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

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

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Preparation for Marie Stopes South Africa, May 2020

Contents

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Executive summary

In the Choice on Termination of Pregnancy Act (Act No. 92 of 1996) (henceforth CTOP Act), the decision to terminate a pregnancy within the first 12 weeks of gestation is placed with the pregnant woman, with the grounds for granting an abortion thereafter being relatively open (including continuing pregnancy affecting the woman socio-economically). Despite the promise of the CTOP Act, and initial indications of its implementation leading to decreased maternal morbidity and mortality, several challenges have been noted. Considering these concerns, MSSA wishes to offer appropriate information and service provision to rural populations in the Eastern Cape of South Africa. 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 people living in rural areas. Currently MSSA only operates in seven of the nine South African provinces and has no presence in rural areas.

This research project was conducted in the Eastern Cape Province of South Africa

Other research in South Africa points to the following:

- There is significant evidence of illegal and unsafe abortion taking place, despite the liberal abortion legislation. Reasons for accessing informal services provided by womxn[1] 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.
- Womxn's choice of providers is influenced by many factors, including the quality of the service, travelling distance, availability of funds, privacy and confidentiality, the type of procedures offered, cleanliness, staff competency, positive attitudes of staff, speed of service, the possibility of obtaining family planning afterwards, and fear of traditional medicines or providers.
- Significant barriers to accessing formal abortion services include: 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. Health service providers tend to be resistant to the second trimester dilation and evacuation (D&E) procedure, mainly because it means more active provider involvement. There is also a lack of infrastructure, physical space and personnel to respond to the demands for second trimester abortion.
- 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.

1 We use the word "womxn" in acknowledgement of gender diversity.

- 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.
- For HIV-positive womxn, stigma adheres not only to an abortion, but also, contradictorily, to the pregnancy itself. Young womxn may also be subject to more stigma than older womxn. While womxn experience significant stigma in terms of abortion, health professionals who do offer the service may also face negativity.

Methodology

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). The DCE design 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. The study population was individuals living in rural Eastern Cape communities. Given the diversity of the province, three sites were selected based on the Municipal Demarcation Board's classifications. Purposive and snowball sampling were employed for the qualitative portion of the study and cluster sampling for the quantitative portion. In each site we conducted in-depth interviews with 20 individuals between the ages of 18 and 45. DCE questionnaires were administered to 616 participants across the three sites (207, 209, and 200 respectively). An expert panel was consulted throughout the research process, and a partnership was formed with a local organisation in each site. 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.

Findings and recommendations relevant to planning

In this section on planning, we outline what the findings mean in terms of MSSA's aim of launching service delivery models that are acceptable to rural populations in the Eastern Cape. This includes preferences for facility type, services and types of abortions offered in the facility, travel and cost requirements to attend the facility, and preferred opening times.

Preferences for facility type

> Confidentiality is especially important to womxn seeking abortions.

> 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. The differences can be explained by participants' experiences with the current healthcare contexts of the three communities.

> The least preferred option was the MS clinic partnered with a traditional healer. When it comes to abortions, traditional healers are not trusted.

Recommendations:

> A catchment area approach should be taken in relation to facility type. 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.

> Mechanisms to ensure confidentiality are: no obvious external indication concerning the particular service being offered; locating a clinic next to other facilities that draw people. The entrance to the clinic should not, however, be located where people congregate.

Preferences in terms of services

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, a range of services should be offered. This finding dovetails with the qualitative findings regarding confidentiality.

> 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.

> The type of additional services could be decided upon after consultation with local NGOs about the needs in the particular community.

> Offering both first and second trimester abortion is strongly recommended.

Preferences in abortion type offered by facility

Medication abortion is preferred over surgical abortion. Disaggregation by site produces a different picture, however. It is possible that preference for medication abortion in sites 1 and 2 is related to the strong need for confidentiality in these sites, with medication abortion avoiding the need for a longer clinic stay.

Recommendations:

> Clinics should stock and offer medication abortion, where possible.

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

> The preference for medication abortion may have implications in terms of the training of providers and the stocking of clinics with abortion commodities. Were only medication abortions provided (e.g. in mobile clinics), these services would be used and appreciated.

Preferences in travel requirements to attend facility

> There is ambivalence about traveling for an abortion: (1) the costs of travelling are clearly a barrier to accessing an abortion; (2) participants expressed the need to travel far in order to maintain confidentiality.

> The pooled DCE data show a preference for a facility located within participants' village followed closely by a facility located in the nearest city.

> Site 2's results show no statistical differences between the various options, which may have to do with its relative proximity to a small town and a major city.

Recommendations:

> A catchment area approach to the provision of services in rural areas should be taken.

> Rural villages in the Eastern Cape are spread over hundreds of square kilometres; servicing these areas might require unconventional approaches, e.g. home visits by community health workers, telephonic consultations, limit the number of visits womxn need to make to the clinic.

