Adolescents' knowledge about abortion and emergency contraception: a survey study

Valencia
Lebogang Seutlwadi
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Supervisor: Professor C. Macleod

Co-supervisor: Mr G. Steele

Thesis submitted in fulfillment of the requirements

for the degree of Masters of Arts

in Psychology

Rhodes University

Abstract

Adolescents have become focal points of discussions and debates regarding sexuality and reproductive health matters. However, little research has been done particularly in South Africa to examine their knowledge concerning abortion and emergency contraception. Research indicates that a substantial proportion of adolescent pregnancies are unintended or unwanted. Abortion and emergency contraception are both time-sensitive services. Thus having accurate and comprehensive knowledge about both abortion and emergency contraception is pivotal, in the case of unintended or unwanted pregnancy or when engaging in unprotected sex or experiencing contraceptive failure that could lead to pregnancy.

The 1994 International Conference on Population and Development (ICPD) defined reproductive health rights for both men and women as the right to "decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so" (p. 60). That is, men and women should "have the right to make decisions concerning their reproduction free of discrimination, violence and coercion" (ICPD, 1994, p.60). Based on these definitions, it is rather evident that comprehensive and accurate knowledge are at the core of one's ability to make an informed consent. This is confirmed by Adler's (1992, p. 289) definition of informed consent or choice "a) access to sufficient information b) understanding the information c) competence to evaluate potential consequences d) freedom to make a choice and e) the ability to make and express that choice". It is from this framework that this study emerged. The aim of this study was to examine adolescents' knowledge concerning abortion and emergency contraception.

The participants were Grade 11 learners between the ages of 15-24 years from five different schools in the Buffalo City Municipality. A sample of 514 was achieved. Data were analysed using descriptive cross-tabulation, chi-square and qualitative methods where appropriate. The results revealed that most of the participants did not have sufficient accurate knowledge concerning the Choice on Termination of Pregnancy Act, consequences of legal abortion and emergency contraceptive pills to make informed decisions. Furthermore, data also revealed that the participants' schools play a role in their sexual activity, their knowledge about the Choice on Termination of Pregnancy Act and about emergency contraceptive pills. Although this method made it feasible for the researcher to make general assumptions, non-responses were one of the limitations of the study. Similar research in various municipalities/cities in and outside the Eastern Cape is recommended so as to increase further awareness concerning

the level of knowledge that adolescents have about contraceptive pills particularly emergency contraceptive pills, the Choice on Termination of Pregnancy Act and abortion in general.

Acknowledgements

My Family and Friends- I would like to thank my mom, uncle, Nkululeko and my friends for all their prayers, for being there for me when I felt discouraged, for always believing in me and for keeping me sane and laughing especially when everything became daunting.

My Supervisor- to Professor Catriona Macleod, there are no amount of words that can express my sincerely and deeply felt gratitude for supervising this research paper, for all you have done for me, for your advice and for never giving up on me even when the road got tough.

Co-supervisor- thank you to Mr Gary Steele for never being too busy even for the 'not so challenging' questions, for being patient with me and for making stats fun.

Participants- Last but not least, I am deeply indebted to all the principals that allowed me into their schools, to all the Life Orientation teachers for all their support, the parents that allowed their children to participate in this research and to all the Grade 11 learners that partook in this research because without your co-operation this research would not be possible.

NRF- thank you to NRF for supporting and funding this research.

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List of acronyms

CLA	Christian Lawyers Association
CSG	Child Supportive Grant
CTOPA	Choice on Termination of Pregnancy Act
CTOP	Choice on Termination of Pregnancy
DoH	Department of Health
DET	Department of Education and Training
D&C	Dilatation and Curettage
EC	Emergency Contraception
ICPD	International Conference on People and Development
IEC	Information, Education and Communication
MVA	Manual Vacuum Aspiration
NAFCI	National Adolescent Friendly Clinic Initiative
PASS	Post-Abortion Stress Syndrome
PPASA	Planned Parenthood Association of South Africa
SADHS	South African Demographic and Health Surveys
TOP	Termination of Pregnancy
WHO	World Health Organisation

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Chapter 1

Introduction

1.1. Introduction

Adolescents have become focal points of discussions and debates regarding sexuality and reproductive health matters, partially due to the fact that in many cases they engage in sexual activities with little or misguided reproductive health information (Alubo, 2001). This lack of information which often leads to several reproductive health problems, such as unintended pregnancies, unsafe abortions, maternal morbidity and maternal mortality, formed one of the topics at the 1994 *International Conference on Population and Development* which took place in Cairo.

The 1994 International Conference on Population and Development (ICPD) called for the recognition of women and girls' reproductive health and reproductive rights. ICPD (1994, p. 60) defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition implies that "people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so" (ICPD, 1994, p. 60). This definition of reproductive health and its given implications are intertwined with the reproductive rights of both men and women, which are defined by the ICPD (1994, p. 60) as the right to "decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so"; men and women should "have the right to make decisions concerning reproduction free of discrimination, coercion and violence".

Comprehensive information and access to safe, effective and affordable health-care services are fundamental rights for both men and women but more so for women as in most cases they are the ones who unfortunately are often perceived to be solely responsible for any reproductive health problems that may occur. Based on a reproductive health approach, factual information and accessibility to reproductive health-care services should not only be made available to everyone but should also be guaranteed. This is especially so when bearing in mind that reproductive rights embrace other basic human rights that are recognised both nationally and internationally such as

"bodily integrity, personhood, equality and diversity" (Women and Law in Southern Africa Research Trust, 2002, p. 32).

It should be noted, however, that without comprehensive and factual information most of these rights will remain unexercised. Although accessibility to safe, effective and affordable reproductive health-care services is essential, these services will be utilised correctly and effectively only if women, including adolescents, have accurate and adequate knowledge about reproductive health matters, consequently enabling them to make informed consent about their reproductive health. Adler et al. (1992, p. 289) defined informed choice or consent as "a) access to sufficient information b) understanding the information c) competence to evaluate potential consequences d) freedom to make a choice and e) the ability to make and express that choice".

One common feature amongst all these inter-related definitions is the indisputable need for sufficient information, consequently making it evident that without sufficient knowledge, women, including adolescents, cannot make informed choices. This lack of knowledge and sufficient information has resulted in many women, particularly adolescents, still risking their lives by submitting themselves to illegal abortions. According to a study conducted by Moodley and Akinsooto (2003) in Durban in South Africa, 60.5% of abortions were initiated in the woman's home or boyfriend's place. Of those who induced abortion themselves, 65% claimed that they did not understand the practical implications of the legislation while 68% were not aware of any existing facility for TOP (Moodley & Akinsooto, 2003). Until women have comprehensive information regarding reproductive health matters and their reproductive health rights, women will continue to suffer from maternal morbidity and mortality from preventable causes such as unsafe abortion. Allowing women to make their own informed decisions concerning their reproductive health is not only a basic human right but undoubtedly will improve the health of the country as a whole (Dgedge et al., 2005).

1.2. Rationale for the study and research questions

For women **all over the world**, abortion is a common procedure, **essential** to women's health and **integral** to the provision of comprehensive health care. Each year, more than **210 million** pregnancies occur throughout the world, **40 percent of which are unplanned**. More

than **one-fifth** of these pregnancies – including half of the unplanned pregnancies—**will end in induced abortion** (Dailard, 1999, p. 2, emphasis in the original).

Based on the statement above, most women will experience abortion in their life-time, either personally or through a friend, family or relative. Termination of pregnancy is, thus, a fundamental aspect of reproductive health for women globally.

In South Africa, the Choice on Termination of Pregnancy (CTOP) Act gives women, including adolescents, permission to obtain abortion upon request. Although the CTOP Act has been implemented for over a decade in South Africa, the knowledge that adolescents have about abortion has not been amply explored. This is despite the increasing numbers of adolescents accessing abortion, which is discussed further in subsequent chapters.

Most South African research on abortion and adolescents conducted after the passing of the CTOP Act (e.g. Mojapelo-Batka & Schoeman, 2003; Varga, 2002) has been concerned with basic issues of access, factors influencing adolescents' choice to terminate their pregnancies, their experiences of abortion and parental involvement, with very little attention paid to adolescents' knowledge about abortion. As abortion is a contentious topic, it is important that the fundamental issue of comprehensive knowledge amongst adolescents be researched.

According to a South African study conducted by Schutt-Aine and Maddaleno (as cited in Parker, 2005), the onset of menstruation has been taking place in earlier ages (average of between the ages of 9-11 years) compared to previous years. This means that there is an extended period in which unplanned pregnancies may take place during adolescence (rates of teenage pregnancy are discussed below). Thus, in order to counter the potential predicament that may arise due to this, research on the kind of knowledge that adolescents have about abortion and emergency contraception is essential.

Examining this knowledge is imperative because for women of all ages, an 'unwanted pregnancy' by implication means that, her socio-economic circumstances, gender relations and structural limitations make it detrimental for her some how to carry the pregnancy to term. This is indicated in the data collected by the South African Demographic and Health Survey 2003 (as cited in Department of Health [DoH], 2007), which found that the percentage (34,4%) of teen-

aged women facing unwanted pregnancies is higher than of women across the age range. This is illustrated clearly in the following table.

Table 2 Fertility Planning status (percentages)

	Wanted Then	Wanted later	Wanted no more	Missing	Total
Aged less than 20	20.8	42.6	34.4	2.2	100
Total across age range	50	24.1	23.4	2.7	100

Source: Adapted from Department of Health (2007).

In this research a distinction between pregnancies was made, 'wanted then' (i.e. wanted at conception or planned), 'wanted later' (i.e. unplanned but not unwanted) and 'wanted no more' (i.e. unwanted) (Macleod, 2011). Although 20,8% of teen-aged women planned their pregnancies, for a significant number (42,6%) of them, the pregnancy was not planned but it was not unwanted either (Macleod, 2011). However, the percentage that is of relevance is that of teen-aged women whose pregnancies were neither planned nor wanted. According to Macleod (2011), the percentage of women between the ages of 40-44 years who stated that their pregnancies were 'wanted no more', was comparable to those of teen-aged women at 34.4%.

Internationally, research, such as the studies conducted by Marsiglio and Shehan (1993) and Ekstrand, Larsson, Von Essen and Tyden (2005), has explored adolescents' attitudes towards abortion. These kinds of studies have their limitations as a study on attitudes does not sufficiently examine some of the complexities that adolescents face with regard to abortion. Importantly, in the context of this study although one's attitude is important, in most cases it is influenced by one's knowledge concerning the topic at hand.

Despite South Africa's liberal abortion law, some women still resort to 'backstreet' abortion. This was made evident in an evaluation of the implementation of the Choice on Termination of Pregnancy Act conducted by the Department of Health [DoH] in 2000. According to the Department of Health (2000), there was at the time no change in the prevalence of incomplete abortions since 1994 and only 53% of women aged 15 – 49 years knew that abortion is available upon request for the first 12 weeks. A further 15% of South African women in Gauteng did not know where to get an abortion. Thus 41% had induced abortions using Dutch medicine and the other 46% consulted a traditional healer (DoH, 2000). It should be noted that although the

Eastern Cape was among the lowest, with 47.9%, of incomplete abortions from the first trimester, it was the highest, with 52%, incomplete abortions from second trimester (DoH, 2000). Taking into account that there might be other underlying factors (e.g. stigma, lack of access to legal services) contributing to these high percentages, lack of knowledge could still be a primary barrier to women obtaining legal abortion. This is affirmed by a study conducted by Ratlabala, Makofane and Jali (2007) who reported that adolescents from the rural areas of Limpopo have low levels of knowledge about abortion.

Thus it is within this context that a survey concerning the knowledge of abortion and emergency contraception among Eastern Cape adolescents was undertaken. This survey is a comprehensive report of adolescents' knowledge about abortion and emergency contraception. It examines adolescents' knowledge of the stipulations contained in the Choice on Termination of Pregnancy Act, knowledge of legal and illegal methods of abortion, knowledge of consequences of legal abortion, knowledge of somebody having undergone a termination of pregnancy, sources of information and knowledge of Emergency Contraceptives [EC]. Both abortion and EC are included as either are potential avenues in avoiding conception and pregnancy that have occurred but are unwanted or unintended.

The above questions were related to the definition of informed consent or choice given by Adler et al. (1992). That is, it is only through the accomplishment of (a) access to sufficient information, (b) understanding the information and (c) competence to evaluate potential consequences, that (d) freedom to make a choice and (e) ability to make and express the choice are possible. This study granted the researcher the opportunity to understand (a) what access adolescents have to information regarding abortion and whether this information is sufficient, (b) adolescents' broad understanding of legal abortion and emergency contraception and (c) their competence to evaluate potential consequences of legal abortion and emergency contraception versus taking an unwanted pregnancy to term.

1.3. Context: emergency contraception

Over the past years, the post-apartheid South African health legislature has developed a reproductive health policy package that is widely accepted as one of the most progressive in the world (Maharaj & Rogan, 2007). This reproductive health policy package included the

introduction of Emergency Contraceptive pills. Emergency Contraceptive pills are clinically defined as "the use of a drug or device, as an emergency measure to prevent or reduce the risk of an unwanted pregnancy" (Cheng et al., as cited in Maharaj & Rogan, 2007). EC is effective for use any time during the menstrual cycle under conditions where sexual intercourse occurred and where a woman makes an informed decision to use them (DoH, 2003). However, EC is most commonly used after unprotected sex or method failure such as the bursting of a condom. Although EC can be used up to 120 hours after unprotected sex, it is strongly recommended that it be taken within 72 hours of unprotected sex. EC does not cause abortion; it delays or inhibits ovulation, disrupting follicular development and/or interfering with the maturation of the corpus luteum (Feijo as cited in Maharaj & Rogan, 2007). Pregnancy is the only contraindication of EC; hence it is argued that the sooner they are taken, the more effective they are.

There is a variety of emergency contraceptive pills worldwide. However, Norlevo (progestin only), Ovral and Nordette (combination of progestin and estrogen) are the most commonly provided contraceptives pills in South Africa (Blanchard, Harrison & Sello, 2005; Maharaj & Rogan, 2007). EC has short-lived side-effects such as nausea and vomiting. EC has been recognised both internationally and locally as being an important commodity with respect to the realisation of women's reproductive health rights. As a result, EC can be obtained for free in public health facilities and can also be bought over the counter without prescription. Furthermore, in an attempt to increase accessibility to all women, including minors, there is no age restriction or parental consent required for obtaining emergency contraceptives.

EC is currently the only method used post-coitally, which means that they are thus far the only contraceptives that have the ability to serve as an effective option for women including adolescents who want to avoid unwanted and/or unintended pregnancies post unprotected coitus. However, lack of promotion of EC, which consequently contributes to lack of accurate knowledge about EC, has rendered it ineffective. That is, "only about one in four women attending public health clinics in South Africa have heard of emergency contraception" (Klitsch, 2002, p. 128). This lack of knowledge on emergency contraceptive pills is discussed in-depth in the following chapter.

1.4. The context: The CTOP Act

The Abortion and Sterilisation Act of 1975 was the first legislation in South Africa to permit abortion (Dickson-Tetteh & Rees, 1999). However, due to the fact that abortion was granted under stringent conditions, abortion remained inaccessible. That is, legal abortion could only be obtained if childbirth presented a serious threat to the woman's physical health, danger of permanent damage to her mental health, or where the woman was mentally handicapped, or rape or incest had occurred or the child would be born with a mental or physical handicap (Abortion and Sterilisation Act, No. 2, 1975). The procedure for obtaining abortion was complicated and time-consuming, serving as an additional barrier to abortion accessibility. The Abortion and Sterilisation Act required the woman's doctor to recommend the procedure and two other doctors to claim in good faith that the procedure was indicated, and at least one of the doctors should have been practising for at least four years (Abortion and Sterilisation Act, 1975). Lastly, neither of the doctors could participate in the procedure and abortion had to take place in a state-controlled health facility or in a place specially intended to provide abortions (Abortion and Sterilisation Act, 1975). Due to these strict conditions, only about 40% of applications for abortion were approved each year (Dickson et al., 2003). Thus, the majority of women faced with unwanted or unintended pregnancies opted for 'backstreet abortion'. This resulted in "44,868 women being admitted to South Africa's public hospitals each year with incomplete abortions, with at least one-third presenting with signs and symptoms indicating that the abortion procedures they had undergone were unsafe" (Dickson et al., 2003, p. 278).

After South Africa's first democratic elections in 1994, new abortion legislation was passed in 1996 as part of the new government's effort to promote safe, accessible abortion services to all women especially poor and previously disadvantaged woman (Dickson et al., 2003). From February 1997, the South African Parliament implemented the Choice on Termination of Pregnancy Act, making abortion legal upon request for all women, including minors, up to 12 weeks gestation period. Up to this point trained midwives can provide the service and abortion can be performed at primary health facilities (Choice on Termination of Pregnancy [CTOP] Act, 1996). The Act further provides for abortion from 13-20 weeks gestation on physical and mental health grounds if performed by a doctor who is of the opinion that the pregnancy poses a risk to the woman, or the foetus may suffer physical or mental abnormality, or the pregnancy results

from rape or incest, or that the continued pregnancy would affect the social or economic circumstances of the woman (CTOP, 1996). Abortion is permitted after 20 weeks if performed by a doctor after consulting another medical practitioner or midwife certified to perform abortions to confirm that the pregnancy would endanger the woman's life or it would result in foetal malformation or injury to the foetus (CTOP, 1996).

Due to the significant number of cases of maternal mortality and morbidity related to unsafe abortions prior to 1997, the South African government was committed to making abortion services available and accessible to all women. Thus, not only did the government ensure that termination of pregnancy can be obtained for free in all public health facilities, but in 2003 it allowed any health facility with a 24-hour maternity service to offer first trimester abortions services without the ministerial permission that was previously required (CTOP Amendment Bill, 2005). Furthermore, all registered nurses who completed the prescribed TOP training courses were also allowed to perform first trimester abortions (CTOP Amendment Bill, 2005).

Despite the government's attempts to promote women's reproductive rights and to ensure their reproductive health by the implementation this Act, much controversy, debate and opposition was evoked. In response to some of those who opposed abortion, the law allowed for conscientious objection on the part of the providers. However, they are obligated to refer the woman to a willing provider as preventing a lawful termination of pregnancy or obstructing access to a facility that provides abortion is an offence (CTOP, 1996).

Since the implementation of the CTOP Act, approximately 529 410 women have had safe and legal abortions in South Africa (IPAS, 2009). Based on these statistics, it is evident that the Choice on Termination of Pregnancy Act has undoubtedly made abortion more available. In 1999, the number of women presenting at hospitals with abortion-related morbidity had decreased to 9.5% compared to the 16.5% in 1994 (Cooper et al., 2004). Furthermore, the number of legal terminations of pregnancy performed annually in South Africa has steadily increased, from 29.375 in 1997 to 77.201 in 2009 compared to approximately 1000 legal abortions performed each year in South Africa prior to the implementation of the Choice on Termination of Pregnancy Act (Cooper et al., 2004; Guttmacher et al., 1998; Health Systems Trust, 2009).

Despite this steady increase of legal abortion, accessibility, including information on available services, remains a problem for some women especially adolescents (Berer, 2004). The latter statistics of legal abortion are only a fraction of all abortions carried out. Even though the percentage of functioning facilities designated to provide abortion have increased from 33% in 2001 to 48% in 2003, services remain limited and discriminatory (Berer, 2004; Cooper et al., 2004). Many health care providers are openly hostile towards women seeking abortion, others try to discourage them particularly those who assert conscientious objection, instead of referring them to a willing provider (Cooper et al., 2004).

It is worth noting that despite the fact that abortion has been legal in South Africa for over a decade, statistics on abortion are still difficult to obtain (Panday, Makiwane, Rancho & Lesoalo, 2009). According to the Health Systems Trust (2006) maternal death in the Eastern Cape has increased from 56 in 1998 to 129 in 2003. Although not all of these maternal deaths are due to induced abortion, there is still a need for concern since induced abortion (mostly under unsafe conditions) is one of the leading causes of maternal mortality among women (Braam & Hessini, 2004).

1.5. Context: rates of pregnancy and TOP among adolescents

Teenage pregnancy in this research is defined as the percentage of women aged between 15-19 who are mothers or who have ever been pregnant (Makiwane & Udjo, 2006). There is much debate whether teenage pregnancy has increased or declined over the years. According to the results of the October Household Survey conducted by Makiwane and Udjo (2006, p.19), the "rates of adolescent pregnancy decreased in the 1980s, increased somewhat in the mid-1990s, and have remained relatively stable from the mid-1990s to 2003". Moultrie and McGrath (2007) assert that teenage fertility fell by at least 10% between 1996 and 2001. They also argue that the percentage of women under the age of 20 years presenting at antenatal clinics has remained stable at 19.4%, 19.2% and 19.5% (Moultrie & McGrath, 2007).

Rates of adolescent pregnancy decrease with increasing education (DoH, 2007b). This is evident in the fact that only "20% of 15-19 year-old women with a Grade 6-7 education, and only 7% with a higher education, reported having ever been pregnant" (DoH, 2007b, p. 20). Furthermore, according to the 2003 South African Demographics and Health Survey (SADHS) "33.7% of

unmarried young women with an education of Grade 6-7 and 65.8% with higher education" indicated having used a condom at last sex (DoH, 2007b, p.38). Evidently, education is a pivotal factor in the decrease of teenagers giving birth, either by means of increased usage of barrier methods such as condoms or the ability to make informed decisions such as the use of EC or abortion in an event of contraceptive failure or unprotected sex.

It is estimated that minors account for 12% of all termination of pregnancies since the legalisation of abortion (DoH, 2009). Research conducted by Buchmann, Mensah and Pillay (2002) in Soweto calculated the proportions of pregnancies that end in TOP (which has resulted in a more reliable measure of unwanted pregnancies compared to the DoH report of statistics on age-related terminations). According to Buchmann et al. (2002) 23% of pregnancies carried by 13-16 year old young women end in abortion, 14.9% in the 17-19 year age range, 12.7% in the 20-34 year age range, and 16.2% in the 35+ age range.

Despite contrary evidence to the increase of teenage fertility, the debate remains unabated. One of the issues that has impassioned this argument is that of the Child Support Grant (CSG). Popular opinion states that the Child Support Grant has led to a perverse incentive for teenagers to conceive. Although this commonly held opinion could be supported by the Planned Parenthood Association of South Africa survey as cited in DoH (2009), which reported that 12.1% of teenagers who had fallen pregnant deliberately stated CSG as the reason. Further research was conducted to explore whether there is a correlation between teenage pregnancy and Child Support Grant. No such association was found (HSRC as cited in DoH, 2009; Makiwane & Udjo, 2006). Ironically, it was discovered that there has been a decrease in early fertility after the introduction of CSG and that only 20% of teenage mothers are recipients of the CSG (DoH, 2009). These results are in accordance with those found in the studies conducted by DoH (2009) and Pettifor et al. (2005).

As termination of pregnancy appears to have increased amongst minors since the legalisation of abortion, assessing the rates of teenage pregnancy is difficult. This is made evident by the fact that according to the EMIS, 2004-2008 (as cited in Panday et al., 2009) the rate of pregnant learners has increased. However, this is contrary to national trends in fertility due to the fact that the analysis of provincial trends shows a concentration of learner pregnancies in the Eastern Cape, KwaZulu-Natal and Limpopo (Panday et al., 2009). Given the reported decrease in rates of

teenage pregnancy referred to above, it is difficult to say whether these figures imply an increase in teenage pregnancy or an improvement in the reportage.

1.6. Summary of research methods

Survey methodology was used in this study for numerous reasons. Firstly, surveys are ideal for big samples. Secondly, they serve as the best method when dealing with sensitive and controversial topics such as abortion. Thirdly, owing to the relative anonymity, surveys help respondents to feel less threatened in revealing their honest opinions than in face to face interviews.

Multi-stage sampling was used in this study, namely stratified sampling of the type of schools, simple random sampling of actual schools and purposive sampling of grades used within schools. The population in this study (the schools in the Buffalo City Municipality) were divided into five subpopulations, namely Private schools, former Department of Education (DET) schools in the urban area, former DET schools in the rural area, former House of Representative schools popularly known as 'coloured schools' and former Model 'C' schools previously known as 'white' schools. The schools selected within each of these subpopulations were randomly selected. The study was limited to both male and female Grade 11 learners. Informed consent from the principals, the parents, and learners was obtained before the study commenced.

The data were collected by means of self-administered questionnaires. However, after some initial difficulty, the researcher explained the instructions, informed the participants that if they did not know the answer they should indicate this or write why they did not want to answer the question rather than leaving it blank. The questionnaire used was constructed by the researcher with the questions being based on areas of interest identified in the literature review. Due to lack of localised literature especially with regard to adolescents' knowledge concerning abortion, the questions used were worded in such a way that they fit the South African context. The questionnaire was initially constructed in English, and later translated into Afrikaans and isiXhosa as these, in addition to English, are the dominant languages in Buffalo City. The questionnaire was piloted before the finalised version in the study was administered.

Statistical analysis was used to analyze the data. Descriptive statistics were used so as organize data. Inferential statistics were also used with specific reference to the Chi-square test, which

made it possible for the researcher to examine the relationship between different categories such as schools and knowledge of the CTOP Act; sexual activity and knowledge of the CTOP Act; sexual activity and knowledge of EC; schools and knowledge of EC.

1.7. Summary of chapters

This thesis explores adolescents' knowledge of abortion and emergency contraceptives. The study has been contextualised by the discussion of emergency contraceptives, the Abortion and Sterilisation Act of 1975 and the Choice on Termination of Pregnancy Act of 1996, and the statement that knowledge is a necessary condition for women to exercise their reproductive rights such as access to safe, affordable abortion health-care services free of discrimination and violence.

