself, not adhering to the tenets of womanhood (which include reproducing), being a "loose" womxn, and being irresponsible.

I don't have anything to report but I want to tell you this; abortion is wrong, and it has repercussions which most people turn a blind eye to and rush to get out of a situation which they could have prevented by using contraceptives. (HB004)

A pregnant womxn is supposed to decide on her choices and evaluate them. To consider the baby inside her abdomen and eliminate selfish behaviour. Instead of thinking for herself only, the baby deserves to live so the womxn must put aside your own preferences and safety of the child. (HB004)

Someone who has had an abortion gets judged. They say that she doesn't love herself and they gossip about her. Even though we do not know the reasons or what caused her to do an abortion. So, I could say, she gets judged. (HB006)

No there is something wrong with abortions because you exit the role of womanhood. You are now the side chick when you get pregnant then have an abortion. You are no longer a womxn. The difference is that when you get an abortion you are no longer considered a womxn but a loose womxn. (BI016)

Apparently, the first time you have an abortion is usually because you have fallen pregnant by accident or made a mistake. The second time, a person tends to be judged because people say she cannot keep making the same mistake all the time. She is doing it on purpose. (HB003)

The most common consequence of such judgement is that womxn who abort are gossiped about. This gossip is the social mechanism through which womxn are marked as inferior to the ideals of womanhood, and through which shame concerning the abortion is promoted. As seen in the last extract below, this gossip can last for years.

They say very bad things about her. (BI006)

They have a lot to talk and gossip about. You see all of that? It is better when you go and your stomach is small. If your stomach is big, they will look at you negatively. (HB002)

In such a case, if people knew that, they would gossip and talk about you having done an abortion. And they would also laugh about you and ruin your reputation. It would result in you feeling like you are a nobody or you have done something terribly wrong, and even possibly end in you running away to go live elsewhere, all because people are speaking about you. (HB003)

The community becomes judgemental, such that the womxn is no longer talked about positively. They shame the womxn for abortion and because she is not married. (HB004)

Someone who has had an abortion gets judged. They say that she doesn't love herself and they gossip about her. (HB006)

They would normally gossip about the person and make derogatory remarks about the person; especially in instances where the pregnancy was known by the community. (HB010)

Without a doubt they will start gossiping about her. I mean, her pregnancy would have already been showing, so she will be the talk of the town, because

they will say she has killed her baby. (HB013)

They won't like it. They will judge you and speak ill of you. (HB017)

The one who terminated the pregnancy and was already showing, the community will not let her rest because everyone saw her. Then the other one because she was not showing, people won't know unless she tells people about it that she aborted the pregnancy because she wanted to. Even then, the people will still give her trouble. Just like me, I had an abortion in 2003 but there are people who still remind me of that. (HB020)

While gossip was spoken of as the main mechanism through which stigma and shame accrued to womxn who have had an abortion, direct action aimed at regulating the behaviour of womxn was also referred to

No, they might scold at her a lot if she had an abortion. To us it's better to hear that you had a miscarriage than to hear you had an abortion. (BI016)

Then we have a discussion, we say sit and we will have a discussion because it's unlawful. That's not how we do things. (BI016)

We wouldn't like it one bit. We would sit her down with her husband since she's married and want to know what happened for the pregnancy to disappear. When the baby is showing and they go to a hospital, they need to come back and say the baby didn't make it if there is no baby. These days you are able to come back with the child and have a funeral, and we can see that the baby did not make it. Now if there is no baby, then we need to investigate what happened to the baby… Even in that situation (unmarried), it is still the same, they have to go to the hospital and come back with the child either living or dead. Even if the person says the child is gone and is in the hospital, the phone call will come informing you to go and fetch the body of the child. (SV010)

Here direct discussions with the womxn (and possibly her partner) are meant to provide a clear message of acceptable behaviour. Trying to fudge the issue (e.g. pretend that the womxn had a spontaneous rather than induced abortion) is seen as unacceptable.

More drastic actions were outlined in some cases. In site 1 these answers were shaped/influenced by an event where a newborn child's body was found in the bushes. Generally, reference to calling the police occurred in cases where illegal abortions were performed.

The community arrests the womxn and calls the police to take her away to be arrested and interrogated at the police station. (BI002)

She gets called upon mob justice and gets chased away. (BI012)

Uh there is a person I know that tried to do an abortion and then she thought that maybe it was difficult now to live to her like the burden was too much she ended up being sent away now. She then left to stay in another place. (HB005)

There were several references to womxn voluntarily leaving the community or being sent away as a result of the stigma and shame. Dealing with the shame accruing to abortion consisted, for the most part, of disguising the abortion (undergoing the procedure prior to the pregnancy being known or visible, pretending that the abortion was spontaneous) or leaving the community to avoid repercussions.

c) Attitudes toward to married womxn who abort: conjugalised pronatalism

Talk of married womxn who undergo an abortion was underpinned by what is called conjugalised pronatalism. Pronatalism, as outlined by Morison et al.(Morison et al., 2015) is premised on a number of key assumptions: First, having children is seen as natural and fundamentally located in human instincts and biology. Second, childbearing is viewed as a significant developmental milestone in the normal progression through heterosexual adulthood and as a significant marker of normal gender development. Finally, parenting is seen as personally fulfilling, and as essential for a happy and meaningful life.(Morison et al., 2015, p. 185)

Conjugalised pronatalism refers to these assumptions being firmly cemented within the marital union to the extent that not bearing children must be explained through exceptional circumstances.

In our data, married womxn who abort were depicted as the most stigmatised. This is mainly, as the respondents noted, because having children in marriage is 'mandatory' (BI001).

When a womxn is married into a family, she is expected to expand the family by having children. (BI002)

Why would anyone have abortion when they are married? I know I would not. (BI012)

Here married couples are expected to get pregnant and have children, so now if they terminate pregnancy that is seen as wrong. However, if it's young girls who do this, it is not wrong. (BI015)

Well, yes, they want to have children for the wedlock, you have to have something for the wedlock, you really cannot have no children for the wedlock, you must make sure that you have children. If you can't have children in the wedlock, they mock you, and you break up with your husband. (SV002)

If you're not married, they won't blame or judge you. If you're married then, the elderly people might judge you because they don't understand. … elderly people see these things differently. They see it differently especially if you're married and have an abortion because here in order to be considered a wife you have to have children. (BI015)

Respondent BI015 above indicates that the elders (who are seen as the custodians of culture) reinforce conjugalised pronatalism. Indeed, the requirement to have children in marriage was seen by participants as being embedded in cultural norms and the desires of the extended family, especially in-laws.

As Xhosas we have a belief that when a womxn is married, she has to bear children for her husband. (HB011)

When you are married, yes, because it is important to have children, because a man can want his lobola back because you aren't giving him children. You know that amongst Xhosa people, you are an insult if you are not giving birth. (BI010)

When you are married terminating a pregnancy is not necessary. Your in-laws want a child, so it is not necessary for someone to terminate a pregnancy when they are married. (BI017)

OK. I am certain that regarding those who do not have children, it is not the right thing to have an abortion because each and every family needs to have children. For instance, their parents would like to have grandchildren, you understand? I mean, it does not make them happy at all that a couple may decide that they do not want children whereas they expect grandchildren. (HB015)

Even the family will have its whispers unless someone explains it to them, that they were not ready for a child. But I don't think that the family will take it lightly, in view of the fact that, when they tied the two in a matrimonial knot, they expected children out of the union. (HB016)

While willingly not having children within wedlock was depicted as shameful, involuntary infertility was also seen as sad or alternatively shameful.

The infertile ones we won't mention because they are suffering. They want children but cannot have them. (BI010)

If you are married for more than 6 months without falling pregnant some will say you are barren. (SV009)

However, although you do not want a baby yet, but people will have questions about why you don't have a baby because they have been together now for about 8 years or so. Then they will start suspecting whether you have a problem with fertility or maybe assume that you are infertile. (HB019)

They'll say "So and so married a barren womxn. She is a male who can't give birth." You become an insult to the community. (BI010)

Can you see where the problem is? You see, regarding the married couple, there is usually no happiness because if you can't have a baby you are being insulted. You also get insulted by your husband. Sometimes, you see yesterday, I was at work. There is

this sister that I work with, she is not from here at [local community], she is from [another community close by]. She was also insulted by other ladies because she can't have children and she has been married for a while now. I take this like it's been said to me, "she is in the marriage, can you imagine she is married and yet she is being insulted by her husband even". (SV002)

Suspicions of infertility when a womxn is married without children appear to be rife. Participant BI010 points to two reactions – one of empathy for the womxn's assumed suffering within a pronatalist society, and the other gendered shaming (the womxn is like a man) that is extended to the community. The insult of infertility is rendered, in participant SV002's account, not only by the community, but also by the spouse.

Given the high value placed on conjugal fertility, various solutions were suggested in terms of voluntary or involuntary childlessness.

So rather you have at least one child or two at the most. When you get married your in-laws give you a name, Nontsikelelo or Nosivuyile, in that you must give them children but not too many children because you will annoy your husband if you are always pregnant or giving birth. When you give him children, give him a few so that he knows you are fertile, he has a kid or two with. (BI010)

They can see that they (couple) have everything except a child, and therefore, they would wish that God blesses them with a baby, do you get that? However, they would not know that the womxn does not want a child because every time she gets pregnant, she gets an abortion, maybe she has done that 4 to 5 times. (HB019)

Some would suggest that you should go and do ritual healing. Maybe the reason you do not have a baby is that you need a traditional ceremony so that your ancestors help you get a baby. However, you find out she has no problem with fertility and for that matter she does not need any ritual assistance, because she knows that she is fertile but because she has a lot of money, she terminates her pregnancy every time she gets pregnant. Due to the fact that she doesn't want baby responsibilities and she still wants to have autonomy and live her life the way she wants to live it, free from any form of constraints. However, people in the community would say it has been long now, and they don't have babies. Yet, there must be something wrong with them. (HB019)

Participant BI010 argues that the solution to the stigma of voluntary childlessness is – well – having a child, just not too many (which some participants said is annoying). Participant HB019, on the other hand, suggests that community members will either pray for a person they suspect is infertile or suggest a traditional ceremony. It is hoped that these supernatural interventions may assist with fertility. This participant shows how the act of illicit or secret abortions undermines the good will of the community who is trying to help the womxn overcome infertility.

When not having children within marriage is associated with abortion, explanations must be sought. The stereotype of an adulteress is attached to married womxn who abort. The "fallen womxn" stereotype is not only attached to married womxn but also unmarried ones who are accused of having affairs with married mxn.

If she is married and has an abortion, it is assumed that womxn [from this village] are unfaithful womxn who cheat and get pregnant by mxn that are not their husbands. (BI009)

When you choose to have an abortion when you are married, people tend to think that the child is not your husband's child. If you choose to have an abortion when you are not married, people think that maybe you were impregnated by a married man or someone else's boyfriend or the man who impregnated you left you. They tend to think those kinds of things. (HB003)

A married womxn maybe has cheated, and she now wants to have an abortion because of that, since she did something wrong, I mean, that's what the community will be thinking. (HB013)

They would look at her badly. They would say the baby was not her husband's and that's why she is getting an abortion. (SV007)

Appeals to conjugalised pronatalism were evident in much of the data. On the odd occasion, however, there were voices of dissent, particularly from site 3.

Because in this day we are living in, there is no longer, there is no longer an expectation that someone has a child when they are married, you see? (SV018)

A couple. A married couple is expected to have children, you see . . . Not that you're forced, because there are married couples who have no children, or have no children yet. I'm just saying, in my opinion. (SV022)

These small acts of resistance appealed to modern time ("in this day"), which contrasts with the references made to culture and elders in perpetuating conjugalised pronatalism.

d) Attitudes towards rape victims who abort

As indicated above, rape was seen by key informants as a legitimate reason for wanting an abortion. Most participants indicated that communities were in favour of abortion in the case of rape. There were, however, nuances in the responses as indicated below.

A small number of participants (none in site 3) used the language of "choice" to indicate that it would be the rape victim's own decision whether to abort or not.

I would say that it depends on her. If she doesn't want to keep the baby, maybe because it will remind her of what happened, she can take that decision. (HB006)

Yes, or they will ask her what she wants to do, whether she wants an abortion or not. (SV007)

The decision lies with the victim whether or not she keeps the child. She will decide. (SV012)

They can't force her to keep the baby or force her to abort when she feels different about it. It's all dependent on the person carrying the baby. (SV015)

The stigma that usually attaches itself to abortion was seen by key informants as being mitigated in the case of rape.

Then if the pregnancy is the result of rape and you abort it, it's seen as the right and acceptable thing to do by the community members. (BI015)

I mean I don't think that they will judge her much considering that the pregnancy is due to rape. (HB013)

They [the community] understands because they were raped and did not ask for a child but got raped. (SV006)

It will be difficult to judge that in a bad light. Let's say 90% of the community will support that action. Because this person was raped, they were not lovers, he just wants to spoil the child's future… But the community will not put blame on her. The only problematic section of the community could be the elders. Elderly people are used to sugar-coating terrible deeds. (HB016)

They won't judge her because she was raped by someone she doesn't know. She doesn't know the father, so she chose to get an abortion. (SV007)

Indeed, not only would stigma not accrue to womxn who terminate a pregnancy in the case of rape, active support and compassion may be provided.

Perhaps let's say, she has found herself pregnant. She then decides to terminate the pregnancy as she doesn't want the baby to serve as a reminder of what had happened to her. Or she decided to keep the baby. What we need to do as a family is to support her. (HB006)

The people in the community are normally compassionate towards both the child and mother. (HB010)

They don't take it badly because they know what happened, you got raped so they know you didn't get raped because you wanted to, so they'll support you. (HB017)

Several justifications were provided for the necessity of an abortion in the case of rape. These frequently had to do with the poor outcomes expected of children conceived by rape, in particular that a child of rape cannot be loved or will be disabled.

Pregnancy due to rape I think the child can't be loved. It is a difficult situation because there was no consent. (BI002)

Even if you knew the person, you will be very angry and want to abort because of what he did to you and you will not be able to love and accept your baby. (HB011)

Support could be afforded to the rape victim because they hate the act. Making matters worse is impregnating their daughter whose child will grow in the family. They will hate the baby. (HB016)

That's they should go to the clinic as early as possible, cause they won't be able to leave with the child, she won't love the child since she did not want one but it was because of rape. (SV010)

A child that is a result of rape become disabled. You give birth to a disabled child because he/she is not planned. (BI012)

Another justification centred on the idea that a father should always be known, which rapists may not be. This reasoning fits with the emphasis on conjugalised reproduction. The difficulty of explaining the lack of a father to the resultant child was emphasised by participants.

Yes, they do [sympathise with a rape victim's abortion]. Because sometimes maybe the person was raped by multiple people and will not know who the father is. (HB007)

In that kind of situation, I would not like it at all, I wouldn't support it because we wouldn't even know who the father of the child is. … It is important for a child to know their father. So, imagine when that mother has to tell the child that no they are a result of rape. It won't sit well with the child and they might end up doing something drastic like taking their life. (HB018)

Yes, they have to accept the situation because she doesn't know who raped her. No one would want to keep such a child. I would also abort. (SV001)

No that can never be right. We cannot keep a baby who has no father, a child from a rape. It could not be right with me too. (SV008)

It becomes very difficult on the side of rape because they would say that they want to have an abortion because they are thinking that when the child grows up they will want to know who their father is and it would be difficult to explain. (SV011)

I'd probably understand [that she chooses an abortion]. The circumstances under which she fell pregnant, and maybe because her rapist is a stranger, and the difficulty she'll have, explaining to the child when it gets older. (SV022)

She doesn't know the father of the child… she was raped by a stranger. At least, if she was raped by someone she knows, she would know the person who made her pregnant. When you are raped by a person you do not know, you can then abort the baby. (SV005)

The spectre of the fatherless child looms large here. Not knowing the father is seen as a terrible burden both to the womxn and the child. Participant SV005's response is telling, however. It is only rape by a stranger that counts. If a womxn is raped by somebody she knows, then abortion is probably less acceptable.

A further justification was the trauma of the rape and the child being a reminder of the event.

Not very easy, not very easy at all. Most people think abortion straight away because it all comes as a reminder that maybe you can have this anger when you see that baby. Yes, it is your baby, but you probably have flashbacks about that day when you see the child's face, you see the perpetrator's face. So, someone thinks "Ey, I don't have an option, but I tried", they abort my child because it will be a reminder on how they got here. (HB009)

On the contrary, we may suggest that she keeps the child only for her to feel traumatized for the rest of her life because she will always remember how her child was born. (HB015)

If I was raped, I will not keep the baby because this will be a constant reminder which will open wounds that my baby is a product of rape. He was not conceived the normal way. (SV002)

While rape was seen as a legitimate reason to terminate a pregnancy, a large number of respondents (especially in site 1) argued that a rape victim should not abort, or

that families would convince her not to terminate the pregnancy.

In that situation [rape], when a womxn is already pregnant, they do not do anything here. Children who grow up in the rural areas - their parents convince them to keep the baby. (BI002)

Ehh… they may advise her not to abort the child because she didn't choose to get pregnant. She fell pregnant because of rape. (BI003)

They will advise them to abort the child, but some families insist on keeping the child even though the experience was painful, but they feel they have no choice but to keep the child. (HB007)

They look at you badly in that circumstance [aborting due to rape] as well because the circumstance is irrelevant, acknowledging the fact that your pregnancy is not of your own will or doing. (BI010)

I would have no choice but to accept the pregnancy because I am already pregnant. I might not even know the person who raped me, so I would just have to accept. (BI014)

It won't sit well with them because even if you are raped you shouldn't take out what happened on the baby. (HB017)

I don't think anyone can do something about it, besides accepting the baby because the deed has been done, there is nothing they can do to undo it. (SV015)

Two arguments are of note here. The first is that as the conception was forced upon the womxn, she is not to blame (as she would be should there be conception outside of marriage). The second is the question of acceptance. In a pronatalist community where childbearing is an expected function of womxn, conception by rape, while regrettable, is something to be endured.

In site 2 services were said to be available to mitigate the effects of the rape so that abortion isn't necessary.

When the child is born out of rape the parents of the girl go to social workers. The social workers will make a plan. The child (the one carrying the baby) who has been raped and the parents will be put into counselling to show them that it is not the end for the child (the one carrying the baby). The baby who is conceived from the rape will also get introduced to the social worker and get counselling so that they can also live a good life. (HB001)

On the other side I would say they must keep the baby and just take them to an adoption place because at the end of the day they won't constantly wonder who the father of the child is. Even though that child could've been something in life, a teacher maybe. (HB003)

Some respondents said that the community would judge a rape victim. In this they spoke to what is known as rape myths – the act of shifting the blame of rape from perpetrators to victims.(Suarez & Gadalla, 2010)

The whole community judges you and all your actions are attributed to the fact that you got raped. (BI010)

Some of them even say, "That person has been raped and so we do not want anything to do with them." (SV003)

They do not view her in a negative way, but there are two things that they would say or ask. Firstly, why was it that she got raped in the first place? What was she wearing? And the community always has something to say. So, if she was wearing something short or something that is body revealing then they will put a blame on her … But you find out some parents allow their children to go out wearing things that are body revealing and some parents buy those stuff, and as result once she got raped the community will point fingers to those who allow their children to wear such clothes. Therefore, the community will then say the parents are to blame for their children being raped and got pregnant. (HB019)

It becomes difficult because some will believe that you were raped and some will not believe that you were raped, as if you asked for it. So, there are those who are on your side and those who are not. (HB020)

I do not know because mostly people here are careless, rape cases do happen but there is consent between the two. It happens in forests, roads and when a person has been caught, she accuses the partner as raping her whereas they have agreed, and it is not taken seriously and dissipates in the thin air. (SV016)

Participant BI010 uses the passive form ("you got raped") instead of the active form ("he raped her") to describe rape. This way of describing rape dovetails with the other instances of rape myth – womxn get raped because of the clothes they wear, womxn ask for rape, and womxn make rape up. Participant HB019 indicates how shifting the blame to the victim may include blaming her parents or family for allowing her to act in ways that attract rape.

e) Attitudes towards pregnancy amongst teenagers and abortion

According to participants across the three sites, pregnancy amongst teenagers is generally viewed in a negative way. Issue is taken with the fact that pregnant teenagers might not end up completing school and that the teenager's parents or grandparents may have to care for the child. These kinds of attitudes to early reproduction is not unusual in South Africa.(C. Macleod, 2011)

Agreements or plans to have babies between younger couples or children do not make sense because they both need to finish school, grow and work and then make plans to have children. (BI010)

Yes, it's an issue. The community feels they are too young for what they have done because you can't go and fall pregnant when you haven't even completed school. You are still too young. (HB007)

When she is not married and is a school learner, the parents get disappointed. I think even an outsider parent gets disappointed because when you are a parent you are not only a parent in your house but you are a parent even out there and you know her future can become bleak. She can stop going to school regularly. Maybe the mother may not allow her to keep the baby or want her to raise the baby and then she will get behind at school. (HB012)

Wow! That will be a bad thing. For a school-going child to get pregnant is a disgrace. That will delay the female partner in her studies whereas there will be no disruption on the side of the boy's studies. Parents, once being made aware of the situation tend to let their child give birth. Thereafter they look after the baby and let the mother return to school. (HB016)

I know the responsibility of giving birth to a child because when that child is sick, they are dependent on me, as the grandparent. I had a vision of my child studying and making it in life. Now they cut those plans with having a child. (BI017)

These extracts illustrate the commonly held view concerning the correct timing of reproduction - after schooling is complete, and as participant HB012 indicates, after marriage. The participant, HB012, refers to what is called social parenting - where adult members of a community share parenting responsibility for children who are not their biological offspring. Participant HB016 interestingly points to the gendered dimension of early reproduction (repercussions for the young womxn but not her conception partner), while participant BI017 speaks to personal experience in relation to her child giving birth.

Young womxn who conceive are subjected to gossip. They are judged for: not taking sufficient care, being badly brought up, being promiscuous.

In this era, kids do not care whether they are young or not. If they thought of having kids, they do not care about the needs of the baby; they just think and do. If not so, then that child becomes a responsibility of their parents. (HB011)

Very badly because people talk. The community gossip about people so much. It's as if the child was not brought up the right way or they don't follow their parent's teachings, or the child is sleeping around - although maybe it was her first time having sex and she was unfortunate and got pregnant. So, she is always stigmatised as if she is always doing wrong. (HB020)

People will keep talking always and you can't help that, when a father of the baby says he wants the baby, people will not get involved. They will just keep talking, and the couple will just have to ignore them. (SV002)

Some participants made connections between this kind of stigma and young people deciding, or being coerced, to terminate their pregnancy.

The community judges, people judge. For example, young children get pregnant and we tend to judge them a lot. We even call them names… Some teenagers decide to have an abortion because they start thinking of various things, like what the community will say, what their parents will say, so they terminate. (HB017)

Yes, we do not want too many pregnancies coming from young couples but that does not mean that we must force them to have abortions just because they are too young. (HB015)

Participants indicated that the parents of the teenager, especially the mother, is likely to make the decision on whether to abort or not. If the teenager's parents are willing and able to look after the child she will not abort, but if not, or if the parents are concerned about their or their daughter's reputation, they would take her to the hospital to have an abortion. This obviously contradicts the CTOP Act, in which minors are empowered to make their own decisions regarding the outcome of a pregnancy.

It is bad (abortion), but some parents do such things. They would see that the child is still young and will bring the reputation of the family into disrepute and be the laughingstock of the village. (HB016)

In the case of abortion, the parent makes the decision. When the child doesn't have a parent, if they were raised by their grandmother, the grandmother makes the decision. Most of these children go to school in the location or in Port Elizabeth and because the parent does not want to be humiliated, they secretly abort the child and when we notice the child is no longer pregnant. (SV014)

Some participants argued that abortion is the right decision if a teenager conceives, while others were against abortion

It's acceptable, it's the right thing to do an abortion if you're too young to take care of the child. (BI015)

Some would understand but others won't understand. (SV006)

f) Stigma, class and community perceptions of abortion

Respondents were asked who are more likely to be judged for having an abortion, a rich womxn or a poor womxn? This question elicited some understanding of the dynamics of class in these areas. While there was a relatively equal distribution between those who reported rich womxn to be more judged and those who reported poor womxn to be more judged, the explanations given as to why rich womxn might not get judged elucidated how class-based power relations might be operating in the community.

The situation may be that person who is rich, you'll find that some people judge her … while you find that maybe other people love her because they know that maybe she is rich. They don't bad mouth her because they know that maybe that person has money. But you find that when maybe it's a person who doesn't have money people look down on her in the community and bad mouth her. (HB005)

They will normally be intimidated because the lady might get them arrested because she can afford lawyers. (HB007)

They will gossip about the poor one and others will somehow say she did it because of her situation. No one wants to be on the bad side of a rich person, so they will not even gossip about her. (HB011)

Because they feel that if they can go to the rich womxn's house and talk about what the poor womxn did, the rich womxn would be able to give them something, but with the poor womxn since she doesn't have anything, they won't benefit from her. (SV003)

These extracts paint in stark terms the power relations that play out around class. According to these participants, wealthier womxn who terminate a pregnancy will be spared judgement as community

members fear intimidation or welcome the possibility of currying favour with a person with resources.

Although rich womxn are slightly less likely to be openly judged for having an abortion, they are criticised as they are able to financially take care of a child. The same logic is what, for the most part, lets poor or unemployed womxn off the hook for having an abortion.

The wealthy one is the one who planned the pregnancy and can take care of the child. She has money, she works and all that. The other one is doing the right thing to abort because she has no money. (BI015)

They will ask questions because they will wonder why they [wealthy person] had an abortion because they have the money to raise a child. Maybe they might understand the poor one and say she wouldn't be able to raise a child. (HB017)

The one who is not struggling is not supposed to have abortion. The one who is struggling knows her situation so she doesn't want to have a child that will also struggle. So, she decides on abortion, or maybe the boyfriend is denying [paternity]. (SV001)

Although poverty was seen generally as an acceptable reason to terminate a pregnancy, some participants indicated that was not always an exemption from judgement.

She is not allowed to get an abortion, a person who is poor and married. (HB001)

Some will say she was right because she had no way of raising the child and looking after it. Some will say she could have kept it and a plan would have come along. You hear? (SV007)

We make sure we report them. They are the ones that should be arrested. Even the poor one .Why did they make a child all to have an abortion? They must give birth to them; they will just have to use the R400 grant money and buy Huggies and clothes from Pep. (SV010)

They [the community] feel hurt because they feel that had the person spoke up, they would have been helped. They would have seen what they could do to assist her with her child. (SV011)

Participant HB001's statement illustrates how conjugal status trumps poverty. If the womxn is married, poverty is not an excuse for an abortion. Participants SV007, SV010 and SV011 speak to possible solutions to poverty in relation to childbearing: making a plan, using the child support grant money, and asking the community for support. The logic here is that if there are solutions, there is no reason to terminate the pregnancy.

Some respondents indicated that when community members make assumptions about the reasons for an abortion, they do not factor poverty into the equation.

They do not take that into consideration (that you were too poor to have a child). They just assume that if you want an abortion while you are in a relationship, then you must have been cheating on your partner, or that you are sick with something like HIV and you do not want to give birth to a child that is HIV positive. People just tend to make assumptions along those lines. (HB003)

Rich or not, there is no difference. (HB015)

Despite financial standing. We did the same thing so our judgement will be the same. (SV004)

In these extracts participants indicate that poverty is not factored into judgements regarding abortion. Indeed, other factors such as infidelity or living with HIV are considered more likely reasons than poverty.

Barriers to having an abortion

Participants were asked whether they could think of any barriers womxn in their community might face when they have decided to have an abortion. The most prominent barrier mentioned was in reference to confidentiality, as discussed above. The second most prominent barrier reported upon, ironically, was that distance is a problem. This presents a double bind. Womxn are taking a risk going to a local clinic in terms of confidentiality, but if they do not have money for travel, they might have to take this risk or forfeit their right to an abortion. Some of the other barriers are related to the issue of confidentiality and distance, such as costs, and failing to present for an abortion within the legal time limit. Many participants also spoke about fear of abortion and its potential consequences as a barrier

and fear of hostility towards abortion at clinics or from those to whom they turn for advice. Other barriers include partner attitudes, lack of support, lack of information on abortion and abortion services, and the fear of abortion being illegal. These are discussed below.

a) The inability to maintain confidentiality in the process of accessing an abortion

As has been discussed, womxn who have an abortion are at risk of being judged by the community to such as extent that it is having a detrimental effect on their right to access abortion, including forcing them to travel far even in cases where a closer facility is available. The main stated reason was that health workers at local clinics would break confidentiality. Extracts outlining this have been presented above. Here we provide extracts in which participants spoke to particular cases to emphasise the point.

There was a girl who had an abortion and the news got out that she had an abortion because someone who worked at the local hospital leaked the information without any consent. As she told me, she was also seen by someone who is familiar to her when she went into that room, so she [the person seeing the girl] suspects that she might have been going to get an abortion. To that person's knowledge, it was not the girl's first abortion, but her third. After that, a lot of people spoke about her and it became very well known that she had an abortion. It got so bad that she ended up leaving the village because it affected her so much, she even lost a lot of weight. She is no longer around here. (HB003)

There are challenges, for example if my sister does not have a phone, I am the one who is called when she is needed and the personnel from that clinic do not have a secret. They tell over the phone reason for their call and if they do not get me, they phone another and divulge the reason for their call. Most of the people who were using that clinic have their secrets known by the villagers. (SV016)

b) Distance and costs

An often-quoted barrier to accessing an abortion is the distance that womxn need to travel. Hospitals are usually in the nearest city or large town, but even clinics are sometimes hard to access. The issue of distance was especially prominent in site 1. The issue of distance is connected to the question of costs. To travel is expensive and distant travel requires accommodation. Since abortions are free in public hospitals, the issue of cost and distance is the same.