> Telemedicine is a new option for rural communities since the COVID-19 outbreak. Local service providers (e.g. pharmacists and other primary care providers) could act as package pick up points. While the telemedicine model maintains clients' confidentiality and reduces costs (transportation, opportunity costs), it was also the second least favoured option by respondents. Its use would need to be accompanied with clear messages about its safety and the quality of services provided.

Preferences in cost requirements to attend facility

Distance is obviously connected to the question of costs.

No cost is preferred. Pooled data showed that participants preferred to pay R500 followed closely by R1400 which might indicate that paying for an abortion is not completely out of the question to those who are looking for a service with specific characteristics.

Recommendations:

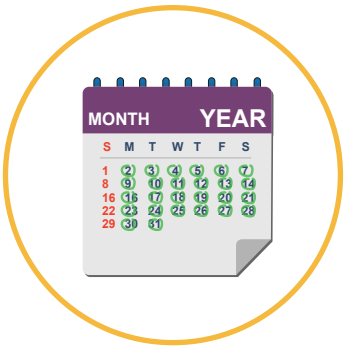
> MS should look at ways to subsidise their (future) rural clinics to increase usage, especially as womxn will incur expenses travelling.

> Where payment is required, R500 seems to be the most acceptable.

> MS should also consider finding ways to provide free contraceptive services and free pregnancy tests, if possible. Partnering with local NGOs and training their community healthcare workers in assisting womxn with pregnancy detection could also potentially reduce costs.

> 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.

> Given the low resource base in rural communities, the financial sustainability of models developed in rural areas will need consideration, including the possibility of cross-subsidisation.



Preferences in opening times of facility

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.

In site 1, the extension of hours to Saturday is a more prominent preference. 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:

> Extended hours over weekends are recommended if only one clinic is opened. . If a dual catchment area approach is taken, hours could be adjusted to suit the type of clinic.

Findings and recommendations for implementation

In this section on implementation, we outline what the findings mean in terms of MSSA's aim of reducing barriers to safe abortion care, reducing stigma, and ensuring access to quality service provision for people living in rural areas. This includes recommendations in relation to knowledge of abortion laws, procedures and facilities, attitudes and understandings of abortion, barriers to abortion and the decision-making process.

Knowledge of abortion laws, procedures, and facilities

> Knowledge of the legality of abortion was relatively good, as well as knowledge of the existence of abortion facilities.

> Clinics and hospitals were seen as the most reliable sources of knowledge. In relation to other forms of communication, participants prefer traditional non-interactive media (pamphlets, posters, radio, and TV) followed by trusted others, including family, friends and home-based carers.

Recommendations:

> Continued information provision and normalisation of abortion is important. MSSA should introduce marketing approaches that will meet the information needs of rural communities.

> With support from MSSA, community health workers could also assist with disseminating such information, and with referrals where necessary.

> Given the remoteness of many rural areas, MSSA could consider using local and community radio stations and organising events within rural communities.

Community attitudes and understandings of abortion

> Many participants viewed abortion as 'not right' or equated it with murder.

> Despite this, participants indicated that abortion was a disputed subject in the community. Circumstantial acceptance of abortion was mentioned by participants.

> Womxn who have undergone an abortion are likely to be judged. 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. Married womxn who abort were depicted as the most stigmatised.

> Communities are in favour of abortion in the case of rape, except if a womxn is raped by somebody she knows. Worryingly, some participants said that the community would blame the rape on the victim.

> Pregnant teenagers are stigmatised, potentially resulting in their being coerced to terminate their pregnancy.

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.[See report for recommendations to effect these].

Barriers to having an abortion

> Fear of breaches of confidentiality. Desire for confidentiality was linked to stigma.

> The distance to clinics means that if womxn do not have money for travel, they might have to take risk breaches of confidentiality or forfeit their right to an abortion.

> Fear of hostility towards abortion at public health clinics or from those to whom womxn turn for advice

> Conception partner's attitude or lack of support.

> Fear of legal abortions, which are tainted by poor consequences of illegal abortions, including those performed by traditional healers.

Recommendations:

> Emphasis on the extreme importance of confidentiality in training providers and all employees.

> Public campaigns that address myths relating to the physical or psychological consequences of safe abortion provision.

> Forming partnerships with local public health clinics, civil society organisations and local NGOs to ensure smooth referral and that womxn are not discouraged from accessing services.

> It may be useful for MSSA to partner with NGOs that work on issues of masculinities to address the gender dynamics.

> Engage local healers about the importance of safe abortion procedures and the need for referral.

The abortion decision-making process

> The most prominent reasons given for an abortion were connected to the conception partner, including abandonment, paternity denial and lack of support.

> Families, especially parents, can be important support structures, but may also be hostile in the context of unplanned pregnancies.

> A major factor is finances.