While knowledge is required for women to make informed choices and give informed consent about reproductive health matters such as abortion and emergency contraception, there are other factors that serve as barriers and controversies with regard to the realisation of these reproductive rights consequently leading to their violation. These barriers and controversies are discussed in-depth in Chapter 2, in part because they also have implications in terms of the kinds of information adolescents will have access to. Chapter 3 gives a comprehensive discussion of how these barriers and controversies amongst other factors have played a role in the knowledge, or lack thereof, that adolescents' have about termination of pregnancy and emergency contraception. Both Chapter 2 and Chapter 3 also examine the progress made by the International Convention on the Rights of the Child on employing the requests of U.N. Committee on the Rights of the Child, that is, governments must take measures to combat unsafe abortions among adolescents, urging "States parties (a) to develop and implement programmes that provide access to sexual- and reproductive-health services, including family planning, contraception and safe-abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes toward adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education" (Committee on the Rights of the Child as cited in Parker, 2005).

Chapter 4 discusses the methodology used in this research, that is, sampling methods, how the instrument was constructed, how data were collected, analysis methods and the results of the pilot

study. The findings of this study and the accuracy of adolescents' knowledge concerning abortion were checked against existing literature.

All the similarities, differences and patterns found in the results are explored extensively in Chapter 5. Chapter 6 is an elaboration of Chapter 5 as it explores and discusses further the results explored in Chapter 5. The implication of the similarities, differences and patterns found in Chapter 5 and the impact they have in adolescents' reproductive health and reproductive rights are discussed in Chapter 6. Chapter 7 draws the whole research together. That is, it is a summary of aspects that are important in this research and it also highlights recommendations made and limitations of the study. And lastly, appendix A to D contains examples of the letters sent to the Department of Education in East London, to the schools, the parents and the consent form that was signed by the participants. Appendix E is an example of the questionnaire that was used in the study.

Chapter 2

Reproductive health rights and abortion: definitions, controversies and barriers

2.1. Introduction

It has been argued in the introduction chapter that sufficient and accurate knowledge is central to women's abilities to exercise their reproductive rights such as access to safe, affordable abortion health-care services. Knowledge grants women the opportunity to make informed choice and to give informed consent regarding reproductive health matters such as abortion and emergency contraception. This is evident in Adler et al.'s (1992) definition of informed consent or choice.

Although comprehensive knowledge is the crux of informed consent or choice (hence the rationale for this study), it is not enough on its own. In other words, knowledge is power only if one has the freedom and ability to make use of that knowledge. If there are factors hindering this freedom and ability, the knowledge becomes futile. That is, there are factors that serve as barriers and controversies with regard to the realisation of women's reproductive rights subsequently leading to their violation.

These barriers and controversies are not only factors restricting reproductive health services, but also form the context within which knowledge and information concerning termination of pregnancy is gained. Thus, this chapter examines factors that serve as barriers and controversies not only to the availability and accessibility of health-care services but also in terms of the accessibility and quality of information that is disseminated and received concerning abortion and emergency contraception. These barriers and controversies are discussed further in the following sections. First, however, the definitions and elements of reproductive health rights are discussed.

2.2. Elements of reproductive health rights

Providing adequate, affordable, acceptable and accessible health services, and information, education and communication programmes to women across all ages and socio-economic status are primary elements of reproductive health rights (African Union, 2003). It is on the basis of these elements and the definitions given by ICPD for reproductive health and reproductive health rights that *The African Charter on Human and People's Rights* was adopted in July 2003 in

Maputo, Mozambique. *The African Charter on Human and People's Rights* contains a protocol on women's rights especially health and reproductive rights. The protocol specifies that women, including adolescents, have a right to control their fertility, to decide whether to have children, the number of children and the spacing of children and to choose any method of contraception. This implies that men and women have the right to be informed about reproductive health matters and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law (The Beijing Conference, 1995). These have to be respected and promoted by health providers at all levels (African Union, 2003; World Health Organization, 2003a). However, in South Africa most of these elements are yet to be respected and promoted. That is, although abortion and emergency contraceptive pills have been legalized and are available upon request for years, negative attitudes towards both services has compromised the acceptability and accessibility of these services (Dickson et al., 2003; Mwaba & Naidoo, 2006). In addition to the negative attitudes, lack of adequate resources and staff serve as barriers to service provision consequently affecting the IEC programmes (Dickson et al., 2003).

An important aspect of the reproductive health rights and an important component of the accessibility and appropriateness of services is the provision of information, education and communication. Information, education and communication also known as IEC are a combination of strategies, approaches and methods that use different sources of information such as mass media to disseminate information about reproductive health matters (Cherie, Mitkie, Ismail & Berhane, 2005). Teenage sexuality is a reality that can neither be denied nor ignored. Thus, candid conversations concerning reproductive health matters are important. Ensuring that adolescents have accurate knowledge and understanding about reproductive health matters, forms the basis for informed choices. Hence encompassed in the IEC is the process of learning that empowers people to make informed decisions, modify behaviour and change their social conditions (UNFPA, 1998). The IEC creates an open dialogue about sensitive and controversial topics such as sexual violence, female genital mutilation, safe motherhood and providing contraceptives to adolescents and HIV/AIDS (UNFPA, 1998).

Although IEC plays a positive role in increasing the knowledge of the target group and in changing their behaviour and attitude, much more information, education and communication regarding termination of pregnancy and emergency contraceptive pill is still needed (Parajuli, 1996; Puri, Hazari & Kulkarni, 2006). That is, even when discussing issues such as family planning, provision of contraceptives or teenage pregnancy, abortion and emergency contraceptives are seldom mentioned or discussed. This lack of information on abortion and emergency contraceptive pill contributes to the existing inaccurate knowledge amongst adolescents regarding abortion and emergency contraceptives. It also amplifies their erroneous beliefs and the stigma attached to termination of pregnancy and emergency contraception.

In South Africa, the National Adolescent Friendly Clinic Initiative (NAFCI), loveLife, Soul City, Young Men's Christian Association, The Better Life Option (BLO), Planned Parenthood Association of South Africa (PPASA) and DramAidE are some of the programmes that play an imperative role in the IEC promotion and awareness of adolescents' sexual and reproductive health matters. Although most of these programmes are primarily focused on HIV/AIDS, they have created a channel of communication and a flow of information about topics that are often referred to as 'taboo' or 'forbidden' to talk about openly. Most of these programmes are multi-media and multi-dimensional sexual and reproductive health awareness campaigns, integrating clinical, counselling and educational services for adolescents and teachers (DoH, 2009). It is due to this multi-dimensional approach of tackling sexual and reproductive health matters, that some of these programmes such as NAFCI and loveLife have been referred to as success stories (DoH, 2009). These programmes have to some extent enhanced accessibility, affordability and acceptability of some reproductive health services such as condom usage.

The following section discusses controversies that form the backdrop within which IEC regarding reproductive health is provided and that have frequently denied many women the opportunity to exercise and enjoy their reproductive health rights.

2.3. Controversies with regard to Termination of Pregnancy

Abortion has been legal in South Africa for over a decade, yet continues to foster an impassioned debate that has developed into a clash between the reproductive rights of the woman and the

rights of the foetus. Although societal attitudes towards abortion have varied across cultures and times in history, abortion remains an insoluble dilemma that continues to evoke bitter and emotional controversy (Rathus, Nevid, & Fichner-Rathus, 1997).

The following section will give an in-depth exploration of religious and moral connotations towards abortion specifically with regard to reproductive health rights versus the rights of the foetus. The primary focus will be on Seventh Day Adventist, Roman Catholic, Islam and the Protestant church as these are some of the most prominent religious domains. This is followed by a discussion of the controversy concerning parental involvement in the decision of an adolescent to terminate a pregnancy.

2.3.1. Religion

The controversy over abortion continues virtually unabated, with religion playing a primary contributory role in perpetuating conflicts over this issue (Johnson & Hoffman, 2005). Not only does religion play a role in the shaping of societal views and attitudes towards abortion but it also structures women's experiences of abortion and their consequent behaviour.

Smart (1989) argues that rights-based arguments are problematic because the right of choice for the woman is countered by the right to life of the foetus, and this in turn positions women who terminate their pregnancies as baby killers. This right to life approach is most often, although not exclusively, accommodated within religious rhetoric in such a way that it asserts the kind of behaviour that the woman should display.

Despite the fact that popular opinion suggests that there is a clear-cut opposition to abortion on the part of some religious bodies, this position has historically changed for different religious groups. That is, "although there are differing worldviews about the ultimate importance of the foetus, most religious groups go to great lengths to distinguish between elective and traumatic abortions both morally and politically" (Johnson & Hoffman, 2005, p. 165). Johnson and Hoffman (2005, p. 165) define elective reasons for abortion as "when a woman doesn't want any more children" and traumatic reasons as "rape, incest, severe foetal deformity or risks to the mother's life". From the given definitions, it is evident that though religious groups do not condone abortion, they are tolerant of traumatic abortion. This is made evident by the Seventh Day Adventists who argue that abortion may be permissible only when the pregnancy threatens

the mother's life or when the pregnancy is a result of rape or incest (Johnson & Hoffman, 2005). Similarly, Islam views abortion as murder and wickedness, and the Protestant church considers it as a sin but both religions share the same sentiments as the Seventh Day Adventist church with regard to when abortion is permissible (Finlay, 1996; Oye-Adeniran, Adewole, Umoh, Iwere, & Gbadegesin, 2005).

For the Roman Catholics, however, not only is the use of contraceptives and premarital sex prohibited but so is abortion which is argued against as the killing of an innocent helpless foetus (Evans, 2002). Although the official policy of the Catholic Church involves an extreme pro-life position, over the past 30 years there has been considerable diversity within the group which has polarised the Catholic community (Evans, 2002; Johnson & Hoffmann, 2005). This polarisation could be caused by the fact that over the past 30-35 years abortion attitudes have become more sensitive depending on the type of abortion the woman undergoes (Johnson & Hoffman, 2005). However, the Catholic Church still firmly holds the belief that the natural right to life of a foetus is absolute, fundamental and non-negotiable (Dilton, 1996; Evans, 2002). Despite these on-going debates, the Catholic Church "dismisses quite readily arguments about elective abortions" (Johnson & Hoffmann, 2005, p. 165).

It is acknowledged that the values and principles that both religion and morality advocate for may have positively influenced some young people's sexual behaviour in delaying their sexual debut, consequently preventing unwanted and/or unintended pregnancies, abortion and STIs. However, from the arguments mentioned above, it is clear that a woman is less likely to face scrutiny, condemnation and rejection from religious groupings if she had a traumatic abortion. Religions are, for the most part, opposed to abortion, implying that a woman has to have been violated first and/or suffering from severe emotional distress or trauma in order for her to exercise her reproductive rights 'freely'. That is, not only does religion structure women's experiences of abortion as previously mentioned but it also limits their choices in terms of what to do when faced with an unwanted pregnancy and which emotions are appropriate after an abortion. Furthermore, in the context of religious controversy over abortion, IEC on traumatic abortion is seen as unproblematic, whereas IEC on abortion upon request is opposed.

2.3.2. Morality

For many people, religion is the only language of morality. As a result what is condemned by religion is automatically seen as immoral. This is affirmed by the words of the Croatian president Franjo Tudjman who stated that "women who have abortions are mortal enemies of the nation; their gynaecologists, traitors. Their acts are appalling because they hinder the birth of little Croats, that sacred thing which God has given society and the homeland" (Feldman & Clark, 1996, p. 15). Some have also argued that abortion indicates a moral decline in the "public conscience" where the "sanctity of life" is increasingly unprotected (Hadley, 1996, p. 76). The choice to terminate a pregnancy not only causes great dissension within the realm of religion but it also gives rise to moral problems. That is, "a woman's morality in relation to abortion is called into question most explicitly by the frequently made claim that women have abortions for 'trivial' reasons or for 'convenience'..." (Ussher, 2000, p. 343). Moral sanctions are instituted against extramarital pregnancies and abortions, with the latter being seen as a morally repugnant act. Hence some adolescents view abortion as 'murder' or 'killing your own child' (Gibson, 2007; Varga, 2003).

Kenyon (1988) argues that the choice to have an abortion will be a reflection of a moral stance, whether recognised or not. If this choice clashes with the general moral opinion of the population, then stigmatisation is bound to occur with the situation being worse for adolescents and unmarried women. It is also argued that abortion is a 'moral injustice' to the foetus. This argument ultimately rests on an argument of the rights of the foetus which are placed in opposition to the rights of the woman as illustrated above (Johnson & Hoffmann, 2005; Smart, 1989). Based on these views it is clear that having an abortion is constructed in such a way that it is morally wrong and thus a choice that has to be justified incessantly. Within this context, providing IEC on abortion can be viewed as advocating for morally reprehensible acts.

2.3.3. Informed consent and parental involvement

The Choice on Termination of Pregnancy Act evoked much controversy especially with regard to the fact that minors do not need parental consent. According to Adler, Ozer, & Tschann (2003, p. 211) "out of 158 countries in which legal abortion is available, 55 countries permit abortion only

when it is necessary to save the life of the woman and 28 countries require parental consent" at the time of their research.

This controversy has become a debate of parental involvement *versus* adolescents' competency and hence their ability to act upon full reproductive rights. It has been argued that the debate stems from parents wanting to protect their adolescent children from making harmful decisions and to promote family functioning by ensuring that parents become involved in their daughters' decision making (Adler et al., 2003). That is, the primary factor in this debate is whether adolescents are competent enough to make independent informed decisions. Yet parental consent is not required for prenatal care or if adolescents decide to carry the pregnancy to term or place the child for adoption (Adler et al., 2003). It can be argued that these are sensitive and 'high-risk' decisions that need competency, consequently highlighting the paradoxical nature of this debate.

The rationale for a parental involvement law is that adolescents are incompetent in making adequately informed choices. However, in most cases, the information is disseminated in such a way that "with adults the focus has been on providing information in a way that assures informed consent whereas with children and adolescents, the focus has been on competence to make an informed choice" (Adler et al., 1992, p.289). According to Koucher and DeMaso (as cited in Adler et al., 1992, p. 289), competence is defined as the ability to "a) understand the information presented b) display reasoning in the decision-making process c) make a choice/decision and d) appreciate the consequences of the decision". From the given definitions of competence and of informed choice it is clear that sufficient knowledge is intrinsically linked to one's ability to make autonomous informed decisions. That is, lack of sufficient accurate knowledge makes these informed choices and decision-making difficult.

It has been argued that, given comprehensive and factual information, teenagers are capable of making informed choices. This is supported by a study conducted by Forster and Sprinthall (as cited in Adler et al., 1992) which stated that there were no differences found between adolescents and adults in reasoning tasks directly assessing the abortion decision. Adler, Kegeles, Irwin and Wibbelsman (as cited in Adler et al., 2003, p. 213) stated that further research suggests that "adolescents are consistent in their reasoning and decision making, behaving in ways that conform to rational models of decision making".

Based on what has been discussed, it is clear that the parental involvement debate shifts the focus from adolescents' knowledge to their ability to make an informed decision. The central debate, however, should not only be whether adolescents are capable of making autonomous decisions but also whether they have sufficient accurate knowledge to make these decisions. Furthermore, based on the definition given of informed choice, access to comprehensive information, and understanding this information, are some of the primary requirements for informed decision-making. This is complicated, however, by the fact that the information that is given to adolescents is typically in accordance with predefined norms, focussing on morals, religious values, principles, abstinence, guidance to rightful living and the sanctity of life, with options such as abortion or adoption being depicted as having detrimental consequences (Macleod, 2011).

Making parental consent mandatory in the decision–making process may result in unsafe or forced abortions, as was the case with some of the adolescent women in rural Maharashtra, India (Ganatra & Hirve, 2002). Chaotic, unsupportive or abusive homes where the girl's pregnancy could be the result of being sexually abused or raped by a male relative are other crucial factors that need to be taken into account in terms of the debate on parental consent (Gerson, 2006). Mandatory parental consent to termination of pregnancy forces some adolescents to put their reproductive health rights in the hands of the very same people who violated them in the first place which, in Gerson's (2006, p. 79) words, is "a form of violence in itself". In other words, mandatory parental involvement may cause more harm than good.

As a result, it can be argued that based on what has been discussed thus far and on findings from other studies (Adler et al., 2003; Adler et al., 1992; Gerson, 2006; Reddy, Fleming, & Swain, 2002), there is no evidence to support the rationale for parental involvement laws. Although parental consent is not mandatory in South Africa, the same debates that have taken place in the international literature came to the fore in The Christian Lawyers Association's (CLA) legal challenge regarding this clause. That is, in 2003, CLA filed a suit at the Pretoria High Court to make parental consent mandatory and that if consent was not obtained, abortion should be refused (Macleod, 2011). The application failed. Nevertheless, the argument that parents should be involved may be shared by some health care providers (Macleod, 2011), which creates an additional barrier to services.

It is due to intricacies such as those discussed above that Ussher (2000, p. 340) argues that although abortion is a health issue, it is also a "procedure which brings together medical, social, psychological, moral, legal and political issues in what is often an extremely controversial way". This complex combination is reflected in abortion's unusual position as a medical procedure specifically controlled by law (Ussher, 2000). This will be illustrated further in the following section as it is concerned with barriers to accessing abortion services such as legal aspects of abortion in South Africa and surrounding countries among other factors.

2.4. Barriers to accessing Termination of Pregnancy

Access to legal termination of pregnancy is seen as a fundamental aspect of reproductive rights. However, there are many barriers to this. For example, the Choice on Termination of Pregnancy Act is one of the most liberal abortion laws in sub-Saharan Africa. However, gaps remain in the implementation of reproductive policies and service delivery, particularly in the area of termination of pregnancy (Cooper et al., 2004).

The *International Conference on Population and Development* and *The African Charter on Human and People's Rights* have argued for the recognition of women's reproductive rights including liberalisation of the abortion law. However, effective implementation of reproductive health policies and the laws that endorse them is hampered by the legal status of abortion in other countries, staff attitudes, stigmatization, attitude and knowledge of contraceptives. These factors will be discussed further in the following sections.

2.4.1. Legal aspects

"Although the legal status of induced abortion is not the only factor influencing women's ability to access abortion services, it remains a key determinant" (Rahman, Katzive, & Henshaw, 1998, p. 56). In other words whether abortion is prohibited or permitted plays a pivotal role in women's health and reproductive rights. Abortion is strongly regulated by the state, meaning that abortion laws regulate women, in most cases through conditions that women must meet in order to obtain abortion. That is, the legal status of induced abortion in a country helps to determine the accessibility and availability of safe, affordable abortion services which in turn influences the rate of maternal morbidity and mortality (Rahman et., 1998).

Since the International Conference on Population and Development which was held in Cairo in 1994, there has been a trend towards the liberalisation of abortion laws, and this trend is evident in 64 countries which allow abortion either with no restrictions or on broad socio-economic grounds (Ngwena, 2004; Sai, 2004). However, despite this growing trend, there are still 124 countries that prohibit abortion completely or allow it only to save the woman's life or health (Sai, 2004).

Prior to unpacking the afore mentioned statements and the impact that an abortion law has on the availability and accessibility of safe abortion services, a description of the term 'legal' will be given so as to build a clear understanding of what is meant by 'legal' abortion. According to Rahman et al. (1998, p. 59) "a nation's laws often contain conditions that must be observed for an abortion to be classified as legal". Therefore, only abortion that is performed under these conditions can be deemed as being legal. As previously mentioned, these conditions vary from being restrictive, which typically means abortion is permitted only to save the life of the woman, to being less restrictive meaning that abortion is permitted without restrictions (Rahman et al., 1998). Countries such as Canada, United States, Cuba, Greece, Germany, France, Netherlands and Sweden are among the 64 countries that permit abortion upon request (Rahman, 1998, p. 58). It should also be noted, however, that countries such as Brazil, Ireland, Switzerland and Poland, to name a few, are among those countries that permit abortion only to save the woman's life, mental health and/or physical health (Rahman et al., 1998, p. 58).

Unfortunately, the majority of the Sub-Saharan African countries fall under the 124 countries that have restrictive abortion laws except for South Africa (Ngwena, 2004). It is due to these unduly restrictive abortion laws that millions of women resort to unsafe, illegal abortions. Hence, developing countries are host to 95% of unsafe abortions (World Health Organisation as cited in Ngwena, 2004). With the exception of South Africa and Zambia, other SADC countries, namely Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Swaziland, Tanzania, Zaire, and Zimbabwe have refused to acknowledge in their abortion laws that socio-economic circumstances account for why the majority of women seek abortion (Ngwena, 2004, p. 710).

While acknowledging that reproductive rights are more than access to safe legal abortion, it is important to note that access to safe legal abortion is directly linked to reducing maternal

mortality and morbidity caused by unsafe illegal abortions. From what has been discussed thus far, it is clear that Africa has a long way to go and this is perceptible from the high rates of women, including adolescents, who die every day from 'backstreet abortions' or from trying to induce the abortions themselves (Braam & Hessini, 2004).

However, as aforementioned, South Africa is amongst the countries that permit abortion upon request for all women including minors. The Choice on Termination of Pregnancy Act makes the South African abortion law unique and liberal, compared to the abortion laws in the majority of Sub-Saharan African countries. In an attempt to broaden access to safe legal abortion, TOP can be obtained for free in public health facilities (Cooper et al., 2004; Berer, 2004). Furthermore, qualified midwives can provide first trimester abortions consequently increasing service availability (Cooper et al., 2004). In spite of the implication of the South African abortion law, service accessibility, stigmatization, attitudes of staff and lack of knowledge concerning abortion in general and concerning the Act itself has hampered with the effective implementation and success of this law.

This legislation has not thus far guaranteed the accessibility and availability of abortion services. That is, in 1999 "only 32% of the 292 facilities that were designated to perform abortion services in South Africa were functioning, with 27% being in the private sector" (Dickson et al., 2003, p 277). Out of the 32%, only 1.1% of public sector facilities that were providing abortion services were available in the Eastern Cape, with a substantial number of them rendered non-functional during certain periods when committed providers were absent or on leave (Dickson et al., 2003). However, the number of functioning designated facilities increased to 48% a number of years later (Cooper et al., 2004). It should also be noted that the number of legal terminations of pregnancy has gradually increased, from 29.375 in 1997 to 77.201 in 2009 (Cooper et al., 2004; Health Systems Trust, 2009). Based on this, one can assume that a large number of women still have limited or no access to legal abortion services. Hence, South Africa has the highest number of second-trimester abortions amongst other countries with legalised terminations of pregnancy (Department of Health, 2005). That is, over 20% of abortions across South Africa are performed at a gestational period greater than 12 weeks, with 24% of these abortions being performed on teenagers (Morroni & Moodley, 2006; Department of Health, 2005). The effects of these barriers are further reflected in the proportion of women who continue to use illegal or self-induced

abortion methods (Jewkes et al. as cited in Dickson et al., 2003). These delays, shortages of trained personnel, staff attitudes and staff refusals to provide terminations, hinder the effective implementation of the CTOP Act (Harrison, Montgomery, Lurie & Wilkinson, 2000).

2.4.2. Stigmatization

Prior to colonialism, there was no law regulating abortion even though it was tacitly accepted in many traditional African cultures (Ngwena, 2004). That is, abortion was regarded as a family matter and not something to be discussed in the public domain or indigenous courts (Poulter, McClain, Kaurise, Mugambwa, & Milazi as cited in Ngwena, 2004). This may have contributed to the manner in which people react towards abortion, with abortion frequently being treated with stigma, secrecy, moral, and religious sanctions. Abortion stigmatization is a silent and ignored contributor to statistics of maternal mortality and morbidity (Lithur, 2004). Even in South Africa where abortion is legally available upon request up to 12 weeks, stigma and other factors may severely restrict access to abortion services. Hence this section discusses the impact of stigmatisation on women and how it serves as an obstacle for acquiring knowledge.

Abortion was a family matter that was governed by customary law and it is from this history that even to this day, discussion on abortion and sexuality remain to a large extent a taboo in African societies (Hord & Wolf, 2004). Hence Hadley (1996, p. xii) argues that abortion is one of those rare experiences that seem to be "too personal, too taboo" to talk about. Yet in most cases it ironically develops into a "sensationally and bewilderingly public" issue (Hadley, 1996, p. xii). In other words, abortion has developed into a debate between the interests of society and those of the individual. This debate is intensified further by the fact that, traditionally, abortion is perceived as a shameful act which is also preached against by some religious leaders who perceive it as being against biblical teachings (Lithur, 2004). As a result, abortion is highly stigmatised from a social, religious, moral, psychological and traditional point of view.

As a result of this stigmatization, many adolescents resort to 'backstreet' abortion as it has been argued that the "act of obtaining an abortion from a public clinic or hospital carries double stigma of two socially objectionable acts – the girl becoming pregnant and choosing to have abortion in response to the pregnancy" (Varga, 2002, p. 289). This stigma is described in the comments of

two rural girls participating in a focus group discussion who explain how a girl would be treated if she had an abortion (Seutlwadi, 2007, p. 56):

> One girl comments that: "people will look at her funny and talk about her that she is a murderer because she had an abortion", while the second girl says "if she is my friend, people at home will tell me to stop walking with her because she does dirty things, she is a killer".

Based on these girls' comments it is clear that "abortion is a controversial issue touching on religious, cultural, moral and traditional values" (Lithur, 2004, p. 73). These factors unfortunately outweigh the health implications of abortion and this is evident in the way women who choose to terminate their pregnancies are treated by both their families and community (Seutlwadi, 2007). Due to this deeply-rooted stigmatisation of abortion, abortion services remain inaccessible despite abortion being legal and providing IEC regarding abortion remains difficult. Furthermore, this stigmatisation has influenced the attitudes of health-care providers which will be discussed further in the following section.