It is difficult because from our community… to the clinic is far. We travel for a day. If you leave your house at 10AM you will get back home around 4PM. The clinic is across a river, so we use small boats to get to the clinic. There is someone who helps us to cross the river, sometimes we wait by the river and wait for the person to drive the boat to the other side where there is a clinic. (BI002)

Yes, for example when someone wants to have and abortion in a lawful way they can't because we don't have facilities, so they end up doing it themselves… Some need money and they won't have the money to do an abortion… I don't know how much money they need. Some just opt for traditional healers who allow them to pay after the medicine has worked. (BI013)

[Nearest city] is far away, you pass two towns before you get there, even our own town is far from us because when you go to our town the transport fare is R40.00 and the return is R80.00. I'm not too sure how much it is when you go to [second nearest town]. [Nearest city] is further from [second nearest town]. (BI018)

It [distance as a barrier] is important because sometimes you must travel if you go to that place you need to have money to go when you are going there. (HB005)

As I said, people don't know about terminations here, so no one has terminated because of the way services like that are out of reach. Even if you think about it, it won't happen because it is not available even in [nearby town] which is far! Rather you just keep your baby, you see... (SV004)

c) Gestational limits: being turned away and lack of knowledge

Termination of pregnancy is, obviously, a time limited service. The CTOP Act differentiates between first and second trimester abortions. Second trimester abortions are offered in fewer facilities than first trimester abortions, which results in the need for referrals should a womxn in her first trimester of pregnancy report to a facility only offering first trimester procedures.

Where participants provided anecdotes of people they know that wanted, but failed, to abort, the reason was always that the public hospital turned them away because their pregnancies are too far along. It is unclear whether these womxn were turned away from first or second trimester facilities. Failure to procure an abortion at a public hospital often lead desperate womxn to seek help from a traditional healer.

An example is a person who went to have an abortion and was told that the pregnancy was far along. When you have reached a certain number of months you cannot have an abortion but she told herself that she is going to get an abortion so a traditional man arrived (corrects herself) womxn from the village and gave her something and after that the abortion was completed in the house but what happened then is the traditional healer ended up taking the womxn's life and she did not live. (HB001)

Yes, there are, because if you are late and the baby has grown, then they are unable to assist you because the baby is too big. I have heard people going from hospital since they were told they cannot be assisted when the baby is already grown, they go to these posters. I had a friend who passed away in 2015, who went to the hospital and was told that it's a full-grown baby and is moving so they cannot terminate. She went to the place which she saw in [nearby town]. She told me when she came back from this place that she saw a poster and went. After two days, I was here in [local town] and she was in [nearby town]. After two days I got a call from her family saying that they found her dead in her room, she bled to death. So, there is danger to it. (HB020)

These tragic stories reflect findings in research by Harries et al.(Harries, Orner, et al., 2007, p. 5) who indicate the following as reasons for womxn accessing abortions late in their pregnancies: "from inappropriate referrals and being sent from one facility to another before being seen, to waiting a further two weeks for an appointment as clinics were fully booked."

While distance and costs impact on the womxn's ability to reach a facility in time, it also has to do with womxn simply not knowing the legal stipulations around abortion, or even that they are pregnant.

No, some don't end up getting abortions. They head that side but then they are turned down and they end up saying the girl is too far along in her pregnancy to terminate it. Because they're most likely just learning about the rules in abortion. They don't know the months and the rules. (BI016)

Some people cannot tell when they are pregnant. Maybe they only notice when they are 2 months and 3 weeks pregnant, and that's too far along in the pregnancy. (HB018)

The latter - accurate pregnancy detection tests and correct gestations dating - has been highlighted in the literature as a factor in womxn presenting for second trimester abortions (Harries, Orner, et al., 2007).

d) Fear of abortion or the consequences of abortion

It is widely believed that abortion, especially an abortion performed under illegal circumstances, will lead to death, morbidity or infertility. The occurrence of mortality or morbidity as a result of unsafe abortion tended to taint people's understanding of abortion in general.

You get so heartbroken in such an unpleasant circumstance [unwanted pregnancy]. Others consider abortion, but also reconsider that because of its associated risks such as dying and end up keeping the baby. (BI009)

You might die. If you are lucky enough and you do not die, you will not be well. Also, the child might be badly affected. (BI012)

Then to get out of such a situation she will think the easiest way is to abort the pregnancy. However, some

would keep the baby because of the fear of infertility in the future and end up [giving it up for] adoption and do other things. (HB004)

I do not want to do that because sometimes if I terminate a pregnancy I might die or you find that my womb will never be okay, I will have issues with it my whole life. So, it's better I keep the baby. (SV009)

People are scared of dying and now they don't want to do abortion but rather keep their children. (SV010)

There are [barriers], because maybe by getting an abortion she will never have a child again. (SV023)

The fears referred to here are in relation to unspecified abortion practices, suggesting that the consequences of unsafe abortion may be generalised to safe abortion services.

e) Healthcare staff hostility towards abortion

Health workers were often described as helpful, especially in certain areas, but some participants said that they would fear going to the hospital because of health workers' attitudes.

There is someone I know, and she told it in such a way that was not pleasant. They say you get there at the hospital and get told to decide if you want an abortion or what. When you get there, they do not treat you well when you are going to get an abortion, but many people come back alive. (HB001)

Yes, the distance is long because I was from here to [nearby city] but I made plans to go. When I got there, the clerk who gave me my folder, read the letter first. It's a procedure to read the letter first before they could assist so that they know where to refer you to which facility around the hospital. She found out I wanted to do abortion. There was a line behind me full of people, then she shouted, "You were supposed to stand in a line. You are here for an abortion. Even if the ambulance brought you, you are supposed to stand in a line." So, everyone who was there was alerted but since it was me, I didn't care, I waited for my folder. After she was done cursing me, she gave me my folder. I left. Anyone could've been offended but I didn't care because I already made a decision. (HB020)

Research has shown that healthcare providers who are not directly involved in abortion service provision may act as effective barriers to womxn accessing the service (Harries, Orner, et al., 2007), as seen in these quotes.

Some participants generalised their experiences of healthcare provider attitudes in other reproductive health settings to abortion service provision.

I do not know. They also discourage me at the hospitals. A person will go to the hospital to give birth and they will just get shouted at at that hospital. (BI007)

Yes, in the case whereby you find out that the pregnant womxn, she does not want to go to the public clinic simply because she is not on good terms with certain nurses who work there and she will say she cannot go there because she assumes that the nurse that she has an issue with will not treat her the same way as the other patients. She believes she will be mistreated because of the issue she has with the nurse. Then, she will decide to go to a private clinic. (HB019)

Participant BI007 is referring to what is known as obstetric violence, which includes, amongst other things, neglect, verbal and emotional abuse, physical abuse, sexual abuse, and lack of confidential and consensual care. Its occurrence in obstetric units in South Africa has been well documented.(Chadwick, 2016)

Participants also referred to abortion healthcare providers trying to persuade womxn not to have an abortion.

I do not know whether it was signage she saw on the wall or they explained the process that you are going to be operated on. I think they explained the process to her, gave her advice and that is where she maybe decided not to go ahead with the abortion. (HB011)

She [the nurse at the TOP clinic] will give you advice and even change your view. She could tell you to not terminate the pregnancy and might tell you how the child could come handy in your old age. And you might begin to visualise your future. (HB016)

Even at the clinic they are afraid of being shouted at because other people are sensitive. At the clinic they won't just take you to terminate, they will ask you questions. I think this is their way of determining if you are serious about what you want to do. (HB018)

While obtaining informed consent does requires that healthcare providers explain procedures, research conducted in South Africa has shown that nurses may, indeed, try to dissuade particular people from having an abortion. This includes creating a hierarchy of deserving clients, being dismissive of repeat abortions, suggesting that abortion leads to negative consequences, moralising about abortion, and pushing womxn to consider adoption, as found by Mavuso and Macleod (2019) in their research in the Eastern Cape.

f) Partner attitude

Partners can be supportive of an abortion and provide the financial help a womxn needs to have an abortion, but they can also be a major barrier to a womxn's decision to have an abortion. Participants indicated that some womxn opt to abort without the knowledge of the partners out of fear that their partner would stop them or would terminate the relationship.

You end up not being loved by the man whose baby you aborted. (HB001)

No, she did not tell me about the process, but in our conversation, she told me that she has had an abortion before and that after that her boyfriend stopped loving her due to her actions. (HB013)

When I first met my boyfriend, I was 13 years old and so I dated him and got pregnant when I was 15 years old… He taught me how a man sleeps with a female but after all that he turned against me. (SV009)

A major consideration was partners shaming the womxn in public for having undergone an abortion, even if he agreed to the abortion.

For instance, if the guy that impregnated her knows that she terminated the baby the guy will always talk nasty things about her and call her all sorts of names because she aborted the baby. Therefore, she will be stigmatized for doing that and the guy will be bitter about the fact that she aborted his child. So, every time the guy sees her with another man, he will always make funny comments so that she could feel guilty about the termination. As a result of that it will be difficult for the girl to find another to be in love with. Therefore, she will have to go to another place in order to be at peace and be away from the stigma that the guy has created for her. (HB019)

Even where the couple has agreed to get an abortion and they will still continue dating, but, once they have an argument or a misunderstanding, the guy then will bring up the abortion thing as something to weaken her or make her feel guilty… He does not forget. Say, for example, the couple goes out somewhere to have some fun. Maybe while they are there, it happens that some random guy approaches her and chats with her. He will be angered to see her chatting with other guys, he will act funny, asking her, "How can you talk with someone else while you are with him there?" You understand? He will then bring this abortion thing again and say it out loud in front of the public. As a result, people will be shocked to hear that you have done abortion. It does not matter anymore that you guys had actually agreed together to get an abortion because people do not know that. All they know is what they are hearing right now. Therefore, the blame or the stigma would be on you only, and the guy will not tell them that you both decided to get an abortion, so blame is always on the womxn, because she is the one who has terminated her pregnancy. (HB019)

He will ask her about it and if it is true that she did abort he might break up with her and then he'll go around the community slandering and telling everyone what you did in order to humiliate you. (BI013)

Given the high status in which fertility is held with the communities that formed part of this research, knowledge of an abortion can become a powerful weapon in a (former) partner's arsenal should he feel aggrieved with the womxn or with her decision to terminate the pregnancy.

g) Lack of information and knowledge of rights

Not knowing that abortion is a right or the basic information around the procedure was mentioned by participants as a barrier.

Although people do abortion, they hide it and they do it while it is in the early stages. They are scared of it, they hide it, it's not out there yet, they do not know it is within their rights. (HB002)

They do not think it is legal if they fall pregnant from unprotected sex with their boyfriends, because they knew that they could fall pregnant and did not protect themselves by using a contraceptive, whether it's the injection or a condom. They do not think being ready or not wanting a child is reason enough to have an abortion. (HB003)

To be honest, a lot of people do not know. Many of the people who do know are those who have gone to work in places like big towns or cities, where they have heard that places to terminate pregnancies in a safe manner are available. There is no one at the local clinics or hospitals who has been given that information. The problem is that others do not have that information. (HB003)

Some still have the idea that you can be arrested for it. (HB017)

As I said, people don't know about terminations here, so no one has terminated because of the way services like that are out of reach. Even if you think about it, it won't happen because it is not available even in [nearest town] which is far! Rather you just keep your baby, you see… (SV004)

Participant HB003 speaks to a standard response that womxn receive from nurses when pregnancies were unwanted: why were they not using contraceptives, or not using them properly?(Mavuso & Macleod, 2019) Participant HB003 suggests that fear of such questions acts as a barrier to abortion. The same participant refers to differences between urban and rural areas in access to information.

The abortion decision-making process

The decision-making process of a pregnant womxn who is considering an abortion was probed among the participants. This question, along with other questions, surfaced the process of decision-making, who is involved in the decision-making, and what might be the drivers of womxn choosing abortion in the communities. As highlighted in the extract below, there are multiple reasons why a womxn may terminate a pregnancy.

I understand and even the ones I used to blame in hospital I no longer blame now because it has come me that they were aborting because the grant is small, they were aborting because they don't work, they were aborting because the boyfriend or husband says it's not his baby, they were aborting because it is rape. Because I had never given myself time to ask them, but I just told myself that they are cruel but even today I have reasons. I know why they performed an abortion. (HB012)

The reasons why a womxn might choose an abortion was a topic most participants engaged with robustly and which often ended up in self-reflection. This section will discuss the most prominent reasons, which were partner-related, and then go on to discuss the multiple other reasons such as poverty, family attitudes, multiple partners and casual sex.

a) Partner-related reasons for choosing an abortion

The most prominent reasons given were connected to the conception partner. It seems that unmarried womxn are extremely vulnerable when an unplanned pregnancy occurs since, as the participants continually pointed out, mxn could simply deny the pregnancy, leave, or insist on the abortion. Generally, mxn were described in a negative way, but even more so when it came to the topic of support during pregnancy, especially outside of marriage.

I think that [choosing to abort] would be because of the hurt they would have experienced from their partner because the partner would deny impregnating her. (BI001)

[In the event of an unplanned pregnancy] the guy is going to deny that he impregnated me and then we end up having an abortion. (HB011)

You see, when it comes to that, we as female the first thing that comes to our mind is abortion because you will find out that the baby isn't being accepted by the father, of which you also don't want to raise the baby by yourself. You decide to terminate the pregnancy. (HB020)

My daughter is being beaten by her boyfriend. He says she must go do a DNA test. Our children are in relationships with very rude children. He comes to my house and demands my daughter, while he is shouting from the gate. They are even drinking alcohol but the other one is pregnant. My child's boyfriend is denying the child. He is busy with other girls and abusing my child. I am sure it's a boy child because that's what people say. When he is born, he is going to look like him. He says my child must go and have a DNA test. How is she going to do that while they are staying together? (SV001)

I never told my dad. I told my mother and said I'm aborting this first pregnancy because the reason is that the father of this child is denying that he impregnated me. My mother said if you say so then that is fine because I'm also not working as you can see I'm also sick. And my dad is also not working and so my dad said, "Okay abort, my child, there's no problem." (SV003)

The question of paternity denial has been raised in several studies conducted in the Eastern Cape and elsewhere.(Bottoman, 2018; Kalyanaraman, 2019; C. Macleod et al., 2019)

Multiple partnerships put womxn in even more of a vulnerable position since sexual partners are even more likely to deny a pregnancy or because they fear that knowledge of the infidelity might end their main relationship.

If I am in multiple sexual relationships, as I said before, with two or three people, none will want to accept the child because they know that once I am not here, another man comes to lay with me. (BI010)

In a situation like this one, that is where abortion is necessary. For example, I personally didn't get pregnant by my main boyfriend, I got pregnant by someone else. I really wanted to abort the child then but didn't know what to do. In my mind I was thinking of what I was going to do, so it's a problem. It's a very big problem. (BI015)

For example, if someone who is married knows that the child that they are carrying is not the husband's because they have a partner on the side, they can decide to terminate the pregnancy fearing that the marriage will be over. (BI018)

It becomes worse when I get pregnant under such circumstances, having other boyfriends. And my boyfriend is having other girlfriends. That could cause me to take a decision on my own to do it [an abortion]. Because I would not be certain as to who the father of the child is, due to that I have other boyfriends on the side. (HB016)

It becomes a tricky situation more especially to the female because when you say so and so impregnate you and people know you have more than one partner, the community tells you that it's not so and so's child or your child doesn't have a father. So, it becomes really difficult that you end up raising the baby alone. (HB020)

The reason… I made a decision to abort the first child. My husband's family said the child isn't my husband's and therefore I decided to abort rather than to keep a child that I don't even know who the father was, you understand? (SV003)

When they get pregnant from a person, they have just met it becomes hard to tell the person because the person won't believe it. They might be worried about their other relationship that will be ruined. Or they might suggest that she aborts the child. They normally say that we will see when the baby is born if the baby is theirs which means the girl will struggle alone.(SV014)

These participants suggest the following outcomes in the case of pregnancy in the context of multiple partnerships, all of which may lead to a decision to terminate the pregnancy: fear of not knowing who the conception partner is, judgement from the community, pressure from the main partner's family, or from one of the partners. Proof of paternity was seen as paramount.

Another reason womxn choose to abort, according to participants, is because their partners do not want a child and insist on an abortion.

These days the issue of planning pregnancy depends on the male partner. Because when I barge in with a pregnancy, the boyfriend might tell me that he does not want a baby. In my mind I will have two ideas: this person says he does not want a child, but he did not use a condom, and I did not practise family planning. I was not aware that I was going to get pregnant and when I am pregnant that's it. It is at such times that you decide to delete the baby. Are you going to keep the baby after having been told that he does not want one? He will say here's the money, go and abort… The male partner takes the decision and you play along because you are pleasing him. I am protecting the relationship. Because my partner says, here's the money, go and abort because I am too busy for a child. Then you realise that this person does not want the child. It is your partner. You are still hoping to continue with the relationship. He gives you the money, he does not just say I do not want the baby and abandons you. He says he does not want the child and he put his purse on the table. It is what makes one to go and terminate the pregnancy. (HB016)

Normally, it does happen sometimes that when you are pregnant the father of the baby is adamant that he does not want the baby. (SV002)

He will be surprised obviously, maybe he doesn't want the child, then out of nowhere you tell him "I am pregnant "He will be surprised, but you are already pregnant. Some even say "Go and have an abortion, because I don't want the child" maybe you want the child and end up keeping the child because you want the child, sometimes you end up and go and have an abortion. (SV010)

Participant HB016 paints a detailed picture of male partner insistence on an abortion. The gender dynamics around contraception usage in preventing a pregnancy and access to the financial resources to enable a termination of pregnancy are neatly laid out.

Womxn are also said to consider an abortion because they fear their partner will leave. Abandonment was seen as most likely in the event of an unplanned pregnancy.

When you encounter an unplanned pregnancy, the mxn leave you. Then you become stressed and lose the baby. Others choose abortion because they think their mxn will leave them, and they are not willing to have a fatherless child. (BI009)

It is circumstances of having no one to lean on, because you now become the sole parent of this child as the father runs away. Have you ever raised a child alone? It is horrible. (BI012)

Sometimes it's no different because sometimes even though you're married to a person, when you fall pregnant the partner leaves you or you break up and they never care about you whereas in the beginning they loved you. (HB007)

In some situations, the father runs away, so you must find a job to support your child. (HB017)

In addition to physical abandonment, participants spoke about mxn being unable or unwilling to support the pregnancy and child financially.

Most times they do abortion the female does the abortion because the male says that he doesn't have money to raise the child since his parents are still paying for his education. (BI003)

She told me that she can't stay with the child's father when he isn't doing anything for her, he doesn't/can't even buy her toiletries or shoes or clothes that's why she wants to abort (SV003)

Well, when they do not want the child, their friends can also influence them to abort because it can never

whatnot. He would not look after you and they then end up terminating. (SV017)

Participant SV017 speaks to the anticipation amongst womxn's peers that mxn will not support them during pregnancy or childbearing.

In some instances, participants spoke of a cultural phenomenon known as *ukwaliswa* or *ukubukuzana*. This phenomenon is described by Bottoman (2018) in her research on the pregnancy support narratives of womxn living in a rural area of the Eastern Cape. Mxn leave temporarily during pregnancy because of the pregnancy hormones or mood (often directly translated, as the foetus does not want the father). During this time, mxn may engage in other sexual activities, which is justified through the normalisation of mxn's "uncontrollable sexual desires". Mxn may return once the baby is born.

Some stay together until the baby is born, some can even break-up and be together again when the baby is born. Or they may not even want to sleep in the same room. You may not even want him next to you, because he smells bad (body sweat) as if he didn't bath. (SV005)

The womxn develops things [when she is pregnant]. She starts having strange feelings on her tummy and feels nauseous and vomits. Her complexion changes. She gets cheeky. Sometimes she fights with her boyfriend. Something like that… Usually at that time they are not on good terms. Only when she comes back with the baby are they on good terms again. The baby's mom calls the baby's father to tell him she has a baby and they are back on good terms. (SV008)

Womxn also fear that the conception partner will neglect her or withdraw support because she is pregnant.

A factor that would influence them to go do an abortion could be the fear that they might be neglected by the person that made them pregnant. (BI007)

…when you are pregnant as a womxn when you and your partner had not planned to be pregnant, sometimes the guy stops paying attention to you so then you end up aborting the pregnancy and getting an abortion is not easy. (BI013)

Maybe when maybe her family does not accept you find that she is stressed now because she doesn't have support from family even the partner does not support so you find that now in all this you feel alone and want now ways to relieve yourself so that you can move on with your life. (HB005)

She has no one providing for her. She is struggling alone. She is always asking herself questions, so she ends up deciding to abort. (SV001)

Participant discussion of paternity denial, partner abandonment, or partner coercion to terminate a pregnancy painted pictures of negative gender relations, with mxn being positioned as uncaring and irresponsible. Not all discussions depicted partners in negative ways, however. Participants also indicated that womxn may seek to terminate their pregnancy if the relationship with the conception partner was casual or not strong.

The thing is these children when they are disappointed by the father of the baby… the child would rather go to all of these hospitals. (BI016)

Maybe one of them wants the option of an abortion because they were not dating. Maybe a mistake had happened, and they ended up sleeping together, so the womxn might want to opt for an abortion, since she was not in love the person who has made her pregnant. (HB013)

You see, according to me. I had these thoughts that Ok this has happened, and I am not ready, and I don't like the father of this child. The only thing that came to my mind was abortion. (HB020)

They would choose to have an abortion, because they don't want the baby. You'll never stay with a person you don't want; she'll have an abortion. (SV015)

b) Family-related reasons for choosing an abortion

Families, especially parents, can be important support structures to people living in rural areas. However, according to participants, families may be hostile in the context of unplanned pregnancies, and womxn may

choose to have abortions out of fear of their response.

Another one [reasons for choosing abortion] would be because they fear their parents. (BI007)

Some abort because at home their father beats them every time they leave the house and threaten them with "the day you get pregnant, you will know me." So, a girl will see no other solution but to abort. (BI010)

The girl was convinced [by her boyfriend to have an abortion] because she feared her parents would reprimand her as this would've been her second child. (BI017)

The womxn was afraid of her family, and of her partner as the partner was a bit older than herself. (HB010)

I was scared of my mother because she is a quiet person, and I saw that she does not like this. I heard that she mentioned to my family that she hates what I did. (HB011)

Perhaps I am also afraid of my parents and they are wicked at home and won't accept this pregnancy. (HB014)

Various reasons were provided for the families' disapproval of the pregnancy, including their being religious and fearing that shame will accrue to the family.

For some womxn, it could be that their families are religious. In such a case as when a young womxn falls pregnant, she may choose a place where her parents will not find out about the abortion and will also have no influence on the outcome of the pregnancy. (HB015)

It is bad, but some parents do such things. They would see that the child is still young and will bring the reputation of the family into disrepute and they will be the laughingstock of the village. (HB016)

While, for the most part, family influence was portrayed as above (womxn terminating the pregnancy to avoid strong family disapproval), participants also spoke about families actively coercing womxn into having an abortion.

It depends, sometimes people terminate pregnancy because the family took that decision on their behalf. Some families ask their children to do an abortion because they feel humiliated that their child fell pregnant at a very young age. It might happen that they never wanted to have an abortion in the first place. People who have aborted can't just be ignored; they should be offered support because they might be dying inside. However, families don't consider that; they just decide that it's going to be a secret between the family while the child might be hurting and is in need of support. (SV014)

c) Poverty and the decision to abort

According to participants, a major factor in the decision to abort is the womxn's fear that she cannot afford to take care of a child, or another child.

Not having much, the one thing that scares a person from having a baby is not having anything. A child is an expense because they have to be supported even when they are still in the tummy. They have to be constantly monitored and checked via the tv [scans], to see if the baby that is carried is okay, that is the first step. (BI017)

Yes, I mean, I mean (pause) for example when a person has a young child and decide that they cannot have this one, and sees that it would be better to terminate the pregnancy because they will not be able to look after another child because there already is a young one who needs to be taken care of, they then see it would be better to terminate the pregnancy. (BI018)

Other situations could be that, one wants the baby but there's no money to support it. Yes, there are grants but, in some families, they are struggling even with the help of grants. So maybe someone thinks of those matters. (HB006)

Firstly, the reason would be that she would say she is unemployed, and if she were to keep the baby, she would not have means of caring or raising the baby. And, she has no idea how to deal with or raise a child. (HB019)

This is because some youth abort because they are concerned about their homes' poverty and wonder what the child will eat if they keep it. Then friends will advise

abortion to get out of the difficult situation. (BI002)

Some ill-treat you because they wonder why you would get pregnant knowing that your family is poor. And they will say things to you, and you will realise that this is hurting you. Then some decide to abort the baby. (SV005)

These participants responses illustrate the complexities surrounding poverty in pregnancy. The high levels of unemployment make this a distinct possibility for womxn living in rural areas. Family financial resources tend to be minimal, and the child support grant does little to alleviate the penury state of the family. The expenses incurred during pregnancy, and in looking after a child (particularly if there are other children) are seen as prohibitive in such contexts. Participants BI002 and SV005 refer to the social recognition of these factors. BI002 refers to support from friends, while SV005 discusses negative reactions from community members to pregnancy in the context of poverty.

d) Learners/teenagers and the decision to abort

It was often stated that a teenager who conceives might choose to have an abortion. This decision is somewhat dependent on the financial standing of her parents. An early pregnancy might be accepted by a family if they are willing and able to take care of the baby while the mother continues her schooling. Families were reported to be more involved in the decision-making process when the pregnant womxn is young.

Family members and the community perceive unwanted pregnancy as wrong. If a student gets pregnant, it's problematic that she fell pregnant, because who is going to look after the child, who is going to feed the child because the social grant is not enough. On the other side the father is probably a student/learner too. (HB004)

Some teenagers decide to have an abortion because they start thinking of various things, like what the community will say, what their parents will say so they terminate. (HB017)

She was a child still at school and was embarrassed to be seen at school pregnant, so her mom gave her the money to go to those places and she came back to school. (SV006)

It depends, sometimes people terminate pregnancy because the family took that decision on their behalf, and some families ask their children to do an abortion because they feel humiliated that their child fell pregnant at a very young age. (SV014)

The association of education with better financial prospects within these communities, and the possibility of pregnancy disrupting schooling means that early timing of a pregnancy becomes a distinct factor in the decision to terminate a pregnancy.

e) Readiness for a baby and the decision to abort

It was argued by participants that abortion is only truly accepted in extreme circumstances such as rape. Despite this, several respondents said that simply not being ready to have a baby (or another baby) might be reason enough for an abortion.

I would say when you know that the other person does not want a child, and they have not had one with their own partner, a person ends up wanting to do an abortion. An example is if the person is not married, you see? (BI007)

The person thinks perhaps that they are not ready for a baby, or they see that there already is a small child and will therefore not be able to have another child whilst there is a young one. (BI018)

Let's say one didn't want to have a child because they didn't feel ready to have one. (HB012)

That's when you as individual decide that you don't want a baby and you still want to be independent not a parent, then, you will go and have an abortion secretively. (HB019)

It's a tricky situation when there is an unwanted pregnancy, for example, my husband passed away in 2008. In 2009 I had a boyfriend and I got pregnant. The first thing that came to my mind was, I just buried my husband and I don't really love this guy. I was involved

with him because I was stressed. I decided to abort. I didn't want his approval I went for abortion. So, people who were around us at that time were happy that I did, some were not. I didn't care about anyone else, but the decision I took was for my own good. (HB020)

It could be because she doesn't get along with the boyfriend. Or that she doesn't want the child. (SV012)

f) Community reactions and the decision to abort

While the act of an abortion leaves a womxn open to judgment by community members, so does having an unplanned pregnancy, especially if you are poor and/or unmarried. Some womxn therefore choose to secretly have abortions to avoid the stigma of an unplanned pregnancy. Stigma is dealt with in detail above.

If we did not plan the pregnancy with my boyfriend, that will lead me to having an abortion. Maybe my suffering might also make me want to abort. Also the fear of parents and community members especially if you are a person that has many children. (HB011)

Some ill-treat you because they wonder why you would get pregnant knowing that your family is poor. And they will say things to you, and you will realise that this is hurting you. Then some decide to abort the baby. (SV005)

g) Lack of antenatal care and the decision to abort

Antenatal care clinics tend to be over-crowded and over-stretched in South Africa, despite significant efforts by the Department of Health to improve prenatal care in order to reduce maternal mortality and morbidity. (Feltham-King & Macleod, 2020) In rural areas, this is exacerbated by the distance womxn must travel to reach public health clinics. Participants indicated that some womxn might choose an abortion over a pregnancy because even a pregnancy is a stressful and expensive process.

So, a person can have an abortion because the whole pregnancy will be a difficult journey because of the lack of accessibility of healthcare facilities that are close by. (BI013)

The one thing that scares a person from having a baby is not having anything. A child is an expense because they must be supported even when they are still in the tummy. They must be constantly monitored and checked via the tv [scans], to see if the baby that is carried is okay, that is the first step. In our village we do not have those kinds of safety measures so that a child can be seen in the early stages of pregnancy if they are okay. We need those kinds of things here. (BI017)

I would like to have children but because I was mistreated [at the hospital], I took a decision that, no, I will never have children again because I think that maybe this time if I have a child again, the child would live, and I would die. So, I took a decision that let me stay with the child I already have. (SV011)

Preferences for abortion care

An initial analysis of the data focused on identifying preferences for abortion care in the data to inform the quantitative component of the research. The following preferences were identified: confidentiality-related preferences, distance-related preferences, cost-related preferences, preferences for standalone or multiple service provision, preferences for type of facility and preferences for safety. These are discussed below.

a) Confidentiality-related preferences

Many people reported that the need for confidentiality is the main determining factor when choosing where to go for an abortion. Some argued that womxn would choose a traditional healer or get advice on how to abort from a friend in order to avoid going to a public clinic or hospital, whereas others argue that traditional healers or friends cannot be trusted and it is better to go to a hospital. Regardless of what could possibly provide confidentiality, it was said that womxn do not want people close to them to find out that they had an abortion. These people might be community members, family members or partners. The reasons given are mainly to avoid the stigma of having had an abortion.

I would choose a safe place because in those other places there is a lack of confidentiality. Everyone in the community will talk about the fact that you have visited that particular place to do abortion. (SV002)

Oh, I think when she chooses to go abort the pregnancy, she will first choose a place where she can be sure that it will protect her so it is not known that she went to abort a pregnancy.... It is something that will not destroy her relationship with the boyfriend; he must not know; it mustn't be known. (HB012)

The reasons given are mainly to avoid the stigma of having had an abortion, but also to remain in control of their choice.