> Pregnancy may be seen as a stressful and expensive process.

Recommendations:

> Service providers should be alert to the social dynamics that may underpin the decision-making process.

> Training community health workers in the listening skills required to assist womxn in making an autonomous decision may be useful.

> Peer support mechanisms and a positive work environment would assist with healthcare providers should be in place for healthcare providers.

The recommendations are consolidated in the conclusion of this report in relation to: approach and planning facilities, partnerships, mechanisms to ensure confidentiality, training, and marketing.

Introduction

The CTOP Act (*Choice on Termination of Pregnancy 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 woman, with the grounds for granting an abortion thereafter being relatively open (including continuing pregnancy affecting the woman socio-economically).

The CTOP Act (*Choice on Termination of Pregnancy Act No.92 of 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 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 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 Department of Health designation (Moodley & Akinsooto, 2003) or use herbal infusions to self-abort (Harries et al., 2012).

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 people living in rural areas. 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.

This is the short report for the study entitled *An Assessment of Abortion Seeking Behaviours and Preferences in Rural Communities of the Eastern Cape, South Africa.* In this report we present the background of the study against the backdrop of current research in the country. We outline the design and methodology used in the study and we present the findings and recommendations from the data. For an in-depth discussion of the study and its findings, please refer to the *long report.*

Background

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 section, South African studies exploring the following are discussed: factors relating to service preferences; barriers to accessing abortion services; and experiences of womxn seeking abortion services.

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 wide range of products 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 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 (Belay & Sendo, 2016; Penfold et al., 2018). 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., 2015). 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., 2015). 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, 2020; C. I. 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 et al., 2007) Within the actual healthcare sessions, providers may impose their own religious beliefs during counselling or consultation (Harries et al., 2007). Hodes (2016) 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.(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 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 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 et al., 2007).

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. (Dickson et al., 2003) 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.

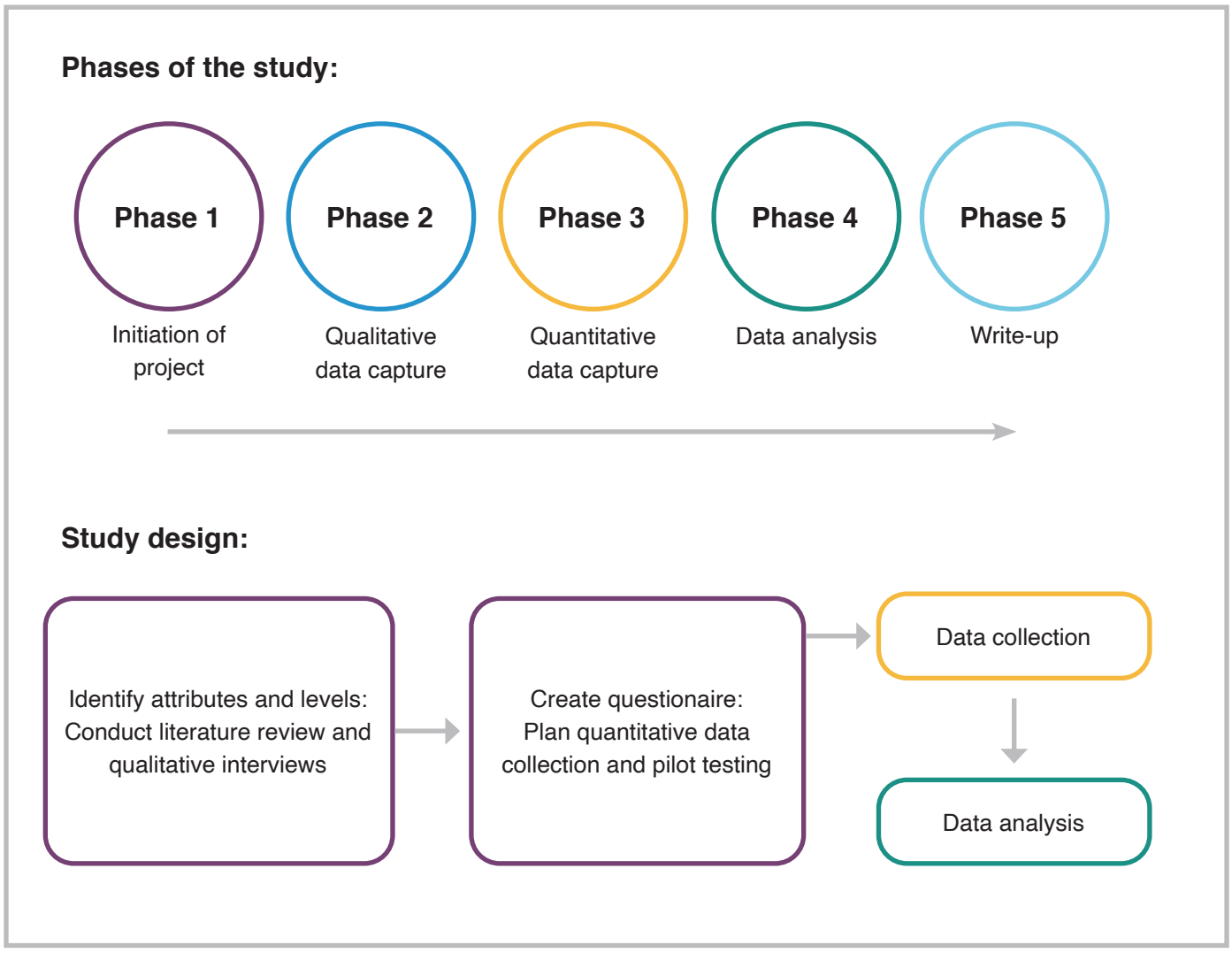
Additionally, a study by Kaswa et al. (2018) found that having to travel to other towns or cities in search of abortion services is costly not only financially, but also emotionally. For unemployed womxn living in poor socioeconomic conditions, having to travel far may involve having to make childcare 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.