2.4.3. Attitudes of staff

The attitude of health-care providers is pivotal to service accessibility especially since counselling is the key component of the IEC programme. According to the IEC principles, a counsellor should strive to ensure that every service user has the right to the "information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion" (UNFPA, 1998, p. 8). Moreover, the counsellor should provide accurate and complete information to the user so that he or she can make his or her own decisions concerning which part of the service she or he will use (UNFPA, 1998). Counsellors are not supposed to give advice or decide which service the user must use. Rather they are supposed to explain to the user about the service required, side-effects and for whom it is considered most suitable (UNFPA, 1998). The role of the counsellor or health care worker and what he or she should strive for was enforced further by the 'Policy Guidelines for Adolescent and Youth Health' released by the South African Department of Health in 2001 which states that health care workers are supposed to "facilitate easy, cheap and private access to all forms of contraception and use multimedia methods to provide adolescents with accurate and comprehensive information" (DoH, 2001). However, it has been found in other

countries that most health providers, teachers and other potential sources of support are often discriminatory with regard to teenage sexuality, and reproductive health services and information being provided to adolescents due to cultural sensitivities, religious beliefs, moral values and gender discrepancies (Cornejo & Silva, 2004).

As Gardner (1972) argued 38 years ago, the attitude of the physician is as important as the procedure itself as some physicians might feel a certain moralistic zeal in performing abortions, which might compromise the health and well-being of the pregnant woman. That is, personal values, religion, culture and views of health-care workers may affect the quality of information and care as well as the accessibility of service especially for adolescents. This is re-inforced by Jewkes et al. (as cited in Wood & Jewkes, 2006, p. 114-115) who stated that South African nurses from Limpopo and Eastern Cape were commonly described by adolescents seeking sexual and reproductive health services as "rude, short-tempered and arrogant, and liable to harass clients without any provocation".

This behaviour is evident in a study conducted by Walker (1996) whereby 70% of the sampled Primary Health Care nurses rejected abortion. To them women who choose abortion are "irresponsible, unthinking and promiscuous but most importantly they are denying their role as mothers and rejecting their identity as women" (Walker, 1996, p. 51). Similar findings were found in a study conducted by Harrison et al. (2000) where only 6% of South African nurses in KwaZulu-Natal supported abortion on request. The remaining nurses argued that abortion is against accepted community and societal norms, and that the Choice on Termination of Pregnancy Act would encourage teenagers to "sleep around" and "be irresponsible" (Harrison et al., 2000, p. 426). As a result of this impassioned opposition against abortion, younger colleagues may have been "discouraged from stepping forward to participate in service provision" (Harrison et al., 2000, p. 428).

It is partially due to these judgemental and moralising attitudes that adolescents resort to 'back-street' abortions. The staff's attitude serves as a barrier to the use of a range of health facilities for adolescents. This is elucidated by a 15 year old South African girl when she said: "Most abortions for girls our age are done backstreet....because at the hospital they refuse to do it for us" (Varga, 2002, p. 289). Based on this, it can be argued that one of the reasons why many

adolescents still undergo 'backstreet' abortions is owing to provider resistance and the nurses' attitude towards abortion, which is further intensified in the face of teenage pregnancy.

It can also be argued that since in most cases nurses are the health personnel that adolescents meet for their sexual and reproductive health needs, the nurses' judgemental attitude has a direct impact on the level and quality of knowledge adolescents have about emergency contraceptives and abortion. That is, since most nurses have stigmatised adolescent sexuality, it is highly unlikely that they will discuss issues such as emergency contraception and abortion with adolescents without judging them and/or trying to influence them not to have sex. This is made palpable by South African nurses who stated that they felt very uncomfortable giving adolescent girls contraceptives because they were children (Wood & Jewkes, 2006). Similar attitudes were found amongst Zambian and Kenyan nurse-midwives who strongly disapproved of "adolescent's pre-marital sex, contraceptive use, masturbation and abortion" (Warenuis et al., 2006, p. 125). It is possible that it is due to such judgemental attitudes and statements that many adolescents are faced with unwanted pregnancies despite contraceptives being available free of charge in public health facilities.

2.4.4. Knowledge of and attitudes toward contraceptives

"Safe sex amongst adolescents is a complex issue and condoms are embarrassing for some and uncomfortable for others" (Ekstrand, Larsson, Von Essen, & Tyden, 2005, p. 985). Contraceptive use is a highly contested domain for most adolescents, and as a result preventing an unwanted pregnancy that may result in abortion is not that easy. This is primarily due to factors such as schools, churches, non-governmental organisations, nurses, adolescent girls' mothers and male sexual partners who may play a pivotal role in the decision making process and may send contradictory messages to adolescents such as contraceptives can "completely block the tubes" (Warenuis et al., 2006; Woods & Jewkes, 2006, p. 114). These factors have a direct impact on adolescents' attitudes, practices and knowledge of contraceptives. For instance, according to a study conducted by Smit, McFadyen, Harrison and Zuma (2002), 13.3% of South African adolescents from the rural areas of Kwa Zulu-Natal did not use contraceptives due to disapproval from partners, mothers, religion or cultural values.

According to South African Demographic and Health Suveys 2003 (DoH, 2004), only 65% of sexually active women were using contraceptives in 2003, while the rest relied on traditional methods such as periodic abstinence (rhythm method), withdrawal and folk/other methods. Contraceptive use is highest amongst currently married people and people who already have three children. Level of one's education is related to one's use of contraceptives and the use of contraceptives is highest among White and Asian women and lowest among African women. According to this, adolescents who are sexually active fall under those who rely on traditional methods or do not use contraceptives. Adolescents may be impressionable, thus contradictory messages about fundamental issues such as contraceptives, especially to sexually active people, could have detrimental effects (Richeter & Mlabo as cited in DoH, 2009).

Although adolescents seem to have basic facts about contraceptive methods, the quality of their understanding varies considerably. Some adolescents have misconceptions such as pregnancy will not occur when having sex using the withdrawal method, having sex standing or when it is a girl's first time (Richter & Mlambo as cited in DoH, 2009). Lack of accurate and comprehensive knowledge has resulted in 'folk practices' and anecdotal fears amongst adolescents that contraceptives cause infertility. These fears are strengthened by institutions such as the church which is strongly against contraceptive use. According to Warenuis et al. (2006, p. 111) preachers from local African churches preached that contraceptive use "punctures and spoils the eggs". It is due to this kind of inaccurate knowledge that Nigerian adolescents often seek abortion rather than contraceptives despite the fact that the performance of abortion is illegal unless the mother's life or health is in danger (Otoide, Oronsaye, & Okonofua, 2001).

Similar behaviour is found among Kenyan adolescents where only 11% of the 80% of those who are sexually active use contraceptives (Ajayi, Marangu, Miller, & Paxman, 1991). According to Otoide et al. (2001) adolescents understand contraceptives to mean something that interferes with fertility while abortion has similar but short-lived effects. Furthermore, due to negative social and cultural connotations attached to modern contraceptives such as promiscuity and loose morals, many adolescents, including South African adolescents, tend to use traditional and religious methods of contraception (Ajayi et al., 1991; Varga, 2003; Wood & Jewkes, 2006). These methods include "tying a rope containing traditional medicines around the waist, mixing a cloth covered in the woman's menstrual blood with medicines from a traditional healer and burying it

and drinking tea or concoctions prayed over by religious leaders and abstaining from sex before and during menstruation" (Wood & Jewkes, 2006, p. 111).

Side effects are some of the given reasons why some South African adolescents stopped using contraceptives. They complained that contraceptives made them experience "waist pains after sex, weight loss, diminished sexual feeling because of vaginal wetness and menstrual irregularities" (Wood & Jewkes, 2006, p. 111-112). Menstruation was seen as "cleansing the womb of accumulated dirt". As a result not menstruating was described as a state of "blockage" which was often referred to as a dangerous condition (Wood & Jewkes, 2006, p. 112). This "blockage" was interpreted to mean that the contraceptives were not "good for the blood", hence 14.6% of adolescents stopped using contraceptives (Smit et al., 2002; Wood & Jewkes, 2006, p. 112).

All this reflects the limited and inaccurate knowledge that not only adolescents have. This lack of concise knowledge and the limited use of contraceptives are concurrent with the rate of induced abortion amongst adolescents. Hence, for example, Nigerian adolescents, appear to view abortion as something that controls fertility and as an immediate solution to an unplanned pregnancy with limited negative ramifications on future fertility (Ajayi et al., 1991; Otoide et al., 2001).

2.5. Conclusion

Despite the fact that the Choice on Termination of Pregnancy Act was praised as a progressive break-through for South African women, the legalisation of abortion on its own does not ensure the accessibility and availability of abortion services (Harrison et al., 2000). Abortion is a multifaceted issue that has resulted in many barriers and controversies hindering the successful implementation of Choice on Termination of Pregnancy Act.

Different interventions and policies such as NAFCI, PPASA, loveLife, IEC, Policy Guidelines for Youth and Adolescent Health, the South African Schools Act (No. 84 of 1996) have been developed in an attempt to facilitate the recognition of reproductive health and reproductive health rights for everyone including adolescents. However, lack of information on termination of pregnancy and emergency contraception serve as pitfalls for many of these interventions. That is, although a range of policies and interventions are supportive of reproductive health rights, issues

such religion, morality, stigmatization, attitudes of health care providers, parental consent debates and not giving comprehensive information on all reproductive health matters and services hamper the effectiveness of legislation such as the CTOP Act.

IEC interventions serve as the basis for reproductive health rights because they created an open dialogue about sensitive and controversial issues that for a long time were not spoken about openly or otherwise. However, their neglect of reproductive health aspects such as abortion and emergency contraception which are as equally important to women's, including adolescents', fundamental reproductive health and reproductive health rights, is problematic and may cause unnecessary and preventable maternal morbidity and mortality amongst women, particularly adolescents. That is, due to the fact that abortion and emergency contraception are hardly spoken about, they have been open to speculation and unfounded claims.

IEC takes place within a context. As a result, the controversies surrounding abortion and emergency contraceptives pills have implications in terms of the quality and type of IEC that is provided. For instance, as illustrated above, within some religious environments IEC about abortion for 'traumatic reasons' may be acceptable but abortion upon request is not. Furthermore, what is condemned by religion is often seen as immoral. Thus, within some moral contexts IEC on abortion and emergency contraceptive pills particularly when targeting adolescents, may be seen as promoting atrocious immoral acts. Both these controversies have directly or indirectly played a role in the debate of parental involvement *versus* adolescents' competency. That is, although evidence suggests that given comprehensive and factual information, adolescents are capable of making informed choices, the parental debate remains impassioned. Some health care providers may share the same sentiments as the CLA amongst other organizations, with regard to mandatory parental consent, consequently affecting the dissemination of IEC on abortion and emergency contraceptives.

Knowledge and dissemination of accurate information can empower women, including adolescents, across all ages and socio-economic status, and grant them the opportunity to make informed choices and give informed consent with regard to their reproductive health matters. As a result, knowledge will be the focus of the following chapter especially amongst adolescents. That is, the following chapter will be discussing adolescents' knowledge concerning abortion with specific reference to their knowledge of the Choice on Termination of Pregnancy Act, its

stipulations, their knowledge of EC, consequences of abortion, methods used to perform legal and illegal abortion and their sources of information.

Chapter 3

Knowledge concerning abortion and emergency contraception

3.1. Introduction

The previous chapter has made it evident that abortion is a sensitive and complicated subject. There are many factors that influence reproductive choice. Based on what has been discussed thus far, it is clear that many of these factors serve as barriers to women's, including adolescent girls', access to IEC concerning abortion as well as to clinic services for contraceptives and other reproductive health concerns.

Abortion has been legal in South Africa for over ten years while EC has been readily available for almost the same number of years. Yet for many women abortion and EC remain foreign concepts. As will be discussed in this chapter, this may be due to lack of accurate knowledge about abortion and EC which could be attributed to some of the factors that were discussed in the previous chapter. This lack of knowledge has resulted according to researchers in some adolescents having erroneous beliefs and anecdotal knowledge about abortion and emergency contraception. Furthermore, this lack of adequate accurate knowledge may have prevented many women, especially adolescents, from claiming their reproductive rights, thus, making 'backstreet' abortion the only viable option when facing an unwanted pregnancy.

The kind of knowledge that adolescents have about abortion and emergency contraception is important as it plays a fundamental role with regard to their reproductive health. In other words, accurate knowledge of emergency contraception and abortion is essential in preventing unwanted pregnancies, unsafe abortions, maternal morbidity and maternal mortality amongst adolescents. Hence this chapter will give an in-depth exploration of research concerning the kind of knowledge that adolescents have about abortion and emergency contraception.

It should be noted, however, that this chapter will discuss the knowledge that both adolescents and adults have about abortion and emergency contraception. Adults' knowledge of abortion and emergency contraception is examined due to the fact that there is a dearth of localised literature, especially concerning knowledge about abortion among adolescents. Furthermore, the kind of

knowledge that parents/adults have about abortion and emergency contraception is directly or indirectly passed down to their adolescent children. That is, adults may serve as primary sources of information for some adolescents. Hence adolescents' sources of information are also examined.

This discussion will be divided into themes in an attempt to go beyond examining knowledge on a more general level. These themes will include knowledge of: the legal status of abortion in South Africa; provisions of this law such as requirement for parental or spousal consent; the gestation limit of legal abortions; methods used to perform both legal and illegal abortions; the perceived physical and psychological consequences of both legal and illegal abortions; emergency contraceptive pills and sources of information. Studies conducted in South Africa will be compared with the results of research in other countries.

3.2. Knowledge of the legal status of abortion and provisions in the law

Knowledge of the legal status of abortion is fundamental in terms of how women will seek services. That is, accurate knowledge about the legal status of abortion is pivotal due to the fact that it has direct implications for women's access to safe, affordable and legal abortion services. Knowledge of the legal status of abortion and the underlying stipulations of the law are a stepping-stone to the recognition of women's reproductive rights.

3.2.1. Knowledge of legal status of abortion

South Africa was one of the first countries in sub-Saharan Africa that legalized abortion (Mwaba & Naidoo, 2006). There was much debate around this legislation. Thus one would assume that people would be well-informed about the Choice on Termination of Pregnancy Act and its stipulations (Ngwena, 2004).

Despite the controversy surrounding abortion, one-third of the women surveyed in the Western Cape did not know that abortion is legal in South Africa (Morroni, Myer, & Tibazarwa, 2006). Similar findings were found in a study conducted by Jewkes et al. (2005) whereby 54% of South African women who had abortions outside of the legal abortion services reported to have done so because they did not know that abortion was legal. Furthermore, in a survey study conducted by Mwaba and Naidoo (2006, p. 56) with undergraduate psychology students from a South African

university, "19% of males and 16% of females believed that abortion was illegal in South Africa".

It could be argued that these percentages reported by Mwaba and Naidoo (2006) are low in comparison to the above mentioned one-third of women in the Western Cape. However, when taking into account the fact that these are university students who have access to all kinds of sources of information, these percentages are very high. These are people that one would assume have comprehensive knowledge about reproductive health matters such as sex, contraceptive use, and abortion, among other things. Thus, it is disquieting that there is such a high percentage of students who have inaccurate knowledge about the legality of abortion especially when considering the fact that at the time of this study, the Act had been implemented for almost 10 years. Furthermore, according to a nationally representative survey conducted by Simbayi, Chauveau and Shisana (2004), 16½ years was the median age of first sexual debut for 54,6% of 15-24 year olds. Thus, it is very unlikely that all these students who have inaccurate knowledge about the legality of abortion are not sexually active.

Lack of knowledge is a factor in other countries as well. For instance, abortion is illegal in the Philippines. However, the majority of the participants in a study conducted by Flavier and Chen (1980) thought that abortion was legal, with 76% talking from experience as compared to the 53% without experience. Based on this, one can conclude that the 76% of those who were talking from experience, either know someone or have personally undergone an illegal abortion. The need for comprehensive and factual information is evident in a study conducted by Becker, Garcia and Larsen (2002) whereby 54% of the sampled Mexican men and women aged between 15 and 24 years did not know the legal status of abortion in Mexico. However, what is more distressing is the fact that Mexican medical professionals believed that abortion was always illegal whereas abortion is legal under some circumstances. The lack of sufficient and accurate knowledge amongst health professionals serves as an additional obstacle to women's access to safe and legal abortion services.

3.2.2. Knowledge of provisions within the law

Knowing whether abortion is legal or not in one's country is not sufficient, because it is the provisions within the law that essentially dictate under what circumstances abortion is legal. Hence the stipulations contained within the Act governing the legality of abortion are important. That is, the legality of abortion or the Choice on Termination of Pregnancy Act cannot be separated or spoken about without taking its stipulations into account. Much of the debate that occurred around the implementation of the Choice on Termination of Pregnancy Act was not based exclusively on the fact that abortion was legalized, but also on some of the stipulations of the Act such as that a minor does not need parental consent to obtain legal abortion (Mwaba & Naidoo, 2006).

Despite the impassioned and controversial debate that occurred due to some of the stipulations of the Choice on Termination of Pregnancy Act and the extensive media coverage of the law before its implementation in 1998, 90% of South African women who were seeking abortion had no knowledge of the conditions under which abortion was legal (De Pinho & Morroni as cited in Mwaba & Naidoo, 2006). Similar results were found in a recent survey study conducted by Mwaba and Naidoo (2006) with students from a South African university whereby:

> Twenty-eight percentage of males and 23% of females believed that women under the age of 18 years could not have a legal abortion. Forty percent of males and 42% of females believed that a married woman needed her husband's permission to have legal abortion. Eleven percent of males and 8% of females believed that only unmarried women could have a legal abortion. And lastly, 67% of males and 46% of females believed that parental consent was required for a female under the age of 18 years to have a legal abortion.

It is interesting to note how these findings are embedded in a patriarchal system where women are deemed legally incapable of making autonomous decisions despite the fact that these decisions have direct implications for them. Only an unmarried woman is expected to legally be allowed to make autonomous decisions regarding her own fertility, whereas females under the age of 18 years or married women are expected to need permission from their parents or spouses in order to exercise the same right as unmarried, older women.

3.2.3. Knowledge of gestational limit of legal termination of pregnancy

"Abortion is a time-restricted health service" (Morroni et al., 2006, p. 2). Thus it is paramount that women have accurate knowledge of these time constraints because beyond 12 weeks abortion is no longer available upon request. That is, beyond 12 weeks termination of pregnancy is available under limited circumstances. As a result women need to know these time restrictions so that they can make informed decisions concerning when they seek assistance with an unwanted pregnancy.

As previously mentioned, knowing the legal status of abortion is not sufficient and this is made evident by the results found in a survey study conducted by Morroni and Moodley (2006) with sexually-active women from the Western Cape Province in South Africa. Out of 567 who knew about the legality of abortion, 48% did not know there was a time restriction for a legal termination of pregnancy on request. Furthermore, 76% of those who knew there was a time restriction, did not know what the time restriction was. Thus, despite the fact that most of these women know that termination of pregnancy is legal, 'backstreet' abortion might remain a viable option when faced with an unwanted pregnancy as a result of this lack of adequate and accurate knowledge of the gestational limit. Those presenting for a termination of pregnancy in the second trimester may not be able to obtain a legal termination of pregnancy and may thus opt for an unsafe procedure.

Comparable results were found in a study conducted by Sturgeon (2008) where 61,8% of third year male students from a South African university had inaccurate knowledge about the gestation weeks under which legal abortion can be obtained. Although the two populations are not necessarily demographically similar, it is interesting that a higher percentage of the male participants in Sturgeon's (2006) study were unaware of the gestational date limit than were the females in Morroni and Moodley's (2006) study.

Similar results were found in other countries such as Nigeria where Nigerian adolescents believed that abortion referred to the "termination of pregnancy after 3-4 months" (Otoide et al., 2001, p. 78). This gestation limit is likely to be for an illegal abortion because under the Nigerian law termination of pregnancy is illegal unless the mother's life is threatened by the pregnancy (Otoide et al., 2001). This is opposite to the laws governing abortion in Latvia. In Latvia abortion is

available upon request up to 12 weeks and up to 28 weeks abortion is permitted in case of rape or if medically indicated (Melgalve et al., 2005). However, almost half of abortion clients that were sampled did not have accurate knowledge about the gestational limits for obtaining a legal abortion (Melgalve et al., 2005). Abortion clients in this study refer to women seeking abortion.

Lack of accurate knowledge about the time constraints for obtaining a legal abortion has dire consequences for the pregnant woman, due to the fact that in South Africa from 12 and from 20 weeks of gestation, termination of pregnancy is available under limited and very limited circumstances respectively. Not only does this make abortion less available but it also means that women who cannot obtain a legal abortion because they do not fall under these circumstances, either carry an unwanted pregnancy to term or opt for 'backstreet' abortion.

3.3. Termination of Pregnancy procedures

As previously mentioned abortion is a time-restricted service and, as a result, various procedures are employed when terminating a pregnancy legally depending on the gestation limit. There are two categories with regard to methods used for termination of pregnancy in South Africa, namely, surgical and medical (DoH, 2000; Cooper et al., 2005).

Medical abortion, previously known as RU-486, refers to the oral and vaginal administration of a regimen of mifepristone and misoprostol (Cooper et al., 2004; Cooper et al., 2005). Mifepristone softens the cervix and blocks the action of progesterone (a hormone needed to maintain a pregnancy) (Ipas, 2008). Misoprostol also softens the cervix but, in addition, causes the uterus to contract so as to expel the embryo (Ipas, 2008). 200mg of mifepristone orally and 800mg of misoprostol vaginally may be administered up to nine weeks of pregnancy either at home or at the clinic (Cooper et al., 2005). A different dosage is used in the second trimester and administration takes place only at the clinic. In 2001, different dosages of mifepristone and misoprostol were approved by the South African Medical Control Council (Cooper et al., 2005). A regimen of 400mcg misoprostol and 600mg mifepristone can be administered orally up to eight weeks of pregnancy. However, since 2002 this drug regimen has only been available in designated private physician and non-governmental organization (NGO) practices (Cooper et al., 2005). It is worth noting that medical abortion gives women the opportunity to control their fertility as it can also be administered by the woman herself. It has a 98% success rate if used

within the first nine weeks (Ipas, 2008). Women for whom this medical abortion was unsuccessful can seek Manual Vacuum Aspiration to treat incomplete abortions (Ipas, 2008).

Surgical abortion is an alternative to medical abortion, and it is also used for incomplete abortions. Surgical abortion refers to different methods used to evacuate the uterus using different instruments. Dilatation and Curettage (D&C) also known as 'sharp curettage', Manual Vacuum Aspiration (MVA) and Suction curettage are different types of surgical abortions used in South Africa (Berer, 2004; Cooper et al., 2005; DOH, 2000). Although D&C and Suction curettage were standard methods of abortion, due to the high risks and major complications that are associated with them, medical experts discourage using them if alternative methods are available (Baird & Flinn, 2001). MVA is a safer and more effective method. Hence it is used by 90% of South African midwives (Baird & Flinn, 2001; Ipas, 2008). Surgical abortion comprises of using instruments in the uterus. As a result it can only be performed by properly trained midlevel providers in a clinical setting, and some designated facilities use anaesthesia for this procedure (Baird & Flinn, 2001; DOH, 2000).

Lack of accurate knowledge and misinformation has resulted in anecdotal beliefs with regard to how abortion is performed. Thus, the following sections give an in-depth explanation of knowledge of methods used for both legal and illegal abortion in South Africa and its surrounding countries.

3.3.1. Knowledge of procedures for legal terminations of pregnancy

Regrettably, there is a scarcity of research done on knowledge of procedures for legal termination of pregnancy in South Africa. Thus, this section will be based on international studies.

A lack of knowledge of how legal abortion is performed is evident in qualitative research. For example, a 17 year old sexually active Swedish adolescent stated that: "most people only know that the baby is taken out, not how it's actually done" (Ekstrand et al., 2005, p. 984). Others believe that legal abortion is performed by "cutting off the arms and legs and sucking out the brain" (Ekstrand et al., 2005, p. 984). Similar results were found in a study conducted by Stone and Waszak (1992, p. 63) with adolescents from cities across the US not only believing that abortion is a dangerous procedure that is both physically and mentally painful but also that it "could kill a young woman while they're trying to kill or take it out or whatever they do, take a

knife or whatever and accidentally cut her, you know accidents do happen". It is clear that this kind of knowledge will do more harm than good in the sense that if this is the kind of information that is conveyed, then young women may to take an unwanted pregnancy to term due to fear of what could happen during the procedure.

Lack of accurate knowledge about the procedures used to perform legal termination of pregnancy was also found among women seeking abortion in a study conducted by Melgalve et al. (2005) in Latvia. The aim of the study was to assess the sampled women's knowledge about medical and surgical abortion. At the time that this study took place, surgical abortion was the only available procedure. However, medical abortions were approved soon after the data were collected, meaning that there was much debate and media coverage of the procedure. Fifty-three percentage of the sample knew the legal status of surgical abortion, and almost 31% of the sampled women had heard of medical abortion. Some participants were confused between medical abortion and emergency contraception (Melgalve et al., 2005). Although medical abortion became an alternative option for women seeking abortion in Latvia, their lack of knowledge with regard to medical abortion might have rendered this alternative ineffective.

Lack of knowledge can result in calamitous consequences especially when one is faced with an unwanted or unintended pregnancy. The following section discusses knowledge of the hazardous methods used by women in a desperate attempt to deal with an unwanted or unintended pregnancy.