For some womxn, it could be that their families are religious (in which case they would go far to lower the chances of their family finding out). In such a case as when a young womxn falls pregnant, she may choose a place where her parents will not find out about the abortion and will also have no influence on the outcome of the pregnancy. (HB015)

The preference for confidentiality has a great influence on most of the other preferences such as distance, cost, type of services provided and type of facility. Thus, we will discuss them within these contexts.

b) Distance-related preferences

Respondents were asked whether they thought that a womxn living in their community hoping to have an abortion would choose a clinic that was close by or far away. The majority of respondents said that womxn would choose a clinic that was far away or at least not within their own community even if it meant the process was more costly. Where the reason was given for this choice, it was always related to the need for confidentiality.

It is important, when it is far everyone will go there because it is far, so no one will see her. The majority of the local ones are closer. People will see you and ask themselves many questions. It is important that one chooses the one that is far. (BI009)

They can pay a lot of money and go far because that person does not want to have the stigma that they had an abortion. (HB001)

Confidentiality issues, because locally people would go around telling other people about the abortion, which will affect one's confidence and trust. Hence womxn resort to abort in a nearby town rather than locally. (HB004)

Participants indicated that breaches of confidentiality came from two sources: either people would see womxn going into a local clinic or hospital and speak about it, or the nurses would breach confidentiality. Large hospitals were seen as providing a certain level of confidentiality if the area in which people obtain abortions is not obvious.

Yes, I can go, I feel safe at [hospital in nearby town] because I catch a taxi that will drop me in [nearby town approximately one-hour drive away]. No one knows what I'll be doing there, even the nurses. They won't tell anyone that "so and so was here, doing this and that". Or maybe the person who saw me in the hospital probably knew me from our village and they don't know why I came to the hospital. (HB009)

It will depend where the womxn wants to go. At this clinic everyone will know you aborted, or you can choose to go where you will not be known. Because at the clinics we use, it's already obvious to the people what you're going to do when you enter a certain room. (SV005)

Well, since we are known at this clinic, we are familiar with almost everyone at this clinic. You would never really trust a nurse because a person can take your information and share it to others because we know each other here. They would probably choose a place where no one knows them. (SV015)

The fear of breaches of confidentiality and the need to travel to avoid such an occurrence affects other reproductive health issues, in particular testing for HIV.

I don't know in which way you are asking but what happens is that we are of this village and we are scared to use our own clinic because news travels fast. What people fear the most is getting tested [for HIV], so they say people will gossip about your results. People choose to go to other clinics like [this one in a nearby village] … Other people go as far as using taxis to go to the clinics only because they are avoiding the one at

[the local town] and they do not want to be tested there. (HB011)

Participants indicated that if a local institution could ensure confidentiality, then people would use it. Confidentiality in terms of nurses not divulging your situation and in terms of absolute privacy were emphasised as important.

If there was a clinic, they would go to the clinic … If you felt safe with the fact that they will not disclose your problem to other people so that you will not be humiliated [you would go there]. (BI013)

Well, it must be a place, it's important to be a safe place. I must not be sitting and wait to abort in an open room. It must be a safe place and a trustworthy person must do this. It can't be a place where suddenly the door is opened, passersby are looking out the window to see what I was doing. (HB009)

Participants acknowledged that when the costs of travelling to a distant place cannot be afforded, womxn are likely to turn to informal means of aborting.

I would say if they do not have any other way, they must do it the traditional way, like how I have explained that people do it by combining different things. Because in this case they do not want people to know and going to the hospital will be a problem. Maybe they will come across someone who knows their mother or someone who will say "I saw so and so at the hospital", whereas her family didn't know she went there. So, when it reaches her family, they will want to know why she was there. So, I would say they can use the traditional route, but I also do not support it 100 percent. (HB018)

Some would prefer to go far, and others choose to do it here with the assistance of their friend by doing it at home. So, I'll sleep from 07:00 till 17:00, everyone will leave me alone and give me space because they know I am a sickly person so I'll tell them that I am sick, and they will leave me alone. The mixture will work in my body till I can feel it is time to take the baby out after my long sleep. (BI010)

Some respondents did say they would prefer to go to a local clinic if they were in the position of a womxn needing an abortion.

I think if maybe you are here it would be easier because you won't pay more money compared to when you are going far. (HB005)

Ewe, it may be money because sometimes you have to travel and go to the clinic. They cannot call an ambulance for you to go get that. You are still delaying and not going to get it. You must also get a return, maybe you do not get it then your stomach continues to grow. The pregnancy will not wait for that… (HB005)

When I come to a clinic here am I scared of being caught? When I'm doing this am I thinking of being caught? Am I doing it as a secret? I honestly wouldn't be afraid of anything and after that I would go back home. I wouldn't go far when the clinic is here to do the abortion. Let me just say I wouldn't hide anything. Because when I am hiding it I would have to go to [closest city]. I would have had my reasons that made me do it, I wouldn't just get an abortion for no reason. (BI015)

The main reason cited for choosing a local clinic is to avoid the financial costs of travel. Another reason given was that the abortion is time-restricted, and travelling is time-consuming. HB005 also refers to the fact that womxn may be turned away from TOP clinics that have a full caseload, and therefore have to travel again. Indeed, South African research shows that a significant number of womxn do not receive the abortion care that they requested (Gerdts et al., 2014). Participant BI015's response represents an outlier in terms of responses. Here we see the operation of resistance. Speaking personally, this participant defies the imposition of stigma, and argues that her reasons for wanting an abortion should be sufficient for acceptance thereof.

c) Cost-related preferences

The question was asked whether a womxn in their community seeking an abortion would be willing to pay for an abortion. The answers to this question were somewhat tainted by the fact that public hospital abortions are free, whereas illegal abortion providers charge money. Thus, some people said that the ones

you pay for are not safe and others insisted that you shouldn't pay because government services are free. Nevertheless, expenses were listed as a factor

I would say its expenses [the most important factor], they would struggle with the expenses to have an abortion. (SV011)

The expense would be the determining factor for me. You would choose a clinic but one that costs less than the others. (BI013)

In questioning why people would choose to pay when they could just go to a public clinic for free, participants indicated that the expenses are offset by confidentiality or safety.

Maybe it's the low prices. But then again, it's free at the clinic. So why wouldn't they use a clinic? Maybe they would go to a paying place because they know they won't see people that they know, unlike at the clinic. (SV010)

I think I'll pay there because you can hide from the community from their gossip and judgement, so you sacrifice your money there. (HB009)

I think that they would choose to rather not pay any money at all. Only if they did not have fear of how their partners, families and the community will perceive them for having abortions locally. Fear of people's perception is what normally compels most womxn to pay a lot of money to go far for abortions. (HB018)

The doctor might cost me R5000 but they will do the abortion and clean my womb afterwards so it would be worth it, and I would also leave "the thing" behind and not take it with me. The doctor will dispose of it for me; no one will ever see it. (BI010)

Participant BI010 speaks to both safety and confidentiality. Payment is "worth it" for a proper procedure and for the confidentiality that comes with not having to dispose of the products of pregnancy (womxn may need to do this themselves in cases of self-induction or the provision of medication abortion through illegal providers).

Some also argued that they might be willing to pay if it meant they did not have to travel. Indeed, participants understood the interweaving of travel and service expenses.

I think when there is a place close by for an abortion, maybe where there is money that needs to be paid for an abortion, they can get the money. You understand? Either way, you will have to spend money because you will have to use public transport to get where you are going. (HB002)

It was also mentioned that womxn might be willing to pay, but unable to, and that willingness to pay would depend on people's financial situation. Again, a lack of money is likely to lead womxn to opt for an informal abortifacient. Overall, people reporting a willingness to pay and those not willing to pay were more or less equal in number.

d) Preferences for standalone or multiple service provision

None of the respondents stated a preference for a standalone abortion clinic. Those who had an opinion on what a clinic that offers abortions should look like suggested that it should offer a multiplicity of services and should not actively present itself as an abortion clinic.

Not a practitioner only for abortion, as anyone would know you have aborted, even if you did not, but if you enter that building, they will assume you went there to abort. (HB004)

Maybe a person will be embarrassed that they could be seen by me entering a place of that nature when we know what that place is for. (HB013)

The one that's combined with other medical facilities so they can also feel safe. (HB017)

Firstly, it is because the people of this village are very judgemental and it affects people so badly, they end up not being okay. So, if it is labelled 'counselling', whoever goes to the clinic will assume that the person who goes into that room has had an abortion or that is why they are coming out of there. That rumour will go around the

village and people will talk about you, based on that assumption. As you walk out of there, you will even notice people standing there and staring at you with judgement. (HB003)

In my opinion, they would see it as any other clinic that helps people, because it would not be restricted to services for womxn. It would have general services. If a clinic would have service for everyone, it would not be seen as a clinic that is - how do you say in Xhosa? - as one that is befouled [sinister], that kills people's children. But should it be a clinic with all services, you see? (SV018)

Participants emphasise, once again, the imperative of confidentiality. Participant HB003 indicates that even a place offering abortion counselling should consider mystifying its official purpose. Some participants indicated that people might believe that a stand-alone abortion clinic is actively persuading womxn to have abortions.

e) Preference for type of facility

Despite the issues with breaches of confidentiality and some intermittent complaints about the quality of care provided at public facilities, most respondents said they would suggest going to government clinics or hospitals. The use of public clinics is justified as being the safest option.

I think the main reason to go to hospital is safety and it's legal so the simplest way that you do the right thing, you know you won't be harmed, there are no complications. You will be treated well rather than listening to what people say or say "take a certain medicine, what-what" approach. (HB009)

One respondent said that they would choose a private clinic to avoid a breach of confidentiality at a public facility. Others said that their fear of being found out is likely to drive them to illegal providers or traditional healers.

Preferred characteristics of the facility include non-judgemental attitudes of staff. Judgmental staff make people turn to informal or illegal abortion options.

Judgemental questions such as "Why did you not protect yourself? Did you not know you could get pregnant?" discourage them so much that they end up taking the risk of seeking outside help, which is not safe or getting other pregnancy termination ideas from other people, because they do not feel free to get safe abortions. (HB003)

The requirement to queue when one gets to the clinic or hospital has been normalised and was not mentioned as a problem.

They wait. It does not matter how long, because they want to be assisted. (BI009)

It gets full so there is no waiting period because you will get there and queue. Something you do for yourself is to wake up early and make sure you are first or second or you get there and there's no one because it is not a daily thing to have an abortion. (HB009)

Given the distances that people may travel to obtain an abortion, not being provided with an abortion on the day they present for it was considered problematic, however.

Sometimes a person is determined to abort at any cost and opt for a short cut because at the hospital it won't be done immediately. (HB004)

The difficulty of womxn being sent from one facility to another or being told to come back on a different day has been reported on in the literature (Greaves et al., 2014).

f) Preferences for safety

The question of safety was a prominent topic of conversation. It is well-known that illegal providers such as 'those with the posters', traditional healers, and home-made concoctions are unsafe. Not a single respondent suggested that abortion seekers should use them, although they had opinions as to why they might want to (relating to confidentiality and costs).

An example would be me paying R300 to someone who is going to get plants and herbs that they will know will work. I don't have to travel; this person stays here in the village. I'll drink the mixture and be fine, but I won't really be fine because it is not the same as going to the hospital. The problem is that I do not have the money. (BI010)

I would say if they do not have any other way, they must do it the traditional way, like how I have explained that people do it by combining different things. Because In this case they do not want people to know going to the hospital will be a problem. Maybe they will come across someone who knows their mother or someone who will say "I saw so and so at the hospital", whereas her family didn't know she went there. So, when it reaches her family they will want to know why she was there. So, I would say they can use the traditional route but I also do not support it 100 percent. (HB018)

Safety was a major determining factor mentioned by participants in womxn seeking abortion. Since the consequences of an unsafe abortion (in particular the fear of infertility) fed directly into the pronatalist imperative that womxn face in these communities, it is no wonder that safety would be their first choice.

No, I personally would go to any provider anywhere I feel is safe and right to get an abortion. When I feel better, I would then go back home. No one knew I was pregnant because there was no baby bump showing yet and I had not told anyone. (BI015)

When you do not go to the right places, the hospital, and you listen to other people's ideas you can be in danger of dying, you and the baby that you were aborting. You did not go to a place that offers the right help. That is why you should go to the right places like the hospital to go get the right clarification so that you do not take other substances. (HB002)

I chose the hospital because I felt safe. There was an experienced doctor and I didn't care what people said about me. But no one is judged at the hospital, they respect your decision. (HB020)

Quantitative findings

Regression analysis of preference data (DCE analysis)

The analysis of choice data is based on the random utility model (Manski & McFadden, 1981) where each respondent faces a choice amongst a number of alternatives repeated under a number of scenarios or choice situations. The utility obtained from a specific alternative in a particular scenario is linked to the attributes and the coefficients are estimated using multivariable Multinomial logit regression (MNL).

Regressions were run for the pooled sample as well as by sex and site in order to explore any differences in preferences in these groups. We present the estimated coefficients and their standard errors by attribute in the following tables[1] . Statistically significant coefficients suggest that the particular attribute is associated with the utility of choosing an alternative. It is evident that results from the pooled sample regression are mostly influenced by preferences among womxn as the sample size is much larger. In the following, we show the same coefficients from regressions run by site. This allows for an exploration of differences in preferences between sites and as well as differences in the significance of these coefficients.

Preferences in abortion facility type

Tables 3 and 4 present the results regarding facility type. The pooled data show that having an MS clinic within a government facility is the most preferred option. However, there is not a significant difference between preference for this type of facility and preference for an MS mobile clinic. As such, both options seem to be acceptable overall. Given the general negativity towards traditional healers in relation to abortion services (surfaced in both the qualitative and quantitative data), it is unsurprising that MS partnered with traditional healers is the least popular option overall.

There are, however, important differences in preferences across sites. In site 1 preference for an MS clinic within a government facility type is high (statistically significant compared to all other options). In site 2 participants expressed a strong preference (statistically significant) for MS clinic in pharmacy over a MS clinic in a government facility. Indeed, a MS clinic in a government facility was the least preferred option in site 2, although preferences for other options (stand-alone, partnered with traditional healer, mobile clinic) were not significantly different to preferences for the MS clinic in a government facility.

1 Note that although attribute coefficients are presented and discussed by attribute, they were all included in the same regression (multiple variable regression).

Participants from site 3 have similar preference patterns to those of the pooled data regarding the facility type (although the mobile clinic is slightly preferred over the MS clinic in a government facility).

The differences can be explained by participants' experiences with the current healthcare contexts of the three communities. The qualitative data show that in site 2 there are major confidentiality issues with nurses in local clinics, explaining why the MS clinic in a clinic or hospital is the least preferred. In site 3, a mobile clinic provides most of the health care people receive. The preference of site 3 participants for the mobile clinic speaks to their satisfaction with this form of health care provision, although the current mobile clinic does not provide abortions.

The least preferred option was the MS clinic partnered with a traditional healer. This is also explained by the qualitative data which show that when it comes to abortions, traditional healers are not trusted. Albeit preferred by the mxn, standalone clinics were not a preferred option overall.

The pooled sample was dominated by female respondents, but a breakdown according to sex shows that male respondents differ in their preferences for type of clinic from female respondents. While womxn expressed strong preferences, mxn were more neutral in selecting a type – none of the types differed significantly from an MS clinic in a government facility.

Table 3: MNL regression coefficients for facility type (pooled sample and by sex)

Facility type (vs MS in government facility)	Pooled	Female	Male
MS mobile clinic	-0.060 (0.094)	-0.009 (0.106)	-0.216 (0.221)
MS clinic in pharmacy	-0.179** (0.070)	-0.235*** (0.078)	0.022 (0.170)
MS stand-alone clinic	-0.315*** (0.083)	-0.482*** (0.094)	0.221 (0.191)
MS partnered with traditional healer	-0.377*** (0.072)	-0.442*** (0.081)	-0.194 (0.172)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Pooled preferences for facility type

1 Marie Stopes clinic in a government hospital

2 Marie Stopes mobile clinic

3 Marie Stopes clinic in a pharmacy

4 Standalone Marie Stopes clinic

5 Marie Stopes clinic in a traditional healer's practice

Table 4: MNL regression coefficients for facility type by site

Facility type (vs MS in government facility)	Site 1	Site 2	Site 3
MS stand-alone clinic	-0.529*** (0.148)	0.004 (0.152)	-0.488*** (0.143)
MS mobile clinic	-0.666*** (0.178)	0.258 (0.162)	0.038 (0.167)
MS clinic in pharmacy	-0.436*** (0.124)	0.233* (0.127)	-0.335*** (0.122)
MS partnered with traditional healer	-0.801*** (0.134)	0.064 (0.124)	-0.513*** (0.129)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Pooled preferences for facility type according to research site

SITE 1:

1 Marie Stopes clinic in a government hospital

2 Marie Stopes mobile clinic

3 Marie Stopes clinic in a pharmacy

4 Standalone Marie Stopes clinic

5 Marie Stopes clinic in a traditional healer's practice

Pooled preferences for facility type according to research site

SITE 2

1. Marie Stopes clinic in a pharmacy
2. Marie Stopes mobile clinic
3. Marie Stopes clinic in a traditional healer's practice
4. Standalone Marie Stopes clinic
5. Marie Stopes clinic in a government hospital

SITE 3

1. Marie Stopes mobile clinic
2. Marie Stopes clinic in a government hospital
3. Marie Stopes clinic in a pharmacy
4. Standalone Marie Stopes clinic
5. Marie Stopes clinic in a traditional healer's practice

Preferences in services offered

Tables 5 and 6 present data on preferences for the services offered. Pooled data and data from womxn participants show a very strong preference for abortion to be offered with other health services. While abortion offered with contraceptive services is preferred over abortion services only, combining abortion with other general services is the most preferred option. This result is consistent across all three sites, indicating a robust finding in terms of offering services in rural areas of the Eastern Cape. Male respondents, once again, were more neutral in their selections, with no specific preference for services emerging as statistically significant over others.

Table 5: MNL regression coefficients for services offered (pooled sample and by sex)

Services offered (vs abortion only)	Pooled	Female	Male
Abortion and other health services	0.658*** (0.138)	0.824*** (0.153)	-0.009 (0.328)
Abortion and contraceptives	0.332*** (0.076)	0.375*** (0.084)	0.086 (0.180)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Pooled preferences for services

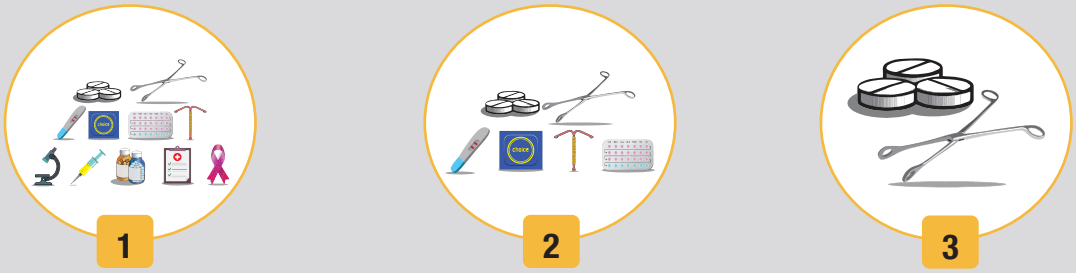


Table 6: MNL regression coefficients for services offered by site

Services offered (vs abortion only)	Site 1	Site 2	Site 3
Abortion and other health services	0.612** (0.253)	0.773*** (0.248)	0.836*** (0.239)
Abortion and contraceptives	0.099 (0.134)	0.544*** (0.144)	0.527*** (0.130)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Preferences in type of abortion

Tables 7 and 8 present the data concerning preference for the type of abortion offered. Medication abortion is the most preferred option in the pooled data. Surgical abortion is the least preferred (statistically significant). The dislike of surgical abortion could account for the statistical difference between medication and "both types" preferences (both types preferred less than medication abortion). This pattern is evidenced across both womxn and mxn respondents, although mxn's preference for medication and both types is not statistically significant. Disaggregation by site produces a different picture, however. Although medication abortion is preferred over other options in site 3, the differences in preferences is not statistically significant. This means that in site 3, providing medication, surgical or both types of abortion may be acceptable. In site 1, however, participants expressed a strong preference for medication abortion over both types as well as surgical abortion. In site 2, medication abortion is strongly preferred over surgical abortion, and preferred (but not as strongly) over both types. These results indicate the requirement for some nuance in relation to type of abortion provided across different types of rural settings. While the reason for the strong preference for medication abortion in sites 1 and 2 was not probed in this research, it is possible that this preference is related to the strong need for confidentiality in these sites, as well as the possibility of a longer clinic stay.

Table 7: MNL regression coefficients for type of abortion (pooled sample and by sex)

Type of abortion offered (vs medication only)	Pooled	Female	Male
Both	-0.357*** (0.110)	-0.406*** (0.122)	-0.177 (0.263)
Surgical	-0.537*** (0.097)	-0.551*** (0.108)	-0.479** (0.234)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Pooled preferences for abortion type

1 Medication abortion

2 Medication and Surgical abortion

3 Surgical abortion

Table 8: MNL regression coefficients for abortion type by site

Type of abortion offered (vs medication only)	Site 1	Site 2	Site 3
Both	-0.750*** (0.199)	-0.357* (0.201)	-0.087 (0.191)
Surgical	-0.617*** (0.175)	-0.958*** (0.181)	-0.140 (0.165)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Preferences in location of abortion facility

Tables 9 and 10 present the results of preferences for the location of the facility. Pooled data reveal a strong preference for facilities to be located within the participants' village over being located in a nearby village or the nearest town. Preference for facilities in the nearest city is slightly weaker than preference for a facility in participants' village, but this is not statistically significant. Mxn respondents had less firm preferences than womxn overall. Disaggregation by site reveals that sites 1 and 3 follow the pattern of the pooled data, with preferences for facilities in their village or in the nearest city (site 3 has a slight preference for location in the nearest city over participants' village). Site 2's results show no statistical differences between the various options, with a slight preference for location in the nearest town.

Interpreting these differences in results is complicated. In expressing a preference regarding location of facilities, it is likely that participants are balancing confidentiality against distance and cost. The overall preference for own village and nearest city seems to talk to these two major factors – own village reduces cost

and distance, while nearest city provides the possibility of anonymity and reduced possibilities of breaches of confidentiality. The fact that site 2 differs in the expression of location preference from the other two sites may have to do with its relative proximity to a small town and a major city. Participants may not feel that going to the nearest city is any different to going to the nearest town. In this site, location in a nearby village is the least preferred (although this is not statistically significant in relation to location in own village).

Combined these results appear to point to the possibility of a catchment area approach to the provision of services in rural areas. Those rural areas close to towns or cities may be serviced by facilities in towns or cities, while those further afield may need services within their own village as well, probably in the form of mobile clinics.

Table 9: MNL regression coefficients for facility location (pooled sample and by sex)

Location of facility (vs in my village)	Pooled	Female	Male
Nearest city	-0.037 (0.088)	0.023 (0.098)	-0.221 (0.210)
Nearby village	-0.359*** (0.070)	-0.519*** (0.079)	0.267* (0.162)
Nearest town	-0.413*** (0.091)	-0.571*** (0.101)	0.211 (0.220)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Pooled preferences for location of facility

Table 10: MNL regression coefficients for facility location by site

Location of facility (vs in my village)	Site 1	Site 2	Site 3
Nearest city	-0.060 (0.155)	-0.046 (0.161)	0.131 (0.153)
Nearby village	-0.529*** (0.126)	-0.095 (0.130)	-0.438*** (0.118)
Nearest town	-0.980*** (0.163)	0.014 (0.171)	-0.472*** (0.159)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Preferences in abortion cost

Tables 11 and 12 outline results for price preferences. No cost abortion is much preferred over paying for an abortion, as expected. Paying R500 is preferred to paying R800 or R1400. Of interest, however, is the fact that paying R800, and not R1400, is the least preferred option. This may indicate that participants anticipate quality services to be provided with a higher price. This pattern is consistent across mxn and womxn participants.

Disaggregation by site reveals some differences, however. Sites 1 and 2 data reflect the pooled data, with no cost being strongly preferred to any sort of payment, R500 being preferred to R800 and R1400, but with paying R1400 being preferred to paying R800. In site 3, paying R800 is the most preferred option after not paying, with paying R500 and R1400 being more-or-less equal in least preferred options. It is possible that with closer access to employment opportunities, participants in site 3 are willing, if payment is required, to pay what they feel is an amount that reflects good service (R800). While these results are interesting, they do not, in the research team's opinion, mean that differences in prices should be considered across different rural areas. Given the low resources in these communities, no payment will obviously be the first choice, but, if payment is required, R500 seems to be the most acceptable.

Table 11: MNL regression coefficients for abortion price (pooled sample and by sex)

Price (vs no cost)	Pooled	Female	Male
R500	-0.403*** (0.069)	-0.429*** (0.077)	-0.311* (0.165)
R800	-0.722*** (0.118)	-0.720*** (0.130)	-0.829*** (0.291)
R1400	-0.533*** (0.078)	-0.502*** (0.087)	-0.752*** (0.185)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

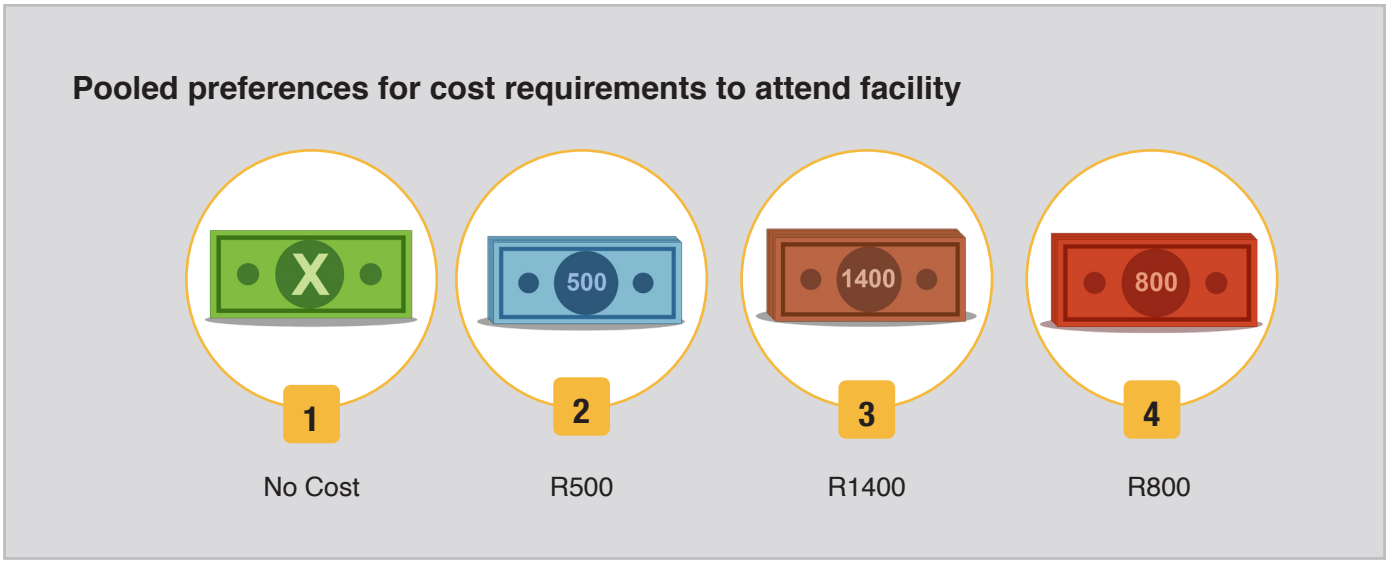


Table 12: MNL regression coefficients for abortion price by site

Price (vs no cost)	Site 1	Site 2	Site 3
R500	-0.369*** (0.126)	-0.517*** (0.124)	-0.496*** (0.123)
R800	-1.000*** (0.207)	-0.784*** (0.227)	-0.293 (0.196)
R1400	-0.506*** (0.138)	-0.667*** (0.145)	-0.410*** (0.133)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Price preferences or willingness to pay (WTP) for abortion services are reported for different levels in the following table. WTP estimates are useful because they provide a common interpretable monetary value, useful for comparing preferences for service models between sites. WTP can also contribute to decision making for the pricing of services where perceived to maximise respondents' utility. Positive figures suggest the amount respondents would be willing to pay for the associated attribute, and negative values can be interpreted as R"0" WTP.

It is important to note that WTP estimates are subject to hypothetical bias and may be overestimated because respondents are not actually asked to spend money from their own budget. Also, responses were limited to categorical variables. For this reason, findings must be interpreted cautiously and not be used as the primary method for informing service prices.

Overall, respondents in this study are not willing to pay the existing minimum price for SA/PAC services at MSSA clinics: R500/£23.

Facility types: pooled data estimates show that respondents were WTP approx. R418/£19 for abortion services provided in a clinic embedded in a government hospital. For other facility types, respondents were not WTP more than R61, suggesting that demand would be low at these facility types.