Methods

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).

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 (Blaauw et al., 2010; Kruk et al., 2010), and potential users of health services.

The 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.



Research questions

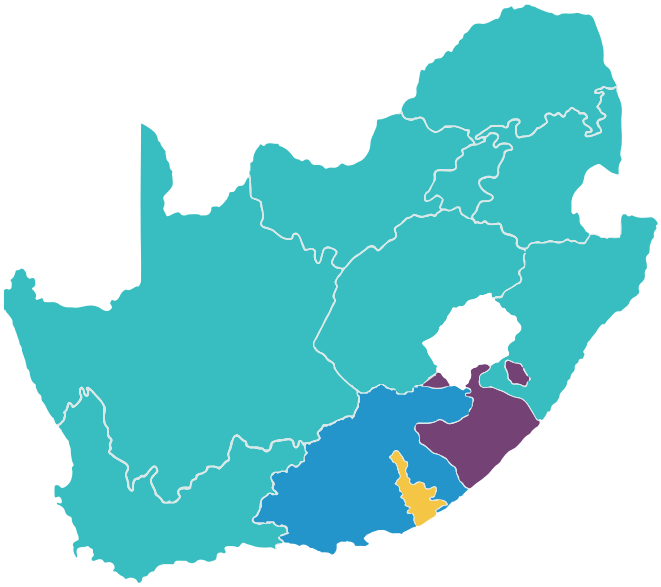
The following research questions guided the study:

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?

Data sampling and research sites

The study population was individuals living in rural Eastern Cape communities. 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). 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 (Statistics South Africa, 2017) 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 show 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.

Rural populations in the Eastern Cape 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.



Research sites:

Eastern Cape Province

Transkei - site 1

Ciskei - site 2

Commerical farming - site 3

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. We identified three separate communities, each with slightly different geographical characteristics. One area, in the former Transkei, is far away from any town or city (site 1); the second, in the former Ciskei, is closer to a town (site 2); and the third is in a commercial farming community closer to a city (site 3).

Purposive and snowball sampling were employed for the qualitative portion of the study and cluster sampling for the quantitative portion. Sampling and recruitment were 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.

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 (see long report appendix) 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.

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. Each partner organisation nominated a panel member who provided specialised input. These panel members are either members of the local community or work closely with the local community. Partnership agreements laying out partner involvement and expectations were written up and signed. Partner involvement included providing expert feedback in the panel, assisting with recruitment of participants, training of home-based carers, and collecting data using the DCE.

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. The strengths and limitations of the study are outlined in detail in the longer research report.

Findings and recommendations

The findings of this study 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.

Findings and recommendations relevant to planning

This section aims to contribute towards MSSA's aim of launching service delivery models that are acceptable to rural populations in the Eastern Cape. 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.

Pooled preferences for facility type

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

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

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 although it is important to bear in mind that the male pool size is very small.

Preferences for facility type according to sex

WOMXN

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

MXN

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

Recommendations: Preferences for facility type

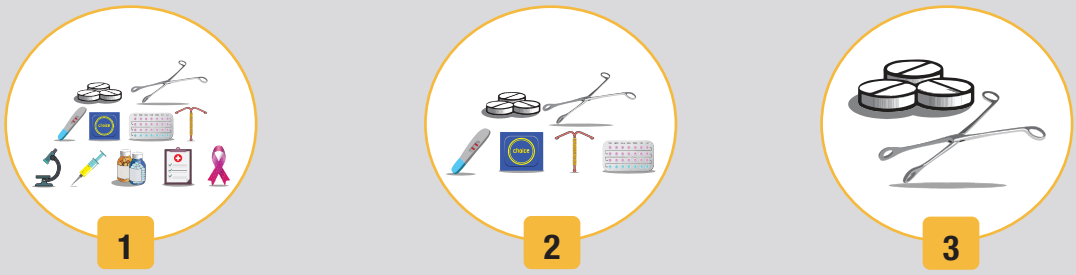
- Given the diversity of responses across the sites, it may be of benefit to open clinics in different forms depending on the type of rural area in which the clinics will be located. In other words, a catchment area approach should be taken.