3.3.2. Knowledge of illegal termination of pregnancy procedure and consequences

Worldwide, 19 million women are estimated to undergo unsafe abortions each year and 60% of these unsafe abortions are performed among women under the age of 25 years (Shah & Ahman, 2004). "Close to 100 African women die every day and many more are injured as a result of unsafe abortions, with 40% of all unsafe abortions occurring in women between the ages of 15 and 24 years" (Braam & Hessini, 2004, p. 44). Despite the high maternal mortality rates, adolescents in sub-Saharan Africa still undergo 'backstreet' abortions or induce their own abortions in fear of social stigma, especially in the rural areas. Consequently their probability of future infertility is increased as opposed to those who aborted legally (Zabin & Kiragu, 1998).

Cervical or vaginal trauma, sepsis, haemorrhaging, uterine perforation, genital lacerations and tetanus are some of the consequences of unsafe abortions due to the use of invasive suppositories (Hord & Wolf, 2004; Mbonye, 2000; Olukoya, 2004; Zabin & Kiragu, 1998). It has been argued that these consequences can be more serious in younger people than in adults, and in some cases they may lead to pelvic inflammatory disease and infertility (Hord & Wolf, 2004; Olukoya, 2004). Prolonged bleeding, the foetus not passing completely from the body, nausea, vomiting, diarrhoea and pain are other complications that could be caused by illegal and unsafe abortion (Olukoya, 2004; Oye-Adeniran et al., 2005). It should be noted that some of these infections and consequences are primarily due to the fact that the procedure is performed by untrained practitioners or the woman induces the abortion herself (Zabin & Kiragu, 1998). It is interesting to note that even though Nigerian respondents were aware of the complications caused by unsafe abortion through personal experience or experience of relations, neighbours, friends and partners, a substantial number of them still seek unsafe abortion (Oye-Adeniran et al., 2005).

It is acknowledged that not all these unsafe abortions are due to lack of knowledge. Some are due to abortion being illegal or due to restrictive abortion laws in most countries. In South Africa it is estimated that, while the Choice on Termination of Pregnancy Act has reduced the number of unsafe abortions dramatically, a number of women continue to undergo unsafe abortion (Moodley & Akinsooto, 2003).

Although knowledge of legal termination of pregnancy procedures can be obtained through formal channels, knowledge of illegal termination of pregnancy procedures is spread through informal networks. These networks are surprisingly efficient. Thus knowledge of the methods used in unsafe terminations of pregnancy are relatively well-known. In a study conducted by Varga (2002, p. 288) with South African adolescents, it was stated that "a mixture of Jik (laundry bleach), fizzy soft drinks, milk, Sta-soft (fabric softener), Epsom salt and castor oil" are used to soften the stomach so that the girl could go to the toilet and "lose the baby". Comparable situations are found in research conducted by Seutlwadi (2007) with Eastern Cape adolescents where an 18 year old girl stated that from what she had heard, abortion is committed by drinking Gordons (dry gin) neat or drinking a homemade remedy such as Oros (orange flavoured juice/cordial).

Similar results were found in a study conducted by Ogoh (2001) with Nigerian adolescents where out of all those who face an unwanted pregnancy, only 25% sought assistance of medical care providers while the rest engaged in do-it-yourself procedures (which typically involve the ingestion of herbs, roots and the use of available substances that are usually non-medical) or have the abortion performed by peers. "An overdose of Andrew's liver salt, blue Omo washing detergent and dogonyaro (neem tree commonly used for malaria)" is one of the do-it-yourself procedures used by Nigerian adolescents to terminate a pregnancy (Ogoh, 2001, p.114). An excessive in-take of sugar may be used when the pregnancy is less than a month (Ogoh, 2001). Zambian women, on the other hand, are known to use twigs, detergents or gasoline, or take large doses of chloroquine or malariaquine (Archibong, 1991; Castle et al. as cited in Zabin & Kiragu, 1998). For Egyptian adolescents, "beating or violent massage of the abdomen, introducing a plant stalk, catheter, feather or wire into the uterus, injecting substances into the uterus, drinking herbal preparation or taking various drugs" are some of the methods they use when faced with an unwanted pregnancy (Seif & Dawla, 2000, p. 52).

Despite the fact that unsafe abortions are the leading cause of maternal mortality and morbidity, most Nigerian adolescents believe that they have limited negative impact on their fertility and any complications that may occur are seen as remote and as occurring only when several steps have failed (Otoide et al., 2001). The lack of knowledge about the potential consequences of unsafe abortion means that adolescents are at risk in terms of the dire and irreversible consequences of unsafe abortions.

The use of untrained providers and women inducing the pregnancies themselves using a variety of hazardous methods is not unique to Africa. For instance, in Latin America "inflicting voluntary trauma (punches, falls), oral or vaginal administration of natural products (teas, infusions, vegetables, seeds), manufactured products (beer, wine, soapy substances, bleach) or pharmaceutical products (quinine, laxatives, estrogens) and insertion of physical objects (catheter, sharp objects) into the uterus" are some of the methods used to terminate an unwanted pregnancy (Allan Guttmacher Institution [AGI], 1996, p. 1). These methods are similar to those used by sexually active Mexican adolescents when resolving an unwanted pregnancy (Becker et al., 2005). It should be noted that there is a seven year gap between these two studies yet the

participants' methods of terminating an unintended pregnancy are similar, which means that this knowledge of how to illegally terminate an unwanted pregnancy has been passed on.

3.4. Knowledge of Emergency contraceptive pills

Emergency contraceptives serve as an effective option for women including adolescents who want to avoid unintended pregnancies. However, due to lack of knowledge, this kind of contraception remains inaccessible and ineffective. This is evident in a study conducted by Mqhayi et al. (2004) where only two women out of 193 had ever used emergency contraceptive pills, despite the fact that 39% engaged in unprotected sexual intercourse without the intention of conceiving in the previous year. Sixty nine women in the above mentioned study did not know about emergency contraceptive pills (Mqhayi et al., 2004). As a result, the majority of them did not consider emergency contraceptive pills after having unprotected sex. Furthermore, in a study conducted by Smit et al. (2001) 43% of the women who knew about emergency contraceptive pills, lacked knowledge of the time period within which emergency contraceptive pills need to be taken after engaging in unprotected sexual intercourse.

This lack of knowledge, however, is not only found amongst potential users, but it is also evident amongst some of the health care workers. Seventy three percent of South African pregnant student nurses had no knowledge of emergency contraceptive pills despite the fact they are involved in health care (Netshikweta & Ehlers cited in Mqhayi et al., 2004, p. 138). Similar trends of this lack of knowledge were also found amongst Nigerian health care workers, where "13% incorrectly believed that they caused abortion and 26% believed that they both prevent pregnancy and induce abortion. Another 13% said they did not know" (Ebuehi, Ebuehi & Inem, 2006, p. 91).

Lack of accurate knowledge concerning emergency contraceptive pills is partially owing to its limited promotion and access. This is made evident by a South African study conducted by Blanchard, Harrison and Sello (2005) amongst pharmacists in Soweto and the Johannesburg Central Business District where two pharmacists incorrectly described emergency contraceptive pill as an abortifacient. This inaccurate knowledge is problematic especially amongst health care workers, as it results in incompetent work and denies women the opportunity to make informed choices.

3.5. Knowledge on risks of termination of pregnancy

Apart from the negative moral connotations associated with abortion, it is also believed to pose significant psychological and medical risks. This is made evident in a study conducted by Ekstrand et al. (2005, p. 55) where, according to most adolescents, abortion is "medically dangerous and emotionally damaging". However, there is controversy regarding the medical and psychological consequences of abortion, with research indicating that there are few consequences to legal abortion. This is discussed below, together with research on knowledge of the consequences of abortion.

3.5.1. Physical/medical and psychological consequences of legal termination of pregnancy

"Induced abortion is a ubiquitous practice, experienced throughout time by a significant number of women all over the world" (Stotland, 2001, p. 27). Risk factors associated with this practice depend primarily on whether the woman has access to safe legal abortion or resorts to unsafe abortion. Legal abortion, performed under safe conditions, carries relatively few medical risks compared to risks of childbearing. Mortality risks are twenty times greater for pregnancy and childbirth than for abortion among young women who are between the ages of 15 and 19 years (Adler et al., 2003). Abortion performed in the first 12 weeks results in few or no physical complications provided it was performed legally and safely (Zabin & Kiragu, 1998). It should be noted that the primary reason why legal abortion has few physical consequences in South Africa is because it is performed by qualified nurses and midwives in designated hospitals and/or clinics. Furthermore only qualified doctors can perform pregnancy terminations from the second trimester (Dickson et al., 2003).

It has been argued that abortion is a very traumatic experience which may result in psychological dysfunction, and more so among teenagers as adolescents fail to make a clear cause-effect connection between intercourse and pregnancy (Trad, 1993). It is imperative for one to note that the extent of this traumatic experience and the subsequent psychological effects thereof depend to some extent on the practitioner's attitudes but primarily on whether the abortion was performed legally or illegally. However, based on numerous studies of psychological responses following abortion, it is reported that there is no empirical evidence of psychological or emotional harm

regardless of how long ago the woman had the abortion (Adler et al., 1992, Charles, Polis, Sridhara & Blum, 2008). According to Stotland (2001), the rate of women suffering any major psychiatric problems is at least ten times greater after childbirth than after abortion. She further argues that if women do suffer psychologically, it is usually owing to other factors such as "poor social support, coercion (to have an abortion) and pre-morbid psychological stress or disorder" (Stotland, 2001, p. 28). In other words, carrying an unwanted pregnancy to term poses more psychological problems than having an abortion, except in cases where women are coerced into having an abortion.

Although some women may experience negative psychological responses after an abortion, one would assume that these negative responses are heightened for adolescents especially when taking Trad's (1993) argument into account. However, contrary to popular supposition, a number of studies have shown that adolescents who aborted their pregnancies showed significant drops in anxiety and depression but increased levels of self-esteem, control and positive state of mind (Adler et al., 2003). In addition, not only were there no significant differences in age, in terms of psychological functioning pre-abortion and post-abortion, there were also no significant differences in the reasoning and awareness of the consequences of choosing abortion between adults and adolescents (Adler et al., 2003). A further attempt to destigmatize abortion was made by Charles et al. (2008). Charles et al. (2008) reviewed 21 studies rated from excellent to very poor in terms of methodology, quality, validity of the results, and taking into account the intentions of the pregnancy (wanted or unwanted) when doing comparisons and preconception mental status of the woman. There was a general pattern of neutrality from most studies that were regarded as high quality, which implies that there is no significant difference in terms of mental health sequelae between those who terminated their pregnancies and those who carried their pregnancies to term (Charles et al., 2008).

However, studies with the most flawed methodologies (rated as poor or very poor) consistently found a negative relationship between abortion and mental-health outcomes (Charles et al., 2008). Thus it can be argued that it is based on such studies that arguments against abortion have often favoured the Post-Abortion Stress Syndrome (PASS) as evidence of the psychological harm caused by abortion (Cooper et al., 2005). PASS is a term commonly used by psychiatrists who are opposed to abortion. It is used to refer to the emotional and psychological consequences of

abortion. Although this psychological problem has never, in fact, been integrated into any psychiatric diagnostic system, it continues to strengthen the social stigma of pregnancy termination.

This social stigma, among other previously discussed barriers, have led many women to resort to clandestine abortions, for fear of being alienated or shunned by their communities (Zabin & Kiragu, 1998). This is corroborated by a 20 year old rural girl in South Africa when she said "most abortions are done backstreet because girls don't want the community to know what they are doing" (Varga, 2002, p. 288). It is due to this secrecy and the pressure and need to conceal the abortion, that some women may experience sensations of sadness, regret and guilt longer than those who had legal abortions (Adler et al., 1992).

3.5.2. Knowledge of medical and psychological consequences of abortion

Evidently abortion itself carries few medical risks. Thus there is little basis for the declaration that abortion leads to severe physical consequences. However, the very act of looking for these risks by those who are against abortion suggests a strong belief that such effects are to be expected which in turn perpetuates the idea that abortion is dangerous. Due to the fact that it has been tactfully omitted by those who are opposed to abortion, that these risks differ significantly depending on whether abortion was legally or illegally performed, there is fear among adolescents that abortion causes infertility (Varga, 2002). This fear of infertility is rooted in the fact that in most African cultures fertility is an "integral part of the cultural construction of the female self" (Preston-Whyte as cited in Varga, 2003, p. 160).

Hence 38% of South African women from a study conducted by Morroni, Myer and Tibazarwa (2006) considered legal abortion to be an unsafe procedure that reduced future fertility. For some American adolescents not only is abortion an unsafe procedure but it is also dangerous when performed earlier (Stone & Waszak, 1992). Thus, many adolescents do not know that when abortion is performed legally in a hospital or authorized facilities, chances of infertility are lowered (Zabin & Kiragu, 1998). This incorrect knowledge and erroneous beliefs, may be primary reasons why many adolescents, both locally and internationally, (as illustrated in the two latter studies) do not know that it is best to terminate a pregnancy earlier because abortion is a

time-restricted service. It is worth noting that there is a dearth of literature on knowledge of psychological consequences of abortion both nationally and internationally.

The following section explores adolescents' sources of information and how these sources have contributed to the knowledge that adolescents have about reproductive health matters but more specifically about abortion.

3.6. Sources of information

It has been found that in countries like Nigeria, Egypt and the USA that adolescents have the least access to comprehensive reproductive health information and services (Feldman & Clark, 1996; Otoide et al., 2001; Seif & Dawla, 2000). The lack of concise knowledge about abortion, contraceptives and the legal status of abortion, including the incorrect assumptions about women's rights (or lack thereof), are related to the kind of sources of information that people, especially adolescents, have. Teenagers are susceptible to persuasion. Hence campaigns that restrict abortion have targeted teenagers with an abundance of literature, while pro-choice literature is less available and less likely to be geared towards adolescents (Stone & Waszak, 1992, p. 52).

According to a study conducted by Morroni and Moodley (2006) with South African women, only 9% of those who knew about the legality of abortion had ever discussed abortion with a health-care provider. Since it is impossible that only this 9% are sexually active, it means that those who fall outside this 9% have the church, media or friends as their primary source of information.

A contributing factor to why there may be limited dialogue between adolescents and health-care workers is owing to the health-care workers' attitudes. South African nurses from the Western Cape have been described as "rude", "inhuman" and "not caring" (Jewkes, Abrahams & Mvo, 1998, p. 1785). These nurses were known for routinely scolding, shouting, slapping and verbally abusing their patients especially adolescents. One nurse was reported shouting at an adolescent that "she was not there when we were making love in the shack, so I should not bother her (with my pain)!" (Jewkes et al., 1998, p. 1786). Similar attitudes were found in a study conducted by Warenuis et al. (2006, p.124) where 80% of Kenyan midwives and 94% of Zambian midwives disagreed that "abortions should be allowed for adolescent girls with unwanted pregnancies".

It is as a result of these kind of attitudes and behaviour that the National Adolescent Friendly Clinic Initiatives (NAFCI) were initiated. NAFCI was established in 1999 as an integral component of multi-dimensional HIV/AIDS youth programme called loveLife (Dickson, Ashton & Smith, 2007). The standards and criteria of the NAFCI were developed on the basis of established characteristics and attributes of adolescent-friendly services, including having adolescent-specific policies and non-judgmental staff, ensuring privacy and confidentiality and having an attractive environment (Dickson et al., 2007). In an attempt to overcome negative attitudes and behaviour towards young people seeking reproductive health services, staff, clerks and the security are asked to explore their attitudes. In addition, staff is trained by NAFCI facilitators in the standards of adolescent friendly services and problem-solving methodology to assist them in finding solutions to barriers in implementing the standards of NAFCI (Dickson et al., 2007). It is worth noting that although NAFCI has improved the quality of care provided to young people seeking reproductive health services, many clinics have not implemented this programme due to condemnation of adolescent's sexual activities (Dickson et al., 2007).

Life Orientation is a compulsory and examinable learning programme, defined by the Department of Education as cited in Macleod (2009, p. 7) as "the study of the self in relation to others and to society". The aim of the sex education component of this learning area is to primarily promote sexual and reproduction knowledge and condom self-efficacy (Magnani et al. as cited in Macleod, 2009).

Macleod (2011) identifies two approaches used in Life Orientation sex education manuals. The first approach is a liberal humanist approach. According to this approach, the individual has choices and teachers are instructed to be conscious of their views and beliefs with regard to teenage sexual relationships (Macleod, 2011). The second approach is a conservative approach where sex education is about encouraging norms, moral and religious values that will guide adolescents to the path of rightful living (Macleod, 2011). According to this approach "the role of the educator or parent is not to present alternatives and assist the teenager with informed choice, but rather to guide them on the path of rightful living" (Macleod, 2011, p. 42). Despite the fact that these approaches are very different from each other, the internal conundrum of 'adolescence as a transition' (i.e. they are no longer children but they are not adults either) is evident in their use of danger and diseases as guiding metaphors. That is, teenage pregnancy, abortion, adoption,

single parenthood, early marriage are depicted as personally damaging, a disaster with negative psychological, social, educational and health consequences (Macleod, 2009; 2011). These metaphors are illustrated in the following extract written by Vergnani and Frank (as cited in Macleod, 2009, p. 73):

> Abortion is always traumatic for the mother and can have long-term negative consequences for her particularly if it conflicts with her religious values

This use of danger and diseases as metaphors in sex education is not only in South African manuals but can be found in sex education manuals from other countries. For example, these metaphors were also used in the Kenyan secondary education book on *Social Education and Ethics* written by Otiende et al. (as cited in Mitchell, Halpern, Kamathi & Owino, 2006, p. 26), which states that:

> Young people who procure abortion often end up leading depressed, frustrated, unwholesome and lonely lives which usher them into a further abyss of depravity and drug addiction. A girl will always know and live with the reality that she wilfully smothered and killed her unborn child. It is fairly haunting and dauntingly prickly to one's conscience. Hallucinations, dementia and ultimate madness are the likely consequences for the victims.

As a result of the attitudes of some health service providers and educators and in some cases lack of information, adolescents tend to rely on informal sources for information about their sexuality (Nwagwu, 2007). The media (newspaper, magazines and movies), internet and friends/peers are important sources of information for reproductive health matters for adolescents (Nwagwu, 2007). Thus it is not surprising when 61% of Nigerian adolescents indicated that they would consult a friend for help or information about reproductive health matters (Ogoh, 2001). This information is learnt and passed on to peers, despite the fact that do-it-yourself procedures or the assistance of peers in terminating a pregnancy are major causes of maternal morbidity and mortality (Ogoh, 2001).

In a South African study, it was found that many adolescents reported that they have been provided with very little and vague information about sexual matters from their mothers, teachers

or female relatives (Wood & Jewkes, 2006). According to Wood et al. (as cited in Wood & Jewkes, 2006), some adolescents reported that their first knowledge about sex derived from sexual initiation by men and others described friends as important sources of information who gave them advice and with whom they exchanged stories about sexual matters.

Thus in addition to the health-care workers' attitudes and the misinformation disseminated by the education system, religious fundamentalists in the US "have attacked abortion rights by spreading false information, opening fake hotlines and by other efforts, in order to disseminate anti-abortion propaganda misinformation" (Feldman & Clark, 1996, p. 15). Other religious fundamentalists are actively engaging in disinformation and spreading fear by falsely claiming that abortion increases the risk of breast-cancer (Berer & Ravidran, 1996). In South Africa, there are Christian websites such as Neobirth Pregnancy Care Centre, Africa Christian Aid and Pregnancy Crisis Centre or Pregnancy Care Centre that also disseminates and accentuates unsubstantiated negative health and psychological consequences of abortion such as suicidal impulses, hostility, promiscuity, depression, guilt and shame (Macleod, 2011). Hence Stone and Waszak (1992, p. 52) and Macleod (2011) argue that "anti-abortion, conservative morality and religion" indirectly serve as sources of information for many adolescents, due to the fact that they still influence sex education manuals and programmes.

Unsafe abortions, maternal morbidity and maternal mortality caused by lack of knowledge or failed contraceptives among women especially adolescents are preventable. However, this will not be possible as long as adolescents are denied comprehensive and factual reproductive information. Many adolescents are at an age where they are engaging in sexual activities. Thus, it is of fundamental importance that they are equipped with accurate and comprehensive information about reproductive health matters including abortion so that they can make an informed choice should they be faced with an unintended or unwanted pregnancy. That is, adolescents cannot rely solely on the media, internet and friends as primary sources of information otherwise this cycle of inaccurate knowledge, ignorance and misconceptions regarding abortion, contraceptives and sex will continue.

3.7. Conclusion

Although there is limited research on knowledge of abortion and emergency contraception, the extent of the lack of knowledge discussed in this chapter is of concern. This is especially so when, after many years of the implementation of the Choice on Termination of Pregnancy Act and EC being made available in both private and public sectors in South Africa, there are still women, including adolescents, who do not know that abortion is legal and available upon request, what emergency contraceptives pills are, and the period within which they need to be taken. Some of these adult women, who also do not have sufficient knowledge about reproductive health matters, serve as primary sources of information for some adolescents. This is disquieting primarily because it enables the perpetuation of erroneous beliefs and inaccurate knowledge.

Knowledge of the legal status of abortion and its underlying stipulations are fundamental to all women, including, adolescents. However, as illustrated in this chapter, 54% of South African women in a survey did not know that abortion was legal. This lack of knowledge has direct implications to their access of safe, affordable and legal abortion services, especially when taking into account the fact that abortion is a time-sensitive service. Furthermore, lack of knowledge and misinformation has resulted in anecdotal beliefs with regard to how legal abortion is performed and the aftermath of legal abortion. This lack of knowledge and misinformation may be one of the reasons why some women still undergo 'backstreet' abortions or induce their own abortions. Emergency contraceptive pills are an effective option for women, including adolescents, who want to avoid unwanted or unintended pregnancies. However due to lack of knowledge amongst potential users and amongst some health care workers, they remain inaccessible. Both these services are time-sensitive, thus lack of knowledge and misinformation compromises their efficacy and in some cases women, including adolescents' reproductive health.

Adolescents are not expected to be sexually active even though they may be. As a result, information and services are often not available to them as illustrated in the chapter. However, the reality of the matter is that adolescents are engaging in sexual activities and abortion and the use of emergency contraceptives has become an integral part of their reproductive lives. Thus accurate knowledge about abortion and emergency contraceptives is essential. The fact that there is a dearth of localised literature concerning adolescents' knowledge about abortion and

emergency contraceptives is disappointing because both these services have become fundamental parts of women's, including adolescents', reproductive health particularly in South Africa where abortion is available upon request and EC can be obtained for free in public health facilities. Ensuring that a viable option to prevent an unwanted pregnancy after unprotected sex or contraceptive failure is available for all women, including adolescents, is imperative. Furthermore, making certain that safe, affordable and legal abortion is available and accessible to all women, including minors, and that they have accurate knowledge about abortion and emergency contraceptives is vital.

This study examined adolescents' knowledge about abortion and emergency contraceptives. It examined adolescents' knowledge about both legal and illegal abortion, including their knowledge of the conditions stipulated in the Choice on Termination of Pregnancy Act. It also investigated their knowledge about physical/medical and psychological consequences caused by abortion, be it legal or illegal, and if they knew anyone who has had an abortion. And since there is much confusion between medical abortion and emergency contraceptives, their knowledge about emergency contraceptives and their sources of information was also examined. The following chapter gives an in-depth exploration on how this study was executed.

Chapter 4

Methodology chapter

4.1. Introduction

Previous chapters have provided a discussion of the rationale and the context of this study. This chapter gives an in-depth explanation of methods employed in this study. That is, this chapter provides a discussion about the paradigm used, the sample, research questions, instrument construction, pilot study, data collection and the methods of analysis and interpretation. The following section discusses the paradigm used and its implications, ethics of the study and limitations of the methods used.

4.2. Research design

Paradigms are defined as "all encompassing systems of interrelated practice and thinking that define for researchers the nature of their enquiry along three dimensions: ontology, epistemology and methodology" (Durrheim & Terre Blanche 2006, p. 6). In other words, not only do paradigms help researchers determine which questions are relevant to their topics and how those questions should be asked and answered, but they also play a pivotal role in how data are collected, analyzed and interpreted.

Due to a dearth of localized literature, this research serves as an explorative study from a positivistic stance which examined Eastern Cape adolescents' knowledge concerning abortion and the accuracy of this knowledge. According to this paradigm, a researcher using this approach attempts to logically link the abstract ideas of the relationship to precise measurements of the social world (Neuman, 2003).

Surveys collect systematic and factual data, making it possible to "describe, compare or explain knowledge, attitudes and behavior on a more general level" (Fink, 1995, p. 1). Furthermore a survey is ideal for large samples, which was very pertinent to this research (Nardi, 2003). Limitations of surveys such as a low response rate, the requirement for simple questions and no opportunity for probing (Ruane, 2006) were kept in mind. As a result, relevant measures were taken to ensure that the above mentioned limitations were dealt with effectively which will be

demonstrated in this chapter. That is, through the pilot study the researcher was able to highlight problematic areas in the questionnaire consequently increasing the reliability and validity of the findings.

Due to the fact that this study was aimed at obtaining impartial information about a sensitive and controversial topic, questionnaires were used. This was owing to the fact that questionnaires have increased levels of anonymity, thus allowing participants to be more candid especially when talking about sensitive and controversial topics such as abortion (De Vaus, 2002). The questionnaires also had the effect of making the researcher less intrusive as the researcher adopts an objective stance. It should be noted, however, that due to the fact that abortion is a very sensitive and controversial topic which makes objectivity almost impossible, the researcher adopted a reproductive health rights approach which stresses that knowledge concerning reproduction is a fundamental aspect of reproductive health. This approach, however, should only be evident in the write-up of the thesis. Care was taken to word the questions in the questionnaire in a neutral fashion.