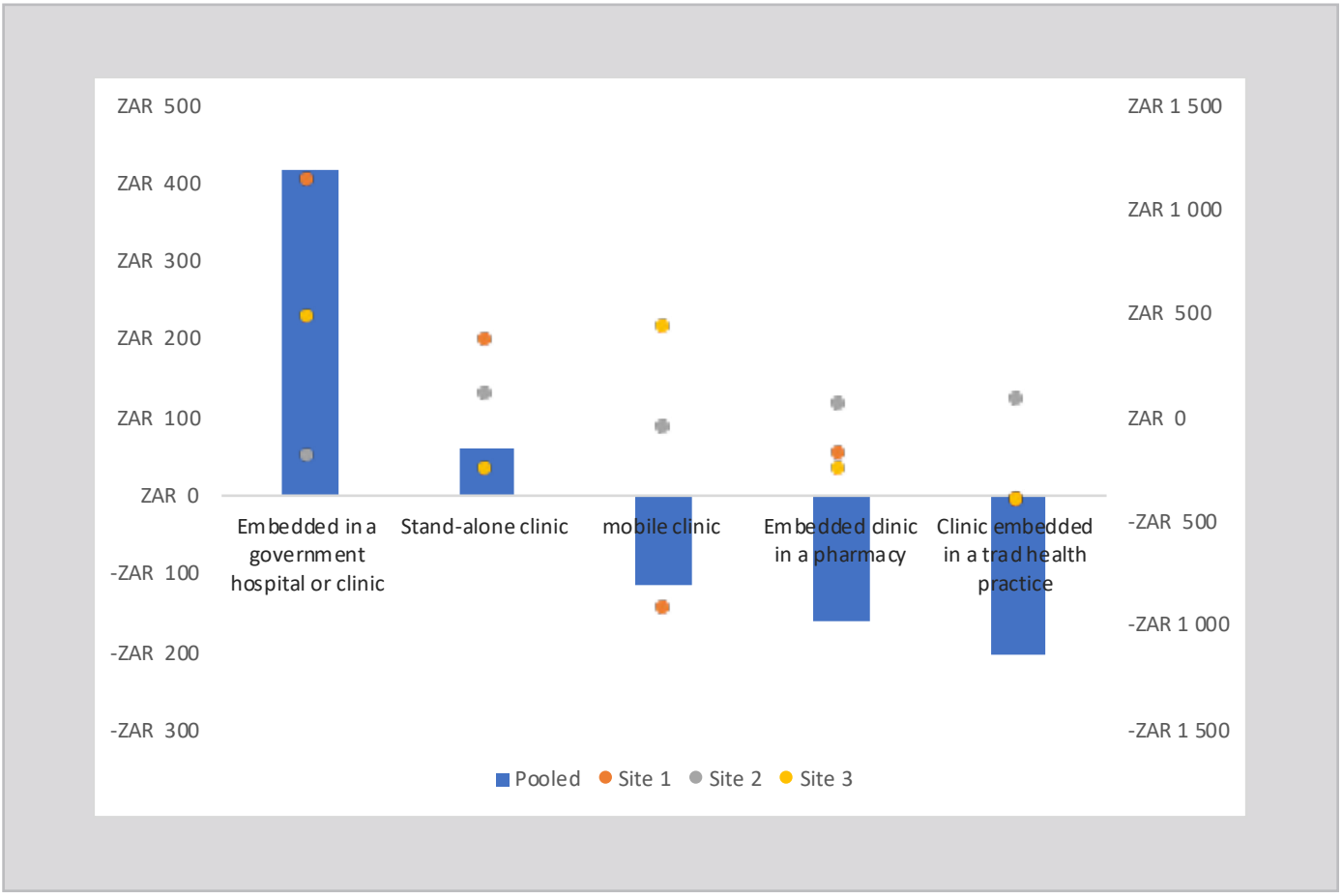
Services available: pooled data estimates report that respondents were WTP to pay an approx. R450/£21 for abortion services if provided at a facility that offered a range of health care services, R51/£2 if abortion and contraceptives were available, but R0 if abortions were the only service on offer. 'Abortion only' facilities were least preferred across all sites and corresponds with the desire for anonymity and confidentiality identified in interviews.

Table 13: WTP (ZAR/for an abortion service without transport costs included)

Marie Stopes facility type	Pooled	Site 1	Site 2	Site 3
Embedded in a government hospital or clinic	**ZAR 418**	**ZAR 1 140**	-ZAR 190	**ZAR 475**
Stand-alone clinic	ZAR 61	ZAR 366	**ZAR 107**	-ZAR 254
Mobile clinic	-ZAR 115	-ZAR 920	-ZAR 52	ZAR 428
Embedded clinic in a pharmacy	-ZAR 159	- ZAR 179	ZAR 51	-ZAR 249
Clinic embedded in a traditional health practice	-ZAR 205	-ZAR 406	ZAR 84	-ZAR 400

Services offered in this facility	Pooled	Site 1	Site 2	Site 3
Abortions only	-ZAR 501	-ZAR 447	-ZAR 494	-ZAR 518
Abortions and contraceptive services	ZAR 51	-ZAR 188	ZAR 190	ZAR 156
Abortions and other health services such as STI testing; cervical cancer screening, etc.	**ZAR 450**	**ZAR 634**	**ZAR 304**	**ZAR 362**
Type of abortion service available in this facility				
Medical abortion (up to 12 weeks pregnant)	**ZAR 234**	**ZAR 442**	**ZAR 383**	-ZAR 224
Surgical abortion (between 12 and 20 weeks pregnant)	-ZAR 351	-ZAR 172	-ZAR 713	ZAR 21
Medical and surgical abortion (up to 20 weeks pregnant)	ZAR 117	-ZAR 271	ZAR 330	**ZAR 203**
Location of this facility				
In my village/community	**ZAR 393**	**ZAR 825**	ZAR 22	**ZAR 352**
In a nearby village/community/ township	-ZAR 128	-ZAR 36	ZAR 72	-ZAR 380
Nearest town	-ZAR 177	-ZAR 967	**ZAR 325**	-ZAR 166
Nearest city	-ZAR 87	ZAR 178	-ZAR 419	ZAR 194
Opening hours of facility				
Monday to Friday; 8:30AM – 4:30PM	-ZAR 62	ZAR 1	ZAR 194	-ZAR 483
Monday to Friday with extended opening hours; 9AM – 10PM	**ZAR 301**	-ZAR 36	**ZAR 547**	ZAR 351
Monday to Saturday; 8:30AM to 4:30PM	ZAR 101	**ZAR 266**	-ZAR 232	**ZAR 468**
Monday to Saturday Extended opening hours: 8:30 to 10PM	-ZAR 341	-ZAR 230	-ZAR 508	-ZAR 336

Figure 4: WTP (ZAR) by facility types for pooled and site-specific subgroup



Preferences in facility opening times

Tables 14 and 15 contain analyses of responses to opening times. The options for opening times included possibilities for extended hours within the working week, normal office hours but with the addition of Saturday, and a combination of the above. Pooled data revealed a strong preference for extended hours during the week, followed by a more-or-less equally strong preference for normal office hours Monday to Saturday. Interestingly, the combination of both (Saturday and extended hours) was not favoured. This may have to do with participants' appreciation of the logistical difficulties in keeping facilities open for such a length of time as well as the fact that such an arrangement is unlikely. Although mxn and womxn differ slightly in their preferences, it is clear that both prefer facilities to operate outside of week office hours, whether through extension into the evening or to Saturday.

When the data are disaggregated across sites, differences in preferences for operating hours emerge. For site 1, extension of hours to Saturday is the strongly preferred option. This may have to do with the relative distance of this site from towns or cities. People may be unable to take advantage of evening opening times because of the distance they have to travel home. Participants in site 3 indicated a more-or-less equal preference for extended evening hours and the extension to Saturday. Site 2 participants expressed a strong preference for extended evening hours, followed by a preference for facilities to be open on Saturdays. The preferences expressed in sites 2 and 3 may have to do with their relative proximity to towns where facilities may be located. In terms of this preference, it may be best to extend hours to Saturdays to cover both far-flung rural areas as well as those closer to facilities.

Table 14: MNL regression coefficients for opening times (pooled sample and by sex)

Opening times (vs 8.30-16.30 Monday to Friday)	Pooled	Female	Male
8.30-22.00 Monday to Friday	0.198*** (0.040)	0.266*** (0.044)	-0.074 (0.095)
8.30-16.30 Monday to Saturday	0.171*** (0.059)	0.227*** (0.066)	0.009 (0.140)
8.30-22.00 Monday to Saturday	-0.106* (0.061)	-0.073 (0.068)	-0.199 (0.150)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Pooled preferences for opening times of facility

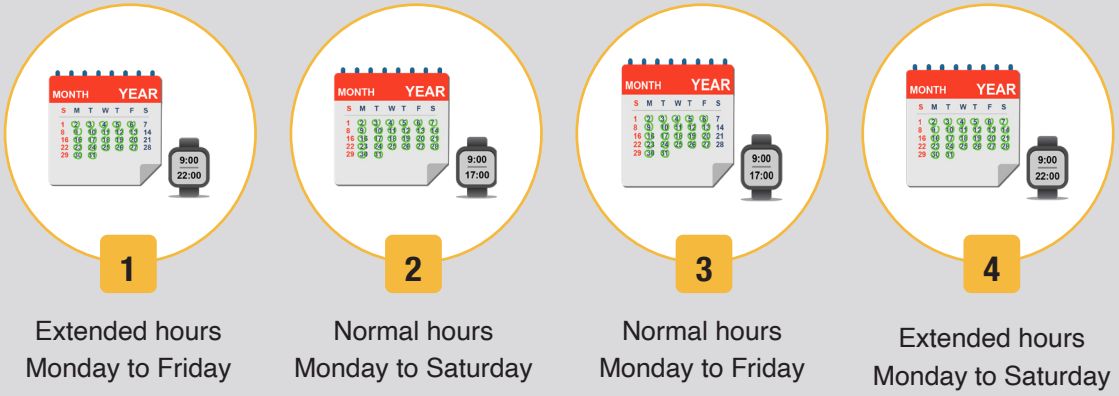


Table 15: MNL regression coefficients for opening times by site

Opening times (vs 8.30-16.30 Monday to Friday)	Site 1	Site 2	Site 3
8.30-22.00 Monday to Friday	0.022 (0.071)	0.218*** (0.069)	0.323*** (0.073)
8.30-16.30 Monday to Saturday	0.305*** (0.105)	-0.204* (0.109)	0.385*** (0.102)
8.30-22.00 Monday to Saturday	-0.028 (0.108)	-0.417*** (0.117)	-0.016 (0.105)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

Descriptive analysis

Basic attitudes towards abortion

Respondents were asked to rate their attitude to abortion on a very simple scale (I think abortion is acceptable; I think abortion is acceptable in some circumstances such as rape; and I think abortion is never acceptable). 19% of respondents thought that abortion was acceptable in all circumstances. While this question does not capture the nuances of abortion attitudes (as was presented in the qualitative data), it gives some indication of the general negativity towards abortion. This kind of negativity towards abortion has been found in other research in South Africa (Mosley et al., 2017)

Table 16: Descriptive statistics of basic attitudes to abortion

Variable	N	Estimate (%)	95% CI	Missing (N)
Attitude towards abortion				4
Acceptable	115	19	(16, 22)	
Acceptable after rape	401	66	(62, 69)	
Not acceptable	96	16	(13, 19)	

Table 17: Descriptive statistics of basic attitudes to abortion by sex

Variable	Overall		Womxn		Mxn	
Attitude towards abortion	**N**	**%, CI**	**N**	**%, CI**	**N**	**%, CI**
Acceptable	115	19 (16, 22)	95	19 (16, 23)	20	18 (11, 25)
Acceptable after rape	401	66 (62, 69)	321	65 (61, 69)	76	68 (59, 77)
Not acceptable	96	16 (13, 19)	80	16 (13, 19)	16	14 (8, 21)
Missing	4					

Figure 5: Pie charts showing attitudes towards abortion, pooled and according to sex

Ranked preferences of abortion facilities (not just Marie Stopes facilities)

Respondents were asked which type of service they, or somebody like them, would choose if they needed to have an abortion: government service, informal provider, traditional healer, self-abortion and private provider.

Table 18 presents the results. Government services were the most chosen, followed by traditional healers. Informal providers were the least preferred. Private providers ranked just below informal providers, possibly because of cost and possibly owing to a lack of interaction with such providers in rural areas.

Table 18: Ranking of abortion facilities

Provider	Mean rank*	Marginal frequency**	
		1st preference	2nd preference
Government service	2.48	375	6
Traditional healer	2.83	19	191
Self-abortion	3.05	8	122
Private provider	3.22	7	129
Informal provider	3.24	201	25

* Mean rank tells how popular a certain option is. Note that a higher rank means a lower number, as 1 is the highest rank

**Marginal frequencies describe how many times an option is put at this ranking spot.

Figure 6: First preference for abortion facility

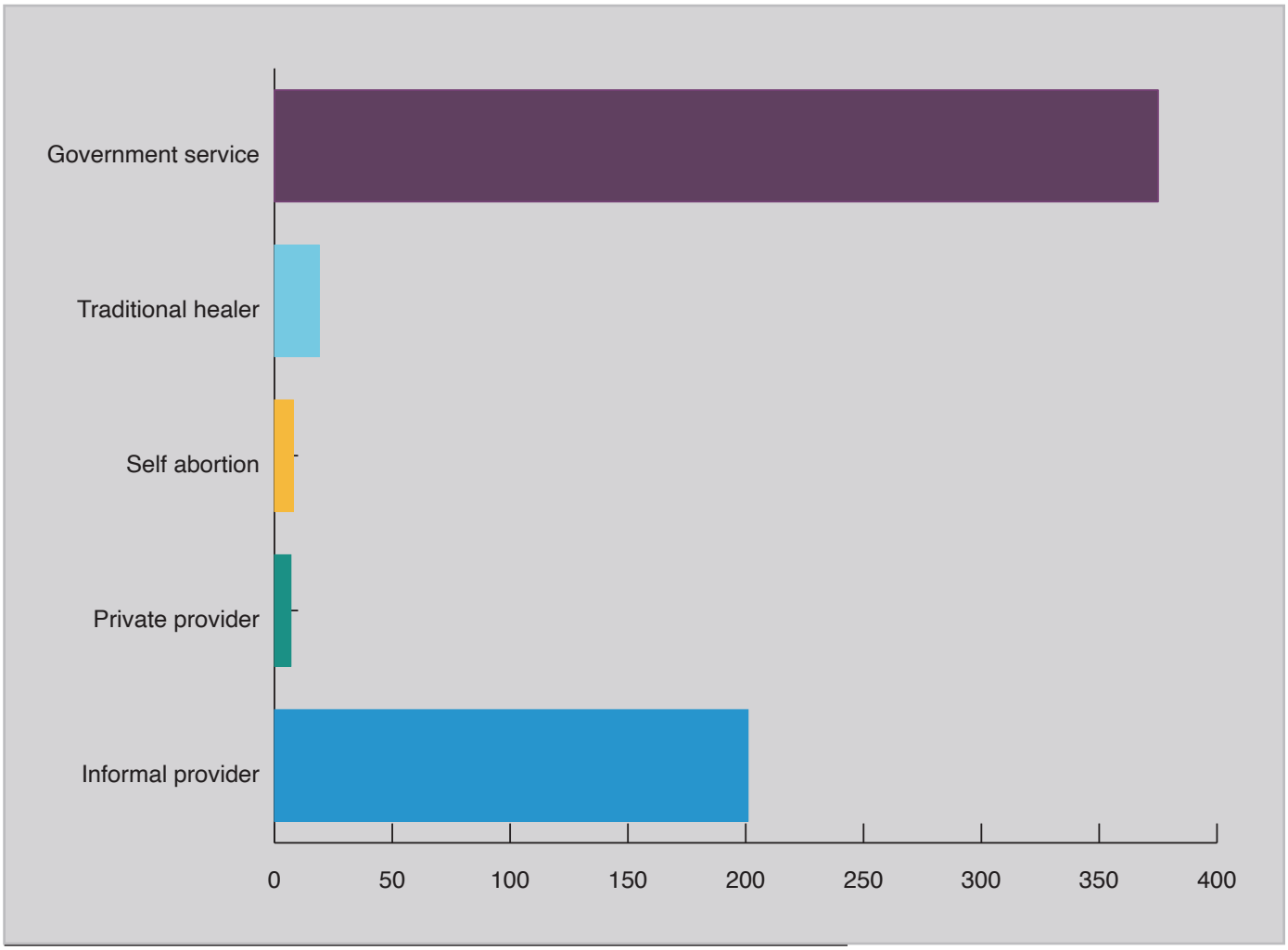
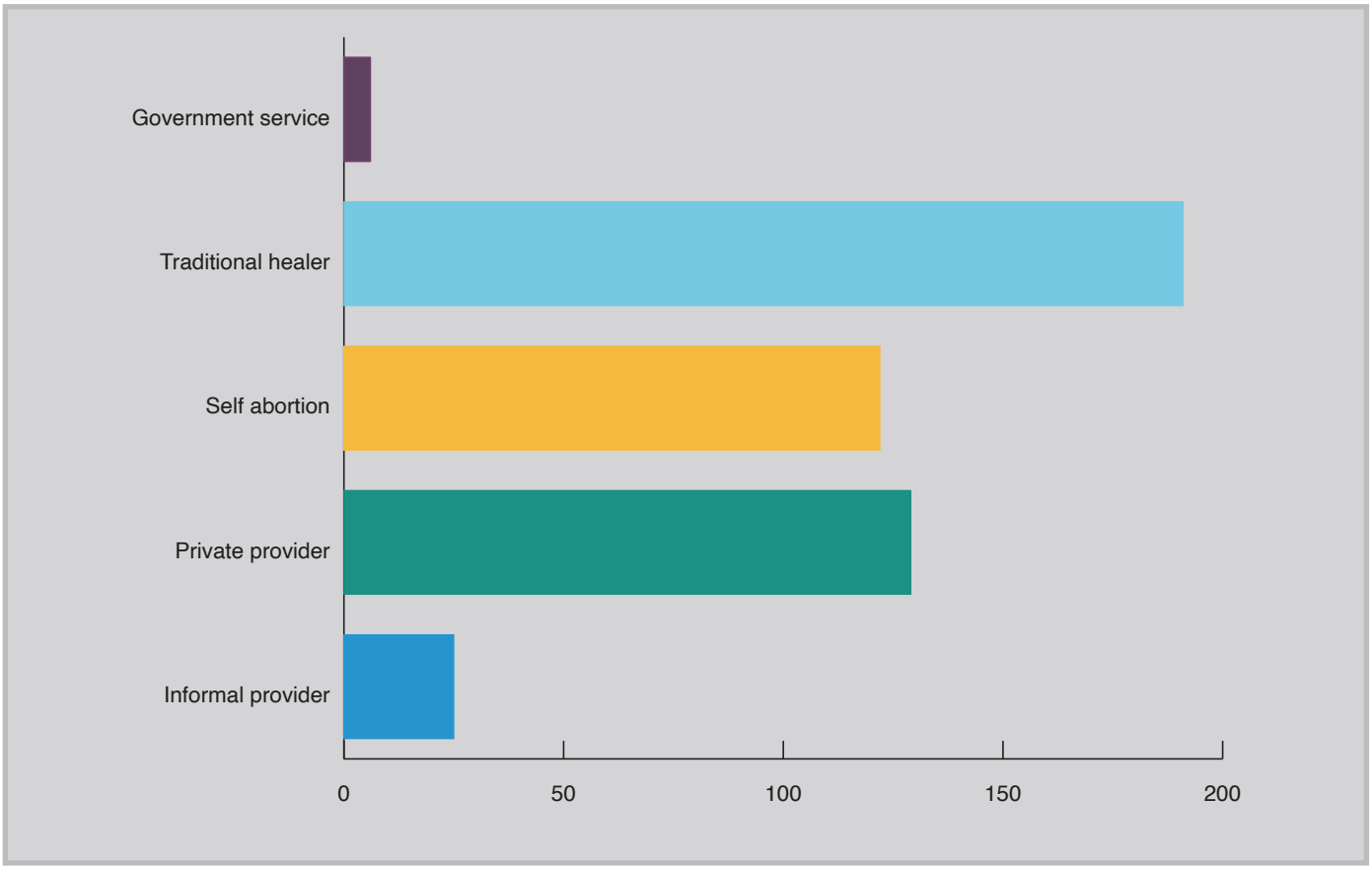


Figure 7: Second preference for abortion facility



Ranked factors in choosing a facility

Table 19 contains the results of responses to the important factors considered in choosing a provider (type of facility, location, price, opening hours). The type of facility appears to be the most important and opening hours the least important. However, differences between the factors appear small, suggesting that all the factors play some kind of role.

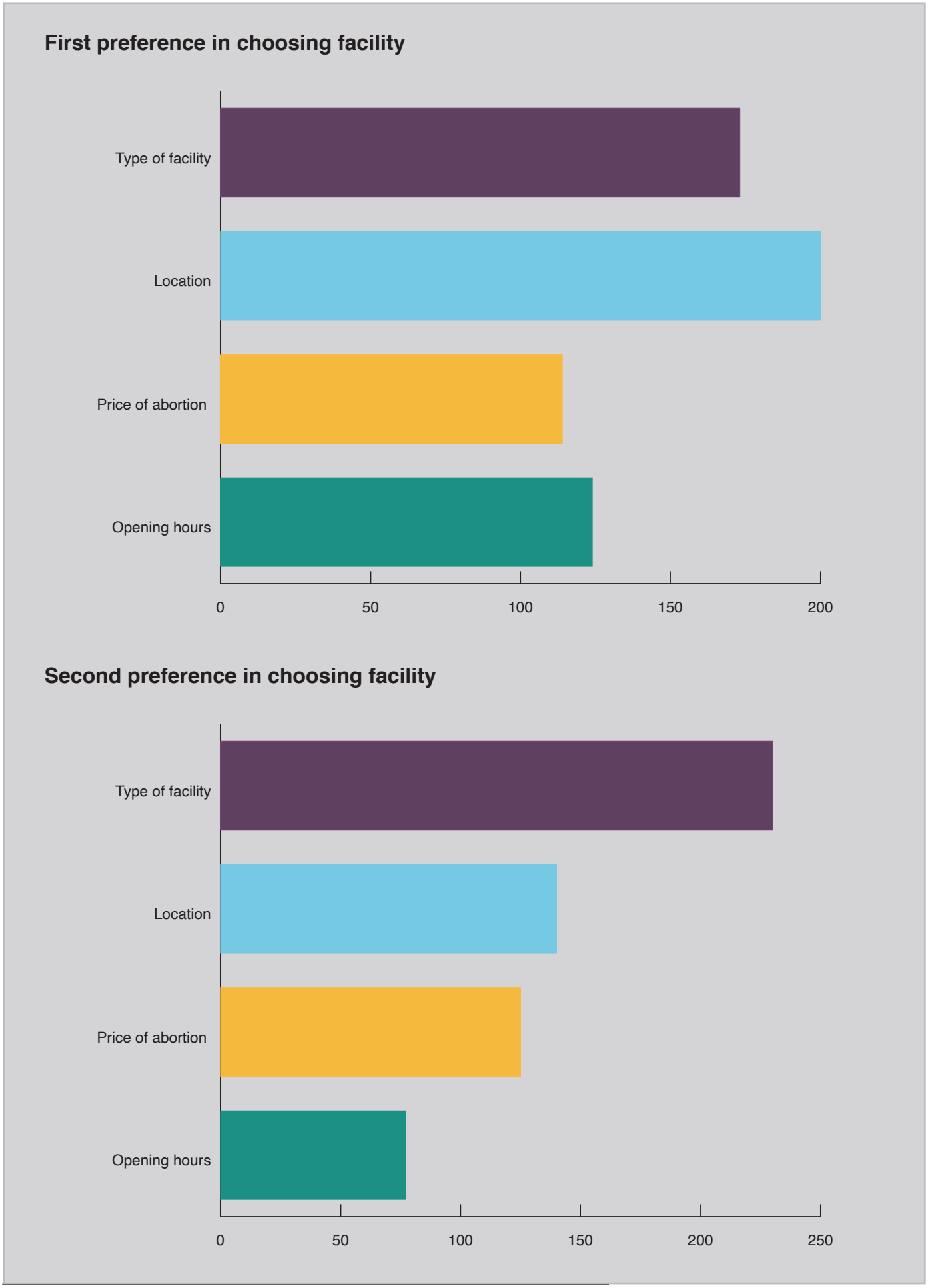
Table 19: Ranking of factors in choosing a facility

	Mean rank*	Marginal frequency**	
		1st preference	2nd preference
importance			
Type of facility	2.17	173	230
Location	2.23	200	140
Price of abortion	2.62	114	125
Opening hours	2.89	124	77

* Mean rank tells how popular a certain option is. Note that a higher rank means a lower number, as 1 is the highest rank

**Marginal frequencies describe how many times an option is put at this ranking spot.

Figure 8: Charts indicating first and second preference in choosing facility



Ranked preferences in information channels

Participants were asked to rank the information channels from which they would like to receive information about abortion. The results are contained in Table 20. Pamphlets or posters were ranked the highest among the information channels. and the internet was ranked lowest. Clumping the sources together, it appears that non-interactive media (pamphlets, posters, radio and TV) are the most popular sources. This followed by trusted others, including family, friends and home-based carers. Formal sources of information including teachers and nurses are ranked lower than informal sources. Toll-free numbers and online sources are the least popular, possibly because of a lack of familiarity with working through the menus (select 1 for X etc.) that come with phoning toll-free numbers or the poor access that rural communities have to Wi-Fi.

Table 20: Ranking of information sources about abortion

Information channel	Mean rank*	Marginal frequency**	
		1st preference	2nd preference
Pamphlets/posters	3.93	175	51
Radio/TV	4	130	79
Friends/family	4.34	78	65
Home-based carer	4.43	29	59
School/university	4.37	94	67
Nurse	4.44	68	60
Toll-free number	4.67	21	48
Online	4.77	17	40

* Mean rank tells how popular a certain option is. Note that a higher rank means a lower number, as 1 is the highest rank

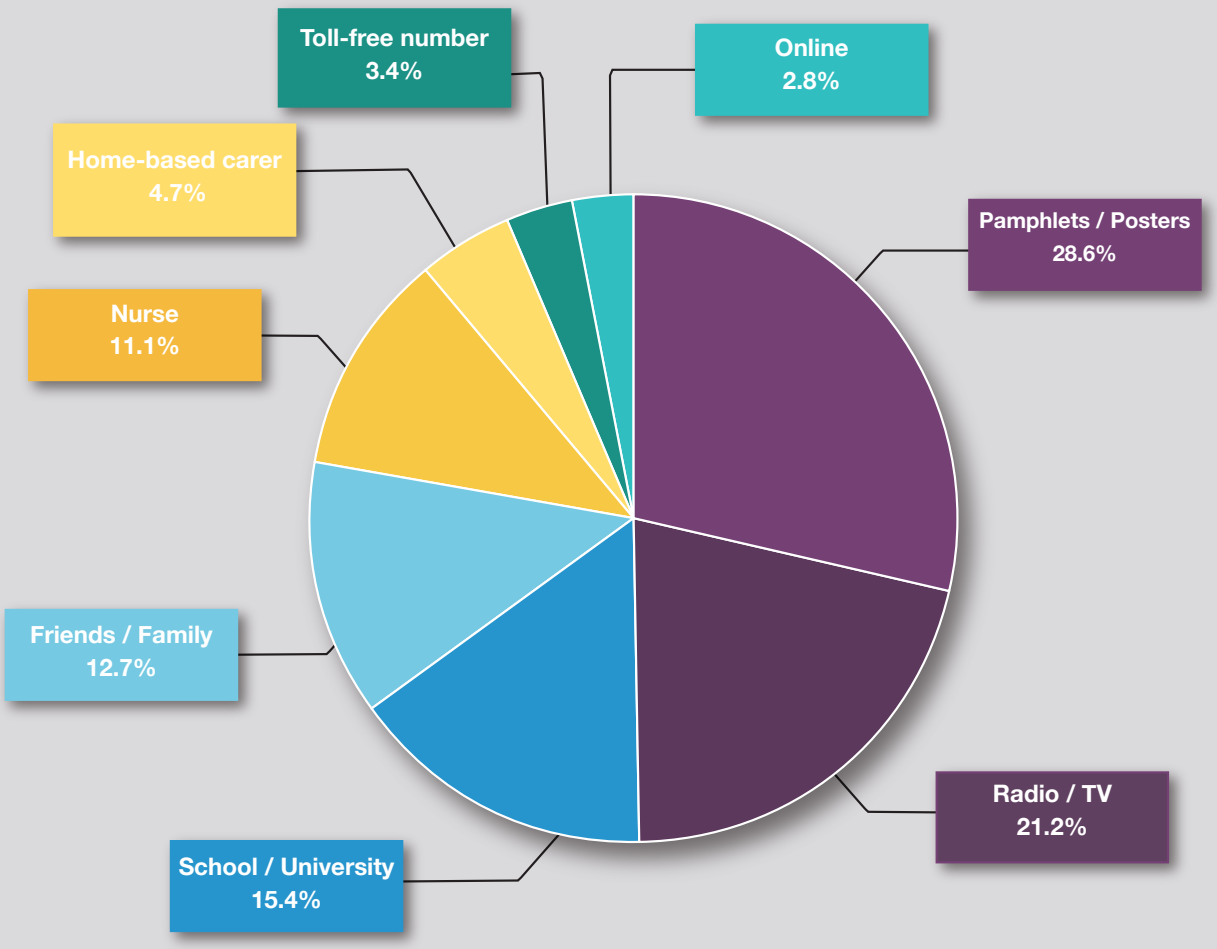
**Marginal frequencies describe how many times an option is put at this ranking spot.

Summary conclusions

Conclusions derived from the quantitative data analysis appear to be in line with the qualitative findings. It showed that attitudes to abortion are still rather negative with the majority of participants finding it acceptable only after rape. The preferred provider is a government facility, and this consistently emerges from the descriptive as well as the regression analysis after controlling for other attributes. Moreover, the type of facility is ranked most important when choosing a facility while the most preferred information channel is pamphlets/posters, both important recommendations for MS when planning new abortion facilities and ways of outreach. Regression analysis revealed certain differences among mxn and womxn and by site. It showed that the most important attribute for mxn is the abortion price which had the largest coefficient and was

Figure 8: First preference of information source on abortion presented in a pie chart

The quantitative data showed that participants prefer traditional non-interactive media (pamphlets, posters, radio and TV) followed by trusted others, including family, friends and home-based carers.



the most significant. They also preferred the abortion to be done in the nearest village than in their village and medication abortion versus surgical.

Results for womxn supported their preference for: MS partnered with government hospital/clinic, facilities offering other than abortion services, proximity of facility, lower price, medication abortion, and extended opening hours, all clear indications to be taken into account when designing new facilities. The analysis by site offers an insight into the ways the area of residence shapes participants preferences, either due to available infrastructure or to community attitudes. The type of facility weighs less in participants' decision making in site 2 than in the other sites. Similarly, location of the facility is least important for participants in site 2. Further investigation to identify reasons for these preferences should look into type of existing facilities, distance from them, travel times and cost for each site. Evidence also shows that there is universal preference for medication abortions (although non statistically significant for site 3), lower price, other health services offered in facility and extended opening times.

In the following section, we consolidate the findings and results surfaced in the qualitative and quantitative studies respectively into recommendations.