- 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:
  - 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.
  - 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.

Preferences for services



Recommendations: Preferences in terms of services

- 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.

Pooled preferences for abortion type

Recommendations: Preferences for abortion type

- 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.

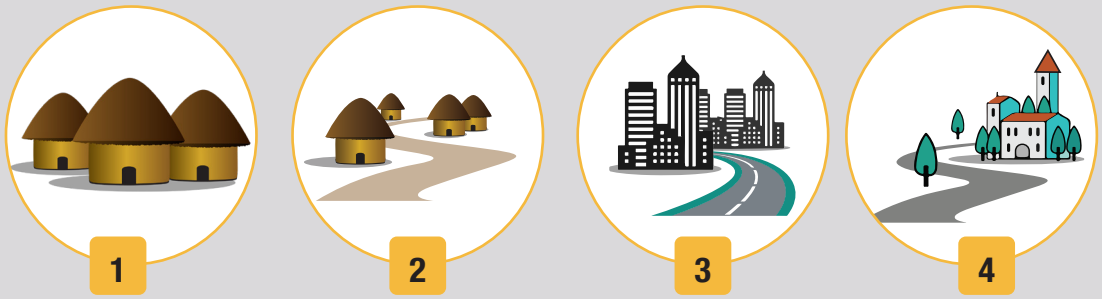
Preferences in travel requirements to attend facility

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.

Pooled preferences for location of facility



Recommendations: Preferences in travel requirements to attend facility

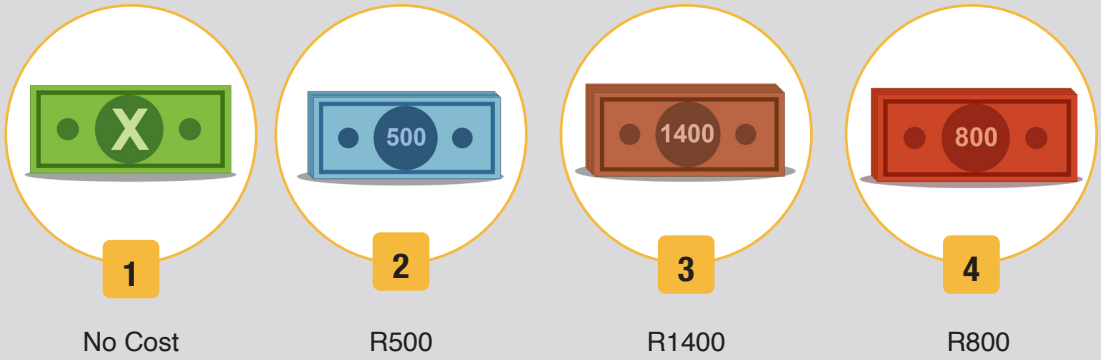
- Combined, these results point to the possibility of a catchment area approach to the provision of services in rural areas. Those rural areas close to towns or cities may be serviced by facilities in towns or cities, while those further afield may need services within their own village as well, probably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

Pooled preferences for cost requirements to attend facility



Recommendations: Preferences for cost requirements to attend facility

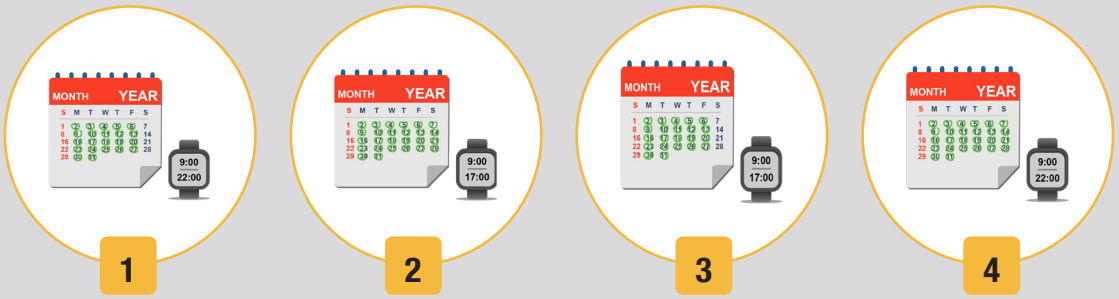
- Given the low resources in these communities, no payment will obviously be people's first choice. As such, it is recommended that MS looks at ways to subsidise their rural clinics to increase usage.
- If payment is required, R500 seems to be the most acceptable. Several participants stated in the interviews 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.

Preferences for opening times of facility

Pooled preferences:



Recommendation: Preferences for opening times of facility

- 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.