4.3. Research questions

The aim of this study was to assess the knowledge that adolescents have concerning abortion and emergency contraception. Thus, the following states the research questions on which this study was based. These questions were derived from problem areas in the literature.

- What are adolescents' understanding regarding the legality of abortion?
- How accurate is adolescents' knowledge about the stipulations of the CTOP Act?
- How accurate is adolescents' knowledge about the methods of legal abortion?
- How accurate is adolescents' knowledge about medical and psychological consequences of abortion?
- What do adolescents know about unsafe abortion?
- What are adolescents' sources of information regarding abortion?
- How accurate is adolescents' knowledge about emergency contraception?

The following section gives a detailed exploration of the characteristics of the sample and how and why it was selected.

4.4. Sample

Multistage sampling was used in this study, which means that more than one level of sampling was used to obtain the final sample. The first method that was used in this study was stratified sampling to identify the schools. Stratified sampling is "used to establish a greater degree of representativeness in situations where populations consist of subgroups or strata" (Durrheim & Painter, 2006, p. 136). The research was conducted in the Buffalo City Municipality in the Eastern Cape. Buffalo City Municipality was befitting to this study due to its convenient geographical location and because it gave the researcher access to a diverse group of participants.

It is acknowledged that owing to the Apartheid legacy, schools fall broadly into various subgroups namely: private schools, former Model C schools, former Department of Education and Training schools (DET) located in townships, former DET schools located in the rural areas, the former House of Representatives schools, which are commonly known as former 'coloured' schools, and former House of Delegates schools, which are former Indian schools. The latter were not used in the stratified sampling, however, owing to the demographics of Buffalo City.

A formal request was made to the Department of Education in East London for assistance with regard to the list of all the schools in Buffalo City Municipality. Subsequent to receiving the list and dividing the schools into these pre-existing subgroups, an additional letter was sent to the Head of the Education Department in East London requesting permission to conduct this study in some of the schools in Buffalo Municipality City (refer to appendix A and further discussion in the Ethics section).

Once permission was granted, simple random sampling was used to select the schools within each stratum. Contact was made with the selected schools to make an appointment with the principals in order to gain access to the schools and to explain the aims and nature of the research (refer to appendix B and further discussion in the Ethics sections). Permission to conduct the research was granted by the principals of the ten randomly selected schools.

Once the schools were randomly selected from each stratum, purposive sampling was used. Purposive sampling is when the participants are selected because they fit the purpose of the study (Durrheim & Painter, 2006). Both male and female learners of Grade 11 constituted the purposive sample of this study. Furthermore, by this age many adolescents are sexually active. Grade 11 learners were decided upon as learners would be in their late adolescence and therefore possibly more knowledgeable than younger learners.

The Eastern Cape is among provinces with high levels of early pregnancy. That is, in 1998, 18.2% of adolescents had already been pregnant in Grades 8-11 (SADHS, 1998). However, the percentage of adolescents in Grades 8-11 in SADHS 2003, (DoH, 2007b), who have ever been pregnant was 11.4%

It should be noted that the percentage of those who have ever been pregnant is higher than those who are mothers. This suggests that abortion, whether obtained legally or illegally ('backstreet'), was a solution for some of these unwanted pregnancies, highlighting once again the significance of accurate and comprehensive knowledge with regard to reproductive health matters. It is due to the information above that a higher grade was apposite for this study, but Grade 12 learners were not included owing to exam pressures.

The following table represents the number of Grade 11 learners that participated in the study. It is worth noting that this table is repeated again in the results chapter where it is discussed.

Table: 1. Number of Grade 11 learners that participated in the study

Type of school	Private school		HOR		Model 'C'		DET-rural		DET-urban		Total
Schools	A	B	C	D	E	F	G	H	I	J	
No of Gr.11 males	1	42	11	7	3	14	12	38	14	28	170
No. of Gr.11 female	2	36	29	42	13	34	27	62	43	55	343
Non-responses		1									1
Total	81		89		64		139		140		514

4.5. Instrument construction

The questionnaire used in this study was developed by the researcher. The questions were derived from the research questions and the specifications of the CTOP Act. The questionnaire was divided into seven sections namely: demographics, knowledge of the Choice on Termination of Pregnancy (CTOP) Act, knowledge of legal and illegal methods of abortion, knowledge of consequences of legal abortion, knowledge of somebody having undergone a termination of pregnancy, sources of information and knowledge of Emergency Contraceptives. As previously mentioned, the aim of this research was to elicit objective information from the participants regarding their knowledge about abortion and emergency contraception. Hence factual questions were asked. However, it was of great importance that the concept being measured was conceptualized before proceeding any further as concepts have a propensity to mean different things to different people. To avoid misunderstandings, knowledge in this study was defined as "anything that is known on a conscious level" (Colman as cited in Naidoo & Mwaba, 2006, p. 53). This definition is conceptually different from that of attitude, which is defined as "a relatively consistent pattern of responses towards a person, object or issue" (Colman as cited in Naidoo & Mwaba, 2006, p. 53) or opinion which is defined as "a belief or judgement that is held firmly but without actual proof of its truth" (The Oxford Study Dictionary, p. 451).

As previously stated, one of the limitations of a survey is that there is no opportunity for probing. Thus both open-ended and closed-ended questions were asked. Closed–ended questions "provide the same frame of reference for all respondents to use in determining their responses" (Weinsberg et al., 1989, p. 67). That is, the questionnaire had uniform questions and fixed responses for all the respondents subsequently maximizing reliability. Furthermore closed-ended questions are quick to answer (Frankfort-Nachmias & Nachmias, 1996), which was ideal for this research as it took place during school hours. Open-ended questions, on the other hand, gave the participants the opportunity to express their thoughts freely but more importantly participants did not have to adapt to the preconceived categories provided by the researcher (Frankfort-Nachmias & Nachmias, 1996). Moreover, open-ended questions allow participants to express their thoughts in a language with which they are comfortable.

Due to the demographics of Buffalo City Municipality, the questionnaire was represented in three different languages that are dominant in Buffalo City Municipality namely: Afrikaans, English and isiXhosa. The questionnaire was translated to Afrikaans by a third year Afrikaans speaking student and the Xhosa translation was done by a Xhosa speaking second year student. To check for variation and to ensure that no meaning was lost in the translation process, back-translation was used. That is, two independent academics from the Afrikaans and Xhosa department were selected and asked to translate the questionnaire back to English so as to verify lexicon equivalence.

Presenting the questionnaire in three languages minimized any confusions that would have arisen due to language barriers. This contributed toward reliability and content validity, which were increased further by the pilot study that was carried out to test the questionnaire before it was finalized.

Different response formats were used in an attempt to try to maintain the concentration of the participants. A funnel sequence was used in this questionnaire due to the fact that the sequence of the questions is as important as the questions themselves and plays a crucial role in how the participants respond to the questions. A funnel sequence can be explained as asking questions from a broad to a specific level. In other words, each successive question was related to the previous question putting the participants at ease as general/broad questions tend to be easy to answer (Frankfort-Nachmias & Nachmias, 1996). This funnel sequence is evident in the questionnaire due to the fact that the participants were asked from a broad level first (i.e. name of the Act) to a specific level (i.e. stipulations of the CTOP Act), (refer to appendix E). As a result, the participants were motivated to supply information. For this information to be meaningful, the response formats were applied in such a way that they accurately measured the operationalized conceptual definition. Moreover, to ensure that all the response formats were inclusive and appropriate, a pilot study was carried out to test the instrument, as formerly mentioned. This helped to increase the reliability and validity of the findings.

Five different types of rating scales divided into two main categories were used in the questionnaire namely: "Yes", "No" and "Not sure"; and "Agree" and "Disagree" as the only alternatives offered for the section on Knowledge of consequences of legal abortion. This offered the respondents limited alternatives so as to avoid the "response-choice-order effect" which

occurs mostly when respondents are offered too many alternatives (Weinsberg et al., 1989, p. 67). Furthermore to ensure that the participants understood the meaning intended by the researcher, the questions were worded in such a way that they could be comprehended by a lay person. In other words, "double-barrelled questions; leading questions, jargon, ambiguity, confusion and vagueness" were avoided (Neuman, 2003, p. 296-270). Furthermore, the questionnaire was constructed in such a way that it took 15-20 minutes to complete which is fitting for this study since it took place during school hours.

The questionnaire is divided into seven sections namely: demographics, knowledge of the Choice on Termination of Pregnancy Act, knowledge of legal and illegal methods of abortion, knowledge of consequences of legal abortion, knowledge of somebody having undergone a termination of pregnancy, sources of information and knowledge of Emergency Contraceptives (refer to appendix E). Question instructions were given for each section, that is, under each section it was indicated how many responses the participant could tick. The following sections will explain why these specific sections were included.

Demographics

Surveys differ in purpose and in targeting participants. Thus, learning more about the characteristics of the target group is important as it also helps in explaining the results of the survey (Fink, 1995). This section was based on factual questions with the aim of eliciting objective information from the participants regarding their background, age, gender, sexual activity, and ended with two questions that introduced the section that followed which was on knowledge of the Choice on Termination of Pregnancy. In other words, the aim of this section was to give a clear picture of who the respondents were and how many had been sexually active in the last 12 months so as to see if there is a difference between those who claimed they have been sexually active and those who claimed they have not been, in terms of the accuracy of their knowledge about abortion. It is noted that there is a possibility of learners not being honest about their sexual activity, with learners possibly providing 'acceptable' responses or what they thought the researcher wanted to hear.

Knowledge of the Choice on Termination of Pregnancy Act

Questions under this section were about the stipulations underlying the CTOP Act. That is, questions under this section explored participants' knowledge with regard to who they thought qualified for termination of pregnancy and who did not. These questions also examined their knowledge concerning the gestation limit within which one can obtain a legal termination of pregnancy, pre and post counseling with regard to termination of pregnancy and where abortion services can be obtained. Accurate and comprehensive knowledge of these questions is crucial because it gives adolescents the opportunity to make informed choices within the period when abortion is still legally performed upon request.

Knowledge of legal and illegal methods of abortion

Anecdotal beliefs have been expressed with regard to how abortion is performed. Thus, this section examined adolescents' knowledge of how abortion is performed both legally and illegally. It is due to this knowledge, or rather lack thereof, that abortion is believed to have dire consequences.

Knowledge of consequences of abortion and of someone who had undergone legal and/or illegal abortion

Adolescents' understanding of the consequences of abortion will have implications in terms of possibly seeking a TOP in the case of an unwanted and/or unintended pregnancy, as well as their responses to TOP. Thus this section examined participants' knowledge of the consequences of legal abortions.

Sources of information

This section explored adolescents' sources of information and these ranged from the media (e.g. movies, radio) to teachers and parents. This section was concerned with how the information that adolescents had about abortion was obtained.

Knowledge of Emergency Contraceptives

This section examined adolescents' knowledge of Emergency Contraceptives because like abortion, Emergency Contraceptives are time sensitive. Furthermore, Emergency Contraceptives

would serve as an effective, cheap, convenient and private option when one is faced with the possibility of an unwanted pregnancy.

4.6. Pilot study

Three schools from the five subgroups mentioned above, were linguistically chosen for a pilot study. 'Linguistically chosen' in this context means that these three schools were primarily selected based on the dominant language spoken by the learners in each school. Five learners were purposively chosen from each of these three schools. The questionnaire was in the three dominant languages spoken by the learners hence the linguistic difference.

One of the schools withdrew from the study during the week of the pilot study because they believed that the topic was too sensitive and controversial. As a result of this, only two schools were able to participate in the pilot study resulting in seven learners, which consisted of both male and female learners.

After the participants completed the questionnaire, they were asked as a group if they understood the layout of the questionnaire, instructions given, format of the questions, the wording and sequence of the questions and if the questions were easy to understand or if they could be phrased better. Participants were also asked if the explanation given of the research made sense and if they had any suggestions regarding the addition of questions they thought could be useful to ask in terms of the research question. Despite the fact that only one question was stated as being confusing and not clear, both questions on methods of abortion were rephrased. This was due to the fact that they did not measure what the researcher wanted to find out. The questions in bold were the original questions and those in bold and italics are the revised version:

- **At Termination of Pregnancy clinics, abortion is performed by.....**
- ***At Termination of Pregnancy clinics, abortion is performed by using.....***

- **When women attempt to terminate the pregnancy themselves or to use an untrained or unregistered practitioner (what some people call**

'backstreet' abortions), the abortion may be performed by.....

- ***When women attempt to terminate the pregnancy themselves or to use 'backstreet' (or illegal services), the abortion may be performed by using.....***

4.7. Data collection

Once the pilot study was completed and the results were analysed, problematic areas (the two questions mentioned above) on the instrument were corrected to ensure the instrument's validity and reliability. Five schools were randomly selected, each from the subgroups mentioned above. (It should be noted that the schools that participated in the pilot study did not participate in the research). An appointment was made with the principals to ask for permission to conduct the study, which was subsequently given.

As previously mentioned, the questionnaire was constructed in such a way that it took 15-20 minutes to complete. Hence in four schools, the research took place during the Life Orientation class while in the fifth school, it took place during a 'study time' period. In the former four schools, Life Orientation teachers for the Grade 11 learners served as assistants to the researcher with regard to ensuring that all the learners who had signed consent forms were available during the agreed time for conducting the research.

The cover-letter is one of the taken for granted pitfalls of surveys as it can affect the response rate (Frankfort-Nachmias & Nachmias, 1996). The cover-letter motivates the respondent to complete the questionnaire. Hence it was written in simple yet professional language with an official head-letter from the Rhodes University, Psychology Department (refer to appendix D). The learners were given this letter prior to the commencement of the research.

During the pilot study, non-responses were not an issue, thus the first set of data were collected by means of self-administered questionnaires. A self-administered questionnaire is an "instrument used to collect information from people who complete the instrument themselves" (Bourque & Fielder, 1995, p. 2). There are different types of self-administered questionnaires, namely: "one-to-one supervision, group administration, semi-supervised administration and

unsupervised administration" (Bourque & Fielder, 1995, p. 2). Due to the fact that this study took place in classrooms, group administration proved to be the most suitable method for this study. One of the major advantages of self-administered questionnaires is that it "allows for more standardization of the questions and an increase in reliability because the researchers are not influencing the responses by clarifying or explaining the items in varying ways to different respondents" (Nardi, 2003, p. 58). Furthermore, self-administered questionnaires counter against low response rate (Nardi, 2003). The questionnaires were administered using the paper and pencil technique and the completed questionnaires were put in a sealed box with an opening on top so as to ensure anonymity of the participants.

It is acknowledged that whilst this method of collecting data served as being ideal for this research, it also had some limitations that could not have been averted and some were unforeseen. Limitations including participants providing socially desirable answers especially with regard to the 'sexual activity' question. Socially desirability refers to participants' tendency to give 'acceptable' answers or to exaggerate their answers so as to conform to social norms (De Vaus, 2002; Neuman, 2003). Another limitation that may have played a role is the observable characteristics of the researcher, such as her gender and race. These characteristics may have affected the way some participants responded to the questionnaire particularly when taking into account the sensitivity and controversial nature of the topic. Participants may have associated certain positions regarding abortion and emergency contraception with the researcher and thus responded accordingly. The last limitation that was unforeseen due to the results of the pilot study was non-responses to some questions. That is, participants did not respond to some questions. It was not known whether these non-responses were due to the participants not understanding the questions, the topic being too sensitive or the participants not knowing the answer. Due to the fact that the researcher did not know which of these reasons were applicable to the questions not answered, the researcher coded them as non-responses. The non-responses did not apply consistently to particular questions, but were distributed across the questionnaire.

The following section discusses how the data were processed and analyzed. The method of analysis used was significantly influenced by the method used to collect data and by the aims of the research.

4.8. Processing and interpretation

Statistical analysis was used for the closed-ended questions with Statistica as the programme used for capturing data. Once the collected data were coded and captured, it was cleaned in an endeavour to have error free data before analyzing it (Durrheim, 2006). The data were cleaned by manually double checking the data set for errors and correcting these errors. In addition frequency tables were run for each variable to verify the corrections made when the data were cleaned manually and compared against the data before it were cleaned.

Descriptive statistics were used to organize, summarize and present a general overview of the data. This included the use of cross-tabulations and frequency tables so as to present data in a meaningful way. Cross-tabulations allow the researcher to "examine frequencies of observations that belong to specific categories on more than one variable" and frequency tables also have the benefit of presenting data with very specific numerical variables (Agresti, 1996, p. 1; Nardi, 2003). These methods were employed primarily because cross-tabulations allow the researcher to identify relationships between cross-tabulated variables and frequency tables "show how often each response (a value) was given by the respondents to each item (a variable)" (Agresti, 1996; Nardi, 2003, p. 116). Separate frequency tables were constructed, each frequency table dealing with a specific variable, for example adolescents' sources of information. The latter type of frequency table is the one that is used in this study.

Inferential statistics go beyond descriptive statistics in that an association between variables may be investigated. Thus inferential statistics were used to examine relationships between different categories such as the schools, those that claimed to have been sexually active in the last 12 months and those that claimed they have not been, and the various knowledge variables. The test that was used for this examination was Chi-square. Chi-square is a nonparametric test or a 'distribution free' test that is appropriate for nominal levels of data (Gillham, 2000). In other words, one is not required to assume or know the distribution of the population when using nonparametric tests. As a result, a Chi-square test, unlike other tests (such as ANOVA) that need to be modified, does not need to be modified irrespective of whether there are two samples being compared or more than two (Argyrous, 1997). That is, Chi-square is very flexible and does not need modification with regard to how many samples are used, making it more suitable for this study.

Taking the research questions into account, it is self-evident that the chi-square test of independence is pertinent to this study (It is worth noting that cross-tabulation was also used so as to get a clear picture of the overall data, discussed further below). The two underlying assumptions of the Chi-square test are, firstly, that expected frequencies must not be smaller than observed frequencies and, secondly, that all items or people in the test must be independent of each other. Both were satisfied. Chi-square overlooks missing data. Hence it was important that the above mentioned assumptions were met in order to get accurate results (Durrheim & Tredoux, 2002). The Fisher's exact test was used for Chi-square in cases where the expected frequency was of five or less and it was also used to check the accuracy of the results of the Chi-square (Durrheim & Tredoux, 2002).

As mentioned, there were open-ended questions in the questionnaire meaning that the data was coded qualitatively so that it could be analysed qualitatively. To be more precise, the researcher had to interpret the responses given. The researcher read and re-read the raw data looking for recurrent themes or rather common methods reported by the participants to perform abortion both legally and illegally. Subsequent to identifying these common methods, a coding system was used. These themes were divided into different coding categories. The methods used in behaviour data and interpreting it made it possible for the researcher to compare the results obtained in this study against what had been said in the literature.

4.9. Ethics

Despite the fact that research ethics remain a dynamic debate, certain procedures were followed so as to keep within the ethical considerations of research. Permission to conduct the study was gained from the Department of Education in East London before contacting the schools (refer to appendix A). Subsequent to permission being granted by the Department of Education, permission to conduct the study was obtained from the principals of the schools (refer to appendix B). The aims and purpose of the study were explained in detail to the parents by means of a letter (refer to appendix C) and the parents were asked to sign if they consented to their child participating in the study. Due to the fact that "researchers must provide potential participants with clear, detailed, and factual information about the study, its methods, its risks and benefits, along with assurance of the voluntary nature of participation, and the freedom to refuse or withdraw without penalties" (Wassenaar, 2006, p. 72), the participants were provided with a

cover letter (refer to appendix D) explaining in detail the aim of the study and instructions on how to answer the questionnaire. Furthermore, the researcher explained who she was, what the study focused on and what was expected from the participants. Participants were also informed that their participation was voluntary, thus they were free to leave the administration venue if and when they felt uncomfortable.

Due to the controversial and sensitive nature of the topic (as illustrated by one school withdrawing from the study as mentioned above), the principals of the schools, the parents of participants and the participants were assured confidentiality and anonymity in all reports.

It is worth noting that only learners whose parents had signed the consent forms and signed participant consent forms were allowed to participate in the study. Furthermore, participants who took part in the pilot study were not allowed to partake in the research.

4.10. Conclusion

This chapter gave a detailed discussion of the research questions, the type of sampling used and why it was used. This chapter also explored in detail how the questionnaire was constructed, structured and rectified based on the results of the pilot study. Furthermore, it gave an in-depth discussion on how data were collected from both the pilot study and the research. Data processing and interpretation were also discussed including ethical procedures followed in this study. The following chapter presents the results of the data collected, processed and analyzed in this chapter.

Chapter 5

Knowledge of CTOP Act and its stipulations: Results and discussion

5.1. Introduction

The purpose of this research was to examine the level and nature of knowledge that Eastern Cape adolescents have concerning abortion and emergency contraception, and how accurate this knowledge is. This examination included their knowledge of the Choice on Termination of Pregnancy Act, its stipulations, perceived medical and psychological consequences caused by legal abortion, if they knew anyone who has had an abortion, their sources of information and their knowledge of Emergency Contraceptive pills typically known as the 'morning-after pill'. Frequency tables were used to present the descriptive statistical data. To go beyond the descriptive presentation of the data, an inferential statistical test, in particular the Chi-square, was used. Through the use of Chi-square and cross-tabulations, the researcher was able to investigate relationships between certain variables. As mentioned in the previous chapter, open-ended questions (i.e., name of the legislation, when it was passed and methods used to perform legal and illegal abortion) were analysed qualitatively due to the variety of answers given by the participants. Their results will be discussed in the following chapter.

5.2. Results of the study

5.2.1. Demographics

This section gives a visual presentation of the characteristics of the participants. Having accurate knowledge of whom the participants are, their sex, age, sexual activity and where they come from (geographical location) is essential in understanding the participants' social reality. Hence detailed descriptive data of the participants' demographics is given.

As illustrated on Table 1, the number of female participants is double the number of male participants. There are 343 females who participated in this study compared to the 170 male participants with the highest number of the participants being in DET rural and urban schools. The higher proportion of female participants is partially due to the fact that according to the school registers, there are more females than males enrolled in Grade 11. That is, from all the

schools that participated in this study (except in the pilot study) there are 606 registered females and 449 registered males in Grade 11. Furthermore, participation was voluntary; thus some males may have felt that abortion and emergency contraceptive pills are 'girl issues' consequently serving as an additional reason for the low male participation rate.

However, the fact that most of the participants are females can be argued as befitting to this study because this research was conducted from a reproductive health rights perspective focusing primarily on women including adolescents' reproductive health matters. This is not to imply that males are less important, but rather that females tend to be the ones who suffer the most from lack of knowledge on these matters. That is, although it is essential for both genders to have accurate and comprehensive knowledge about reproductive health matters as they would benefit tremendously from it, it is important that women are knowledgeable about reproductive health matters and their reproductive health rights. This preference is strengthened further by the common expression of the 'teenage mother' but one rarely hears of the 'teenage father'.

Table 1. Number of Grade 11 learners that participated in the study.

Type of school	**Private school**		**HOR**		**Model 'C'**		**DET-rural**		**DET-urban**		**Total**
Schools	A	B	C	D	E	F	G	H	I	J	
No of Gr.11 males	1	42	11	7	3	14	12	38	14	28	170
No. of Gr.11 female	2	36	29	42	13	34	27	62	43	55	343
Non-responses		1									1
Total	81		89		64		139		140		514

As mentioned in previous chapters, this study was conducted with Grade 11 learners and according to the literature, Grade 11 learners are typically between the ages of 15 and 20 years which was the case with many of the participants as demonstrated in Table 2. However, the gross inequalities in access to education amongst other services that took place during Apartheid and the high levels of poverty particularly in areas previously known as 'homelands', has left the post-Apartheid South African schooling system characterised by "high enrolment and high rates of repetition, dropout, late entry and re-entry meaning that a significant number of older learners,

well past the onset of puberty, may be found in lower grades" (Schindler as cited in Panday et al., 2009, p. 26).This legacy of Apartheid is evident in Table 2 by the fact that Grade 11 learner participants in the DET-rural and DET-urban schools have a higher average and median age and bigger age range. It is worth noting that the learners were asked to give their ages in years only.

Table 2. Participants' age

Type of school	Private school	Model 'C'	HOR	DET-rural	DET-urban
Age range	15-20 yrs	16-19 yrs	15-20 yrs	15-23 yrs	16-24 yrs
Average Age	17.27	16.96	17.11	18.10	18.89
Median Age	17.00	17.00	17.00	18.00	19.00

Table 3 is a representation of the number of participants who claim to have engaged in sexual activity in the past 12 months and those who claim they have not. The split between those who claim to have been sexually active in the last 12 months and those who claim that they have not been sexually active is approximately 50/50. However, out of the 50.19% of those who claim to have been sexually active, 33.99% had been sexually active by the age of 18 years. This compares with the results from the 2003 SADHS (DoH, 2007b) and Pettifor et al.'s (2005) nationally representative household survey that reported that the median age of first intercourse is around 18 years and 17 years, respectively. It should be noted however, that the proportion that claimed to have been sexually active in the last 12 months varied dependent on the school.

Table 3. Participants' sexual activity in the last 12 months.

Type of school	Private school	Model 'C'	HOR	DET-rural	DET-urban	Total
Have been sexually active in the last 12 months	56 (69.14%)	36 (55.38%)	38 (42.70%)	50 (35.97%)	78 (55.71%)	258 (50.19%)
Have not been sexually active in the last 12 months	25 (30.86%)	29 (44.62%)	51 (57.30%)	89 (64.03%)	62 (44.29%)	256 (49.81%)

The following section will include frequency tables that will illustrate the knowledge that the participants have with regard to the name of the legislation and the year in which it was passed.