Conclusions and recommendations

The conclusions and recommendations of the project are presented in the following three sections. We start by presenting the recommendations derived from the review of the literature. We then provide those emanating from the qualitative data and those from the quantitative data. Cross-cutting issues are highlighted as we move through the recommendations and at the end. Please note that integrated findings and recommendations are presented in the executive summary.

Conclusions and recommendations derived from the review of literature

In their systematic review of abortion care indicators, Dennis, Blanchard, and Bessenaar (2017) signal that there is little agreement in the literature on the indicators of quality abortion care. What this potentially points to is that while certain indicators (e.g. good infrastructure and training) may be accepted as applying across contexts, there is also a strong need to hone services to particular contexts.

Some of the issues raised in the literature review (e.g. national guidelines on conscientious objection) cannot be resolved by MSSA's offices. Nevertheless, they point very firmly in the direction of a need for the kind of services that MS is envisaging (i.e. appropriate to the rural communities of the Eastern Cape).

Here we outline recommendations based on this literature review.

1. Specific to rural areas is the fact that clinics are often inaccessible and that access to an abortion often means a great deal of financial spending, not only on the abortion itself, but on the travelling costs. The length of queues at facilities, and the possibility of not having the procedure on the first consultation, contributes significantly towards the expenditure. Furthermore, very poor womxn might not even be able to afford the pain medicine and sanitary pads required in the case of a first trimester abortion. These challenges will be difficult to overcome where rural villages are spread over hundreds of square kilometres and might require unconventional approaches. These could include, for example, finding ways to bring the services as close as possible to the communities, the provision of pain medication and sanitary pads, home visits, telephonic consultations. It could also include finding ways to limit the number of visits womxn living in remote communities need to make to the clinic.

2. Early detection of pregnancy and accurate gestational dating contribute to earlier presentation for abortions. Information on accessing pregnancy testing should be widely disseminated. In addition, working with and training community health workers so that they can assist womxn in estimating their gestational age from last menstrual period may be useful.

3. Community health workers may also be useful in informing womxn of the stipulations of the CTOP Act, and in assisting womxn with the decision-making process. Generally speaking, womxn who present at a termination of pregnancy clinic have already made a decision. Indecision, which may lead to late access, generally occurs prior to this. Training community health workers in the listening skills required to assist womxn in making an autonomous decision may be useful. Community health workers would also need to be trained how to normalise and destigmatise abortion.

4. Given the role that cost plays in the decision-making processes of womxn, in particular those with little means, and given that accessing MSSA services will require procedural costs in addition to travelling and other costs, curtailing costs as much as possible, and in ways that are not burdensome to womxn living in

rural communities, would be necessary to assist in rural womxn's access to the MSSA services.

5. The need for proper and accurate information on abortion procedures is highlighted in the literature. Not only will accurate information reduce inaccurate perceptions and fears around the procedure, it will also go some way towards reducing stigma levels and criticisms. MSSA's marketing material should, thus, contain detailed information of womxn's rights under the CTOP Act, particularly the stipulations of the Act, as well as information on the procedures. With support from MSSA, community health workers could also assist with disseminating such information.

6. Given the important role of gender power relations in sexual and reproductive decision-making, it may be useful for MSSA to consider contributing to public campaigns that seek to undermine negative gendered interactions.

7. Given the remoteness of many rural areas, MSSA could consider using local and community radio stations for marketing and public campaigns. There are an estimated 15.4 million radio sets in South Africa, with community radio attracting almost 8.6 million listeners a week. Additionally, MSSA could consider organising events within rural communities that raise awareness of the services they offer in South Africa and use these events to also share information on illegal abortion.

8. There is a need for suitable and non-judgmental abortion counselling. Not only is this part of South African womxn's reproductive rights, it also functions as a support during what can be a time of anxiety and stress. The guidelines developed by Mavuso, du Toit, Macleod and Stevens, (Mavuso et al., 2018) based on data collected in the Eastern Cape, could prove useful in training counsellors.

9. The integration of counselling and safe, legal abortion within broader sexual and reproductive health services, particularly in relation to HIV care, is important. This is particularly important as research shows that that stigma and misinformation around HIV and HIV care may form a part of womxn's decision-making on abortion, as well as healthcare providers' interactions with HIV-positive womxn seeking abortion.

10. Traditional healers continue to play an important role in the lives of many Black people, including people living in rural communities. Liaising with traditional healers in the area of operation, as well as the public health sector, could help create a streamlined system of referral.

11. Womxn fear breaches of confidentiality and the possibility of encountering judgemental attitudes amongst healthcare providers. MSSA marketing material and campaign events need to emphasise that its services are strictly confidential and that its health care providers will support womxn in appropriate and non-judgemental ways. Additionally, MSSA may need to consider using any existing information or finding out from clients across their clinics, how its counselling services are being experienced, and where necessary, use this information to support staff to provide non-judgmental counselling where necessary.

12. Providers may face stigma and stress in relation to their work. Peer support mechanisms (for example, regular debrief sessions that bring providers together) and the provision of a positive work environment would assist with this.

13. A concerted effort needs to be made to challenge incorrect information circulating about the abortion procedure, and to reduce the stigma surrounding the topic. Once womxn feel confident about the procedure, they will be empowered to make their own decisions. Furthermore, reducing stigma, especially in conservative areas, will be integral to successfully integrating a new clinic into a community. Community leaders, especially those connected to or part of non-profit organisations, are likely to support the challenging of conventional religious and traditional beliefs if this is couched in developmentalist terms and described as a contribution towards the overall health of the community.

Conclusions and recommendations derived from the qualitative data

The interviews conducted with key informants in the three rural sites of the Eastern Cape provided insight into the dynamics in these areas in relation to a stigmatised and sensitive aspect of reproductive health. The most consistently spoken about issue related to abortion is fear of judgment from communities. The vast majority of respondents said that womxn who choose to have an abortion would go to extreme lengths to keep knowledge of it a secret. The most mentioned way to do so was to opt for services that are outside of the community. This complicates the argument that bringing services closer to communities would increase access to it, since especially in site 2, where clinics are more numerous, womxn choose to travel to a more distant clinic to get advice on abortion and people generally, it was argued, opt to do the same for other services such as HIV testing, which is also stigmatised.

There are two ways to address this issue: 1) circumventing the stigma of abortion by providing abortion services in such a way as to minimise the possibility that womxn will be identified for having had an abortion, and 2) addressing the topic of abortion in communities so as to reduce the stigma attached to it and to normalise it as a standard reproductive health procedure. Recommendations will be provided for both. We then address other aspects that were brought up in the qualitative data analysis.

Circumventing the stigma of abortion in communities

Designing facilities so as to increase confidentiality for womxn utilising the services is an imperative if an abortion provider hopes to increase access to womxn living in rural areas. Given the tight-knit nature of many rural communities (as seen in site 1 in this study), ensuring confidentiality may come with trade-offs (such as distance travelled). The following are possibilities.

1. Setting up abortion facilities in medium-sized towns and small cities in the Eastern Cape could reduce the possibility of womxn being recognised by people they know. It will still require womxn to travel and perhaps even stay over in the town/city, but it is perhaps the simplest means of ensuring confidentiality and increasing the number of potential patients able to safely (i.e. confidentially) access clinics. This option does mean that womxn in rural areas will be spending money simply travelling to the clinic. The trade-off here is that if the clinic is too expensive womxn might opt for a cheaper yet unsafe option, most of which are also available in towns and cities, or they might simply use the public hospital, if available.

2. Distance is an important barrier and womxn's lives would be made considerably easier if they had access to abortion and contraception close to where they live. If MS decide that building clinics in villages or small towns is what they wish to do, then we recommend that a clinic is not presented as an 'abortion clinic'. This can be done by providing a variety of essential reproductive health services as well as possibly other health services. Providing contraception, STI testing, pregnancy tests, antenatal care, and other gynaecological services would render the clinic an asset to the community. Providing integrative services is less likely to draw conservative community members' ire when they find out about abortion being performed at the clinic. Womxn going there would simply be seen as going for one of the other services.

3. Unmarried womxn, young womxn, womxn living with HIV, and poor womxn are likely to attract negative attention from communities for various reproductive health activities (e.g. teenagers seeking contraception or pregnancy tests; poor womxn having unplanned pregnancies; womxn seeking HIV testing). The possibility of providing a wider range of related health services - e.g. vaccinations, basic screenings - could be considered to obviate the stigma that may accrue to particular womxn who access a range of reproductive health services.

4. Constructing a clinic, even in cities, but especially in towns, and even more so in villages, would require attempts at reducing the possibility that the service womxn are requesting is known. There should be no obvious external indication concerning the particular service being offered, such as seating arrangements in waiting rooms, or different services being provided in different rooms. The waiting

room should not be immediately visible when the door of the facility is opened and patients inside the building should not be visible from outside through windows.

5. It would be ideal if there is a way to avoid womxn being seen walking to the clinic. In villages buildings are far apart and people are seen walking on the road from afar. Building a clinic next to other facilities that draw people might help womxn escape scrutiny. The entrance to the clinic should not, however, be located where people congregate or sit around outside. In other words, womxn should not be visible entering the clinic.

6. It is recommended that all employees working at the clinic or in outreach services understand the importance of not breaching confidentiality. Ideally, clinic workers should not be drawn from the local community. However, this may not always be feasible or possible, given the remoteness of some areas. Where they are drawn from the local community, additional emphasis should be placed on confidentiality, and the negative outcomes of breaches of confidentiality stressed. Value clarification around reproductive health issues in general, but also abortion, would be needed.

7. Partnering with local public clinics is a possibility worth looking into, especially where they are widespread such as in site 2. Public clinics only refer and do not provide abortions. If the MS facility is set up as part of the clinic in such a way that it is not obvious who does or does not go for an abortion, the presence of the clinic could provide the anonymity that is so essential in rural areas. The presence of the MS clinic can also bolster the service quality and provide the necessary contraceptive services when the clinic runs out. If this option is considered, values clarification workshops will need to be conducted with all staff at the clinic. These would need to emphasise the importance of confidentiality. If the community members do not trust the clinic health workers in maintaining confidentiality and in being non-judgemental regarding their choice, it would defeat the purpose of partnering with a public health clinic in the community. MS might also want to consider doing workshops on abortion counselling with local nurses, so that these nurses can assist womxn in their decision-making in a non-judgemental fashion.

8. It is recommended that MS partners with local community organisations or NGOs. These organisations can benefit from the services and knowledge that MS can provide, while MS can benefit from the legitimacy and the localised knowledge that the community organisation or NGO can provide. Setting up clinics near or next to NGO facilities could help integrate new clinics into the community and NGO home-based carers, where they exist, can draw from the clinic's knowledge and services. Providing home-based carers with correct knowledge concerning womxn's rights under the CTOP Act and about the abortion procedure as well as training them in the importance of confidentiality will potentially have a positive effect in the community. Although many NGO health workers are not in favour of abortion, training could assist with their understanding the importance of abortion in reproductive health. None of the home-based carers we worked with during this study was unwilling to participate and many of them gave their thanks for being given information on the topic since they could now provide it to the people with whom they worked in the community.

9. Another option is to provide services via a mobile clinic. In site 3 farming communities are serviced by a mobile clinic that drives from farm to farm and services a specific place about once a month. It would be worthwhile looking into the possibilities (and drawbacks) that a mobile clinic van can provide. In areas such as site 1 this van would need to have 4x4 capabilities. Once again, however, the concerns listed above (e.g. the mobile clinic being associated with abortion only) need consideration.

Reducing stigma in communities and addressing attitudes towards abortion

It sometimes takes only one conversation with someone to initiate empathy towards a person in a difficult situation, especially if their general circumstances are similar. During some of the interviews many participants expressed empathy, speaking of what their choices might be in such a situation, despite not having been required to do so by the interviewers.

Some participants lamented their own lack of empathy towards womxn who had abortions and bemoaned the tendency to gossip and judge within their communities. Some participants who started off hard-line anti-abortion showed less judgement towards the end of the interview, despite the neutrality of the interview questions. Simply initiating a conversation on a stigmatised topic can start the process of normalising it. If MS wishes to increase access to safe abortion services in rural areas, opportunities to reduce stigma among rural community members should be sought. MS could consider strategies based on the following insights from the data.

1. Almost all participants in our study knew under which circumstances abortion was legal. However, when asked whether people in their communities knew about abortion laws and procedures, the answer was most often no. The most prominent illegal ways mentioned were drinking home-made concoctions or getting concoctions from traditional healers. Backstreet abortion clinics were not prominent or accessible, but people did know about them. As for the procedure, participants did know that legal abortions have a cut-off date, but other than that very little was known. It would be useful for MS to do an information drive in each community that they wish to move into, providing essential information about abortion rights, legality, and procedures. Participants indicated that traditional media were the major (radio, newspapers) were the major source of information about abortion. MS could use these media, or workshops in communities. In the latter, partnering with NGOs or local community groups, especially womxn's groups or church groups (where they are not anti-abortion) would be essential to success.

2. Sources of information on abortion in rural areas include local clinics and other community members. Increasing accurate knowledge in communities would therefore require MS to connect with local clinics and speak to local nurses. Local clinics might be willing to place posters and pamphlets on their premises and nurses might be willing to refer to MS clinics as an alternative to the closest hospital. The CSSR has produced a pamphlet for this purpose drawing on the data collected in this study. Participants indicated that while community members knew of the existence of TOP clinics, they did not necessarily know where they were located. Detailed information on location and contact details of MS clinics should be included in the information provided.

3. A variety of myths and stereotypes have attached themselves to abortion. In moving into a rural area MS will need to address these. Most of these ideas have developed over time due to the use of informal abortifacients, with consequences of unsafe abortion turning into myths about all abortions. Although it seems that participants understand that legal abortions in public clinics are generally safe, there are still fears that abound about the procedure and its consequences. The belief that you can die has allowed abortion to be viewed as something akin to suicide. Some argued that you could never recover from an abortion, that you are 'condemned'. This is because informal abortions often leave womxn with morbid symptoms from which they take a long time to recover. Then, of course, there is the immense fear that an abortion can leave you infertile. The data showed that pronatalist beliefs were held by participants from the three communities, and that participants felt these beliefs were reflected in their communities. Addressing myths in relation to safe abortions and convincing the community of the safety of MS services would be imperative.

4. Despite not being asked to tell personal stories or anecdotes about other community members, participants did speak to personal circumstances. In narrating these stories, participants tended to provide rich contextual information that promoted empathy for the womxn's actions. Storytelling is a powerful tool that can be used in deflecting stigma, promoting understanding, and normalising abortion as a standard reproductive health service. This should be considered in workshops and informational services.

5. It is clear that a number of negative gender dynamics operate in the communities in which data were collected. As has been found in other research conducted by the CSSR in the Eastern Cape, paternity denial, partner abandonment and lack of partner support during pregnancy were mentioned frequently by participants. Although

rape was seen as an acceptable reason to terminate a pregnancy, rape myths that located blame for the rape with the womxn were evident. If the rape assailant was known to the womxn, abortion was seen as less acceptable. Conjugalised pronatalism, in which ideal womxnhood is associated with being married and bearing children, is firmly entrenched. Married womxn who terminate a pregnancy are particularly judged. Addressing these kinds of dynamics in a sensitive, contextually relevant manner through outreach services, and in collaboration with local NGOs would be a useful reproductive health intervention.

6. The CTOP Act follows a rights-based approach. While it is important to emphasise the right of a womxn to decide the outcome of her pregnancy, it is likely that a solely rights-based approach will have little traction in communities that are strongly pronatalist. Participants indicated that their community members will generally accept abortion where such a decision is underpinned by poverty, being unwed, being young, violence in the family, or sexual violence. Stories that highlight how abortion decision-making is located within particular circumstances, and that womxn tend to make decisions based on the principles of care (Chiweshe et al., 2017) could be useful in extending the acceptability of abortion in these communities.

7. The age of womxn when conceiving was spoken to by participants. Stigma accrues to young, unwed womxn with unplanned pregnancies. This stigma results on young womxn hiding their pregnancies and failing to receive the reproductive health services they need. Attention to this demographic group in terms of stigma reduction is important.

Recommendations around costs

Unlike public facilities, MS charges for their services. This is perhaps the most important aspect to consider in MS's decision to provide services in rural areas. Of the DCE participants, only a quarter were employed and more than half of all the participants reported a monthly household income of between R0 and a R1000. It is recommended that MS looks at ways to subsidise their rural clinics to increase usage. It may be worth adding pain medication and sanitary pads to the procedure since these are not readily available for purchase in rural areas. MS should also consider finding ways to provide free contraceptive services and free pregnancy tests, if possible.

It is clear from the data that the distance factor is closely connected to the problem of costs. Travelling is expensive as is the need to stay over in a city. MS would attract more clients if they were closer to communities because womxn would justify paying for an abortion if the cost of transport is reduced. If a womxn must travel to the nearest city or large town to have an abortion, they may choose the free option in the public hospital, unless there are other factors that make the MS clinic more attractive (e.g. no queues, quality of service, confidentiality).

Several participants stated that community members are willing to pay for an abortion if they knew that it would be conducted in a professional, pain-free manner, and that it would be confidential. Some participants said that boyfriends or husbands would give womxn money for an abortion. An issue would be for the womxn with no income who needs to keep their abortion completely confidential from their family and their partner. The most vulnerable of womxn are, therefore, likely going to be unable to access MS services. MS will also need to put protocols in place to deal with situations where desperate and vulnerable womxn arrive to the clinic needing an abortion but are unable to pay.

Second trimester abortions tend to cost more than first trimester ones, not only in terms of the actual procedure, but also the time involved and the possible need for additional trips. Early pregnancy detection could assist with womxn presenting in the first 12 weeks of gestation. Partnering with local NGOs and training their community healthcare workers in assisting womxn with pregnancy detection and talking with them about their decision regarding the outcome of the pregnancy (in a non-judgemental fashion) could potentially reduce costs.

Traditional healers and abortion care

Traditional healers still play an important role in the lives of many South Africans. In the recommendations from the review of literature, it was suggested that MS liaise with traditional healers. The qualitative data, however, shows that traditional healers are not trusted by participants to provide safe abortions. They are seen as

likely to charge people a great deal of money and to give people a concoction that doesn't work, cost them their lives, or render them infertile. In discussions around the safety of abortion it is traditional healers, more than the backstreet abortion providers in cities, who are deemed unsafe. Traditional healers' concoctions have had an immense impact on the ideas that participants in the three rural areas have about abortion and have contributed not only to its stigma, but also fear of the procedure, particularly that it renders womxn infertile or could kill them. It is important that MS keeps this in mind if they choose to partner with local healers. It might be useful to draw local healers into a referral network or partner with an established traditional healer that is trusted in the community, but more generally, partnering with them might have a negative impact on MS's reputation.

Conclusions and recommendations derived from the quantitative data

Information provision

The quantitative data showed that participants prefer traditional non-interactive media (pamphlets, posters, radio and TV) followed by trusted others, including family, friends and home-based carers. Thus, dissemination of information about the services provided by Marie Stopes, as well as about general public reproductive health information, should be through these traditional channels. In addition, workshops with home-based carers would assist in the informal dissemination of knowledge through these care networks. It is likely that if home-based carers provide detailed and accurate information to members of the community during their visits, better information may be passed on between friends and family members, the second preferred source of information.

Factors associated with abortion service preferences

The quantitative data revealed that all of the factors asked about in relation to abortion services play a role in participants' preferences – facility type, location, price and opening hours. This suggests that these factors need to balance in terms of MS planning their service delivery in rural areas of the Eastern Cape.

Results concerning preferences in facility type suggest that a combination of clinics in government facilities and mobile clinics may be the most suitable. Differences in preferences between sites suggest that in some areas a MS clinic in a pharmacy may be preferable. Stand-alone clinics are not recommended.

The most robust finding across all sites was the strong preference for abortion to be offered alongside other health services. This finding dovetails with the qualitative findings regarding confidentiality. Locating clinics within government facilities or a pharmacy would assist with this. If mobile clinics are used as well, or if clinics are located within villages, then offering some non-reproductive health services alongside sexual and reproductive services should be considered.

Medication abortion was the most favoured form of abortion in the pooled data, although the differences in preferences of type of abortion in site 3 were not significant. Obviously, the appropriate type of abortion procedure is frequently determined by medical criteria, including gestational date. On this basis, both surgical and medication abortions should be available. Nevertheless, data show that where medication abortion and surgical abortion are offered to a particular client, medication abortion will probably be chosen. This may have implications in terms of the training of providers and the stocking of clinics with abortion commodities. It also suggests that were only medication abortions provided (e.g. in mobile clinics), these services would be used and appreciated.

Participants indicated a preference for services to be located in their own village or nearest city. These preferences probably relate to the balance between cost, distance, and confidentiality. The varying results across sites suggest that a catchment area approach to the location of facilities may work best. Those rural areas close to towns or cities may be serviced by facilities in towns or cities, while those further afield may need services within their own village as well, probably in the form of mobile clinics or clinics that partner with local NGOs.

Rural areas tend to be economically disadvantaged. In this context, the first preference is not to pay for services. Nevertheless, where payment is required

participants in sites 1 and 2 indicated a preference to pay R500, R1400 and R800, in that order. Participants in site 3 expressed a preference to pay R800, R1400 and R500, in that order. These costs must, however, be set against the costs of travel, with people in far flung rural areas incurring more costs than those in closer proximity to facilities. It is, therefore, recommended that MS consider the lowest possible price across all facilities.

Participants expressed a strong preference for extended hours of operating, although when hours should be extended differed across sites. Participants across all sites recognised the difficulties with providing both extended evening and weekend hours. In the trade-off of providing extended evening hours during the week or extended hours over weekends, the latter is recommended. This will ensure that womxn in both far-flung rural areas, and ones closer by, may access services outside of normal weekday operating hours. Alternatively, if a dual catchment area approach is taken, as suggested above, hours could be adjusted to suit the type of clinic. Clinics in towns or cities could operate with extended evening hours, while clinics in villages (mobile or in conjunction with local NGOs) could operate on Saturdays. Given the fact that rural villages mostly lack street lighting, extended evening hours are not feasible within these locations.

Final conclusions

There is a real possibility for MS to make an important contribution to access to abortion care in South Africa by servicing rural areas. MS has up to now focused on urban populations, hoping to provide services to the largest number of people they can. Building rural facilities will be a challenge and, as the study has shown, will require some changes in the model of services MS have provided up to now. It is quite likely that abortion demands in rural clinics will not be as high as in urban clinics and individual rural clinics may incur financial losses. This is likely known by MS and their desire to nonetheless consider the option is commendable. This study represents their bottom-up approach to identifying the ways in which they could provide the best kind of rural service and take into consideration the specifics of the rural situation.

Apart from the specific aspects discussed in this section, it is worthwhile stating that in servicing rural areas, MS should consider continuing their current bottom-up approach to doing so and specifically focus on being developmental in the process. Setting up a clinic in a rural area is not the same as doing so in an urban area. The process of integrating a service into a rural community will take a great deal of effort and time; requiring actions that might not even be thought about in an urban setting, including partnering with local groups and organisations. MS clinics in rural areas could become a vehicle for developing and sustaining important attitudes towards reproductive health and rights in rural South Africa, and could, if MS adopts a developmental approach towards their service, contribute towards a broader agenda of womxn's equality and liberty.

Strengths and limitations of the study

The Eastern Cape is a province that is particularly affected by poverty and lack of access to resources, the results of the study may or may be generalisable to similar provinces in South Africa (EDEAT, 2017). Nevertheless, the fact that we sampled across three different rural settings means that some of the diversity evident in rural communities has been captured. Findings common across the settings may be generalizable to other rural communities within South Africa.

The present study's use of one-on-one interviews may limit the extent to which community perspectives on abortion seeking behaviours and preferences are obtained. However, the understanding of participants as key informants who report on community perspectives may mitigate this challenge, particularly as the qualitative component was designed to ensure that participants were aware that they were understood as key informants. Furthermore, one-on-one interviews have the advantage of offering greater privacy and confidentiality, which may decrease the likelihood of discomfort when discussing sensitive topics (Penfold et al., 2018).

Studies have noted the challenge that participants may find it difficult to speak about abortion. In the present study this challenge was mitigated to some extent by asking participants to reflect on community views and understandings, as opposed to their own views.

Reimbursement for participation in research is a contentious issue. Ethics debates hinge on participants' ability to refuse consent to participate on the one hand, and the need to acknowledge time spent or reimburse costs incurred by participating in the study on the other. Where reimbursement for participation is a substantial amount, and/or participants are drawn from resource-poor or impoverished settings, reimbursement may greatly reduce the likelihood that individuals will refuse to participate in the study, and is therefore considered unethical (Sathyamala, 2019). These considerations featured in our research as well, particularly as the study was conducted in low-resource areas. For the DCE component of the research, the fieldworkers consisted of the home-based carers employed by the partner NGOs in sites 1 and 2. In consultation with the NGOs, we did not compensate the home-based carers directly, but instead provided money to the NGOs' budget for the employment of these workers. We provided a token of appreciation to research participants for their participation in the qualitative section of the study. This took the form of airtime or data worth R100 sent to their mobile phones.

To develop our attributes for the DCE instrument, we used a literature review, qualitative data, expert panel input, and researcher discussion to develop the attributes and levels. This enabled the identification of attributes which were relevant to the sample.

For this study, the DCE had ten choice tasks with six attributes which had between three and six levels. This is in line with trends around the number of choice tasks and attributes, with fewer tasks resulting in an instrument that is less burdensome to complete. Given that the current study was conducted among participants from rural communities which generally have lower access to formal education, (EDEAT, 2017) and in line with other studies conducted in low-resource, marginalised communities, incorporating pictorial representations was deemed useful to enable usability of the instrument. The understandability and effectiveness of the pictorial representations and of the DCE exercise were assessed during pilot-testing, as suggested in the literature (Terris-Prestholt et al., 2013).

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Appendices

Appendix 1: Interview guide in English

CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

AN ASSESSMENT OF ABORTION SEEKING BEHAVIOURS AND PREFERENCES IN RURAL COMMUNITIES OF THE EASTERN CAPE, SOUTH AFRICA

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

INTERVIEW SCHEDULE

Instructions to fieldworker

1. Describe in detail the purpose of the study and its main objectives and answer any questions the participant has about the study.
2. Explain to the participant what it means to be interviewed as a key informant (i.e. expert about the community) and that they will not be asked to divulge personal information.
3. Ask the participant to sign the consent form.
4. Ask the participant to respond in their preferred language.

Aims of the study

The aim of this study is to assist Marie Stopes South Africa (MSSA) in focusing their service delivery so as to overcome barriers to reproductive choice, including safe abortion care, reduce stigma and ensure access to appropriate service provision for people living in rural areas of the Eastern Cape.

The study seeks to addresses aspects surrounding understandings of problematic /unwanted pregnancies, abortion, abortion legislation and abortion services, barriers to and facilitators of access, to abortion services, perceptions of safety and quality of current abortion services.

Interview questions

1. In this community, what typically happens when a couple wants to get pregnant?

Probe if nothing is forthcoming or if the following elements are not covered:

- What discussions would partners have about having children?
- What happens when a couple *does not* want to get pregnant?

2. What happens when a couple gets pregnant?

- Do they go to the nearest public clinic? Are there other options? How far do they have to travel? Why do they choose to go to that facility?
- What happens during the pregnancy and childbirth?
- How are the partner, the family and the community involved?

3. What happens between a couple if a pregnancy is unplanned?

- How would they decide what to do?
- What does the women's partner usually do?

4. How would family and community members respond to unwanted pregnancies?

- Would partners/family/community members respond differently to an unwanted pregnancy if the couple is married or unmarried? If yes, how?
- What about if the couple are in a committed relationship or a casual relationship?

- What about if one or both partners in the couple are in other romantic relationships?
- What about if the couple already have children or have no children?
- What about if the one or both partners in the couple are very young?
- What about if the pregnancy is the result of rape?

5. If a woman is pregnant but does not want to be pregnant, what are her options in this community?

- Where would she go?
- Who would she ask for information?
- What sort of information would she receive from these sources?

6. Please explain to me how decisions about what to do in cases of unwanted pregnancies are made.

- Who would be involved in making the decision about the outcome of a pregnancy?
- How would the process unfold?
- What would happen if there was disagreement about what to do?

7. If a woman made up her mind that she wanted to get an abortion, what would she do?

- Where or to whom would she be most likely to go to get it done?
- Are there any other places/providers/methods available in this community other than the ones you just mentioned?
- What factors would influence her choice of place/provider/method?

8. What are people's views on the safety and quality of these places/providers/methods?

9. Are there any difficulties a woman might face in obtaining an abortion?

- Any other barriers/difficulties than the ones you already mentioned?
- Without naming any names, do you know of an instance in which someone wished to have an abortion, but could not do so? What was the reason they could not? What did this person do instead?
- Do you think the woman might want to hide the fact that she is getting an abortion? Would she perhaps go to a provider that is far away and where no one knows her?

10. If women were able to choose an abortion service, what influences their decision on where to go?

- Which of the following would be important to them: the cost, the distance, the safety, non-judgemental service, minimal waiting time, a service that is stand-alone or part of other services? [Ask the respondent to elaborate on why the factors identified as important are more important than those identified as less important.]

11. How much do you think people are willing to pay for an abortion?

- Would they prefer to pay less and travel further or the other way around?

12. Without giving a name, do you know of anyone who has had an abortion in your community? How did they describe the process of seeking and having an abortion?

- Did they face any challenges/barriers?

- How did they describe their choice of place/ provider/ method? Why did they choose that place/ provider/ method?

13. What do people in your community know about and understand about the abortion laws in South Africa?

- [if respondent makes a broad statement about legality or illegality] Do people believe that's the case for all circumstances?
- [if respondent answers no] Under what circumstances do people believe abortion is legal/illegal?

14. What do people in your community know about places where you can get legal termination of pregnancy?

- Do they know about accessing an abortion at [insert name of nearest termination of pregnancy clinic]?
- Do they know of any other providers of terminations, even if they are not legal?

15. If the community got to know about a woman having an abortion, what would their responses be?

- How would people in the community feel about a woman having an abortion if:
  - The woman is married or unmarried?
  - The woman is poor or wealthy?
  - The woman's pregnancy is early or late?
  - The partner did or did not want her to have an abortion?
  - The pregnancy is a result of rape?
- Do different figures/groups in the community feel differently about abortion in general?