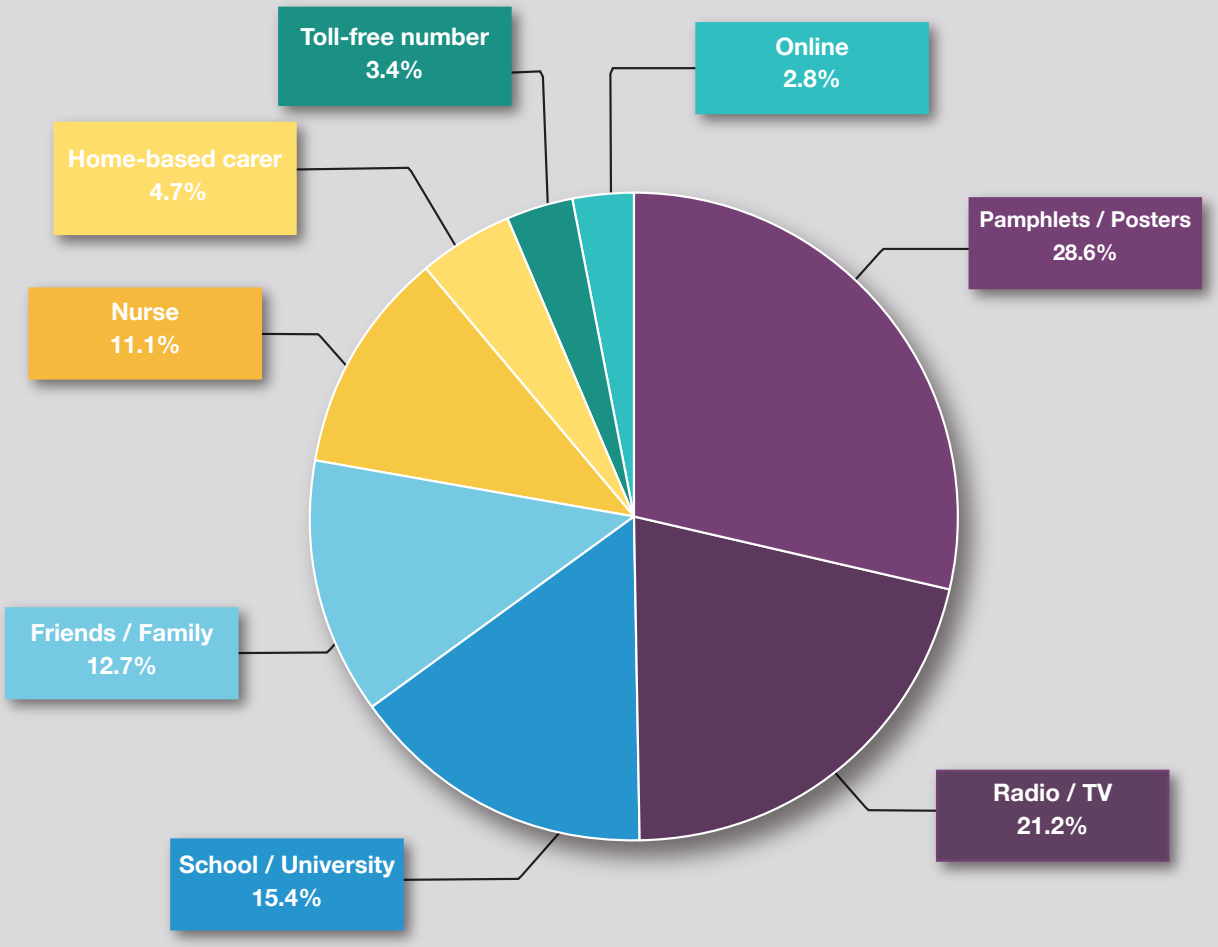
The quantitative data showed that participants prefer traditional non-interactive media (pamphlets, posters, radio and TV) followed by trusted others, including family, friends and home-based carers.

Recommendations: Preferred information sources

- 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.

First preference of information source on abortion

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.



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.

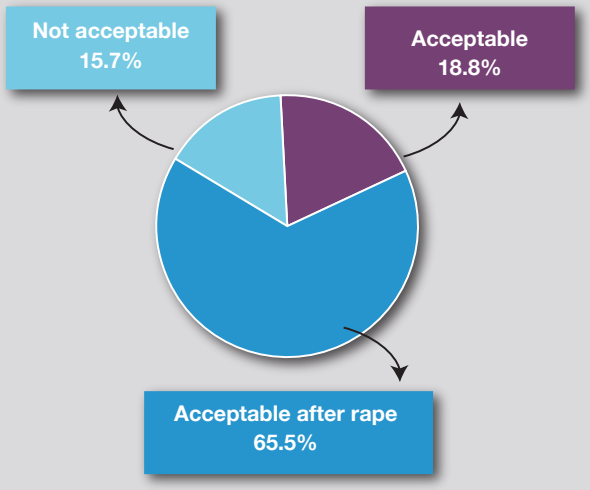
In our data, married womxn who abort were depicted as the most stigmatised. This is mainly, as the respondents noted, because having children in marriage is 'mandatory'. Willingly not having children within wedlock was depicted as shameful; involuntary infertility was also seen as sad or alternatively 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,