5.2.2. Knowledge of the name of the legislation and the year it was passed.

Table 4 below contains results of responses to the question of the name of the legislation dealing with abortion. Over half of the participants explicitly stated not knowing the name of the legislation and 21.40% did not answer the question. Not a single participant could name the Act correctly, although 8.56% of responses included the "termination of pregnancy" component of the wording.

Table 4. Participants' responses to the name of the legislation dealing with abortion.

Name given	N	%
Do not know	283	55.06
Non- response	110	21.40
Termination of pregnancy	26	5.06
Abortion	26	5.06
Termination of pregnancy clinic	17	3.31
Department of Health	9	1.75
Legal abortion organization	8	1.56
Abortion South Africa	5	0.97
Mothers to mothers in Makhiwane	5	0.97
Teenage pregnancy	5	0.97

Abortion centre care	4	0.78
Adolescents	4	0.78
SAAP	3	0.58
Psychology department	3	0.58
Safe abortion	2	0.39
Legal termination of pregnancy act	1	0.19
Killing innocent children	1	0.19
Women working together	1	0.19
Murder	1	0.19
Bill of rights	1	0.19
Abortion legislation	1	0.19

Table 5 illustrates the participants' responses to the year in which the CTOP Act was passed. 54.67% of the participants did not know the year in which the CTOP Act was passed, while almost a third of the participants did not answer to the question. Only 4.85% knew that the legislation was passed in the mid-1990s.

Table 5. Participants' responses to the year when the Act was passed.

Year	N	%
Do not know	281	54.67
Non- responses	118	22.96
2007	30	5.84
2009	30	5.84
1994	23	4.47
2003	5	0.97
2008	14	2.72
Rhodes University	3	0.58
1990	1	0.19
2004	1	0.19
2006	1	0.19
2005	1	0.19
2000	1	0.19
2002	1	0.19
After apartheid	1	0.19
1993	1	0.19
1998	1	0.19
1984	1	0.19

The fact that none of the participants knew the name of the Act or when it was passed is a strong indication that they may also have lack of knowledge or inaccurate knowledge regarding the stipulations of the Act and abortion in general. The results of participants' knowledge concerning the Act and its stipulations will be discussed in subsequent sections.

5.2.3. Knowledge of the Choice on Termination of Pregnancy Act

The Choice on Termination of Pregnancy Act was passed in 1996 in South Africa. According to this Act, termination of pregnancy can be legally obtained upon request and minors do not need parental consent. The following table is a presentation of the participants' knowledge with regard to the legality of abortion.

Table 6. Responses to circumstances under which abortion can be legally performed in South Africa.

Category	Total[N]	Percentage
Illegal: Abortion is illegal in South Africa under all circumstances	60	11.67
Rape, incest or sexual abuse: Abortion may be legally performed ONLY in cases of rape, incest or sexual abuse	75	14.59
Physical or mental harm: Abortion may be legally performed ONLY in cases of potential physical or mental harm to the woman or foetus	26	5.06
Sexual violence and physical or mental harm: Abortion may be legally performed in cases of rape, incest or sexual abuse AND in cases of potential physical or mental harm to the woman or foetus	99	19.26
Upon request: Abortion may be legally performed upon request of the woman up to a certain date of pregnancy	217	42.22
Non-responses	37	7.2
Total	**514**	**100**

A substantial minority of the participants have accurate knowledge of the circumstances under which abortion may be performed, with only 42.22% indicating that a woman may obtain a termination of pregnancy on request up to a certain date of pregnancy. Over half indicated that abortion may be obtained under restrictive conditions or not at all, or did not respond. Just over 10% thought that abortion is illegal under all circumstances.

5.2.4. Knowledge of the stipulations of the Choice on Termination of Pregnancy Act

Knowing the legal status of abortion in one's country is not sufficient. One must also have accurate knowledge concerning the stipulations of the legislation. The following tables and Chi-square results demonstrate the participants' responses to the questions they were asked about the stipulations underlying the Choice on Termination of Pregnancy Act, as well as the significant relationships that exist between sex and knowledge of the Act, sexual activity and knowledge of

the Act and school and knowledge of the Act. Table 7 outlines data concerning the participants' responses with regard to minors being allowed to have an abortion.

Table 7. Responses to whether women under the age of 18 years are allowed to have an abortion.

	Women under the age of 18 years are allowed to have an abortion	
Category	**N**	**%**
YES	257	50.00
NO	110	21.40
NOT SURE	132	25.68
NON-RESPONSES	15	2.92
Total	**514**	**100**

As seen in Table 7, half of the participants were not sure whether minors could obtain an abortion, thought she could not or did not respond. Only half (50%) of the participants knew that minors could obtain abortion.

Table 8 details responses to the requirement of parental consent for a woman under the age of 18 years to have a legal abortion.

Table 8. Responses to the requirement of parental consent for a woman under the age of 18 years to have a legal abortion.

	Parental consent is needed for a woman under the age of 18 years to have a legal abortion	
Category	**N**	**%**
YES	241	46.89
NO	129	25.10
NOT SURE	121	23.54
NON-RESPONSES	23	4.47
Total	**514**	**100**

From Table 8 we see that 46.89% of the participants thought that minors needed parental consent to obtain a legal termination of pregnancy. Just under 30% of the participants either did not respond or were not sure whether she needed parental consent. Only 25.10% of the participants knew that minors do not need parental consent to have a legal abortion.

The following table illustrates the participants' responses to married women being allowed to have a legal abortion.

Table 9. Responses to only married women being able to have a legal abortion.

	Only a married woman can have a legal abortion	
Category	**N**	**%**
YES	58	11.28
NO	348	67.70
NOT SURE	79	15.37
NON-RESPONSES	29	5.64
Total	**514**	**100**

As indicated in Table 9, over two thirds of the participants have accurate knowledge concerning married women being able to obtain legal abortion that is, 67.70% knew that not only married women can have a legal abortion. A third of the participants thought that only married women can have an abortion, were not sure or did not respond.

Table 10 is a representation of the participants' responses to the requirement of spousal consent for a married woman to obtain a legal abortion.

Table 10. Responses to the requirement of spousal consent for a married woman to obtain a legal abortion.

	If a married woman wants an abortion legally, she must have her husband's permission	
Category	**N**	**%**
YES	264	51.36
NO	116	22.57
NOT SURE	117	22.76
NON-RESPONSES	17	3.31
Total	**514**	**100**

As seen in Table 10 51.36% of the participants thought that a married woman needs her husband's permission if she wants to have a legal abortion. Only 22.57% indicated that a married woman does not need her husband's permission to obtain a termination of pregnancy legally. About 25% were not sure or did not respond.

The following table details responses of gestation under which abortion may be obtained upon request.

Table 11. Responses to gestation (weeks) under which abortion may be obtained upon request.

	A legal termination of pregnancy can be obtained upon request up to 12 weeks of pregnancy	
Category	**N**	**%**
YES	218	42.41
NO	62	12.06
NOT SURE	213	41.44
NON-RESPONSES	21	4.09
Total	**514**	**100**

Over half (57.59%) of the participants thought that a legal abortion cannot be obtained upon request up to 12 weeks of pregnancy, or were not sure or did not respond. A substantial minority of the participants have accurate knowledge regarding the gestation period under which abortion can be obtained upon the woman's request (that is 42.41% knew that a legal termination of pregnancy can be obtained upon request up to 12 weeks of pregnancy). Just a little over ten percent (12.06%) indicated that a legal termination of pregnancy cannot be obtained upon request up to 12 weeks of pregnancy.

Table 12 demonstrates the participants' responses of the gestation under which abortion may be performed under certain specified conditions.

Table 12. Responses to gestation (weeks) under which abortion may be performed under certain specified conditions.

	After 12 weeks, abortion may occur only under certain specified conditions	
Category	**N**	**%**
YES	229	44.55
NO	47	9.14
NOT SURE	217	42.22
NON-RESPONSES	21	4.09
Total	**514**	**100**

Over half the participants did not think that abortion may occur under certain specified conditions after 12 weeks, or were not sure or did not respond. 42.22% of the participants are not sure whether abortion may be performed under certain specified conditions after 12 weeks. 44.55% of the participants knew that after 12 weeks, abortion may occur under certain specified conditions.

The following table details responses to the provision of voluntary pre-termination of pregnancy counselling to the woman.

Table 13. Responses to the provision of voluntary pre-termination of pregnancy counselling to the woman.

	Termination of Pregnancy clinics are obliged to provide voluntary *pre*-termination of pregnancy counselling to the woman	
Category	**N**	**%**
YES	259	50.39
NO	39	7.59
NOT SURE	189	36.77
NON-RESPONSES	27	5.25
Total	**514**	**100**

50.39% indicated that Termination of Pregnancy clinics are obliged to provide *pre*-termination of pregnancy counselling to the woman. Almost half of the participants thought that the Termination of Pregnancy clinic is not obliged to provide voluntary *pre*-termination of

pregnancy counselling to the woman, or were not sure or did not respond (7.59%, 36.77%, and 5.25% respectively).

Table 14 is a representation of the participants' responses to the provision of the voluntary post-termination of pregnancy counselling to the woman.

Table 14. Responses to the provision of the voluntary post-termination of pregnancy counselling to the woman.

	Termination of pregnancy clinics are obliged to provide voluntary *post*-termination of pregnancy counselling to the woman	
Category	**N**	**%**
YES	203	39.49
NO	45	8.75
NOT SURE	229	44.55
NON-RESPONSES	37	7.20
Total	**514**	**100**

39.49% of the participants thought that Termination of Pregnancy clinics are obliged to provide voluntary post-termination of pregnancy counselling to the woman. Over half of the participants did not think that Termination of Pregnancy clinics are obliged to provide voluntary *post*-termination of pregnancy counselling to the woman, or were not sure or did not respond, with only 8.75% of the participants indicating that the Termination of Pregnancy clinic is not obliged to provide voluntary *post*-termination of pregnancy counselling to the woman.

Detailed responses to the provision of the voluntary pre-termination of pregnancy counselling to the woman's partner are demonstrated in the following table.

Table 15. Responses to the pre-termination of pregnancy counselling to the woman's partner.

	***Pre*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic**	
Category	**N**	**%**
YES	224	45.58
NO	87	16.93
NOT SURE	176	34.24
NON-RESPONSES	27	5.25
Total	**514**	**100**

45.58% of the participants thought that *pre*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic. Over half of the participants did not think *pre*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic, or were not sure or did not respond. Less than twenty percent of the participants had accurate knowledge concerning *pre*-termination of pregnancy counselling to the woman's partner, i.e. only 16.93% knew that *pre*-termination of pregnancy counselling does not need to be offered to the woman's partner at the Termination of Pregnancy clinic in terms of the CTOP Act.

Table 16 is a representation of the participants' responses to the provision of voluntary post-termination of pregnancy counselling to the woman's partner.

Table 16. Responses to the post-termination of pregnancy counselling to the woman's partner.

	***Post*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic**	
Category	**N**	**%**
YES	164	31.91
NO	104	20.23
NOT SURE	214	41.63
NON-RESPONSES	32	6.23
Total	**514**	**100**

A majority (79.77%) of the participants thought that *post*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic, or were not sure or did not respond, with 31.91% positively thinking that this was a stipulation of the CTOP Act. Only 20.23% knew that *post*-termination of pregnancy counselling does not need to be offered to the woman's partner at the Termination of Pregnancy clinic.

Table 17 details responses to the prevention of a woman from obtaining a legal termination of pregnancy.

Table 17. Responses to preventing a woman from obtaining a legal termination of pregnancy being an offence.

	Preventing a woman from obtaining a legal termination of pregnancy is an offence	
Category	**N**	**%**
YES	172	33.46
NO	145	28.21
NOT SURE	166	32.30
NON-RESPONSES	31	6.03
Total	**514**	**100**

Just a little over a third of the participants have accurate knowledge concerning the consequence of preventing a woman from obtaining a legal abortion. That is, only 33.46% knew that it is an offence to prevent a woman from obtaining a legal termination of pregnancy. 66.44% of the participants did not think that preventing a woman from obtaining a legal termination of pregnancy is an offence, or were not sure or did not respond. Over twenty percent (28.21%) thought that it was not an offence to prevent a woman from obtaining a legal termination of pregnancy.

Table 18 demonstrates the participants' responses to the item concerning the state designating various sites as legal Termination of Pregnancy clinics.

Table 18. Responses to the state designating various sites as legal Termination of Pregnancy clinics.

	The state has designated (chosen) various sites as legal Termination of Pregnancy clinics	
Category	**N**	**%**
YES	237	46.11
NO	60	11.67
NOT SURE	190	36.96
NON-RESPONSES	27	5.25
Total	**514**	**100**

Over half (53.89%) of the participants did not think that the state has designated (chosen) various sites as legal Termination of Pregnancy clinics, or were not sure or did not respond, with 11.67% indicating that the state has not designated (chosen) various sites as legal Termination of Pregnancy clinics. 46.11% knew that the state has designated (chosen) various sites of legal Termination of Pregnancy clinics.

Table 19 details responses to abortion being obtained for free at government Termination of Pregnancy clinics.

Table 19. Responses to abortion being obtained for free at government Termination of Pregnancy clinics.

	Abortion may be obtained free of charge at government Termination of Pregnancy clinics	
Category	**N**	**%**
YES	329	64.01
NO	50	9.73
NOT SURE	110	21.40
NON-RESPONSES	25	4.86
Total	**514**	**100**

Just over two thirds of the participants (64.01%) have accurate knowledge concerning the cost of abortion at government Termination of Pregnancy clinics. Just over a third (35.99%) of the participants thought that there was a fee for obtaining abortion at government Termination of

Pregnancy clinics, or were not sure if it could be obtained for free at government Termination of Pregnancy clinics or did not respond.

The following table demonstrates the participants' responses of nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic.

Table 20. Responses to nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic.

	Nurses must insist on the partner accompanying the woman to the Termination of Pregnancy clinic	
Category	**N**	**%**
YES	229	44.55
NO	113	21.98
NOT SURE	141	27.43
NON-RESPONSES	31	6.03
Total	**514**	**100**

44.55% thought that nurses are required to insist on the partner accompanying the woman to the Termination of Pregnancy clinic. Only 21.98% were aware that nurses were not obliged to insist on the partner accompanying the woman to the Termination of Pregnancy clinic. 33.46% of the participants were not sure or did not respond.

The following section is on the results of the chi-square analysis. Chi-square helps the researcher to see if there are any significant relationships between various variables, that is, to determine if the variables are dependent on each other or independent of each other.

5.2.5. Results of the chi-square

Chi-square was the only inferential statistical test that was used due to the nature of the data and due to the fundamental aim of the researcher. The primary aim of the researcher was to compare observed frequencies with expected frequencies to determine whether there were significant associations, which can only be done through the use of Chi-square. The tables used in this section will demonstrate the results of Chi-square test and the significant associations that may exist.

5.2.5.1. Sexual activity analysis

Abortion is a time-sensitive service. Thus it is important to know if there is an association between one's sexual activity or lack thereof and the kind of knowledge that one has. Table 21 outlines the relationships between participants' sexual activity in the last 12 months and their knowledge concerning the CTOP Act and its stipulations.

Table 21. Relationship between participants' sexual activity and various items on knowledge of the CTOP Act and its stipulations.

Variable one	Variable two	Chi-square
Sexual activity in last 12 months	Knowledge regarding circumstances under which abortion can be obtained legally in South Africa	$X^2(4, N = 477)=2.93$, $p=.569$
	Knowledge regarding minors being allowed to obtain abortion	$X^2(2, N = 499)=1.28$, $p=.528$
	Knowledge regarding the requirement for parental consent	$X^2(2, N = 477)=8.62$, $p=.013$*
	Knowledge regarding married women being able to have legal abortion	$X^2(2, N = 485)=.869$, $p=.648$
	Knowledge regarding the requirement for spousal consent	$X(2, N = 497)=10.31$, $p=.005$*
	Knowledge regarding gestation under which abortion may be obtained upon request	$X^2(2, N = 493)=.813$, $p=.666$
	Knowledge regarding gestation under which abortion may be performed under certain specified conditions	$X^2(2, N = 493)=2.81$, $p=.245$
	Knowledge regarding the provision of voluntary pre-termination of pregnancy counselling to the woman	$X^2(2, N = 487)=8.36$, $p=.015$*

	Knowledge regarding the provision of voluntary post-termination of pregnancy counselling to the woman	$X^2(2, N = 477)=5.52$, $p=.063$
	Knowledge regarding the provision of voluntary pre-termination of pregnancy counselling to the woman's partner	$X^2(2, N = 487)=.759$, $p=.684$
	Knowledge regarding the provision of voluntary post-termination of pregnancy counselling to the woman's partner	$X^2(2, N = 482)=.961$, $p=.619$
	Knowledge regarding the prevention of a woman from obtaining a legal abortion	$X^2(2, N = 483)=1.11$, $p=.573$
	Knowledge regarding the state designating various sites as legal Termination of Pregnancy clinics	$X^2(2, N = 487)=1.66$, $p=.436$
	Knowledge regarding abortion being obtained for free at government Termination of Pregnancy Clinics	$X^2(2, N = 489)=5.62$, $p=.060$
	Knowledge regarding nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic	$X^2(2, N = 483)=.733$, $p=.692$

* indicates significant relationship at the 0.05 level

The following tables provide cross-tabulations of the significant relationships between the variables listed in Table 21

Table 22. Cross-tabulation: sexual activity in the last 12 months and knowledge of the requirement of parental consent for legal abortion.

Sexually active	Parental consent YES	Parental consent NO	Parental consent NOT SURE	Missing responses	Total
YES	46.12%	28.68%	18.22%	6.98%	100%
NO	47.66%	21.48%	28.91%	1.95%	100%

Chi-square results indicate that there is a significant association between sexual activity in the last 12 months and knowledge of the requirement of parental consent for women under the age of

18 years to have a legal abortion. 28.68% of those who claimed to have been sexually active in the last 12 months knew that parental consent is not needed for a minor to obtain a legal abortion compared to 21.48% of those who claimed to have not been sexually active in the last 12 months. Similar percentages thought that parental consent is required, but more of the non-sexually active participants were unsure regarding parental consent than the sexually active participants (29.91% compared to 18.22%).

Table 23. Cross-tabulation: sexual activity in the last 12 months and knowledge of the requirement of spousal consent for legal abortion.

Sexually active	Spousal consent YES	Spousal consent NO	Spousal consent NOT SURE	Missing responses	Total
YES	50.78%	27.13%	17.83%	4.26%	100%
NO	51.95%	17.97%	27.73%	2.34%	100%

According to the chi-square results, these two variables are dependent which means that there is a significant relationship between them. 27.13% of those who claimed to have been sexually active in the last 12 months knew that spousal consent is not required for a married woman to have a legal abortion compared to 17.97% of those who claimed they have not been sexually active in the last 12 months. Similar percentages thought that spousal consent is required (just over half), but more of the non-sexually active participants were unsure regarding parental consent than the sexually active participants (27.73% compared to 17.83%).

Table 24. Cross-tabulation: sexual activity in the last 12 months and knowledge of the provision of pre-termination of pregnancy counselling to the woman.

Sexually active	Pre-termination of pregnancy counselling to the woman YES	Pre-termination of pregnancy counselling to the woman NO	Pre-termination of pregnancy counselling to the woman NOT SURE	Missing responses	Total
YES	46.51%	5.04%	41.09%	7.36%	100%
NO	54.30%	10.16%	32.42%	3.13%	100%

There is a significant relationship between sexual activity in the last 12 months and knowledge concerning Termination of Pregnancy clinics being obliged to provide voluntary *pre*-termination

of pregnancy counselling to the woman. In contrast to the above (Table 23), those who claimed they have not been sexually active in the last 12 months were more likely to know that TOP clinics are obliged to provide voluntary pre-termination of pregnancy counselling to the woman than those who claimed to have been sexually active in the last 12 months. Sexually active participants were more likely to be unsure concerning this stipulation than non-sexually active participants.

On all other variables with respect to knowledge of the stipulations of the CTOP Act there was no significant difference between those who were sexually active and those who were not. It seems safe to conclude, therefore, that, for the most part, sexual activity has not affected the knowledge these participants have regarding the CTOP Act. However, what has been demonstrated by the tables above is that, although the differences were small, it is possible that those who claimed to be sexually active had better knowledge concerning the consent clauses of the CTOP Act.

5.2.5.2. Sex analysis

Gender dynamics, gender-based violence and coercion sex are significant contributory factors to unwanted pregnancies (Department of Health, 2009). Research has indicated that husbands, boyfriends and fathers can act as gate-keepers to whether a woman has an abortion or not (Ganatra & Hirve, 2002; Varga, 2002). Tables in this section outline data concerning relationships between sex and knowledge of CTOP Act and its stipulations.

Table 25. Relationship between sex of the participants and various items on knowledge of the CTOP Act and its stipulations.

Variable one	Variable two	Chi-square
Sex	Knowledge regarding circumstances under which abortion can be obtained legally in South Africa	$X^2(16, N = 476)=4.64$, $p=.326$
	Knowledge regarding minors being allowed to obtain abortion	$X^2(8, N = 498)=8.99$, $p=.011$*

	Knowledge regarding the requirement for parental consent	$X^2(8, N = 490)=4.19, p =.123$
	Knowledge regarding married women be able to have legal abortion	$X^2(8, N = 484)=5.55, p =.062$
	Knowledge regarding the requirement for spousal consent	$X^2(8, N = 496)=3.83, p =.147$
	Knowledge regarding gestation under which abortion may be obtained upon request	$X^2(8, N = 492)=8.92, p =.012$*
	Knowledge regarding gestation under which abortion may be performed under certain specified conditions	$X^2(8, N = 492)=1.11, p =.547$
	Knowledge regarding the provision of voluntary pre-termination of pregnancy counselling to the woman	$X^2(8, N = 486)=5.40, p =.067$
	Knowledge regarding the provision of voluntary post-termination of pregnancy counselling to the woman	$X^2(8, N = 477)=.074, p =.964$
	Knowledge regarding the provision of voluntary pre-termination of pregnancy counselling to the woman's partner	$X^2(8, N = 486)=11.12, p =.004$**
	Knowledge regarding the provision of voluntary post-termination of pregnancy counselling to the woman's partner	$X^2(8, N = 482)=.776, p =.678$
	Knowledge regarding the prevention of a woman from obtaining a legal abortion.	$X^2(8, N = 482)=1.31, p =.518$
	Knowledge regarding the state designating various sites as legal Termination of Pregnancy clinics	$X^2(8, N = 486)=5.54, p =.063$
	Knowledge regarding abortion being obtained for free at government	$X^2(8, N = 488)=5.88, p =.053$

	Termination of Pregnancy Clinics	
	Knowledge regarding nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic	$X^2(8, N = 483)=6.19, p =.05$*

* indicates significant relationship at the 0.05 level

** indicates significant relationship at the 0.01 level

The following tables provide cross-tabulations of the significant relationships between the variables listed in Table 25

Table 26. Cross-tabulation: sex of the participants and knowledge of minors being allowed to have an abortion.

Sex	Minors allowed abortion YES	Minors allowed abortion NO	Minors allowed abortion NOT SURE	Missing responses	Total
Female	45.77%	24.78%	26.24%	3.21%	100%
Male	58.24%	14.71%	24.71%	2.35%	100%

The results above indicate that participants' knowledge concerning minors being allowed to have an abortion was dependent on the participants' sex, that is, there was a higher proportion (58.24%) of male participants who knew that minors were allowed to have a legal abortion in contrast to the proportion of females who thought the same thing. More females than males thought that minors cannot have an abortion (24.78% compared to 14.71%), while a similar percentage were unsure.

Table 27 demonstrates data about the relationship between sex and abortion being obtainable up to 12 weeks of pregnancy.

Table 27. Cross-tabulation: sex of the participants and knowledge of abortion being obtainable up to 12 weeks of pregnancy.

Sex	Abortion obtainable up to 12 weeks YES	Abortion obtainable up to 12 weeks NO	Abortion obtainable up to 12 weeks NOT SURE	Missing responses	Total
Female	46.06%	9.62%	39.65%	4.66%	100%
Male	35.29%	17.06%	44.71%	2.94%	100%

A significant relationship was found between sex and knowledge of legal termination of pregnancy being obtainable upon request up to 12 weeks of pregnancy. A relatively higher proportion of males (44.71%) compared to females (39.65%) were not sure whether abortion can be obtained up to 12 weeks of pregnancy or not and more females than males did not respond.

Inaccurate knowledge concerning what happens at TOP clinics including what the health care workers are obliged to do may have contributed to some women, including adolescents, opting for 'back-street' abortion or inducing the pregnancy themselves.

Table 28 illustrates the relationship between sex and knowledge of the provision of voluntary pre-termination of pregnancy counselling to the woman's partner.

Table 28. Cross-tabulation: sex of the participants and knowledge of the provision of pre-termination of pregnancy counselling to the woman's partner.

Sex	Pre-termination of pregnancy counselling to the woman's partner YES	Pre-termination of pregnancy counselling to the woman's partner NO	Pre-termination of pregnancy counselling to the woman's partner NOT SURE	Missing responses	Total
Female	38.19%	19.53%	35.86%	6.41%	100%
Male	54.12%	11.76%	31.18%	2.94%	100%

Knowledge of Termination of Pregnancy clinics being obliged to provide voluntary *pre-*termination of pregnancy counselling to the woman's partner is dependent on participants' sex. A higher proportion of males (54.12%) in contrast to that of females (38.19%) thought that TOP clinics are obliged to provide the woman's partner with pre-termination of pregnancy counselling.

Lack of knowledge concerning nurses at TOP clinics insisting on the woman being accompanied by a partner may have served as an additional barrier to service accessibility. Table 29 illustrates the relationship between the sex of the participants and knowledge of nurses insisting on the partner to accompany the woman to the Termination of Pregnancy clinic.