16. What, if any, support is provided to women who have had an abortion?

- What type of support do such women need (e.g. medical, psychological and/or community/partner support)?
- What type of support is most important?
- Where/how do you think women should be able to access this support?

17. Without mentioning any names, please can you tell me a story about any of the issues we discussed today?

- Is there anything more you'd like to share with me?

Appendix 2: Interview guide in isiXhosa

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

HONONONGO LOPHANDO NGOKUZIKHETHELA UKUBA NABANTWANA

ISALATHISO SOLWAMKELO LWEPROJEKTHI: MSI 013-19, RUESC 2019-0615-751

ISICWANGCISO SODLIWANONDLEBE

Imiyalelo kumcholacholi wolwazi

1. Nika inkcazelo enzulu ngenjongo yophononongo nang emigqaliselo yalo ephambili uze uphendule nayiphi imibuzo anayo umthathinxaxheba ngophononongo.
2. Chazela umthathinxaxheba ukuba kuthetha ukuthini ukuba ngumphenduli kudliwanondlebe njengomniki-zinkcukacha osentloko (oko kukuthi, ingcaphephe malunga noluntu) kwaye abasayi kucelwa ukuba baxele iinkcukacha ngobuqu babo.
3. Cela umthathinxaxheba ukuba asayine ifomu yemvume.
4. Cela umthathinxaxheba ukuba aphendule ngolwimi lwakhe alukhethayo.

Iinjongo zophononongo

Injongo yolu phononongo kukuncedisa iMarie Stopes South Africa (MSSA) kugqaliso lokunikela ngeenkonzo zayo ukuze kususwe imiqobo esendleleni yokuzikhethela malunga nokufumana abantwana, kuquka ukhathalelo lokuqhomfa ngokhuselo, ukuncitshiswa kwegama elibi nokuqinisekisa ufikelelo kubonelelo lweenkonzo ezifanelekileyo ukwenzela abantu abahlala emaphandleni eMpuma Koloni.

Uphononongo lufuna ukuqwalasela imiba engqonge iingqiqo ngokukhulelwa okuyingxaki / okungafunwayo, uqhomfo, uwisomthetho ngoqhomfo nangeenkonzo zoqhomfo, izithintelo zofikelelo nakubaphumezi balo, kwiinkonzo zoqhomfo, iimbono ngokhuselo nangodidi lweenkonzo zoqhomfo zangoku.

Imibuzo yodliwanondlebe

1. Kolu luntu, yintoni ekholisa ukwenzeka xa isibini sifuna ukukhulelwa?

Cikida xa kungekho nto izayo okanye xa imiba elandelayo ingaphendulekanga:

- Zeziphi iingxoxo abanokuba nazo abalingane malunga nokuba nabantwana?
- Kwenzeka ntoni xa isibini *singafuni* kukhulelwa?

2. Kwenzeka ntoni xa isibini sikhulelwa?

- Ingaba baya kweyona klinikhi yoluntu ikufutshane? Zikhona ezinye abanokuzikhetha? Baza kuhamba umgama ongakanani? Kutheni bekhetha ukuya kolo bonelelo?
- Kwenzeka ntoni ngethuba lokukhulelwa nangelokufumana usana?
- Umlingane, usapho noluntu babandakanyeka njani?

3. Kwenzeka ntoni phakathi kwesibini xa ukukhulelwa kungenasicwangciso?

- Banokusithatha njani isigqibo ngento abafanele ukuyenza?

- Umlingane webhinqa ukholisa ukwenza ntoni?

4. Ingaba amalungu osapho nawoluntu akubona njani ukukhulelwa okungafunwayo?

Ingaba abalingane/usapho/amalungu oluntu bakubona ngokwahlukileyo ukukhulelwa okungafunwayo xa isibini sitshatile okanye singatshatanga? Ukuba ngu-ewe, njani?

- Kwenzeka ntoni xa isibini sizinikele kubudlelwane okanye sikubudlelwane esingazinikelanga kubo?
- Kwenzeka ntoni ukuba omnye okanye bobabni abalingane abasisibini baphinda babe kobunye ubudlelwane bokuthandana nabanye abantu?
- Kwenzeka ntoni ukuba isibini sesinabantwana okanye asinabantwana?
- Kwenzeka ntoni xa omnye okanye bobabini abalingane kwisibini besebancinane kakhulu?
- Kwenzeka ntoni xa ukukhulelwa kubangelwe kukudlwengulwa?

5. Ukuba ibhinqa likhulelwe kodwa belingafuni kukhulelwa, zeziphi izinto elinokuzikhetha phakathi kolu luntu?

- Lingaya phi?
- Lingazicela kubani iinkcukacha?
- Ziinkcukacha ezinjani elinokuzifumana kule mithombo yeenkcukacha?

6. Khawuncede undichazele ukuba izigqibo zenziwa njani ngento efanele ukwenziwa xa ukukhulelwa kungafuneki.

- Ngubani oya kubandakanyeka ekwenzeni isigqibo ngesiphumo sokukhulelwa?
- Inkqubo iza kutyhileka njani?
- Bekuya kwenzeka ntoni xa kukho ukungavumelani ngento efanele ukwenziwa?

7. Ukuba ibhinqa lifikelele kwisigqibo sokuba lifuna uqhomfo, lingenza ntoni?

- Yeyiphi eyona ndawo okanye umntu elinokuya kuye apho lunokwenziwa khona?
- Ingaba zikhona ezinye iindawo/ababoneleli/imigaqo ekhoyo kolu luntu ngaphandle kwale osandul' ukuyikhankanya?
- Yeyiphi imibandela enokuba nefuthe ekukhetheni kwakhe indawo/umboneleli/umgaqo?

8. Zithini izimvo zabantu ngokhuselo nangomgangatho wezi ndawo/ababoneleli/imigaqo?

9. Ingaba kukho naziphi iimeko zobunzima elinokudibana nazo ibhinqa elifuna uqhomfo?

- Zikhona naziphi ezinye izithintelo/iimeko zobunzima ngaphandle kwezi sowuzikhankanyile?
- Ungadanga waxela nawaphi amagama, ingaba kukho nokuba ngubani omaziyo onokuzekelisa ngaye owayefuna uqhomfo, kodwa ongazange akwazi ukulwenza? Sasiyintoni isizathu sokuba angakwazi? Endaweni yoko wenza ntoni lo mntu?
- Ucinga ukuba ibhinqa lingafuna ukuyifihla inyaniso yokuba lenza uqhomfo? Ingaba mhlawumbi lingaya kumboneleli okude kakhulu nalapho kungekho mntu olaziyo?

10. Ukuba amabhinqa ebekwazi ukukhetha inkonzo yoqhomfo, yintoni ephembelela isigqibo sabo sokuba baye phi?

- Zeziphi kwezilandelayo ezinokubaluleka kubo: iindleko, umgama, ukhuselo, inkonzo engagwebiyo, elona xesha lifutshane lokulinda, inkonzo emiselwe yodwa okanye eyinxalenye yezinye iinkonzo? [Cela umphenduli ukuba acacise nzulu ukuba kutheni imibandela echongwe njengebalulekileyo iyiyo ebaluleke ngaphezu kwaleyo echongwe njengengabalulekanga kangako.]

11. Ucinga ukuba abantu bazimisela ukuhlawula malini ngoqhomfo?

- Bangakhetha ukuhlawula imali enganeno kodwa baye kude okanye bangakhetha ukukugqwetha oku?

12. Ngaphandle kokunika igama, ingaba ukhona nawuphi umntu omaziyo okhe wenza uqhomfo kolu luntu? Bayichaze njani inkqubo yokukhangela nokufumana uqhomfo?

- Ingaba baye bajongana nayo nayiphi imingeni/izithintelo?
- Bayichaze njani indlela abakhethe ngayo indawo/ umboneleli/ umgaqo? Kungani bekhethe loo ndawo/ umboneleli/ umgaqo?

13. Abantu kuluntu lwakho bazi ntoni futhi baqonda ntoni ngemithetho yoqhomfo eMzantsi Afrika?

- [ukuba umphenduli wenza inkcazo ebanzi ngokusemthethweni okanye ngokungekho mthethweni] Ingaba abantu bayakholwa ukuba kunjalo malunga nazo zonke iimeko?
- [ukuba umphenduli uphendula athi hayi] Kuphantsi kweziphi iimeko apho abantu bakholelwa ekubeni uqhomfo lusemthethweni/alukho mthethweni?

14. Abantu kuluntu lwakho bazi ntoni ngeendawo apho ungafumana khona ukunqunyanyiswa kokukhulelwa kwakho ngokusemthethweni?

- Ingaba bayazi ngofikelelo kwindawo yoqhomfo apha [faka igama leyona klinikhi ikufutshane yokunqumamisa ukukhulelwa]?
- Ingaba bakhona nabaphi abanye ababoneleli bonqumamiso ababaziyo, nokuba abakho mthethweni?

15. Ukuba uluntu luye lwazi ngebhinqa elenza uqhomfo, lungenza ntoni ngaloo nto?

- Eluntwini abantu baziva njani ngebhinqa elenza uqhomfo ukuba:
  Ibhinqa litshatile okanye alitshatanga?
  Ibhinqa liswele okanye lisisityebi?
  Ukukhulelwa kwebhinqa kusaqala okanye selihambile ixesha lako?
  Umlingane ebefuna okanye ebengafuni ukuba lenze uqhomfo?
  Ukukhulelwa kusisiphumo sokudlwengulwa?
- Ingaba abantu/amaqela eluntwini baziva ngendlela eyahlukileyo ngoqhomfo ngokubanzi?

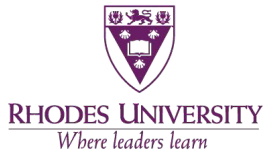
16. Yintoni, ukuba ikhona, inkxaso enikwa amabhinqa afumene uqhomfo?

- Yintoni uhlobo lwenkxaso oludingwa ngamabhinqa anjalo (umzekelo, inkxaso yamayeza, eyokusebenza kwengqondo kunye/okanye eyoluntu/eyomlingane)?
- Yintoni uhlobo lwenkxaso olulolona lubalulekileyo?
- Ucinga ukuba amabhinqa afanele ukufikelela kule nkxaso phi/njani?

17. Ngaphandle kokukhankanya nawaphi amagama, unganceda undibalisele ibali ngayo nayiphi imibandela esixoxe ngayo namhlanje?

- Ingaba ikhona nayiphi enye into onqwenela ukundixelela yona?

Appendix 3: Information sheet to interview guide in English



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

STUDY ON REPRODUCTIVE CHOICE

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

INFORMATION SHEET

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to understand the following information carefully.

The study is being conducted in accordance with the Rhodes University research guidelines: (https://www.ru.ac.za/researchgateway//) and conforms to the National guidelines for research on human subjects: (https://www.ru.ac.za/researchgateway/ethics/nationalguidelinesonresearchwithhumanandanimalsubjects/).

What is the study about?
Due to various challenges affecting reproductive choice, including access to abortion services in poor and rural communities in particular, Marie Stopes South Africa (MSSA) wishes to extend its service provision to the rural Eastern Cape. The aim of this research study is to assist MSSA in focusing their service delivery so as to overcome barriers to reproductive choice, including safe abortion care.

Through this research, we would like to understand people in rural communities' understandings of reproductive choice, problematic/unwanted pregnancy, abortion, abortion legislation and abortion services. We would also like to know what barriers people in rural areas face in accessing abortion services.

We are conducting approximately 60 interviews across three areas in the Eastern Cape - including among farm workers in the western part of the province, in rural villages between East London and Port Alfred, and in a remote part of the Mbhashe Municipal area. Towards the end of the year, we will return to these areas to administer a questionnaire. This questionnaire will inform us of what type of abortion services people living in this area prefer.

Why have you been invited to participate?
You have been chosen to take part in the study for your in-depth knowledge and insight into your community. You are being interviewed as a 'key informant', which means that you will be asked questions about attitudes, preferences and understandings of the topic in your local community.

Do you have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep if you want to and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

Taking part in this study is not an evaluation of your knowledge of the community or of reproductive choices. You do not have to have a particular viewpoint towards the topic of abortion

to participate in this study, nor will your viewpoint be held against you. Your name will not appear on any documents or in any reports that might be seen by friends, family, other members of the community or the local NGO. Whether you choose to take part or not will have no impact on your future dealings with the NGO or the research team. All information you provide will be kept confidential and only in extremely exceptional circumstances (e.g. in cases where a threat to the health, welfare and safety of someone is revealed), is the researcher legally required to pass this information on to an appropriate individual or agency.

What are you taking part in?
In taking part, you will be asked to do an interview which will be audio-recorded with your permission. The interview consists of a set of questions pertaining to community responses to pregnancies, unintended pregnancies, reproductive choice, abortion legislation and abortion services. The interview should not take longer than an hour to complete.

What are the benefits of participation?
Your participation will benefit us greatly in furthering our understanding of access to quality family planning services in rural areas and will affect the way that Marie Stopes designs their interventions. You will be compensated for any costs you incur in getting to the interview venue, and we will be giving all participants a token of appreciation for taking the time to be interviewed. The token of appreciation will be an airtime or data voucher worth R100.00 which will either be given to you at the interview or be transferred to your phone afterwards.

What are the disadvantages of taking part?
There is no personal disadvantage to you in participating. We will not ask you to divulge personal information. However, the research does involve discussions of certain sensitive topics such as abortion. We will take due care to deal with these topics sensitively. Please feel free to terminate the interview at any point if you feel uncomfortable or do not wish to proceed. If, for any reason, you feel any distress in participating in the interview, we will arrange for you to speak to a counsellor concerning the distress.

How will we treat your data?
You will be asked to provide a pseudonym (false name). Your real name will not be recorded on the audio-tape or on any written documents. The interview will be recorded. We will ensure that your interview data is safely stored electronically in a password protected file and that the hard copy is kept safely in locked filing cabinets. Data will be destroyed after a period of up to 5 years. Copies will be shared only with researchers in other institutions if they are to conduct analysis and they will be required to store files only in a secure fashion. Researchers will not keep your interview data on their personal laptops or handheld devices for longer than is absolutely necessary.

Can you withdraw from the study?
Your participation in the study is entirely voluntary. All participants have the right to withdraw from the study at any time, up until the point of analysis (January 2020). Participants also have the right to remove their data from the project, including recorded interviews and transcripts. You can inform the lead country researchers in writing or verbally of your intention to withdraw from the research (see the details below).

What should I do if I want to take part?
The researcher will provide you with the Information Sheet and answer any queries you have. If you are happy to participate, please complete and sign the Consent Form provided, and keep one copy for yourself if you want to. Please also retain this Information Sheet.

Who is organising and funding this research?
The study is organised and led by researchers from Rhodes University working in partnership with the local NGO. This research is being funded by Marie Stopes South Africa.

Who has approved this study?
This study was approved by the Rhodes University Ethics Committee (RUESC), as well as the Marie Stopes Ethics Review Committee.

What will happen to the results of the study?
We propose to publish the findings of the research as a research report that will be used to inform Marie Stopes about expansion and improvement of their services. We will also be producing journal articles based on the data collected. We will provide feedback to your community about the research results in whatever form is deemed suitable by community members. Your name will not appear in this feedback or in any other report or publication.

How can you contact us?
For any further information, please contact the following people:

Lead researcher: Ulandi du Plessis, Critical Studies in Sexualities and Reproduction, Rhodes University, ulandidup@gmail.com, +2783 660 6018.

Head of institute: Catriona Macleod, Critical Studies in Sexualities and Reproduction, Rhodes University, c.macleod@ru.ac.za, +2782 802 9187.

If you have any concerns about the way in which the study is being conducted, please feel free to contact the Chair of RUESC who reviewed the project:

Roman Tandlich, Rhodes University Ethics Committee Chair, r.tandlich@ru.ac.za

Thank you for taking the time to read this information sheet.

Appendix 4: Information sheet to interview guide in isiXhosa

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

HONONONGO LOPHANDO NGOKUZIKHETHELA UKUBA NABANTWANA

ISALATHISO SOLWAMKELO LWEPROJEKTHI: MSI 013-19, RUESC 2019-0615-751

ICWECWE LEENKCUKACHA

Uyamenywa ukuba ube nenxaxheba kuphononongo lophando. Phambi kokuba wenze isigqibo sokuba uyayithatha na inxaxheba okanye akunjalo, kubalulekile ukuqonda ukuba uphando lwenzelwa ntoni futhi luza kubandakanya ntoni. Nceda zinike ixesha lokuziqonda iinkcukacha ezilandelayo ngokuqaphela.

Uphononongo luqhutywa ngokwezikhokelo zophando zeYunivesithi yaseRhodes: (https://www.ru.ac.za/researchgateway//) kwaye luthobela izikhokelo zeSizwe zophando kubalingwa abangabantu: (https://www.ru.ac.za/researchgateway/ethics/nationalguidelinesonresearchwithhumanandanimalsubjects/).

Lumalunga nantoni uphononongo?

Ngenxa yemingeni eyahluka-hlukeneyo echaphazela ukuzikhethela ngokuba nabantwana, kuquka ufikelelo kwiinkonzo zoqhomfo kumaqela oluntu asweleyo ngakumbi awasemaphandleni, iMarie Stopes South Africa (MSSA) inqwenela ukolula ubonelelo lweenkonzo zayo kwiMpuma Koloni esemaphandleni. Injongo yolu phononongo lophando kukuncedisa iMSSA ngogqaliso lokunikela ngeenkonzo zayo ukuze koyiswe izithintelo ekuzikhetheleni ukuba nabantwana, kuquka ukhathalelo loqhomfo olukhuselekileyo.

Ngokusebenzisa olu phando, sinqwenela ukuqonda iingqiqo zabantu abakumaqela oluntu lwasemaphandleni ngokuzikhethela ukuba nabantwana, ukukhulelwa okuyingxaki/okungafunwayo, uqhomfo, uwiso-mthetho ngoqhomfo kunye nangeenkonzo zoqhomfo. Kwakhona sinqwenela ukwazi ukuba zeziphi izithintelo abajongana nazo abantu abakwiindawo ezisemaphandleni malunga nofikelelo kwiinkonzo zoqhomfo.

Siqhuba izihlandlo zodliwanondlebe ezimalunga nama-60 kwiingingqi ezintathu eMpuma Koloni – kuquka phakathi kwabaphangeli basezifama kwinxenye esentshona yeli phondo, kwiilalii ezisemaphandleni phakathi kwaseMonti naseCawa (ePort Alfred), nakwinxenye ethe qelele kwingingqi kaMasipala waseMbhashe. Xa unyaka usiya ngasesiphelweni, siya kubuyela kwezi ngingqi ukuze senze uphando ngemibuzo. Olu phando ngemibuzo luya kusinika iinkcukacha ngokuba loluphi uhlobo lweenkonzo zoqhomfo olukhethwa ngabantu abahlala kule ngingqi.

Kutheni umenywe ukuba ube nenxaxheba?

Ukhethwe ukuba ube nenxaxheba kolu phononongo ngenxa yolwazi lwakho olunzulu nengqiqo ecacileyo ngoluntu lwakho. Ubuzwa kudliwanondlebe 'njengomphenduli osentloko', oko kuthetha ukuba, uya kubuzwa imibuzo ngembonakaliso-zimvo, ngeemeko ezikhethwayo nangeengqiqo zoluntu ophakathi kwalo ngesihloko ekuthethwa ngaso.

Ingaba ubophelelekile ukuba ube nenxaxheba?

Sixhomekeke kuwe isigqibo sokuba uyayithatha na inxaxheba okanye akunjalo. Ukuba wenza isigqibo sokuyithatha, uya kunikwa eli cwecwe leenkcukacha uze ucelwe ukuba usayine ifomu yemvume. Ukuba wenza isigqibo sokuba nenxaxheba, usakhululekile ukurhoxa nangeliphi ixesha unganikanga nesizathu.

Ukuthatha inxaxheba kolu phononongo asilovavanyo lolwazi lwakho ngoluntu okanye ngokukhethwayo malunga nokuba nabantwana. Akunyanzelekanga ukuba ube noluvo oluthile malunga nesihloko soqhomfo ukuze ube nenxaxheba kolu phononongo, ngokunjalo uluvo lwakho alunakujika lukubophelele. Igama lakho alisayi kuvela nakwawaphi amaxwebhu kolu phononongo, okanye nakweziphi iingxelo ezinokubonwa ngabahlobo, lusapho nangamanye amalungu oluntu okanye yiNGO yendawo yakho. Nokuba ukhetha ukuba nenxaxheba okanye akuthandi ukuba nayo, oko akusayi kuba nafuthe kwiindlela ophathwa ngazo kwixesha elizayo yiNGO okanye liqela eliqhuba uphando. Zonke iinkcukacha onikela ngazo ziya kugcinwa njengehlebo, kuphantsi kweemeko ezigqibelele ngokungafani nezinye kuphela (umzekelo, kwiimeko ezityhile okusuba ukonakalisa impilo, impilontle nokhuselo lomntu othile), apho ekuya kufuneka khona ngokusemthethweni ukuba umphandi agqithisele ezi nkcukacha emntwini okanye kwiarhente efanelekileyo.

Yintoni othatha inxaxheba kuyo?

Ngokuthatha inxaxheba, uya kucelwa ukuba ube kudliwanondlebe elizaku rekhodwa. Udliwanondlebe luneseti yemibuzo ngezimvo zoluntu ngokumalunga nokukhulelwa, ukukhulelwa obekungafunwa, ukuzikhethela ukuba nabantwana, uwisomthetho ngoqhomfo nangeenkonzo zoqhomfo. Udliwanondlebe alufanelanga kuchitha ixesha elingaphezu kweyure.

Ziyintoni iinzuzo zenxaxheba?

Inxaxheba yakho iya kuba luncedo olukhulu kuthi ekuphangalaliseni ingqiqo yethu ngofikelelo kwiinkonzo zodidi zokucwangcisa iintsapho kwiingingqi ezisemaphandleni kwaye iya kuba nefuthe kwindlela iMarie Stopes eyila ngayo iintlobo zayo zongenelelo. Uya kunikwa imbuyekezo ngazo naziphi iindleko ozifumene ngokuya kwindawo olukuyo udliwanondlebe, kwaye bonke abathathinxaxheba siya kubanika ibhaso lombulelo ngexesha labo abalichitha ngokuba kudliwanondlebe. Elibhasa luyokuba yi airtime okanye i-data ye R100.

Zinto zini ezingenaluncedo ngenxaxheba?

Akukho ncedo kuqobo lwakho olufumana ngokuba nenxaxheba. Asisayi kukucela ukuba unikele ngeenkcukacha zobuqu bakho. Nangona kunjalo, uphando lubandakanya iingxoxo ngezihloko ezithile ezinobuntununtunu ezifana noqhomfo. Siya kubonisa inkathalo ngobuntununtunu bezo zihloko. Nceda khululeka ulunqumamise udliwanondlebe nangeliphi ixesha uziva ungaphatheki kakuhle okanye ungasanqweneli kuqhuba ngalo. Ukuba, ngaso nasiphi isizathu, uziva unalo naluphi udandatheko ngenxaxheba yakho kudliwanondlebe, siya kwenza amalungiselelo okuba uthethe nomcebisi-zingxoxweni malunga nolo dandatheko.

Siya kuziphatha njani iinkcukacha zakho?

Uya kucelwa ukuba uzithiye igama elingelilo (igama elingeyonyaniso). Igama lakho lenene alisayi kushicilelwa kwiteyiphi emanyelwayo okanye nakwawaphi amaxwebhu abhaliweyo. Udliwanondlebe lona luya kurekhodwa. Siya kuqinisekisa ukuba iinkcukacha zakho zodliwanondlebe zigcinwa ngokhuseleko ekhompyutheni kwifayili ekhuselwe ngegama eliyimfihlelo nangokuthi okubhalwe ephepheni kugcinwe ngokhuselo kwiikhabhathi zeefayili ezitshixwayo. Iinkcukacha ziya kutshatyalaliswa emva kwethuba elinokufikelela kwiminyaka emi-5. Iikopi ziya kudluliselwa kwabanye abaphandi kwamanye amaziko kuphela ukuba bafanele ukuqhuba uhlalutyo kwaye kuya kufuneka ukuba bazigcine iifayili ngendlela enokhuseleko

kuphela. Abaphandi abasayi kuzigcina iinkcukacha zakho zodliwanondlebe kwiikhompyutha zabo abazisingathayo ezizezabo okanye kwizixhobo abaziphatha ezandleni kwithuba elingaphezu kweliyimfuneko ngokuqinisekisiweyo.

Ungakwazi na ukurhoxa kuphononongo?

Inxaxheba yakho kuphononongo yintando yakho kwaphela. Bonke abathathinxaxheba banelungelo lokurhoxa kuphononngo nangaliphi ixesha, kude kufikelelwe kwibanga lohlalutyo (kuJanyuwari ngo-2020). Abathathinxaxheba ngokunjalo banelungelo lokucima iinkcukacha zabo kwiprojekthi, kuquka izihlandlo zodliwanondlebe nezokutolika ngokubhala okukhodiweyo. Unakho ukwazisa abaphandi abaziinkokeli elizweni ngokubabhalela okanye ngonxibelelwano lomlomo ngenjongo yakho yokurhoxa kuphando (jonga iinkcukacha ezingezantsi).

Ndifanele ukwenza ntoni xa ndifuna ukuba nenxaxheba?

Umphandi uya kukunika iCwecwe leeNkcukacha aze aphendule nayiphi imibuzo onayo. Ukuba ukhululekile ngokuba nenxaxheba, nceda uzalise uze usayine iFomu yeMvume oyinikwayo, ngokunjalo zigcinele ikopi ibe nye. Kwakhona nceda ugcine eli Cwecwe leeNkcukacha.

Ngubani oququzelela nonika inkxaso yemali kolu phando?

Uphononongo luququzelelwa kwaye lukhokelwa ngabaphandi beYunivesithi yaseRhodes abasebenza kulwahlulelwano neNGO yendawo yayo. Olu phando lunikwa inkxaso yemali yiMarie Stopes South Africa.

Ngubani owamkele olu phononongo?

Olu phononongo lwamkelwe yiKomiti yeYunivesithi yaseRhodes yeeNqobo zokuSebenza (RUESC), nayiKomiti yeMarie Stopes yoPhengululo lweeNqobo zokuSebenza.

Kuza kwenzeka ntoni kwiziphumo zophononongo?

Sinesindululo sokupapasha okufunyaniswe kuphando njengengxelo yophando eya kusetyenziselwa ukunika iinkcukacha kwiMarie Stopes malunga nokolulwa ngokunjalo nokuphuculwa kweenkonzo zabo. Kwakhona siya kuvelisa amanqaku eejenali asekwe kwiinkcukacha eziqokelelweyo. Siya kunikela ngengxelo kuluntu lwakho malunga neziphumo nangaluphi uhlobo esilubone lufanele amalungu oluntu. Igama lakho alisayi kuvela kule ngxelo okanye nakweyiphi ingxelo okanye upapasho.

Ungaqhagamshelana njani nathi?

Ngazo naziphi iinkcukacha ezithe vetshe, nceda uqhagamshelane nabantu abalandelayo:

Umphandi oyinkokeli: Ulandi du Plessis, Critical Studies in Sexualities and Reproduction, Rhodes University, ulandidup@gmail.com, +2783 660 6018.

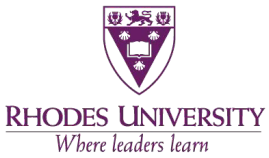
Intloko yeZiko: Catriona Macleod, Critical Studies in Sexualities and Reproduction, Rhodes University, c.macleod@ru.ac.za, +2782 802 9187.

Ukuba unazo naziphi iinkxalabo ngendlela eluqhutywa ngayo uphononongo, nceda uzive ukhululekile ukuqhagamshelana noSihlalo weRUESC oyiphengululeyo iprojekthi:

Roman Tandlich, Rhodes University Ethics Committee Chair, r.tandlich@ru.ac.za

Siyakubulela ngexesha lakho olichithe ngokufunda eli cwecwe leenkcukacha.

Appendix 5: General confidentiality agreement



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

AN ASSESSMENT OF ABORTION SEEKING BEHAVIOURS AND PREFERENCES IN RURAL COMMUNITIES OF THE EASTERN CAPE, SOUTH AFRICA

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

CONFIDENTIALITY AGREEMENT

I, _____ ,the _____

(job description, e.g. fieldworker/interpreter/translator/transcriber/expert panel member/researcher).

I agree to:

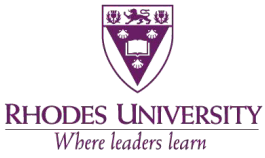
1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. audio files, notes, questionnaires, transcripts) with anyone other than the researcher(s).
2. Keep all research information in any form or format (e.g. audio files, notes, questionnaires, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g. audio files, notes, questionnaires, transcripts) to the researcher(s) when I have completed the research tasks.
4. After consulting with the researcher(s), erase or destroy all information (in any form or format) regarding this research project - including information that is not returnable to the researcher(s) (e.g. information stored on computer hard drives).

_____ _____ _____

(Print Name) (Signature) (Date)

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Rhodes University Ethics Committee (RUESC) and the Marie Stopes International Ethics Committee (MSI ERC). For any questions regarding participant rights and the ethical conduct of research, contact Dr Ulandi du Plessis (+2783 660 6018).

Appendix 6: Confidentiality agreement for translators and transcribers



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

AN ASSESSMENT OF ABORTION SEEKING BEHAVIOURS AND PREFERENCES IN RURAL COMMUNITIES OF THE EASTERN CAPE, SOUTH AFRICA

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

CONFIDENTIALITY AGREEMENT

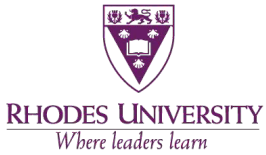
I, _____ , the translator/transcriber agree to:

1. Do the transcription and translation as accurately as possible, follow the provided guidelines, and double-check for accuracy.
2. In the event that the work handed over is decided by the research team to be of too low a quality, I will forgo my payment.
3. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. audio files, notes, questionnaires, transcripts) with anyone other than the researcher(s).
4. Keep all research information in any form or format (e.g. audio files, notes, questionnaires, transcripts) secure while it is in my possession.
5. Return all research information in any form or format (e.g. audio files, notes, questionnaires, transcripts) to the researcher(s) when I have completed the research tasks.
6. After consulting with the researcher(s), erase or destroy all information (in any form or format) regarding this research project - including information that is not returnable to the researcher(s) (e.g. information stored on computer hard drives).