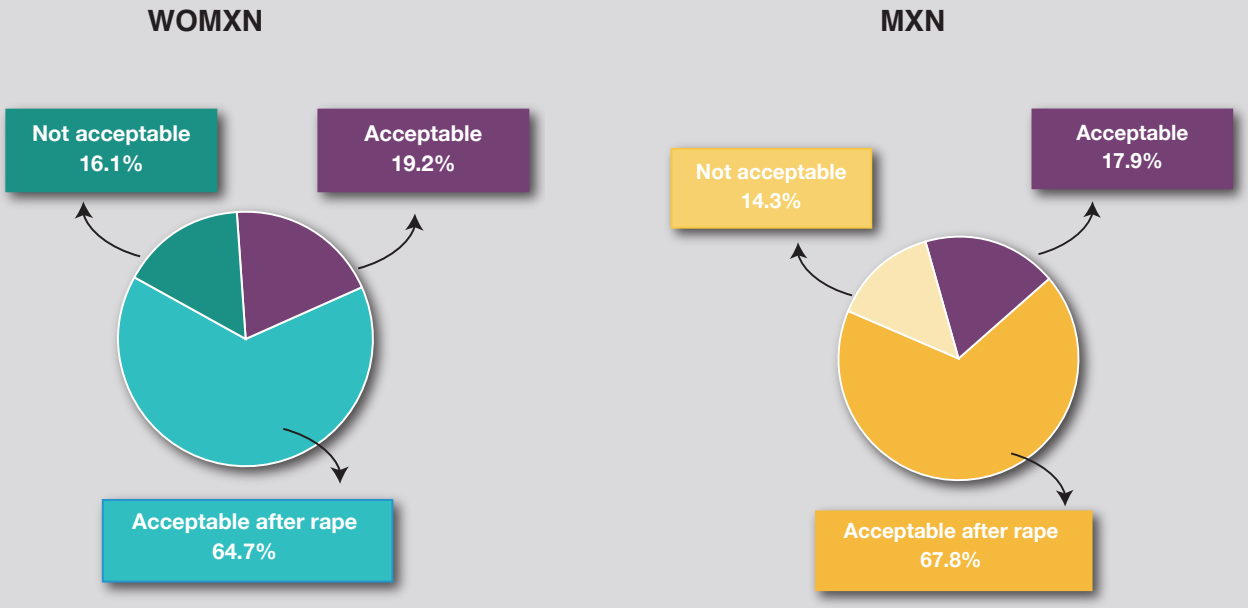
Pooled data on attitudes and understandings of abortion



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.

Community attitudes and understandings of abortion



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.

Conclusion

There is a real possibility for MSSA to make an important contribution to access to abortion care in South Africa by servicing rural areas. MSSA 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.

Findings from this study suggest that MSSA should adopt a **catchment area approach** in relation to facility type. Depending on the area, combinations of clinics in government facilities, mobile clinics and clinics within pharmacies may be considered. Stand-alone clinics should be avoided. A range of services should be offered, in particular sexual and reproductive health services, but also potentially other screening services (e.g. TB, COVID-19). First and second trimester abortion should be offered. Clinics should be fully stocked with medication abortion commodities, given the preference for this form of abortion. Telemedicine could be considered but with clear messages about its safety and the quality of services provided. Costs to the clients should be kept to a minimum, within the limits of financial sustainability and the possibilities of cross-subsidisation. Free contraceptive and pregnancy detection services should be considered to reduce unwanted pregnancies and delays in seeking an abortion. Protocols should be put in place to deal with situations where desperate and vulnerable womxn arrive to the clinic needing an abortion but are unable to pay. Extended hours over weekends are recommended if only one clinic is opened. If a dual catchment area approach is taken, hours could be adjusted to suit the type of clinic.

Partnerships with local public clinics, civil society organisations, local NGOs and traditional healers are important. These organisations and community leaders could advise on the type of additional services to be offered in MSSA clinics. Community health workers could include sexual and reproductive health information in their home visits, assist with pregnancy detection, and refer clients. Partners could assist with community campaigns to reduce stigma, overturn rape myths, work through gender dynamics, and normalise abortion. Traditional healers should be a referral source.

Mechanisms to ensure confidentiality are key. These include there being no obvious external indication that abortion is being offered and locating a clinic next to other facilities that draw people. Confidentiality must be emphasised in all staff training, as well as in meetings with partners and referral sources, in particular public health clinics, traditional healers, and community health workers.