Table 29. Cross-tabulation: sex of the participants and knowledge of nurses insisting on the partner to accompany the woman to TOP clinics.

Sex	Insist on woman's partner YES	Insist on woman's partner NO	Insist on woman's partner NOT SURE	Missing responses	Total
Female	41.11%	24.49%	28.57%	5.83%	100%
Male	51.76%	17.06%	25.29%	5.88%	100%

There is a significant relationship between the sex of the participants and their knowledge concerning nurses insisting on the partner to accompany the woman to the Termination of Pregnancy clinic. A higher percentage of females (24.49%) compared to the male participants (17.06%) knew that nurses do not insist on the woman's partner accompanying her to the Termination of Pregnancy clinic.

Based on the results above, it is difficult to state conclusively which sex had more accurate knowledge concerning stipulations of the CTOP Act. Due to the fact that, in some instances a higher proportion of males had accurate knowledge concerning certain stipulations and the same applies for females regarding certain stipulations. However, the fact that males serve as gate-keepers in some situations and the women are often the ones left with the responsibility of an unwanted and/or unintended pregnancy, it is essential that both males and females have accurate and comprehensive information concerning the CTOP Act stipulations.

5.2.5.3. School analysis

Often our views, knowledge and attitude towards certain things are shaped by our communities or societies. That is, geographical location and socio-economic status contribute to what a person knows and how a person perceives or interprets information concerning certain topics, especially topics that are normally seen as sensitive, controversial or taboo. It is from this understanding that relationships between schools and knowledge about CTOP Act and its stipulations were examined. Tables in this section present significant relationships between schools and knowledge of the CTOP Act and its stipulation. Table 31 demonstrates the relationship between schools and the circumstances under which legal abortion is allowed.

Table 30. Relationship between schools and various items on knowledge of the CTOP Act and its stipulations.

Variable one	Variable two	Chi-square
Schools	Knowledge regarding circumstances under which abortion can be obtained legally in South Africa	$X^2(16, N = 477)=52.27$, $p=.000$**
	Knowledge regarding minors being allowed to obtain abortion	$X^2(8, N = 499)=17.82$, $p=.022$*
	Knowledge regarding the requirement for parental consent	$X^2(8, N = 491)=23.09$, $p=.003$**
	Knowledge regarding married women be able to have legal abortion	$X^2(8, N = 485)=14.64$, $p=.066$
	Knowledge regarding the requirement for spousal consent	$X^2(8, N = 497)=45.29$, $p=.000$**
	Knowledge regarding gestation under which abortion may be obtained upon request	$X^2(8, N = 493)=19.60$, $p=.011$*
	Knowledge regarding gestation under which abortion may be performed under certain specified conditions	$X^2(8, N = 493)=8.07$, $p=.426$
	Knowledge regarding the provision of voluntary pre-termination of pregnancy counselling to the woman	$X^2(8, N = 487)=47.00$, $p=.000$**
	Knowledge regarding the provision of voluntary post-termination of pregnancy counselling to the woman	$X^2(8, N = 477)=22.50$, $p=.004$**
	Knowledge regarding the provision of voluntary per-termination of pregnancy counselling to the woman's partner	$X^2(8, N = 487)=10.45$, $p=.234$

	Knowledge regarding the provision of voluntary post-termination of pregnancy counselling to the woman's partner	$X^2(8, N = 482)=.12.16, p =.144$
	Knowledge regarding the prevention of a woman from obtaining a legal abortion	$X^2(8, N = 483)=8.55, p =.382$
	Knowledge regarding the state designating various sites as legal Termination of Pregnancy clinics	$X^2(8, N = 487)=20.32, p =.009$**
	Knowledge regarding abortion being obtained for free at government Termination of Pregnancy Clinics	$X^2(8, N = 489)=3.22, p =.919$
	Knowledge regarding nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic	$X^2(8, N = 483)=21.99, p =.005$**

* indicates significant relationship at the 0.05 level

** indicates significant relationship at the 0.01 level

The following tables provide cross-tabulations of the significant variables listed in Table 30

Table 31. Cross-tabulation: schools and knowledge of circumstances under which legal abortion is allowed.

Schools	Illegal	Rape, incest or sexual abuse	Physical or mental harm	Sexual violence and physical or mental harm	Upon request	Missing responses	Total
HOR	4.49%	8.99%	2.25%	26.97%	51.69%	5.62%	100%
DET-rural	14.39%	12.23%	6.47%	17.99%	41.73%	7.19%	100%
DET-urban	17.86%	20.71%	3.57%	22.86%	22.86%	12.14%	100%
Private	9.88%	9.88%	6.17%	13.58%	55.56%	4.94%	100%
Model C	4.62%	20.00%	7.69%	10.77%	55.38%	1.54%	100%

There is a significant relationship between schools and knowledge of the circumstances under which legal abortion is allowed. In other words, the participant's school plays a role in the knowledge that the participant has concerning the circumstances under which legal abortion can

be obtained. This is illustrated by the high proportion of participants from private, model C and HOR schools who knew that abortion is available upon request compared to the proportion of participants from both DET-rural and DET-urban schools.

The fact that there is a significant relationship between schools and knowledge of the circumstances under which abortion can be obtained means that there are some participants who, due their geographical location, may think that abortion is obtainable under restrictive circumstances. The kind of knowledge that the participants have with regard to the circumstances under which abortion can be obtained may inform the kind of knowledge that the participants have about the stipulations of the CTOP Act which is demonstrated in the following tables. Table 32 demonstrates the relationship between schools and knowledge of minors being allowed to have a legal abortion.

Table 32. Cross-tabulation: schools and knowledge of minors being allowed to have an abortion.

Schools	Minors allowed abortion YES	Minors allowed abortion NO	Minors allowed abortion NOT SURE	Missing responses	Total
HOR	59.55%	16.85%	23.60%	0.00%	100%
DET-rural	41.01%	25.90%	30.94%	2.16%	100%
DET-urban	41.43%	25.00%	27.86%	5.71%	100%
Private	60.49%	16.05%	18.52%	4.94%	100%
Model C	61.54%	16.92%	21.54%	0.00%	100%

The chi-square results indicate that there is a significant relationship between schools and knowledge of women under the age of 18 years being allowed to a legal abortion. Higher percentages of participants from DET-rural and DET-urban thought that minors are not allowed to have abortion or were unsure about this stipulation. These percentages are higher in contrast to those of participants from HOR, private and model C schools.

Table 33 illustrates the relationship between schools and knowledge of the requirement of parental consent for legal abortion.

Table 33. Cross-tabulation: schools and knowledge of requirement of parental consent for minors to obtain legal abortion.

Schools	Parental consent YES	Parental consent NO	Parental consent NOT SURE	Missing responses	Total
HOR	43.82%	37.08%	17.98%	1.12%	100%
DET-rural	58.99%	16.55%	20.86%	3.60%	100%
DET-urban	41.43%	20.00%	30.00%	8.57%	100%
Private	40.74%	28.40%	25.93%	4.94%	100%
Model C	44.62%	33.85%	20.00%	1.54%	100%

There is a significant relationship between knowledge concerning the requirement of parental consent for women under the age of 18 years to have legal abortion and schools. DET-rural had the lowest proportion of participants who knew that parental consent is not needed for minors to have a legal abortion and the highest proportion who thought that parental consent is required. HOR and Model C schools' participants appear to have the most accurate knowledge with higher percentages indicated that parental consent is not required.

The following table outlines data concerning the relationship between schools and the requirement of a husband's permission for married women to have a legal termination of pregnancy.

Table 34. Cross-tabulation: schools and knowledge of the requirement for spousal consent for a married woman to have a legal abortion.

Schools	Spousal consent YES	Spousal consent NO	Spousal consent NOT SURE	Missing responses	Total
HOR	39.33%	40.45%	20.22%	0.00%	100%
DET-rural	59.71%	11.51%	28.06%	0.72%	100%
DET-urban	60.00%	12.14%	21.43%	6.43%	100%
Private	45.68%	27.16%	19.75%	7.41%	100%
Model C	38.46%	38.46%	21.54%	1.54%	100%

There is a significant relationship between schools and knowledge concerning the requirement of spousal consent for married women to obtain a legal abortion. That is, the knowledge of whether a married woman needs her husband's permission to have an abortion is evidently influenced by one's geographical location. Amongst all the schools, DET-rural and DET-urban had the lowest

percentages of participants who thought that spousal consent was required for a married woman to obtain a legal termination of pregnancy. On the other hand, the highest proportions of participants who thought that a married woman needs her husband's permission for her to get a legal abortion were from DET-rural and DET-urban schools.

Table 35 demonstrates the relationship between schools and knowledge of abortion being obtainable up to 12 weeks of pregnancy.

Table 35. Cross-tabulation: schools and knowledge of abortion being obtainable up to 12 weeks of pregnancy

Schools	Abortion being obtainable up to 12 weeks YES	Abortion being obtainable up to 12 weeks NO	Abortion being obtainable up to 12 weeks NOT SURE	Missing responses	Total
HOR	58.43%	5.62%	34.83%	1.12%	100%
DET-rural	38.85%	16.55%	43.17%	1.44%	100%
DET-urban	33.57%	15.00%	42.86%	8.57%	100%
Private	41.98%	4.94%	45.68%	7.41%	100%
Model C	47.69%	13.85%	38.46%	0.00%	100%

The chi-square results indicate that there is a significant relationship between schools and knowledge of legal termination of pregnancy being obtainable upon request up to 12 weeks of pregnancy. A high proportion of participants from DET-urban, DET-rural and private schools were not sure if abortion was obtainable up to 12 weeks of pregnancy or not compared to HOR and model C schools. In addition a higher proportion of participants from HOR and Model C schools were aware that abortion can be obtained upon request up to 12 weeks.

The following table is a representation of the relationship between schools and the provision of pre-termination of pregnancy counselling to the woman.

Table 36. Cross-tabulation: schools and knowledge of the provision of pre-termination of pregnancy counselling to the woman.

Schools	Pre-termination of pregnancy counselling to the woman YES	Pre-termination of pregnancy counselling to the woman NO	Pre-termination of pregnancy counselling to the woman NOT SURE	Missing responses	Total
HOR	62.92%	1.12%	35.96%	0.00%	100%
DET-rural	34.53%	15.11%	46.76%	3.60%	100%
DET-urban	49.29%	11.43%	27.86%	11.43%	100%
Private	51.85%	1.23%	40.74%	6.17%	100%
Model C	67.69%	0.00%	30.77%	1.54%	100%

There is a significant relationship between schools and knowledge concerning Termination of Pregnancy clinics being obliged to provide voluntary *pre*-termination of pregnancy counselling to woman. DET-rural and DET-urban had the highest percentages of participants, in contrast to HOR, private and model C school participants, who thought that TOP clinics are not obliged to provide voluntary pre-termination of pregnancy counselling to the woman.

Table 37 illustrates a relationship between schools and the provision of post-termination of pregnancy counselling to the woman.

Table 37. Cross-tabulation: schools and knowledge of the provision of post-termination of pregnancy counselling to the woman.

Schools	Post-termination of pregnancy counselling for the woman YES	Post-termination of pregnancy counselling for the woman NO	Post-termination of pregnancy counselling for the woman NOT SURE	Missing responses	Total
HOR	40.45%	4.49%	52.81%	2.25%	100%
DET-rural	37.41%	15.83%	43.17%	3.60%	100%
DET-urban	42.14%	10.00%	34.29%	13.57%	100%
Private	39.51%	6.17%	45.68%	8.64%	100%
Model C	36.92%	0.00%	56.92%	6.15%	100%

Knowledge concerning Termination of Pregnancy clinics being obliged to provide voluntary *post*-termination of pregnancy counselling to the woman is dependent on one's schools. Compared to DET-rural and DET-urban, HOR, private and model C had the lowest proportion of

participants who thought that TOP clinics are not obliged to provide voluntary termination of pregnancy counselling to the woman.

Table 38 demonstrates the relationship between schools and the knowledge concerning designated sites as legal TOP clinics.

Table 38. Cross-tabulation: schools and knowledge of the state having designated sites as TOP clinics.

Schools	Designated sites as TOP clinics YES	Designated sites as TOP clinics NO	Designated sites as TOP clinics NOT SURE	Missing responses	Total
HOR	47.19%	5.62%	46.07%	1.12%	100%
DET-rural	42.45%	20.86%	33.09%	3.60%	100%
DET-urban	50.00%	10.00%	30.00%	10.00%	100%
Private	45.68%	7.41%	39.51%	7.41%	100%
Model C	44.62%	9.23%	44.62%	1.54%	100%

According to the chi-square results, there is a significant relationship between schools and knowledge of the state having designated (chosen) various sites as legal Termination of Pregnancy clinics. DET-rural and DET-urban schools had the highest percentages of participants who thought that the state had not designated sites as legal TOP clinics compared to HOR, private and model C schools. A higher percentage of HOR, Private and Model C school participants indicated that they were unsure compared to DET-rural and DET-urban.

Table 39 outlines data concerning relationships between schools and nurses insisting on the partner accompanying the woman to the TOP clinic.

Table 39. Cross-tabulation: schools and knowledge of nurses insisting on the partner accompanying the woman to the TOP clinic.

Schools	Insist on the woman's partner YES	Insist on the woman's partner NO	Insist on the woman's partner NOT SURE	Missing responses	Total
HOR	33.71%	38.20%	25.84%	2.25%	100%
DET-rural	53.96%	17.99%	25.90%	2.16%	100%
DET-urban	43.57%	15.71%	28.57%	12.14%	100%
Private	45.68%	24.69%	22.22%	7.41%	100%
Model C	40.00%	18.46%	36.92%	4.62%	100%

Knowledge of nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic and schools are dependent. Compared to DET-rural, DET-urban and model C schools, HOR and private schools had the highest proportion of participants who knew that nurses do not insist on a partner accompanying the woman to a TOP clinic.

Schools or rather geographical locations evidently play a role in shaping the kind of knowledge that adolescents have. Thus, a blanket approach may not necessarily be ideal particularly with regard to controversial, sensitive and taboo topics such as abortion.

5.3. Discussion

5.3.1. Discussion of the results of the frequency tables

This section discusses the results obtained from the frequency tables in the chapter. The discussion will be divided into the following sections: the knowledge of the name of the Act, the year the Act was passed, knowledge of the Act and its stipulations.

5.3.2.1. Name of the Act and the year that it was passed

The fact that none of the participants had accurate knowledge about the name of the Act or when it was passed could be taken as an indication of the knowledge or rather lack thereof that the participants have concerning the CTOP Act and its stipulations. However, it seems rather to relate to the fact that adolescents are given vague information concerning these particular facts or alternatively have not paid attention to them, because although none could accurately name the Act or when it was passed, 42.22% had accurate knowledge of the circumstances under which abortion may be obtained (as discussed in the following section), and 8.56% knew that the name of the legislation was related to termination of pregnancy. Lack of knowledge concerning the year the Act was passed could mean two things. Firstly, it could mean that the participants only became aware of abortion during the years they reported. It must be remembered that most of the participants would have been very young at the time of the passing of the Act. Secondly, participants may have chosen years that are constantly spoken about due to historic events related to them such as 1994. From this, it is evident that adolescents find a way to filling the gaps in their knowledge and hence the importance of the dissemination of comprehensive information particularly when targeted at the youth.

5.3.2.2. Knowledge of the Act

A substantial minority (42.22%) of the participants knew that abortion may be legally performed upon request of the woman up to a certain date of the pregnancy. This has implications for many adolescents with unwanted pregnancies in terms of the decision-making process. That is, knowledge that there are no restrictions concerning obtaining abortion legally is one of the more fundamental elements in terms of young women being able to exercise their reproductive health rights.

Just over one third (38.91%) of the participants thought that abortion can be obtained under restrictive circumstances and 11.67% thought that abortion is illegal. This brings to the fore the questions of what measures some of them may resort to when faced with unwanted and/or unintended pregnancies. That is, how many of them may resort to 'back-street' abortion or the use of hazardous methods (discussed in the following chapter) or induce the pregnancy themselves owing to lack of knowledge? It is worth noting that, the fact that 42.22% of the participants have accurate knowledge of the circumstances under which abortion may be legally performed, does not necessarily mean that they are safe from facing similar results as those with inaccurate or lack of knowledge. That is, knowing whether abortion is legal or not in one's country plays an imperative role in the woman's decision-making process with regard to the outcome of her pregnancy. However, knowing the legal status of abortion is not sufficient because every policy or legislation has underlying stipulations that must be adhered to. Hence adolescents' knowledge concerning the stipulations of the Choice on Termination of Pregnancy Act is discussed in the following section.

5.3.2.3. Knowledge of the stipulations of the Choice on Termination of Pregnancy Act

Although half of the participants knew that minors could obtain an abortion does not necessarily mean that minors with unwanted pregnancies are sufficiently informed in terms of their reproductive rights. Without the knowledge of minors' rights within the CTOP Act, these adolescents may be reluctant to approach TOP clinics and may thus resort to 'backstreet' abortions. This may be illustrated by the fact that 46.89% thought that parental consent is required for a minor to have a termination of pregnancy. In cases where minors come from dysfunctional or abusive households, or simply where the minor feels unable to communicate with her parents, this assumption could see her seeking alternate avenues to obtain an abortion.

Abortion is a time-sensitive service. Thus, the fact that only 42.41% knew that a legal termination of pregnancy can be obtained upon request for up to 12 weeks of pregnancy is problematic especially when taking into account that almost half of the participants claimed to have been sexually active in the last 12 months. Albeit 44.55% of the participants knew that after 12 weeks abortion is performed under certain specified conditions, some of them may still opt for 'back-street' abortion.

46.11% of the participants knew that the state has designated various sites as legal Termination of Pregnancy clinics. Although a substantial minority of the participants have accurate knowledge regarding the designated various TOP clinics, 36.96% were not sure.

The patriarchal system we still live in and possibly the belief in the concept of the man having the 'final say', continues to strengthen the perception of women as powerless beings with no form of autonomy or rights which is intensified further by inaccurate or lack of knowledge concerning women's reproductive rights. This has resulted in many of women's rights being violated, including a woman's right to choose the number, spacing and timing of her children and to exercise these rights free of discrimination, violence or coercion. For some women, men being it a boyfriend, husband or father may still have supremacy over sex related matters. That is, there is a possibility that men are still seen as gate-keepers in terms of whether a woman is allowed to have an abortion or not, as illustrated by the participants' responses in which 46.89% and 51.36% thought that parental and spousal consent were a requirement for a legal abortion respectively, and 44.55% thought that nurses needed to insist on a partner accompanying the woman to TOP clinics. Hence the fear of parental retribution or discord with spouses/partners may be one of the reasons why some women, particularly adolescents, still undergo 'backstreet' abortion (Varga, 2002).

According to the Choice on Termination of Pregnancy Act (1996), the provision of non-mandatory and non-directive pre- and post-termination of pregnancy counselling is to be promoted. 50.39% and 39.49% of the participants thought that the Termination of Pregnancy clinic is obliged to provide non-mandatory pre- and post-termination of pregnancy counselling to the woman respectively. A similar number of participants (43.58%) thought that the Termination of Pregnancy clinic is obliged to provide pre-termination of pregnancy counselling to the woman's partner. However, the percentage of those who thought that the Termination of

Pregnancy clinic is not obliged to provide post-termination of pregnancy counselling to the woman's partner was higher (20.23%) than of those who said no for post-termination of pregnancy counselling to the woman.

It is interesting how the man is seen as being important for the decision-making process and in ensuring that the decision is carried through. This is verified by 44.55% of the participants who indicated that it was required for nurses to insist on the partner accompanying the woman to the Termination of Pregnancy clinic. The CTOP Act does not require or even encourage the presence of a partner, presumably because of the assumption of the decision being the woman's alone.

It is due to such beliefs that the ICPD was one of the many conferences that have been held across time calling for the recognition of women's reproductive health rights particularly in developing countries. However, despite the extensive media coverage that arose from these conferences and the continued campaigns for the acknowledgment of women's rights and gender equality, women have inaccurate or a lack of knowledge concerning their rights. Lack of accurate and comprehensive knowledge is evidently a service barrier because even though some adolescents may know the circumstances under which a legal abortion can be obtained, the gestation limit, where it can be obtained and for how much, their inaccurate or lack of knowledge including their uncertainty concerning other equally essential stipulations may deny them the opportunity to exercise and enjoy their reproductive rights.

5.4. Discussions of the results of the Chi-square

This section discusses implications of the significant relationships that were found between sexual activity and CTOP Act including its various stipulations, sex and CTOP Act including its various stipulations and lastly, between schools and CTOP Act including its various stipulations.

5.4.1. Sexual activity x knowledge of the CTOP Act and its stipulations

For most variables there was no significant difference between participants who claimed to be sexually active in the last 12 months and those who did not. Significant relationships were only found between sexual activity in the last 12 months and the requirement for parental consent, requirement for spousal consent and provision of pre-termination of pregnancy counselling for

the woman. A higher percentage of the non-sexually active participants were unsure about the consent stipulations, and a higher percentage of the sexually active participants knew that parental and spousal consent are not required. Despite this, a similar percentage of sexually active and non-sexually active participants thought that parental and spousal consent is required. The fact that a high proportion of those who claimed to have been sexually active in the last 12 months have inaccurate knowledge concerning parental and spousal consent implies that they may resort to illegal methods of abortion when faced with unwanted and/or unintended pregnancies, possibly substantiating Alubo's (2001) argument that many adolescents engage in sexual activities with limited or inaccurate information. However, a higher percentage of those who claimed that they have not been sexually active in the last 12 months thought that Termination of Pregnancy clinics are obliged to provide voluntary pre-termination of pregnancy counselling to the woman.

5.4.2. Sex x knowledge of the CTOP Act and its stipulations

There was no significant relationship between sex of the participants and most of the variables. Significant relationships were found between sex and minors being allowed to obtain abortion; the gestation period under which abortion may be obtained upon request; the provision of voluntary pre-termination of pregnancy counselling to the woman's partner and nurses insisting on a partner accompanying the woman to the Termination of Pregnancy clinic. A smaller proportion of females (38.19%) compared to the proportion males (41.07%) knew that a legal termination of pregnancy can be obtained upon request up to 12 weeks of pregnancy. Only 45.77% of the female participants knew that minors are allowed to obtain a legal abortion. This proportion is significantly lower than that proportion of male participants (58.24%) who also knew that women under the age of 18 years are allowed to have an abortion. This study is undertaken from a reproductive health perspective and is interested in the knowledge of both sexes; however, it is often believed that the woman is responsible for reproductive health matters such as avoiding pregnancy. Thus, it is interesting to note that males had more accurate knowledge concerning these two stipulations than did the females. Reverse proportions were found with regard to Termination of Pregnancy clinics being obliged to provide voluntary pre-termination of pregnancy counselling to the woman's partner. A higher proportion of males (54.12%) compared to that of females (38.19%) thought that Termination of Pregnancy clinics

are obliged to provide voluntary pre-termination of pregnancy counselling to the woman's partner. The same trend was found with regard to the item concerning nurses insisting on the woman's partner accompanying her to the Termination of Pregnancy Clinic, with a higher proportion of males indicating this to be true than females.

Based on the above discussion and percentages it is evident that sex cannot be disregarded where knowledge is concerned of some key stipulations of the CTOP Act. Although males knowledge is important, the fact that a higher proportion of females had inaccurate knowledge concerning minors being able to obtain an abortion and the fact that abortion can be obtained up to 12 weeks should be of concern

5.4.3. Schools x knowledge of the CTOP Act and its stipulations

The discussion on schools x knowledge of the CTOP Act and its stipulations speaks directly to the participants' geographical location and the role that the participants' geographical location might play on their knowledge. That is, the participants' geographical location and the community they live in has a direct influence on their knowledge about the CTOP Act and its stipulations.

Significant relationships were found between schools and knowledge of the circumstances under which abortion can be obtained, the requirement of parental consent, requirement of the husband's permission, abortion being obtainable for up to 12 weeks of pregnancy, provision of pre- and post-termination of pregnancy counselling to the woman, designation of various TOP sites and nurses insisting on the partner to accompany the woman. Knowledge concerning these various stipulations is dependent on the participant's school or rather his/her geographical location and community in which he or she lives.

The highest proportion of participants who thought that abortion was illegal were from DET-rural (14.39%) and DET-urban (17.86%) schools. Although there was some variation in the relationships between other variables and school, this trend of participants from DET-urban and DET-rural school having more inaccurate knowledge persisted. Thus a higher proportion of learners from these schools thought that minors cannot have an abortion, that spousal consent is required, did not know that abortion obtainable up to 12 weeks, thought that pre-termination and post-termination of pregnancy counselling is not provided to the woman, did not know that the

government had designated particular sites to provide termination of pregnancy services. In some cases the DET-rural school participants had the most inaccurate information, viz. that parental consent is required for minors to have an abortion and that nurses need to insist that the partner accompany the woman to the clinic. The level of knowledge illustrated above may be linked to resources and possibly access to things such as the radio/television or movies (seeing that these are major sources of information) and the extent to which LO is taught (seeing that teachers are also a major source of information).

5.5. Conclusion

Less than half of the adolescents had accurate knowledge concerning the circumstances under which abortion can be obtained. It is preferable however, that all adolescents have accurate knowledge about the CTOP Act and its stipulations, though this accurate knowledge is more urgent for those who are sexually active because they are at a greater risk of falling pregnant consequently possibly facing unwanted and/or unintended pregnancy. Furthermore, the fact that a higher proportion of females compared to males, generally, lack information about matters that are fundamental to their reproductive health needs (such as minors being allowed to obtain abortion) needs to be addressed urgently. Due to the fact that as previously mentioned, women are often the ones left responsible for avoiding a pregnancy or facing the consequences of an unwanted and/or unintended pregnancy. Thus empowering women by giving them comprehensive information particularly those who are sexually active has direct bearing on decreasing the rate of maternal morbidity and mortality. Sexual activity may imply higher knowledge regarding sex, but this does not necessarily stretch to reproductive knowledge as illustrated by various studies (Otoide et al., 2001; Varga, 2003; Wood & Jewkes, 2006).