_____	_____	_____
(Print Name)	(Signature)	(Date)

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Rhodes University Ethics Committee (RUESC) and the Marie Stopes International Ethics Committee (MSI ERC). For any questions regarding participant rights and the ethical conduct of research, contact Dr Ulandi du Plessis (+2783 660 6018).

Appendix 7: Consent form to interview guide in English



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

STUDY ON REPRODUCTIVE CHOICE

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

CONSENT FORM

Please tick each box to show that you agree:

☐	I have had the project explained to me and I understand the Information Sheet, which I may keep for my records.
☐	I have had a chance to ask questions and am satisfied with the answers.
☐	I have been given time to consider my decision.
☐	I understand that I am free to refuse to participate or to discontinue participation at any time without any negative consequences.
☐	I understand that I am free to withdraw my data from the study up to the time this is no longer possible without any negative consequence (January 2020).
☐	I understand that if I withdraw my data, it will be destroyed.
☐	I consent to being interviewed.
☐	I consent to having my interview recorded.
☐	I understand that any information I provide will be stored in a way that keeps my identity (and the identities of other people I have talked about) private.
☐	I consent to the use of anonymized quotes in publications from the research (this might include printed and online media) to be shared with donors, academic institutions, other NGOs and other relevant stakeholders.
☐	I understand that in **exceptional** circumstances (e.g. in cases where a threat to the health, welfare and safety of someone is revealed through the research), the researcher will be legally required to pass this information on to an appropriate individual or agency.
☐	I consent to the processing of my information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Protection of Personal Information (POPI) Act.
☐	I consent to my non-identifiable data being stored at the CSSR offices for re-use in future research and analysis by the CSSR and/or Marie Stopes. I understand that it will be fully anonymized before storage. The data will not be used for any other purpose than the purpose for which consent was originally given, and it will be destroyed after five years.

Participant name: _____

Participant signature: _____

Date: _____

Interviewer name: _____

Interviewer signature: _____

Participant Copy/Research Copy

Appendix 8: Consent form to interview guide in isiXhosa

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

HONONONGO LOPHANDO NGOKUZIKHETHELA UKUBA NABANTWANA

ISALATHISO SOLWAMKELO LWEPROJEKTHI: MSI 013-19, RUESC 2019-0615-751

IFOMU YEMVUME

Khawufake oonobumba bokuqala bamagama ebhokisini:

☐	Ndiyichazelwe iprojekthi kwaye ndiyaliqonda iCweCwe leeNkcukacha, nendinokuzigcinela lona.
☐	Ndibenalo ithuba lokubuza imibuzo kwaye ndonelisekile ziimpendulo endizifumeneyo.
☐	Ndilinikiwe ixesha likusicinga isigqibo sam.
☐	Ndiyaqonda ukuba inxaxheba yam kukuthanda kwam, nokuthi ndinokukhetha ukungabi nanxaxheba kwinxalenye okanye kuyo yonke iprojekthi, ngokunjalo ndinakho ukurhoxa nakweliphi ibanga leprojekthi ngaphandle kokohlwaywa okanye kokuthinteleka nangayiphi indlela, futhi andibophelelekanga ekubeni ndinike izizathu ngokwenza njalo.
☐	Ndiyaqonda ukuba xa ndifuna ukurhoxisa iinkcukacha ezigciniweyo endizinikileyo, kuya kufuneka ukuba ndikwenze oko kuJanyuwari ngo-2020 njengoko uhlalutyo lweenkcukacha ezigciniweyo luya kuqosheliswa ngeli xesha.
☐	Ndiyaqonda ukuba xa ndizirhoxisa iinkcukacha ezigciniweyo zam, ziya kutshatyalaliswa.
☐	Ndiyavuma ukubuzwa kudliwanondlebe.
☐	Ndiyavuma ukuba udliwanondlebe lurekhodwe.
☐	Ndiyaqonda ukuba naziphi iinkcukacha endizinikayo ziya kulondolozwa ngendlela yokugcina ukuchongeka kwam njengombandela wabucala (ngokunjalo nokuchongeka kwabantu endithethe ngabo).
☐	Ndiyavuma ukuba kusetyenziswe izicatshulwa ezingenamagama abantu kokupapashwayo okuvela kuphando (oku kungaquka usasazo olushicilelweyo nolusekhompyutheni) noludluliselwa kubaxhasi, kumaziko emfundo, nakwezinye iiNGO nakwabanye abafanelekileyo ababelana ngomdla.
☐	Ndiyaqonda ukuba kwiimeko ezifana zodwa (umzekelo, kwiimeko ezityhileke ngophando ezisuba ukonakalisa impilo, impilontle nokhuselo lomntu), kuya kufuneka ngokusemthethweni ukuba umphandi agqithisele ezi nkcukacha emntwini okanye kwiarhente efanelekileyo.
☐	Ndiyavuma ukuba iinkcukacha zam ziqhutyelwe phambili ngeenjongo zolu phononongo lophando. Ndiyaqonda ukuba iinkcukacha ezinjalo ziya kuphathwa njengehlebo elingqongqo ngokunjalo zigcinwe ngokoMthetho oMiselweyo woKhuselo lweeNkcukacha zoBuqu baBantu.
☐	Ndiyavuma ukuba iinkcukacha zam ezigciniweyo zilondolozwe kwiiofisi zaseCSSR ukuze ziphinde zisetyenziswe kuphando lwekamva nohlalutyo olwenziwa yiCSSR kunye/okanye yiMarie Stopes. Ndiyaqonda ukuba ziya kuba zingenamagama abantu kwaphela phambi kokulondolozwa.

Igama lomphandi: _____
Umsayino: _____
Umhla: _____
Interviewer name: _____
Interviewer signature: _____

Ikopi yoMthathinxaxheba/iKopi yoPhando

Appendix 9: Discrete Choice Experiment answer sheet in English and isiXhosa

RHODES UNIVERSITY
Where leaders learn

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

UHLOLO NGEMIKHWA NOKUKHETHWA NGABAFUNA UQHOMFO KULUNTU LWASEMAPHANDLENI EMPUMA KOLONI, EMZANTSI AFRIKA

QUESTIONNAIRE

PLEASE FILL IN THE RANKED CHOICES MADE BY THE PARTICIPANT, I.E.:

NDICELA UGCWALISE IZINTO/IINDAWO EZIKHETHIWEYO ZANIKEZWA AMANQAKU NGUMTHATHI NXAXHEBA UMZEKELO:

TASK X

- [2] Option 1
- [3] Option 2
- [1] Option 3

UMSEBENZI X

- [2] Ukhetho 1
- [3] Ukhetho 2
- [1] Ukhetho 3

TASK 1

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 2

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 3

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 4

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 5

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 6

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 7

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 8

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 9

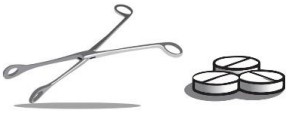
- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

TASK 10

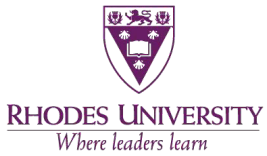
- [ ] Option 1
- [ ] Option 2
- [ ] Option 3

Appendix 10: Discrete Choice Experiment task sheet in isiXhosa

UMSEBENZI 1

UKHETHO 1	UKHETHO 2	UKHETHO 3
Ikliniki yaseMarie Stopes ekwisibhedlele okanye ikliniki yakaRhulumente 	Ikliniki yaseMarie Stopes esebenzisana nendawo enyanga ngokwesintu 	Ikliniki yaseMarie Stopes ezimele yodwa 
Ukuqhomfa kodwa 	Iinkonzo zokuqhomfa nokucwangcisa 	Iinkonzo zokuqhomfa nokucwangcisa 
Ukuqhomfa isisu ngokotyando (Phakathi kweeveki eziyi-12 ukuyela kweziyi-24 umntu emithi) 	Ukuqhomfa isisu ngokusebenzisa iipilisi (Zingekadluli iiveki ezi-yi-12 umntu emithi) 	Ukuqhomfa isisu ngokotyando nokuqhomfa isisu ngokusebenzisa iipilisi (Zingekadluli iiveki ziyi-24 umntu emithi) 
Kwidolophu esondele kum 	Kwilali/kuluntu/ kwilokishi esondele kum 	Kwidolophu enkulu esondele kum 
R1400 (Ngaphandle kwemali yokukhwela) 	R500 (Ngaphandle kwemali yokukhwela) 	R500 (Ngaphandle kwemali yokukhwela) 
Kuvulwa ngo9:00 kusasa kuyovalwa ngo5:00 emva kwe dinara, ukuqala ngoMvulo uyotsho ngoMgqibelo 	Ngomvulo ukuya ngoLwesihlanu amaxesha ongeziweyo, kuvulwa ngo 09AM ukuya ngo 10PM 	Kuvulwa ngo9:00 kusasa kuyovalwa ngo5:00 emva kwe dinara, ukuqala ngoMvulo uyotsho ngoMgqibelo 

Appendix 11: Discrete Choice Experiment consent form in English



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

STUDY ON REPRODUCTIVE CHOICE

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

CONSENT FORM

Please tick each box to show that you agree:

☐	I have had the project explained to me and I understand the Information Sheet, which I may keep for my records.
☐	I have had a chance to ask questions and am satisfied with the answers.
☐	I have been given time to consider my decision.
☐	I understand that I am free to refuse to participate or to discontinue participation at any time without any negative consequences.
☐	I understand that I am free to withdraw my data from the study up to the time this is no longer possible without any negative consequence (January 2020).
☐	I understand that if I withdraw my data, it will be destroyed.
☐	I consent to filling in the questionnaire.
☐	I understand that any information I provide will be stored in a way that keeps my identity (and the identities of other people I have talked about) private.
☐	I consent to the use of anonymized quotes in publications from the research (this might include printed and online media) to be shared with donors, academic institutions, other NGOs and other relevant stakeholders.
☐	I understand that in **exceptional** circumstances (e.g. in cases where a threat to the health, welfare and safety of someone is revealed through the research), the researcher will be legally required to pass this information on to an appropriate individual or agency.
☐	I consent to the processing of my information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Protection of Personal Information (POPI) Act.
☐	I consent to my non-identifiable data being stored at the CSSR offices for re-use in future research and analysis by the CSSR and/or Marie Stopes. I understand that it will be fully anonymized before storage. The data will not be used for any other purpose than the purpose for which consent was originally given, and it will be destroyed after five years.

Participant name: _____

Participant signature: _____

Date: _____

Fieldworker name: _____

Fieldworker signature: _____

Participant Copy/Research Copy

Appendix 12: Discrete Choice Experiment consent form in isiXhosa

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

HONONONGO LOPHANDO NGOKUZIKHETHELA UKUBA NABANTWANA

ISALATHISO SOLWAMKELO LWEPROJEKTHI: MSI 013-19, RUESC 2019-0615-751

IFOMU YEMVUME

Khawufake oonobumba bokuqala bamagama ebhokisini:

☐	Ndiyichazelwe iprojekthi kwaye ndiyaliqonda iCweCwe leeNkcukacha, nendinokuzigcinela lona.
☐	Ndibenalo ithuba lokubuza imibuzo kwaye ndonelisekile ziimpendulo endizifumeneyo.
☐	Ndilinikiwe ixesha likusicinga isigqibo sam.
☐	Ndiyaqonda ukuba inxaxheba yam kukuthanda kwam, nokuthi ndinokukhetha ukungabi nanxaxheba kwinxalenye okanye kuyo yonke iprojekthi, ngokunjalo ndinakho ukurhoxa nakweliphi ibanga leprojekthi ngaphandle kokohlwaywa okanye kokuthinteleka nangayiphi indlela, futhi andibophelelekanga ekubeni ndinike izizathu ngokwenza njalo.
☐	Ndiyaqonda ukuba xa ndifuna ukurhoxisa iinkcukacha ezigciniweyo endizinikileyo, kuya kufuneka ukuba ndikwenze oko kuJanyuwari ngo-2020 njengoko uhlalutyo lweenkcukacha ezigciniweyo luya kuqosheliswa ngeli xesha.
☐	Ndiyaqonda ukuba xa ndizirhoxisa iinkcukacha ezigciniweyo zam, ziya kutshatyalaliswa.
☐	Ndiyavuma ukubhala phantsi iimpendulo zemibuzo ebhaliweyo phantsi.
☐	Ndiyaqonda ukuba naziphi iinkcukacha endizinikayo ziya kulondolozwa ngendlela yokugcina ukuchongeka kwam njengombandela wabucala (ngokunjalo nokuchongeka kwabantu endithethe ngabo).
☐	Ndiyavuma ukuba kusetyenziswe izicatshulwa ezingenamagama abantu kokupapashwayo okuvela kuphando (oku kungaquka usasazo olushicilelweyo nolusekhompyutheni) noludluliselwa kubaxhasi, kumaziko emfundo, nakwezinye iiNGO nakwabanye abafanelekileyo ababelana ngomdla.
☐	Ndiyaqonda ukuba kwiimeko ezifana zodwa (umzekelo, kwiimeko ezityhileke ngophando ezisuba ukonakalisa impilo, impilontle nokhuselo lomntu), kuya kufuneka ngokusemthethweni ukuba umphandi agqithisele ezi nkcukacha emntwini okanye kwiarhente efanelekileyo.
☐	Ndiyavuma ukuba iinkcukacha zam ziqhutyelwe phambili ngeenjongo zolu phononongo lophando. Ndiyaqonda ukuba iinkcukacha ezinjalo ziya kuphathwa njengehlebo elingqongqo ngokunjalo zigcinwe ngokoMthetho oMiselweyo woKhuselo lweeNkcukacha zoBuqu baBantu.
☐	Ndiyavuma ukuba iinkcukacha zam ezigciniweyo zilondolozwe kwiiofisi zaseCSSR ukuze ziphinde zisetyenziswe kuphando lwekamva nohlalutyo olwenziwa yiCSSR kunye/okanye yiMarie Stopes. Ndiyaqonda ukuba ziya kuba zingenamagama abantu kwaphela phambi kokulondolozwa.

Igama lomthathi nxaxheba: _____

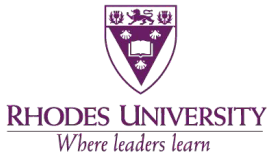
Umsayino womthathi nxaxheba: _____

Umhla: _____

Igama lomphandi: _____

Umsayino womphandi: _____

Appendix 13: Discrete Choice Experiment information sheet in English



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

STUDY ON REPRODUCTIVE CHOICE

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

INFORMATION SHEET

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to understand the following information carefully.

The study is being conducted in accordance with the Rhodes University research guidelines: (https://www.ru.ac.za/researchgateway//) and conforms to the National guidelines for research on human subjects: (https://www.ru.ac.za/researchgateway/ethics/nationalguidelinesonresearchwithhumanandanimalsubjects/).

What is the study about?
Due to various challenges affecting reproductive choice, including access to abortion services in poor and rural communities, Marie Stopes South Africa (MSSA) wishes to extend its service provision to the rural Eastern Cape. The aim of this research study is to assist MSSA in focusing their service delivery to overcome barriers to reproductive choice, including safe abortion care.

For this research, we would like to administer a questionnaire which provides a set of hypothetical options in accessing a service where one can terminate a pregnancy. By choosing your preference in each case, we will be able to identify the general preferences in the community in terms of abortion services.

We are administering approximately 600 interviews across three areas in the Eastern Cape - including among farm workers in the western part of the province, in rural villages between East London and Port Alfred, and in a remote part of the Mbhashe Municipal area.

Why have you been invited to participate?
You have been chosen to take part in the study because you represent a population group within a rural part of the Eastern Cape who might require a service such as is offered by Marie Stopes. Your insight into what characteristics such a facility should have to adequately serve the people in the community is very useful to our research.

Do you have to take part?
It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep if you want to and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

Taking part in this study is not an evaluation of your knowledge of the community or of reproductive choices. You do not have to have a particular viewpoint towards the topic of abortion to participate in this study, nor will your viewpoint be held against you. Your name will not appear on any documents or in any reports that might be seen by friends, family, other members of the community or the local NGO. Whether you choose to take part or not will have no impact on your future dealings with the NGO or the research team. All information you provide will be kept confidential and only in extremely exceptional circumstances (e.g. in cases where a threat to the health, welfare and safety of someone is revealed), is the researcher legally required to pass this information on to an appropriate individual or agency.

What are you taking part in?
In taking part, you will be presented with a list of hypothetical options where you will be required to state your preference. The questionnaire should not take longer than fifteen minutes to complete.

What are the benefits of participation?
Your participation will benefit us greatly in furthering our understanding of access to quality family planning services in rural areas and will affect the way that Marie Stopes designs their interventions. You will be compensated for any costs you incur in getting to the

interview venue, and we will be giving all participants a token of appreciation for taking the time to be interviewed.

What are the disadvantages of taking part?
There is no personal disadvantage to you in participating. We will not ask you to divulge personal information. However, the research does involve discussions of certain sensitive topics such as abortion. We will take due care to deal with these topics sensitively. Please feel free to terminate the questionnaire at any point if you feel uncomfortable or do not wish to proceed. If, for any reason, you feel any distress in participating, we will arrange for you to speak to a counsellor concerning the distress.

How will we treat your data?
Your real name will not be recorded on any written documents. We will ensure that your questionnaire data is safely stored electronically in a password protected file and that the hard copy is kept safely in locked filing cabinets. Data will be destroyed after a period of up to 5 years. Copies will be shared only with researchers in other institutions if they are to conduct analysis, and they will be required to store files only in a secure fashion. Researchers will not keep your interview data on their personal laptops or handheld devices for longer than is necessary.

Can you withdraw from the study?
Your participation in the study is entirely voluntary. All participants have the right to withdraw from the study at any time, up until the point of analysis (January 2020). Participants also have the right to remove their data from the project. You can inform the lead researcher in writing or verbally of your intention to withdraw from the research (see the details below).

What should I do if I want to take part?
The fieldworker will provide you with the Information Sheet and answer any queries you have. If you are happy to participate, please complete and sign the consent form provided, and keep one copy for yourself if you want to. Please also retain this Information Sheet.

Who is organising and funding this research?
The study is organised and led by researchers from Rhodes University working in partnership with the local NGO. This research is being funded by Marie Stopes South Africa.

Who has approved this study?
This study was approved by the Rhodes University Ethics Committee (RUESC), as well as the Marie Stopes Ethics Review Committee.

What will happen to the results of the study?
We propose to publish the findings of the research as a research report that will be used to inform Marie Stopes about expansion and improvement of their services. We will also be producing journal articles based on the data collected. We will provide feedback to your community about the research results in whatever form is deemed suitable by community members. Your name will not appear in this feedback or in any other report or publication.

How can you contact us?
For any further information, please contact the following people:

Lead researcher: Ulandi du Plessis, Critical Studies in Sexualities and Reproduction, Rhodes University, ulandidup@gmail.com, +2783 660 6018.

Head of institute: Catriona Macleod, Critical Studies in Sexualities and Reproduction, Rhodes University, c.macleod@ru.ac.za, +2782 802 9187.

If you have any concerns about the way in which the study is being conducted, please feel free to contact the Chair of RUESC who reviewed the project:

Roman Tandlich, Rhodes University Ethics Committee Chair, r.tandlich@ru.ac.za

Thank you for taking the time to read this information sheet.

Appendix 14: Discrete Choice Experiment information sheet in isiXhosa

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

HONONONGO LOPHANDO NGOKUZIKHETHELA UKUBA NABANTWANA

ISALATHISO SOLWAMKELO LWEPROJEKTHI: MSI 013-19, RUESC 2019-0615-751

ICWECWE LEENKCUKACHA

Uyamenywa ukuba ube nenxaxheba kuphononongo lophando. Phambi kokuba wenze isigqibo sokuba uyayithatha na inxaxheba okanye akunjalo, kubalulekile ukuqonda ukuba uphando lwenzelwa ntoni futhi luza kubandakanya ntoni. Nceda zinike ixesha lokuziqonda iinkcukacha ezilandelayo ngokuqaphela.

Uphononongo luqhutywa ngokwezikhokelo zophando zeYunivesithi yaseRhodes: (https://www.ru.ac.za/researchgateway//) kwaye luthobela izikhokelo zeSizwe zophando kubalingwa abangabantu: (https://www.ru.ac.za/researchgateway/ethics/nationalguidelinesonresearchwithhumanandanimalsubjects/).

Lumalunga nantoni uphononongo?
Ngenxa yemingeni eyahluka-hlukeneyo echaphazela ukuzikhethela ngokuba nabantwana, kuquka ufikelelo kwiinkonzo zoqhomfo kumaqela oluntu asweleyo ngakumbi awasemaphandleni, iMarie Stopes South Africa (MSSA) inqwenela ukolula ubonelelo lweenkonzo zayo kwiMpuma Koloni esemaphandleni. Injongo yolu phononongo lophando kukuncedisa iMSSA ngogqaliso lokunikela ngeenkonzo zayo ukuze koyiswe izithintelo ekuzikhetheleni ukuba nabantwana, kuquka ukhathalelo loqhomfo olukhuselekileyo.
Kolu phando sinqwenela ukusebenzisa uluhlu lwemibuzo equka imizikelo yeentlobo zeendawo abantu abanokuthi bakhethe kuzo ukuze baqhomfe izisu. Ngokukhetha kwakho indawo onokuthi uyisebenzisa kumzekelo ngamnye siyakuthi siqonde ukuba ngeziphi iindawo ezikhethwa luluntu xa befuna iinkonzo zoqhomfo.
Siqhuba uludwe lwemibuzo olumalunga nama-600 kwiingingqi ezintathu eMpuma Koloni – kuquka phakathi kwabaphangeli basezifama kwinxenye esentshona yeli phondo, kwiilalii ezisemaphandleni phakathi kwaseMonti naseCawa (ePort Alfred), nakwinxenye ethe qelele kwingingqi kaMasipala waseMbhashe.

Kutheni umenywe ukuba ube nenxaxheba?
Ukhethwe ukuba ube nenxaxheba kolu phononongo ngenxa yolwazi lwakho olunzulu nengqiqo ecacileyo ngoluntu lwakho. Ubuzwa kudliwanondlebe 'njengomphenduli osentloko', oko kuthetha ukuba, uya kubuzwa imibuzo ngembonakaliso-zimvo, ngeemeko ezikhethwayo nangeengqiqo zoluntu ophakathi kwalo ngesihloko ekuthethwa ngaso.

Zinto zini ezingenaluncedo ngenxaxheba?
Akukho ncedo kuqobo lwakho olufumana ngokuba nenxaxheba. Asisayi kukucela ukuba unikele ngeenkcukacha zobuqu bakho. Nangona kunjalo, uphando lubandakanya iingxoxo ngezihloko ezithile ezinobuntununtunu ezifana noqhomfo. Siya kubonisa inkathalo ngobuntununtunu bezo zihloko. Nceda khululeka ulinqumamise uluhlu lwemibuzo nangeliphi ixesha uziva ungaphatheki kakuhle okanye ungasanqweneli kuqhuba ngalo. Ukuba, ngaso nasiphi isizathu, uziva unalo naluphi udandatheko ngenxaxheba yakho kuluhlu lwemibuzo, siya kwenza amalungiselelo okuba uthethe nomcebisi-zingxoxweni malunga nolo dandatheko.

Siya kuziphatha njani iinkcukacha zakho?
Uya kucelwa ukuba uzithiye igama elingelilo (igama elingeyonyaniso). Igama lakho lenene alisayi kushicilelwa nakwawaphi amaxwebhu abhaliweyo. Siya kuqinisekisa ukuba iinkcukacha zakho neempemdulo zakho zoluhlu lwemibuzo zigcinwa ngokhuseleko ekhompyutheni kwifayili ekhuselwe ngegama eliyimfihlelo nangokuthi okubhalwe ephepheni kugcinwe ngokhuselo kwiikhabhathi zeefayili ezitshixwayo. Iinkcukacha ziya kutshatyalaliswa emva kwethuba elinokufikelela kwiminyaka emi-5. Iikopi ziya kudluliselwa kwabanye abaphandi kwamanye amaziko kuphela ukuba bafanele ukuqhuba uhlalutyo kwaye kuya kufuneka ukuba bazigcine iifayili ngendlela enokhuseleko kuphela. Abaphandi abasayi kuzigcina iinkcukacha neempendulo zakho zoluhlu lwemibuzo kwiikhompyutha zabo abazisingathayo ezizezabo okanye kwizixhobo abaziphatha ezandleni kwithuba elingaphezu kweliyimfuneko ngokuqinisekisiweyo.

Ungakwazi na ukurhoxa kuphononongo?
Inxaxheba yakho kuphononongo yintando yakho kwaphela. Bonke abathathinxaxheba banelungelo lokurhoxa kuphononngo nangaliphi ixesha, kude kufikelelwe kwibanga lohlalutyo (kuJanyuwari ngo-2020). Abathathinxaxheba ngokunjalo banelungelo lokucima iinkcukacha zabo kwiprojekthi, kuquka izihlandlo zodliwanondlebe nezokutolika ngokubhala okukhodiweyo. Unakho ukwazisa abaphandi

abaziinkokeli elizweni ngokubabhalela okanye ngonxibelelwano lomlomo ngenjongo yakho yokurhoxa kuphando (jonga iinkcukacha ezingezantsi).

Ingaba ubophelelekile ukuba ube nenxaxheba?
Sixhomekeke kuwe isigqibo sokuba uyayithatha na inxaxheba okanye akunjalo. Ukuba wenza isigqibo sokuyithatha, uya kunikwa eli cwecwe leenkcukacha uze ucelwe ukuba usayine ifomu yemvume. Ukuba wenza isigqibo sokuba nenxaxheba, usakhululekile ukurhoxa nangeliphi ixesha unganikanga nesizathu.
Ukuthatha inxaxheba kolu phononongo asilovavanyo lolwazi lwakho ngoluntu okanye ngokukhethwayo malunga nokuba nabantwana. Akunyanzelekanga ukuba ube noluvo oluthile malunga nesihloko soqhomfo ukuze ube nenxaxheba kolu phononongo, ngokunjalo uluvo lwakho alunakujika lukubophelele. Igama lakho alisayi kuvela nakwawaphi amaxwebhu kolu phononongo, okanye nakweziphi iingxelo ezinokubonwa ngabahlobo, lusapho nangamanye amalungu oluntu okanye yiNGO yendawo yakho. Nokuba ukhetha ukuba nenxaxheba okanye akuthandi ukuba nayo, oko akusayi kuba nafuthe kwiindlela ophathwa ngazo kwixesha elizayo yiNGO okanye liqela eliqhuba uphando. Zonke iinkcukacha onikela ngazo ziya kugcinwa njengehlebo, kuphantsi kweemeko ezigqibelele ngokungafani nezinye kuphela (umzekelo, kwiimeko ezityhile okusuba ukonakalisa impilo, impilontle nokhuselo lomntu othile), apho ekuya kufuneka khona ngokusemthethweni ukuba umphandi agqithisele ezi nkcukacha emntwini okanye kwiarhente efanelekileyo.

Ziyintoni iinzuzo zenxaxheba?
Inxaxheba yakho iya kuba luncedo olukhulu kuthi ekuphangalaliseni ingqiqo yethu ngofikelelo kwiinkonzo zodidi zokucwangcisa iintsapho kwiingingqi ezisemaphandleni kwaye iya kuba nefuthe kwindlela iMarie Stopes eyila ngayo iintlobo zayo zongenelelo. Uya kunikwa imbuyekezo ngazo naziphi iindleko ozifumene ngokuya kwindawo olukuyo udliwanondlebe, kwaye bonke abathathinxaxheba siya kubanika ibhaso lombulelo ngexesha labo abalichitha ngokuba kudliwanondlebe.

Yintoni othatha inxaxheba kuyo?
Ngokuthatha inxaxheba, uya kukunikwa uluhlu lwemizekelo yeendawo onokuzikhetha xa ufuna iinkonzo zokuqhomfa isisu. Wena ke uya kukhetha indawo onokuthi uyikhethe xa ufuna ezinkonzo. Ukuphendula uluhlu lwemibuzo akuzikuthatha ixesha elingaphezulu kwemizuzu elishumi elinesihlanu (15).

Ndifanele ukwenza ntoni xa ndifuna ukuba nenxaxheba?
Umphandi uya kukunika iCwecwe leeNkcukacha aze aphendule nayiphi imibuzo onayo. Ukuba ukhululekile ngokuba nenxaxheba, nceda uzalise uze usayine iFomu yeMvume oyinikwayo, ngokunjalo zigcinele ikopi ibe nye. Kwakhona nceda ugcine eli Cwecwe leeNkcukacha.

Ngubani oququzelela nonika inkxaso yemali kolu phando?
Uphononongo luququzelelwa kwaye lukhokelwa ngabaphandi beYunivesithi yaseRhodes abasebenza kulwahlulelwano neNGO yendawo yayo. Olu phando lunikwa inkxaso yemali yiMarie Stopes South Africa.

Ngubani owamkele olu phononongo?
Olu phononongo lwamkelwe yiKomiti yeYunivesithi yaseRhodes yeeNqobo zokuSebenza (RUESC), nayiKomiti yeMarie Stopes yoPhengululo lweeNqobo zokuSebenza.

Kuza kwenzeka ntoni kwiziphumo zophononongo?
Sinesindululo sokupapasha okufunyaniswe kuphando njengengxelo yophando eya kusetyenziselwa ukunika iinkcukacha kwiMarie Stopes malunga nokolulwa ngokunjalo nokuphuculwa kweenkonzo zabo. Kwakhona siya kuvelisa amanqaku eejenali asekwe kwiinkcukacha eziqokelelweyo. Siya kunikela ngengxelo kuluntu lwakho malunga neziphumo nangaluphi uhlobo esilubone lufanele amalungu oluntu. Igama lakho alisayi kuvela kule ngxelo okanye nakweyiphi ingxelo okanye upapasho.

Ungaqhagamshelana njani nathi?
Ngazo naziphi iinkcukacha ezithe vetshe, nceda uqhagamshelane nabantu abalandelayo:

Umphandi oyinkokeli: Ulandi du Plessis, Critical Studies in Sexualities and Reproduction, Rhodes University, ulandidup@gmail.com, +2783 660 6018.