Training of service providers should include: alerting providers to people's preference for medication abortion; understanding the local gender and social dynamics underpinning decisions regarding the outcome of a pregnancy; the procedures and ethics of telemedicine; women-centred abortion counselling that builds resilience to stigma, and acknowledges the difficulties that married and young womxn may face in deciding on an abortion; and ways to limit the number of visits womxn need to make to the clinic. Community health workers and other outreach staff should be trained in the listening skills required to assist womxn in making an autonomous decision. Peer support mechanisms and a positive work environment should be in place for healthcare providers.

Marketing should meet the information needs of rural communities. Such material should include normalising abortion as a standard reproductive procedure, stress the safety of abortion performed at MSSA clinics, and address myths relating to the physical or psychological consequences of abortion, in particular fears of infertility. Local and community radio stations and organising events within rural communities could be useful in these endeavours.

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.

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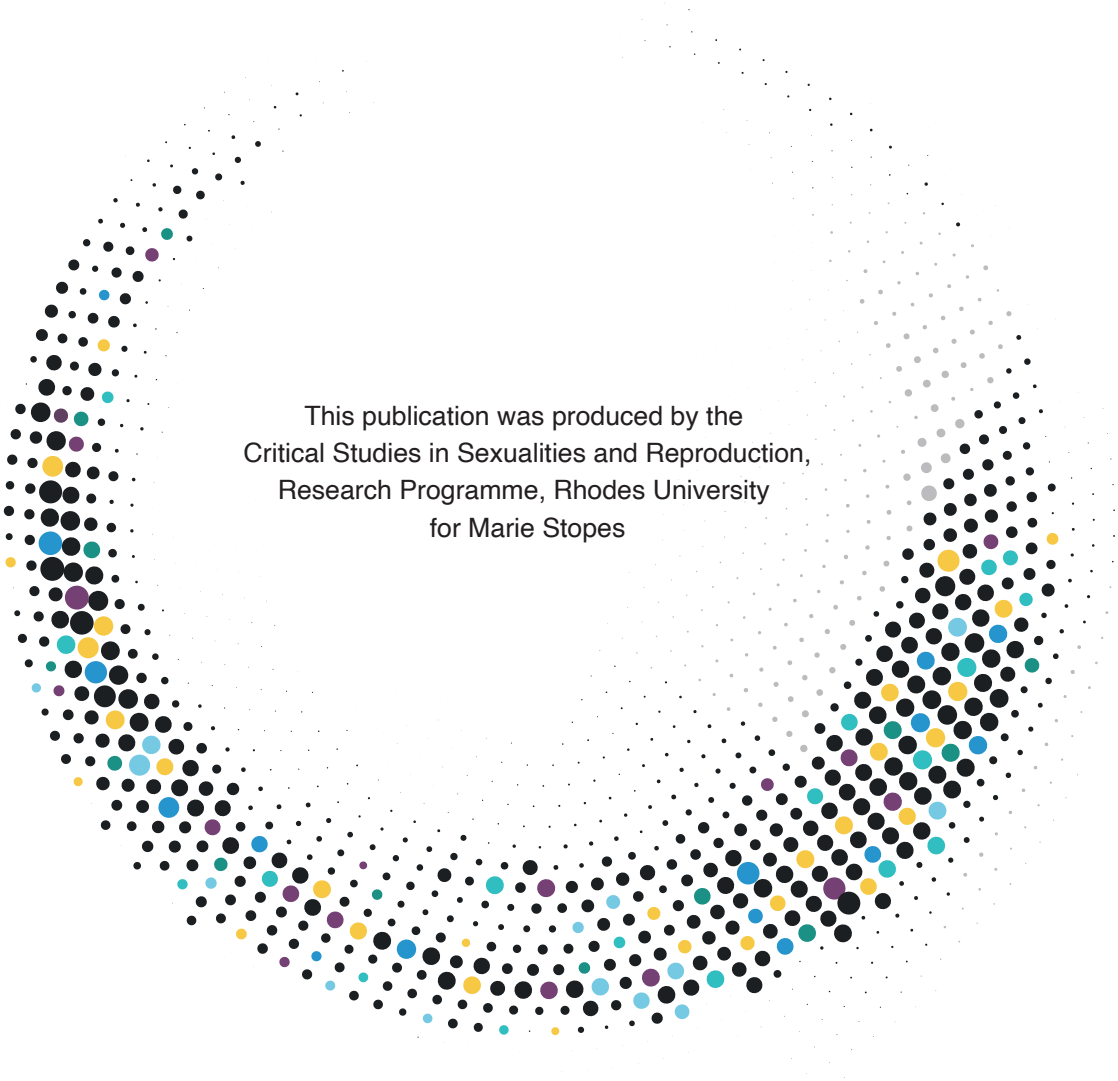

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