Intloko yeZiko: Catriona Macleod, Critical Studies in Sexualities and Reproduction, Rhodes University, c.macleod@ru.ac.za, +2782 802 9187.

Ukuba unazo naziphi iinkxalabo ngendlela eluqhutywa ngayo uphononongo, nceda uzive ukhululekile ukuqhagamshelana noSihlalo weRUESC oyiphengululeyo iprojekthi:

Roman Tandlich, Rhodes University Ethics Committee Chair, r.tandlich@ru.ac.za.

Siyakubulela ngexesha lakho olichithe ngokufunda eli cwecwe leenkcukacha.

Appendix 15: Fieldworker guide to the DCE

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

UHLOLO NGEMIKHWA NOKUKHETHWA NGABAFUNA UQHOMFO KULUNTU LWASEMAPHANDLENI EMPUMA KOLONI, EMZANTSI AFRIKA

FIELDWORKER INSTRUCTIONS FOR QUESTIONNAIRE

- The questionnaire should be administered to at least 200 people. Oluluhlu lwemibuzo kufuneka linikwe abantu abangama-200 ubuncinci.
- 150 – 170 of these people should be women and 30 – 50 people should be men. 150 ukuya kwi-170 kwaba bantu ingabafazi kwaye ama-30-50 abantu kufuneka babe ngamadoda
- All participants should be between the ages 18 and 45. Bonke abantu abathatha inxaxheba kufuneka babe phakathi kweminyaka 18 -45.
- It is preferred that you sit right next to the participant so that you can fill in the questionnaire together. You will guide them, while they tick the boxes. Kuyanqweneleka ukuba uhlale ngasekunene komthathi nxaxheba ukuze nizalise uluhlu lemibuzo kunye. Uya kubakhokela, ngelixa bephawula iibhokisi

STEP 1: Ask the person whether they would like to participate in a questionnaire. Buza umntu ukuba uyafuna nha uthatha inxaxheba koluluhlu mibuzo.

"We are doing a research study on the various challenges affecting reproductive choice, including abortion, in rural communities. We would like you to participate in a questionnaire. Would you like to participate?"

"Senza uphononongo lophando yemingeni eyahluka-hlukeneyo echaphazela ukuzikhethela ngokuba nabantwana,kuquka ufikelelo kwiinkonzo zoqhomfo kumaqela oluntu asweleyo ngakumbi awasemaphandleni. Singathanda ukuba uthathe inxaxheba koluluhlu mibuzo, ungathanda nha uthatha inxaxheba?"

STEP 2: If the person says yes, give them the information sheet and provide a summary of the information sheet. Ukuba lo umntu uyavuma, mnike icwecwe lencukacha umnike isishwankathelo leliphepha.

"The aim of the study is to assist Marie Stopes South Africa in focusing their service delivery to overcome barriers to reproductive choice, including safe abortion."

"Injongo yolu phononongo lophando kukuncedisa I Marie Stopes South Africa ngogqaliso lokunikela ngeenkonzo zayo ukuze koyiswe izithintelo ekuzikhetheleni ukuba nabantwana, kuquka ukhathalelo loqhomfo olukhuselekileyo."

"We are administering approximately 600 questionnaires across three areas in the Eastern Cape."

"Siqhuba uluhlu lwemibuzo olumalunga nama-600 kwiingingqi ezintathu eMpuma Koloni."

1

"Taking part in this study is not an evaluation of your knowledge of the community or of reproductive choices."

"Ukuthatha inxaxheba kolu phonononga asilovavanyo lolwazi lwakho loluntu okanye lokuzikhethela uzala."

"You do not have to have a particular viewpoint towards the topic of abortion to participate in this study, nor will your viewpoint be held against you."

"Akunyanzelekanga ukuba ube nembono ethile malunga nesihloko sokukhupha isisu ukuze uthathe inxaxheba kolu phando, nombona wakho awuyi kuba gwenxa kuwe."

"Your name will not appear on any documents or in any reports that might be seen by friends, family, other members of the community or the local NGO."

"Igama lakho alizukuvela kulo naluphi na uxwebhu okanye kuyo nayiphi na ingxelo enokuthi ibonwe ngabahlobo, usapho, amanye amalungu oluntu okanye i-NGO yasekuhlaleni."

"Whether you choose to take part or not will have no impact on your future dealings with the NGO or the research team. All information you provide will be kept confidential."

"Ukuba ukhetha ukuthatha inxaxheba okanye awuyi kuba naliphi na impembelelo ekusebenzisaneni kwakho nele-NGO okanye iqela lophando. Lonke ulwazi olunika lona luya kugcinwa luyimfihlo."

"The questionnaire consists of a list of hypothetical options where you will be required to state your preference. The questionnaire should not take longer than 15 minutes to complete."

"Oluluhlu mibuzo luqulathe Uluhlu lweenketho zentengiselwano apho kuya kufuneka ucele ukhetho lwakho. Ukuphendula uluhlu lwemibuzo akuzikuthatha ixesha elingaphezulu kwemizuzu elishumi elinesihlanu (15)."

"Please feel free to terminate the questionnaire at any point if you feel uncomfortable or do not wish to proceed. If, for any reason, you feel any distress in participating, we will arrange for you to speak to a counsellor concerning the distress."

"Sicela uzive ukhululekile ukuphelisa iphepha lemibuzo ngalo naliphi na ixesha ukuba uziva ungakhululekanga okanye unqwenela ukuqhubeka. Ukuba, nangasiphi na isizathu, uziva nayiphi na imbandezelo ekuthatheni inxaxheba, siya kulungiselela ukuba uthethe nomcebisi malunga nengxaki."

STEP 3: Ask them if they have any questions and answer their questions. Babuze ukuba ikhona imibuzo abanayo kwaye uphendule imibuzo yabo.

STEP 4: Hand the consent form to them and read out the statements one by one and ask them if they agree. If they agree, tick the box next to the statement. Write their name and surname at the bottom and ask them to sign. Put in the date, write your name and sign. Copy the number that is on the consent form into the box in the top left-hand corner of the questionnaire you are about to fill in with the participant. The participant's consent form and questionnaire should have the same number at the top.

Banike ifom yokuvuma kubo kwaye ufunde iingxelo nganye nganye kwaye ubabuze ukuba bayavuma na. Ukuba bayavuma, phawula ibhokisi ecaleni kwenkcazo. Bhala amagama abo nefani ezantsi kwaye ubacele ukuba basayine. Faka umhla, ubhale igama lakho kunye nesiginitsha. Khuphela inani elikwifom yemvume kwibhokisi ephezulu kwikona yasekhohlo kwiphepha lemibuzo osele uza kulizalisa kunye nomthathi-nxaxheba. Ifom yemvume yomthathi-nxaxheba kunye nekhweshine yemibuzo kufuneka inenombolo enye ngaphezulu.

STEP 5: Explain to them what Marie Stopes is. You can start off by asking them whether they have ever heard of Marie Stopes. If they have, ask them what they know of it. Then explain to them what Marie Stopes is and what their services entail. Cacisela abathathi nxaxheba ukuba yintoni Marie Stopes, ungaqala ngobabuza ukuba sekhe bava nha nge Marie Stopes. Ukuba sekhe bava, babuze bazi ntoni ngayo. Ulandele ucacise ukuba yinton Marie Stopes kwaye iinkonzo zabo zibandakanya ntoni.

"Marie Stopes is a private clinic that provides sexual and reproductive health services such as family planning, STI tests and treatment, cervical cancer screening, HIV counselling and other testing services. Their most important function is to provide abortion services. The service is not free, like at a public hospital, but they provide high quality care and the nurses and doctors are friendly, non-judgmental and will never talk about who went to the clinic or for what. A safe abortion, such as at a Marie Stopes clinic will not affect your future ability to get pregnant and will not put your life in danger. They also provide follow-up care."

"UMarie Stopes yikliniki yabucala ebonelela ngeenkonzo zempilo yezesondo nezokuzala ezifana nokucwangcisa usapho, uvavanyo lwe-STI kunye nonyango, ukuvavanywa komhlaza wesibeleko, ukucetyiswa i-HIV kunye nezinye iinkonzo zovavanyo.owona msebenzi wabo ubonakalayo kukubonelela ngenkonzo yokukhupha isisu. Le nkonzo ayikho mahala, njengasesibhedlele sikarhulumente, kodwa babonelela ngenkathalo ekumgangatho ophezulu kwaye abongikazi noogqirha banobuhlobo, abanakho ukugweba kwaye abanakuze bathethe malunga nokuba ngubani oye ekliniki okanye ngenxa yantoni. Ukukhupha isisu okukhuselekileyo, njengakwikliniki yaseMarie Stopes akuyi kuchaphazela amandla akho okukhulelwa kwaye akuyi kubeka ubomi bakho esichengeni. Ikwanikezela nononophelo lokulandela."

"They provide a medical abortion (point to medical abortion picture) to those women who are up to 12 weeks pregnant. This type of abortion entails going to the clinic and being given pills to drink and then going home. This takes about 15 minutes. The woman will have a heavy period for a week or two and will have to wear sanitary pads."

"Banikezela ngokuqhomfela kwezonyango (khomba umfanekiso wokukhipha isisu kwezonyango) kwabo bafazi abakhulele kwiiveki ezili-12 bekhulelwe. Olu hlobo lokukhupha isisu lubandakanya ukuya ekliniki kwaye unikwe iipilisi zokusela emva koko ugoduke. Oku kuthatha malunga nemizuzu eli-15. Ibhinqa liya kuba nexesha elinzima kangangeveki okanye ezimbini kwaye kuya kufuneka linxibe iipads zangasese."

"Then they provide a surgical abortion (point to surgical abortion picture) to those women who are up to 23 weeks pregnant. This abortion entails some work at the clinic from a doctor, but then the abortion is done. How long you will spend at the clinic will depend on how far along you are in the pregnancy, but it won't take longer than 3 to 6 hours. At the clinic you will be given all the information you need to manage the abortion and any cramping that occurs."

"Emva koko banikezela ngokukhupha isisu (khomba umfanekiso wokukhupha isisu) kwabo bafazi abakhulele kwiiveki ezingama-23 bekhulelwe. Oku kukhupha isisu kubandakanya umsebenzi othile eklinikhi ovela kugqirha, kodwa ke ukususuwa kwesisu kuyenziwa. Ukuba uza kuchitha ixesha elingakanani eklinikhi kuya kuxhomekeka ekubeni ukude kangakanani kukhulelwe, kodwa ayizukuthatha ixesha elingaphezulu kweeyure ezintathu ukuya kwezi-6. Ekliniki uya kunikwa lonke ulwazi oludingayo lokulawula isisu kunye nokuxinana okwenzeka."

"There is currently a Marie Stopes clinic in East London. Marie Stopes is thinking about opening more of them in the Eastern Cape and the research we are doing now is to help them make the right decisions as to what these clinics should look like and offer."

"Kukho ikliniki yaseMarie Stopes eMonti . UMarie Stopes ucinga ngokuvula uninzi lwazo eMpuma-Kapa kwaye olu phando silwenzayo ngoku kukubanceda ukuba benze izigqibo ezichanekileyo zokuba ezi klinikhi zifanele ukubonakala kwaye zinikezela ngantoni."

STEP 6: Ask if they have any questions. Buza ukuba abanayo imibuzo nha

STEP 7: Go through the supplemental questions one by one. If there are questions they do not want to answer, they do not have to. Yiya kwimibuzo eyongezelelweyo nganye nganye. Ukuba kukho imibuzo abangafuni kuyiphendula, akufuneki.

STEP 8: Using the laminated picture sheet, explain the meaning of each picture. Usebenzisa iphepha lokufota lamanzi, cacisa intsingiselo yomfanekiso ngamnye.

The following are the options for facility type:

Oku kulandelayo lukhetho lohlobo lwendawo:

1. Marie Stopes's clinic in a government hospital or clinic. Ikliniki yaseMarie Stopes kwisibhedlele sikarhulumente okanye eklinikhi

Marie Stopes wants to know if you would prefer to go to their clinic if it were inside a government hospital or clinic. This is the picture for it.

UMarie Stopes ufuna ukwazi ukuba ungathanda ukuya ekliniki yabo ukuba ingaphakathi kwesibhedlele sikarhulumente okanye eklinikhi. Lo ngumfanekiso wayo

2. Stand-alone Marie Stopes clinic. Ikliniki yaseMarie Stopes ezimele yodwa.

Like the clinic mentioned in East London, this clinic is situated in its own building. This is the picture for it. Njengeklinikhi ekhankanywe eMonti, le klinikhi imi kwisakhiwo sayo. Lo ngumfanekiso wayo.

3. Marie Stope mobile clinic. Ikliniki yaseMarie Stope esemotweni.

There is the option where Marie Stopes can send out a van that drives around rural areas and stops in a particular village each day. This van will only be able to do the medical abortion – the ones with the pills. They might provide other services like contraception and STI testing too though. Kukho ukhetho apho uMarie Stopes angathumela iveni eqhuba ujikeleze imimandla yasemaphandleni kunye nokuma kwilali ethile mihla le. Leveni iya kukwazi ukwenza isisu sonyango kuphela - kunye nezo iipilisi. Banokubonelela ngezinye iinkonzo ezinje ngokuthintela ukukhulelwa kunye novavanyo lwe-STI.

4. Marie Stopes clinic in a pharmacy.
   Ikliniki yaseMarie Stopes kwikhemesti.

Marie Stopes wants to know if you would prefer to go to their clinic if it were inside a pharmacy. This is a picture of it. UMarie Stopes ufuna ukwazi ukuba ungathanda ukuya ekliniki yabo ukuba ingaphakathi kwekhemesti. Lo ngumfanekiso wayo

5. Marie Stopes clinic partnered with a traditional health practice.
   Ikliniki yaseMarie Stopes ibambisene nenkqubo yezempilo yesintu.

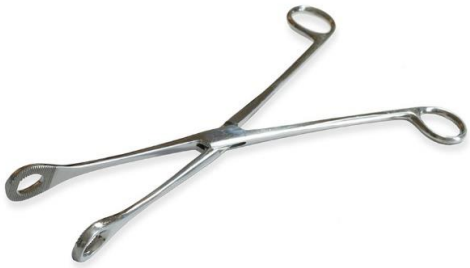
Marie Stopes wants to know if you would prefer to go to their clinic if they partnered with a local traditional healer. UMarie Stopes ufuna ukwazi ukuba ungathanda ukuya kwiklinikhi yabo ukuba bangadibana nomnyangi wemveli wengingqi.

The following are the options for services offered at the facility:

Oku kulandelayo kukhetho lweenkonzo ezinikezelwa kwindawo:

1. Abortions only.
   Ukukhupha isisu kuphela

This facility only does abortions. Eli ziko likupha izisu qha.

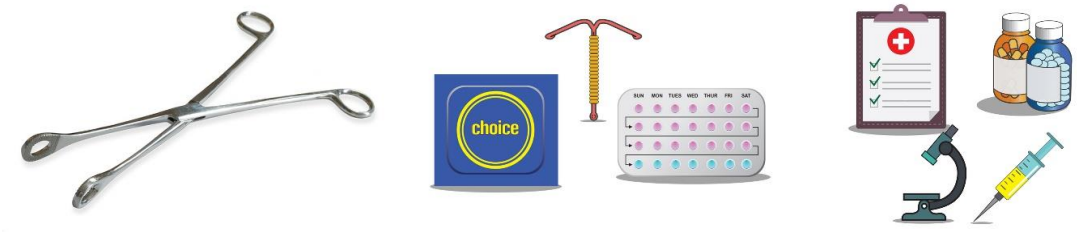


2. Abortions and contraceptives.
   Ukukhupha isisu kunye nokuthintela inzala.

This facility provides abortions and contraceptives. Eli ziko libonelela ngokukhupha isisu kunye nokuthintela inzala.

3. Abortions, contraceptives, and other health services.
   Ukukhupha isisu, ukuthintela inzala, kunye nezinye iinkonzo zempilo.

This facility provides abortions and contraceptives and other health services such as STI testing, cervical cancer screening, etc. Eli ziko libonelela ngokukhupha isisu kunye nokuthintela inzala kunye nezinye iinkonzo zempilo ezinje ngovavanyo lwe-STI, uvavanyo lomhlaza wesibeleko,

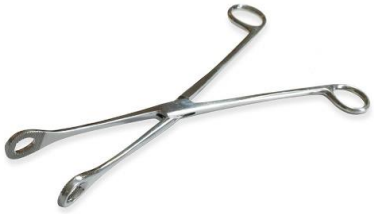


The following are the options for type of abortion offered at the facility:

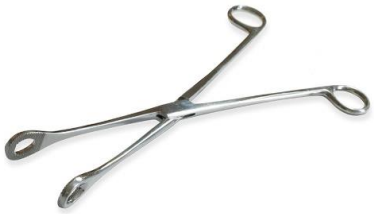
Oku kulandelayo kukhetho lohlobo lwesisu esibonelelwa kwindawo leyo:

1. Medical abortion (up to 12 weeks pregnant)
   Ukukhupha isisu kwezonyango (ukuya kwiiveki ezili-12 ukhulelwe).

2. Surgical abortion (up to 23 weeks pregnant)
   Ukukhupha isisu ngotyando (ukuya kwiiveki ezingama-23 ukhulelwe).



3. Both medical and surgical abortion.
   Zombini intlobo zokhupha izisu.



The following are the options of where the facility is situated:

Oku kulandelayo kukhetho apho indawo ikhoyo:

1. The facility is in my village/township/community.
   Indawo le ilapha kwilali yam / kwilokishi / ekuhlaleni.

2. The facility is in a nearby village/township/community.
   Indawo leyo inga kwilali ekufutshane / kwilokishi / ekuhlaleni.

4. The facility is in the nearest town.
   Indawo le ikwi dolophu ekufuphi.

3. The facility is in the nearest city.
   Indawo le ikwi sixeko esikufuphi.

The following are the options for cost at the facility:

Oku kulandelayo kukhetho lweendleko kwiziko:

1. The service is free (excluding transport).
   Le nkonzo ayihlawulelwanga (ngaphandle kwezothutho)
2. The service costs R500 (excluding transport).
   Inkonzo ixabisa i-R500 (ngaphandle kwezothutho)
3. The service costs R800 (excluding transport).
   Inkonzo ixabisa i-R800 (ngaphandle kwezothutho).
4. The service costs R1400 (excluding transport).
   Inkonzo ixabisa i-R1400 (ngaphandle kwezothutho).

The following are the options for opening hours and days of the facility:

Oku kulandelayo kukhetho lokuvula iiyure kunye neentsuku zesibonelelo:

1. The service is available Monday to Friday; 8:30AM – 4:30PM
   Kuvulwa ngo8:30 kusasa kuyovalwa ngo 4:30 emva kwe dinara, ukuqala ngoMvulo uyotsho ngoMgqibelo
2. Monday to Friday for extended opening hours so 08:30 – 10PM
   Ngomvulo ukuya ngoLwesihlanu amaxesha ongeziweyo, kuvulwa ngo 08:30 ukuya ngo 10:00
3. The service is available Monday to Saturday 8:30 – 4:30PM
   Le nkonzo ifumaneka veki nganye ngoMvulo ukuya ngoMgqibelo, 08:30 ukuya 16:30
4. The service is available every week Monday to Saturday, but for extended hours, so 08:30 to 10 o'clock at night.
   Le nkonzo ifumaneka veki nganye ngoMvulo ukuya ngoMgqibelo, kodwa iiyure ezandisiweyo, kunjalo ngo-08: 30 ukuya ku-10 ebusuku.

STEP 9: Explain how the questionnaire will work. Cacisa ukuba uluhlu mibuzo luzohamba njani

"So in filling in this questionnaire you must try to imagine you have decided to have an abortion, for whatever reason, it doesn't matter, but you need an abortion service and you have to weigh up the pros and cons of the different options. If you know you would never have an abortion, then imagine someone else who might, for whatever reason, decide they want to or need to have an abortion. Try and think of all the types of obstacles that lie ahead of a person who wants an abortion and let it inform your choices here."

"Ke xa ugcwalisa eli phepha lemibuzo kufuneka uzame ukucinga ukuba ugqibe ekubeni usikhuphe isisu, nangasiphi na isizathu, ayinamsebenzi, kodwa ufuna inkonzo yokuqhomfa kwaye kufuneka ulinganise iinzuzo neendlela zokhetho ezahlukeneyo. Ukuba uyazi ukuba ngekhe ukhuphe isisu, cinga ngomnye umntu onokuthi, nangasiphi na isizathu, athathe isigqibo sokuba uyafuna okanye ufuna ukukhupha isisu. Zama kwaye ucinga ngazo zonke iintlobo zezithintelo eziphambi komntu ofuna ukukhupha isisu kwaye makazise ukhetho lwakho apha."

"I've got X amount of choice sets here. Each choice set gives you X different facilities to choose from. Each time the facility will have a different set of characteristics and you must decide which one you would most rather pick considering the set of facility options and their characteristics you are presented with."

"In the first one here you will see the first facility option has the following characteristics…"

"Ndinomthamo we-X weeseti zokhetho apha. Iseti nganye yokhetho ikunika izibonelelo ezahlukeneyo ze-X onokuthi ukhethe kuzo. Ngalo lonke ixesha indawo leyo iza kuba neseti yeempawu ezahlukileyo kwaye kufuneka uthathe isigqibo sokuba yeyiphi onokuthi ukhethe ngokukhetha iiseti zezinto onokukhetha kuzo kunye neempawu ozibonakalisiweyo. Kwinto yokuqala apha uza kubona indlela yokhetho lokuqala eneempawu ezilandelayo."

STEP 10: Ask the final supplemental questions. Buza imibuzo yokugqibela eyongezelelweyo.

STEP 11: Thank the participant and give them their token of appreciation. You should now have a filled in questionnaire and a signed consent form with the same number at the top. Bulela abathathi-nxaxheba kwaye ubanike uphawu lwabo lombulelo. Kuya kufuneka ngoku ube ugcwalise iphepha lemibuzo kunye nefom esayiniweyo yemvume nenombolo enye ngaphezulu.

SOME CONCERNS ABOUT ETHICS IN RESEARCH

EZINYE IZINXIBELELWANO NGEETHICS KOPHANDO

It is important that you don't talk to anyone about who the people are that filled in the questionnaire, or what answers they gave. You must make sure they know that you won't do this.

Kubalulekile ukuba ungathethi namntu malunga nokuba ngoobani abantu abagcwalise kwiphepha lemibuzo, okanye zeziphi iimpendulo abazinikileyo. Kufuneka uqiniseke ukuba bayazi ukuba awuzukwenza le nto.

Participants should be free to answer the questions freely. Do not make suggestions as to what you think will be best. You are not a home-based carer today, you are a researcher.

Abathathi-nxaxheba kufuneka bakhululeke ukuba baphendule imibuzo ngokukhululekileyo. Sukwenza izindululo malunga nokuba ucinga ntoni na. Awunguye umntu okhathalela abantwana ekhaya, namhlanje ungumphandi.

If someone feels uncomfortable with the topic, ask them again if they would like to continue. They should not feel obliged to do it. It is not a problem if someone withdraws in the middle of a questionnaire or say they don't want to in the beginning.

Ukuba umntu uziva ungakhululekanga ngesihloko, bacele kwakhona ukuba banqwenela ukuqhubeka. Abafanele bazive benyanzelekile ukuba bayenze. Akusiyongxaki ukuba umntu urhoxe phakathi kwiphepha lemibuzo okanye athi abafuni kwasekuqaleni.

Appendix 16: Icons and descriptions for DCE images

Ikliniki yaseMarie Stopes ekwisibhedlele okanye ikliniki yakaRhulumente

Ikliniki yaseMarie Stopes esebenzisana nendawo enyanga ngokwesintu

Ikliniki yaseMarie Stopes ezimele yodwa

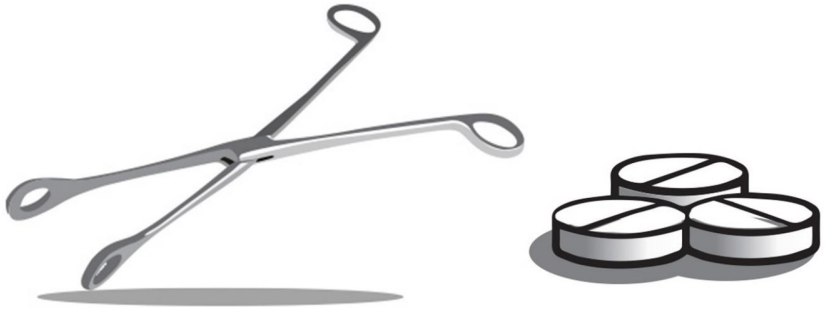
Ikliniki yaseMarie Stopes ekwivenkile yamayeza

Ikliniki yaseMarie Stopes ekwisibhedlele okanye ikliniki yakaRhulumente

Ukuqhomfa isisu ngokusebenzisa iipilisi (Zingekadluli iiveki ezi-yi-12 umntu emithi)

Ukuqhomfa isisu ngokotyando (Phakathi kweeveki eziyi-12 ukuyela kweziyi-24 umntu emithi)

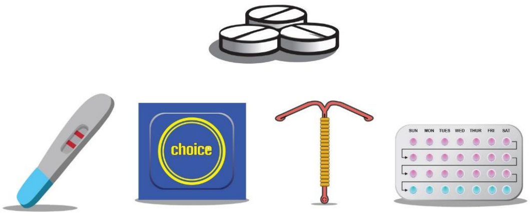
Ukuqhomfa isisu ngokotyando nokuqhomfa isisu ngokusebenzisa iipilisi (Zingekadluli iiveki ziyi-24 umntu emithi)



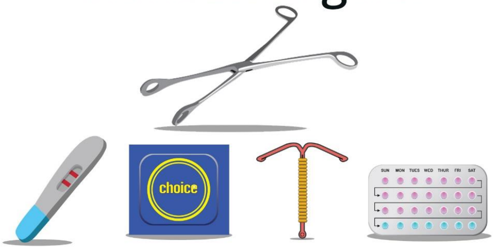
Ukuqhomfa kodwa

Ukuqhomfa kodwa

Iinkonzo zokuqhomfa nokucwangcisa



Iinkonzo zokuqhomfa nokucwangcisa



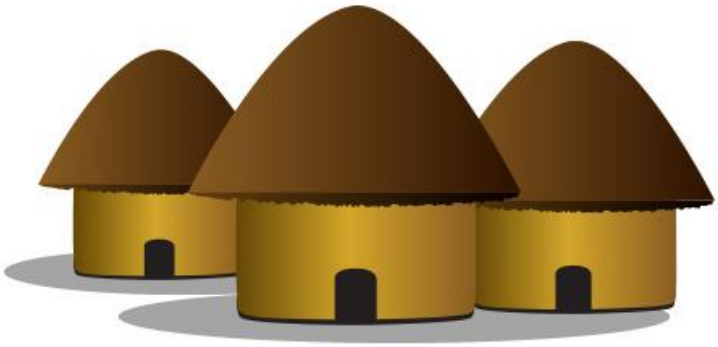
Iinkonzo zokuqhomfa nokucwangcisa

Ukuqhomfa nezinye iinkonzo eziquka uvavanyo lwezifo ezibangelwa kukwabelana ngokwesondo: uvavanyo lomhlaza wesibeleko, njalo njalo

Ukuqhomfa nezinye iinkonzo eziquka uvavanyo lwezifo ezibangelwa kukwabelana ngokwesondo: uvavanyo lomhlaza wesibeleko, njalo njalo

Ukuqhomfa nezinye iinkonzo eziquka uvavanyo lwezifo ezibangelwa kukwabelana ngokwesondo: uvavanyo lomhlaza wesibeleko, njalo njalo

Kwilali yam/
kuluntu lwam



Kwilali/kuluntu/
kwilokishi
esondele kum

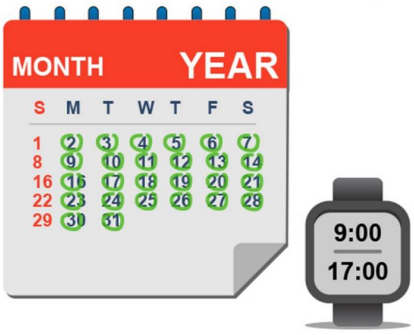
Kwidolophu esondele kum

Kwidolophu enkulu esondele kum

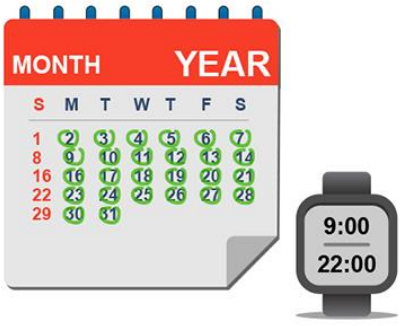
Kuvulwa ngo9:00 kusasa kuyovalwa ngo5:00 emva kwe dinara, ukuqala ngoMvulo uyotsho ngoMgqibelo

Ngomvulo ukuya ngoLwesihlanu amaxesha ongeziweyo, kuvulwa ngo 09AM ukuya ngo 10PM

Le nkonzo ifumaneka veki nganye ngoMvulo ukuya ngoMgqibelo, 08:30 ukuya 16:30

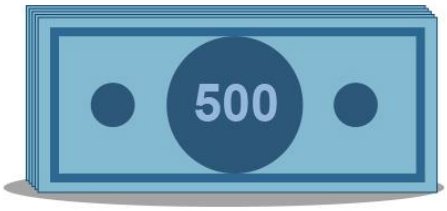


Le nkonzo ifumaneka veki nganye ngoMvulo ukuya ngoMgqibelo, 09:00 ukuya 17:00



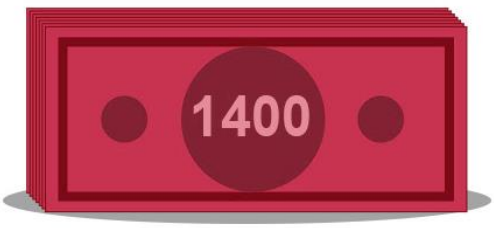
Akukho xabiso libizwayo
(Ngaphandle kwemali yokukhwela)

R500
(Ngaphandle kwemali yokukhwela)



R800
(Ngaphandle kwemali yokukhwela)

R1400
(Ngaphandle kwemali yokukhwela)



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