Moreover, knowledge cannot be separated from one's geographical location as illustrated above. That is, one's geographical location plays a pivotal role in the kind of knowledge one has. For instance a higher proportion of participants from DET-rural schools thought that abortion was illegal while Private schools have the higher percentage of participants who claimed to have been sexual active in the last 12 months. Based on the results and the discussion above, it is evident that adolescents' geographical location must be taken into account when addressing reproductive health matters.

It is acknowledged that abortion is a multifaceted topic, but it is also an effective, safe legal option for a woman faced with an unwanted and/or unintended pregnancy. However, due communities we live in, abortion has become a contentious topic that may be resulting in unwarranted maternal morbidity and mortality of many women including adolescents.

The following chapter is a presentation of results concerning the participants' knowledge of the consequences of abortion, knowledge of EC, and their sources of information.

Chapter 6

Knowledge of the consequences of abortion, and of Emergency Contraceptives, and sources of information: Results and discussion

6.1. Introduction

The aim of this chapter is to give an in-depth explanation and discussion of other factors that were included in the questionnaire. That is, this chapter will present results and discussion of the consequences of abortion, methods of legal and illegal abortion, whether participants think they have sufficient information concerning abortion, their knowledge of Emergency Contraceptive pills and their sources of information.

6.2. Results of the study

6.2.1. Knowledge of the consequences of legal abortion

Perceived consequences of legal abortion inform adolescents' views and behavior towards abortion. That is, the knowledge or rather lack thereof that adolescents have concerning the consequences of legal abortion is one of the primary factors that may play a vital role in the adolescent's decision to either obtain abortion legally, to use 'backstreet' abortion or to continue with the unwanted pregnancy. The frequency tables below highlight the participants' knowledge of the consequences of legal abortion when performed by a trained practitioner at a Termination of Pregnancy clinic.

Table 40 outlines data concerning the participants' responses to legal abortion being a medically safe procedure.

Table 40. Responses regarding legal abortion being a medically safe procedure.

	Is a medically safe procedure	
Category	**N**	**%**
Agree	358	69.65
Disagree	129	25.10
Non-responses	27	5.25
Total	**514**	**100**

Over two thirds of the participants had accurate knowledge of the safety of abortion as a medical procedure, that is, 69.65% knew that abortion was a medically safe procedure. Just under a third (30.35%) did not think that abortion was a medically safe procedure or did not respond.

Table 41 is a representation of the participants' responses regarding legal abortion being a leading cause of infertility.

Table 41. Responses regarding legal abortion being a leading cause of infertility.

	Is a leading cause of infertility	
Category	**N**	**%**
Agree	246	47.86
Disagree	220	42.80
Non-responses	48	9.34
Total	**514**	**100**

Just over half (52.14%) of the participants did not think that legal abortion is a leading cause of infertility or did not respond. Only 42.80% knew that legal abortion is not the leading cause of infertility. 47.86% thought legal abortion is a leading cause of infertility.

Table 42 details responses to legal abortion being medically more dangerous than giving birth.

Table 42. Responses regarding legal abortion being medically more dangerous than giving birth.

	Is medically more dangerous than giving birth	
Category	**N**	**%**
Agree	328	63.81
Disagree	142	27.63
Non-responses	44	8.56
Total	**514**	**100**

Over half of the participants had inaccurate knowledge concerning the dangers associated with legal abortion compared to those of giving birth. That is, 63.81% of the participants thought that legal abortion is medically more dangerous than giving birth. Just over a third thought that legal abortion was not medically more dangerous than giving birth or did not respond. Only 27.63% knew that legal abortion is not medically more dangerous than giving birth.

Table 43 illustrates the participants' responses regarding legal abortion frequently causing death of the woman.

Table 43. Responses regarding legal abortion frequently causing death of the woman.

	Frequently causes death of the woman	
Category	**N**	**%**
Agree	300	58.37
Disagree	171	33.27
Non-responses	43	8.37
Total	**514**	**100**

Almost half (41.64%) of the participants did not think that legal abortion frequently causes the death of the woman or did not respond. Only 33.27% of the participants knew that legal abortion does not frequently cause the death of the woman. Over half of the participants thought that legal abortion frequently causes the death of the woman.

Table 44 details responses to legal abortion being associated with positive feelings of relief.

Table 44. Responses regarding legal abortion being associated with positive feelings of relief.

	Is associated with positive feelings of relief	
Category	**N**	**%**
Agree	162	31.52
Disagree	293	57.00
Non-responses	59	11.48
Total	**514**	**100**

Less than a third of the participants (31.52%) indicated that legal abortion is associated with positive feelings of relief. Over two thirds of the participants thought that legal abortion is not associated with positive feelings of relief or did not respond, with 57.00% of the participants indicating that legal abortion is not associated with positive feelings of relief.

Table 45 demonstrates the participants' responses regarding legal abortion being almost certain to lead to feelings of depression and guilt.

Table 45. Responses regarding legal abortion being almost certain to lead to feelings of depression and guilt.

	Will almost certainly lead to feelings of depression and guilt	
Category	**N**	**%**
Agree	382	74.32
Disagree	87	16.93
Non-responses	45	8.75
Total	**514**	**100**

Three quarters (74.32%) of the participants thought legal abortion will almost certainly lead to feelings of depression and guilt. Just a third of the participants did not think that legal abortion will almost certainly lead to feelings of depression and guilt or did not respond. Less than twenty percent (16.93%) indicated that legal abortion will not almost certainly lead to feelings of depression and guilt.

The participants' knowledge of the consequences of abortion may be informed by the knowledge they have with regard to the methods used to perform legal and illegal termination of pregnancy. Hence the following section is about the knowledge that the participants have with regard to how abortion is performed both legally and illegally.

6.2.2. Knowledge of the methods of legal and illegal termination of pregnancy

Table 46 presents data concerning the participants' responses to illegal methods of termination of pregnancy. It is worth noting that the participants may have mentioned a number of methods and therefore the totals of the percentages in Table 46 and 47 will not be 100. In each table, the open-ended responses from the participants were groups under broad categories.

Table 46. Responses regarding illegal methods of termination of pregnancy.

Method	N	%
Instruments		
Coat hangers/ Crochet hangers	24	21.82
Machinery/tools/equipment/instruments	12	10.91
Scissors	4	3.63
Needles	3	2.73
Gloves	1	0.91
Total		40.00%

Ingestion of sharp/abrasive objects		
Sharp objects/blades	4	3.64
Swallowing/eating steelwool	2	1.82
Pieces of wire	1	0.91
Total		6.37%
Ingestion of pills/medication		
Pills/medication/drugs	38	34.55
Laxatives	2	1.82
Total		36.37%
Ingestion of poison		
Poison	6	5.45
Pesticides	2	1.82
Ratex	1	0.91
Brake-fluid	1	0.91
Paraffin	1	0.91
Total		10.00%
Ingestion of detergents		
'Madubulla'	16	13.64
Bleach/jik	6	5.45
Dishwasher	3	2.73
Cleaning detergents	1	0.91
Powder soap	1	0.91
Total		23.61%
Ingestion of mixture		
Water boiled with steelwool	90	81.82
Water boiled with newspaper	85	77.27
Pills mixed with alcohol	3	2.72
Boiled water mixed with vinegar	1	0.91
Vinegar mixed with Oro-krush and pieces of blades	1	0.91
Coca-cola mixed with bleach	1	0.91
Steelwool mixed with Oro-krush	1	0.91
Steelwool mixed with lemon juice	1	0.91
Total		166.36%
Ingestion of undiluted/strong beverages		
Oro-krush/wild island	46	46.36
Brandy/whiskey/alcohol/beer/menthylated spirit	43	39.09
Boiled gin	10	9.09
Acidic drinks	9	8.18

Black tea/coffee without sugar/coffee without water	8	7.27
Vinegar	6	5.45
Total		115.44%
Ingestion of herbal/traditional medicines		
Stameta	74	67.27
Amayeza wesixhosa	30	27.27
'Muti'/traditional medicine	24	21.18
Herbal remedies	1	0.91
Total		116.63%
Self-harm		
Falling and landing on your stomach	1	0.91
Total		0.91%

This table illustrates the methods that the participants think are used for performing illegal abortion. Ingestion of a mixture of substances (mostly water with steelwool or newspaper), ingestion of herbal/traditional medicine, ingestion of undiluted/strong beverages, ingestion of pills/medication, instruments and ingestion of detergents were the six top categories for the methods of performing illegal abortion stated by the participants.

The following table details responses to legal methods of termination of pregnancy.

Table 47. Participants' responses to legal methods of termination of pregnancy.

Method	N	%
Instruments		
Medical instruments/machinery/tools	29	26.36
Needles/injections	7	6.36
Blades/knives	6	5.45
Surgery/operations	3	2.73
Suction gadgets/vacuum	3	2.73
Scissors	2	1.82
Gloves	1	0.91
Spoon-like instruments	1	0.91
Total		47.27%
Ingestion of pills/medication		
Pills/medicines/drugs	71	64.55

Vaccines	1	0.91
Total		65.46%
Ingestion of poison		
Paraffin	1	0.91
Total		0.91%
Ingestion of mixture		
Alcohol mixed with pills/drugs	1	0.91
Total		0.91%
Ingestion of undiluted/strong beverages		
Strong drinks	2	1.82
Total		1.82%
Ingestion of herbal/traditional medicines		
Stameta	4	3.64
Amayeza wesixhosa	2	1.82
Total		5.46%

There is a possibility that some adolescents are not aware of the distinction between a legal and an illegal abortion. This distortion is evident in some of the methods they think are used to perform legal abortion, for e.g. the ingestion of paraffin or amayeza wesixhosa being used to terminate a pregnancy legally.

It is significant to note that 564 responses were received to the open-ended questions concerning illegal methods of performing abortion and only 134 regarding legal methods. Lack of accurate knowledge with regard to the precise distinction between legal and illegal abortion, and about how legal abortion is performed, may result in many erroneous beliefs but more devastatingly in the use of hazardous methods in an attempt to solve an unwanted and/or unintended pregnancy. This section explores these hazardous methods in detail. According to the information given by the participants, both legal and illegal methods of performing termination of pregnancy fall broadly under the following categories, namely: instruments; ingestion of sharp/abrasive objects; ingestion of pills/medication; ingestion of poison; ingestion of detergents; ingestion of mixtures; ingestion of undiluted/strong beverages; ingestion of herbal/traditional drugs; and self-harm.

6.2.2.1. Instruments

This section refers to the tools that the participants think are used for performing termination of pregnancy (both legal and illegal). Coat hangers/Crochet hangers, machinery/tools/equipment/instruments, scissors, needles and gloves were instruments that were reported as being used to perform illegal abortion with coat hangers/crochet hangers and machinery/tools/equipment/instruments being chosen as popular methods.

Although the participants were not able to name the methods with absolute accuracy, 64.55% of those that gave responses to legal abortion knew that it is performed either medically (through pills) or surgically. 47.27% said that legal abortion is performed by using various instruments such as medical instruments/machinery/tools, surgery/operations, suction gadgets/vacuum and spoon-like instruments. Medical instruments/machinery/tools were the most popular instruments methods chosen by 26.36% of the participants. 13.63% of the participants stated that legal abortion was performed by the use of needles/injections, blades/knives, scissors and gloves.

Interestingly, elaborate explanations of how these tools or machinery (as they were sometimes referred to) are used to perform abortion were only given for legal abortion. According to some of the participants this is how legal abortion is performed: "Certain types of machinery which is said to be painful is put through the vagina. The machinery enters and goes into the stomach where it vibrates and vacuums the fertilized egg inside you" or "the doctor scratches the egg with some tool and spray inside her body to sanitize it so that infections can be prevented".

6.2.2.2. Ingestion of sharp/abrasive objects

Ingesting sharp objects/blades and swallowing/eating steelwool were the methods reported for terminating an abortion illegally, particularly the intake of blades or sharp objects. No method that falls under this category was reported for terminating an abortion legally.

6.2.2.3. Ingestion of pills/medication

This category speaks specifically to the use of pharmaceutical drugs. Although the name or type of pills spoken about was not given, pills were one of the popular methods mentioned for performing both legal and illegal termination of pregnancy across the study.

Once again, details on the use, dosage and the effect of the pills were primarily given for legal termination of pregnancy. "Pills that clean the woman of every dirty thing inside her womb", "Anti-foetus pill which cuts up the foetus inside", "Pills causing pain so you can feel the baby coming as if you are giving birth", "Some give pills to the woman and the baby will come out through the vagina or mouth". The latter explanation of how legal abortion is performed was stated as being seen on TV.

A detailed explanation of how pills were also used to perform an illegal abortion was given: "4 pills and then before you use them don't drink anything for 5 hours and insert the pills at the same time in your vagina and don't move around, sit down or sleep it will be like your in your date (periods) then after drink black tea (5 roses) it will clean that person".

Albeit that graphical details of how both legal and illegal abortion are performed were given, the immeasurable pain that is associated with the performance of legal abortion makes it rather understandable why some adolescents may think that illegal or 'backstreet' abortion may be a better option.

6.2.2.4. Ingestion of poison

The intake of various poisons such as poison, pesticides, ratex, brake-fluid and paraffin were reported methods of illegal abortion, with the drinking of paraffin being most commonly mentioned as a method of performing illegal abortion (one participant mentioned it as a legal method of abortion). It is worth noting that poisons were predominant methods of termination of pregnancy which coincides with what has been stated in literature, both national and international.

"Drinking paraffin and the baby will come through the mouth or vagina" is a description of how illegal abortion is performed when using paraffin as one's method of choice.

6.2.2.5. Ingestion of detergents

Detergents such as 'madubulla', bleach/jik, dishwash liquid, cleaning detergents and powdered soap are methods said to be used for illegal abortion. 'Madubulla' which is a cleaning detergent with a specific purpose for killing insects and cockroaches was the most popular method reported

by the participants. None of the methods in this category were said to be used to perform legal abortion.

6.2.2.6. Ingestion of a mixture of material

Water boiled with steelwool, water boiled with newspaper, pills mixed with alcohol, boiled water mixed with vinegar, vinegar mixed with Oro-krush and pieces of blades, coca-cola mixed with bleach, steelwool mixed with Oro-krush and steelwool mixed with lemon juice are methods stated to be used to perform illegal abortion.

Drinking 'steelwool' water (i.e. boil the steelwool and drink the water) and drinking 'ink' water (i.e. boiling the newspaper specifically *Daily Dispatch* but boil the side that has words only not the side that has pictures) are common methods reported by the participants across different geographical locations. A detailed description of how Oro crush mixed with steelwool is made and used is given by the participant: "steelwool is fined and they drink it with lemon juice for the sour taste then wait for the pain to have an abortion".

Alcohol mixed with pills or drugs is the only reported method for performing legal abortion.

It can be argued that mixture of steelwool with other things, drinking 'steelwool' water and drinking 'ink' water are recently developed methods of performing abortion illegally due to the fact that none of these methods have been mentioned in any literature (both national and international) prior to now.

6.2.2.7. Ingestion of undiluted/strong beverages

The intake of Oro-krush/wild island, brandy/whiskey/alcohol/beer/menthylated spirit, boiled gin, acidic drinks, black tea/coffee without sugar/coffee without water and vinegar are methods stated to be used for performing illegal termination of pregnancy. The drinking of Oro-krush/wild island and brandy/whiskey/alcohol/beer/menthylated spirit are the most popular methods in this category. Drinking strong drinks is the only reported method for performing legal abortion.

6.2.2.8. Ingestion of herbal/traditional medicines

Traditional medicine and herbal remedies are reported methods used for illegal termination of pregnancy, including Stameta (which is a herbal/ traditional drug used to clean the blood, kidney, bladder, stomach), amayeza wesixhosa (traditional Xhosa medicine) and 'muti'/traditional medicine with specific reference to a traditional medicine called 'Umqwahili' which apparently means 'the brake'. This is 'a green traditional medicine filled in a bottle from the sangoma'. The ingestion of herbal/traditional medicines particularly Stameta are methods reported to be used to perform both legal and illegal termination of pregnancy.

Although some of these methods might be recent (in terms of never been recorded before), they are apparently well known amongst adolescents in the Buffalo City Municipality across the different geographical locations. That is, in every school the drinking of 'steelwool' or 'ink' water was mentioned with similar instructions on how to make this 'steelwool' or 'ink' water. It can only be assumed that due to the popularity of these methods, either adolescents speak from experience or know someone who has used these methods and regrettably these methods proved to be effective in that situation consequently validating these hazardous methods.

6.2.2.8. Self-harm

"Landing on your stomach after falling" was described as a method used for performing illegal termination of pregnancy.

6.2.3. Knowledge of someone having undergone abortion

Despite the inaccurate or lack of knowledge many adolescents may have regarding termination of pregnancy, some choose it as a solution for unintended and unwanted pregnancies. The following tables demonstrate the participants' knowledge regarding someone who has had abortion be it legal or illegal.

Table 48. Responses of knowing someone who has had legal termination of pregnancy.

	I know someone who has had a legal termination of pregnancy	
Category	**N**	**%**
YES	183	35.60
NO	266	51.75
NOT SURE	51	9.92
NON-RESPONSES	14	2.72
Total	**514**	**100**

35.60% of the participants knew someone who has had legal termination of pregnancy. Over half of the participants did not know someone who has undergone a legal termination of pregnancy, or were not sure or did not respond.

Table 49 outlines data concerning the participants' responses of knowing someone who has had an illegal abortion.

Table 49. Responses of knowing someone who has had an illegal termination of pregnancy.

	I know someone who has had an illegal termination of pregnancy	
Category	**N**	**%**
YES	133	25.88
NO	287	55.84
NOT SURE	65	12.65
NON-RESPONSES	29	5.46
Total	**514**	**100**

Three quarters of the participants did not know someone who has had an illegal abortion, or were not sure or did not respond, with 55.84% indicating that they did not know someone who has undergone illegal termination of pregnancy. 25.88% (or about 1 in 4) reported knowing someone who has had an illegal termination of pregnancy.

6.2.4. Sources of information

It is important to know adolescents' primary sources of information with regard to reproductive health matters due to the fact that these sources of information have direct influence on

adolescents' knowledge, attitudes and ultimately their behavior. The following frequency tables will demonstrate adolescents' reported sources of information and which sources of information they rely on the most. Participants were able to mark more than one category in this item. Table 50 illustrates the participants' responses regarding sources of information.

Table 50. Responses regarding sources of information.

	I heard about abortion from	
Category	**N**	**%**
Television	410	71.92
Friends	377	66.14
Teachers	361	63.33
Radio	329	57.71
Movies	306	53.68
Clinic	302	52.98
Family/Relatives	278	48.77
Internet	231	40.52
Health campaigns	227	39.82
Parents	201	35.26
Boyfriend or girlfriend	164	28.77
Church	137	24.03

It is notable that three media sources (TV, radio, movies) feature in the top 6 sources of information, each being mentioned by more than half of the participants. Peers are mentioned by two thirds of participants, and teachers by just less than two thirds of the participants. Clinics are mentioned by just over half of the participants.

The table above speaks to information being obtained from a particular source but not the quality, or depth or breadth of the information being passed on. Hence the following section examines whether the participants think they have sufficient information.

6.2.5. Sufficient information

In most cases, it is concluded that adolescents do not have accurate and sufficient knowledge based on the answers they give when questioned about abortion. However, they may be under the impression that their information is not only accurate but also sufficient. Hence in this section, it was not left to chance, assumption or implication as to whether they feel they have sufficient knowledge or not. In this section, they were asked if they felt they had sufficient

information concerning Termination of Pregnancy. Table 51 reflects their responses to this question.

Table 51. Response regarding sufficient information concerning Termination of Pregnancy.

	I feel I have sufficient information concerning Termination of Pregnancy	
Category	**N**	**%**
Yes	119	23.15
No	224	43.58
Not sure	152	29.57
Non-responses	19	3.70
Total	**514**	**100**

Only 23.15% of the participants felt that they have sufficient information concerning abortion. Over half (76.85%) of the participants did not feel like they have sufficient information concerning termination of pregnancy, or were not sure or did not respond. A substantial minority of participants did not feel like they have sufficient information concerning abortion.

The following section represents the participants' knowledge concerning EC due to the fact that EC is a time-sensitive service that has the potential to prevent an unwanted and/or unintended pregnancy after engaging in unprotected intercourse.

6.2.6. Knowledge about Emergency Contraceptives

Emergency Contraceptive pills have the potential of being an effective and accessible option for women who either engaged in unprotected sex or experienced contraceptive failure. The following frequency tables elucidate adolescents' knowledge concerning Emergency Contraceptive pills. Table 52 presents data concerning the participants' responses to EC being used to prevent pregnancy after unprotected sex.

Table 52. Responses regarding EC being used to prevent pregnancy after unprotected sex.

	Emergency Contraceptive pills also known as 'the morning after pill' is used to prevent pregnancy after unprotected sex	
Category	**N**	**%**
Yes	317	61.67
No	59	11.48
Not sure	112	21.79
Non-responses	26	5.06
Total	**514**	**100**

Over half of the participants have accurate knowledge with regard to what EC is used for. That is, 61.67% of the participants knew that EC also known as 'the morning after pill' is used to prevent pregnancy after unprotected sex. Just over one third of the participants did not think that EC is used to prevent pregnancy after unprotected sex, or were not sure or did not respond.

Table 53 demonstrates the participants' responses regarding EC being an abortifacient.

Table 53. Responses of EC being an abortifacient.

	Emergency Contraceptive pills can cause abortion	
Category	**N**	**%**
Yes	114	22.18
No	102	19.84
Not sure	257	50.00
Non-responses	41	7.98
Total	**514**	**100**

22.18% of the participants thought that EC can cause abortion. 77.82% of the participants did not think that EC can cause abortion, or were not sure or did not respond. Only 19.84% knew that EC cannot cause abortion.

Table 54 details responses with respect to the time period within which EC must be taken after unprotected sex.

Table 54. Responses with respect to time period within which EC must be taken after unprotected sex.

	Emergency Contraceptive pills must be taken within 72 hours of unprotected sex	
Category	**N**	**%**
Yes	150	29.18
No	52	10.12
Not sure	275	53.50
Non-responses	37	7.20
Total	**514**	**100**

Less than a third (29.18%) of the participants have accurate knowledge concerning the time frame within which EC must be taken. Almost three quarters were not sure whether EC should be taken within 72 hours, or indicated this was not necessary or did not respond. 53.50% were not sure of the time period within which EC must be taken after engaging in unprotected intercourse.

Table 55 is a representation of the participants' responses regarding EC being free of charge at public health facilities.

Table 55. Responses of EC being free of charge at public hospitals and clinics.

	Emergency Contraceptive pills are free at public hospitals and clinics	
Category	**N**	**%**
Yes	264	51.36
No	67	13.04
Not sure	148	28.79
Non-responses	35	6.81
Total	**514**	**100**

A little over half of the participants have accurate knowledge of the cost of EC at public hospitals and clinics. That is, only 51.36% indicated that EC is available for free at public hospitals and clinics. Over a third (48.64%) of the participants did not think that EC can be obtained free of charge at public hospitals and clinics, or were not sure or did not respond.

Table 56 demonstrates the participants' responses regarding EC being obtainable over the counter at a pharmacy.

Table 56. Responses regarding EC being obtainable over the counter at a pharmacy.

	Emergency Contraceptive pills can be bought over the counter at a pharmacy	
Category	**N**	**%**
Yes	321	62.45
No	42	8.17
Not sure	116	22.57
Non-responses	35	6.81
Total	**514**	**100**

62.45% of the participants knew that EC can be bought over the counter at a pharmacy. Over a third (37.55%) did not think that EC can be bought over the counter at a pharmacy, or were not sure or did not respond, 8.17% thought EC cannot be bought over the counter at a pharmacy.

Responses regarding the requirement of parental consent for minors to obtain EC are illustrated in Table 57.

Table 57. Responses of parental consent being required for minors to get EC.

	Parental consent is needed for a woman under the age of 18 years to get Emergency Contraceptive pills	
Category	**N**	**%**
Yes	143	27.82
No	171	33.27
Not sure	165	32.10
Non-responses	35	6.81
Total	**514**	**100**

Two thirds of the participants thought that parental consent is needed for a woman under the age of 18 years to get EC, or were not sure or did not respond, with only 33.27% indicating that minors do not need parental consent to get EC. 27.82% thought that parental consent is required for minors to get EC.

Table 58 details responses regarding the requirement of spousal consent for a married woman to get EC.

Table 58. Responses of spousal consent being required for a married woman to get EC.

	If a married woman wants Emergency Contraceptive pills, she must get her husband's permission	
Category	**N**	**%**
Yes	190	36.96
No	151	29.38
Not sure	140	27.24
Non-responses	33	6.42
Total	**514**	**100**

Just over a third of the participants thought that a married woman needs her husband's permission if she wants EC. Almost two thirds (63.04%) of the participants did not think that a married woman needs her husband's permission if she wants EC, or were not sure or did not respond. Less than a third (29.38%) of the participants knew that a married woman does not need her husband's permission if she wants EC.

Table 59 illustrates responses regarding EC having long-term side-effects.

Table 59. Responses regarding EC having long-term side-effects.

	Emergency Contraceptive pills have long-term side-effects	
Category	**N**	**%**
Yes	124	24.12
No	52	10.12
Not sure	304	59.14
Non-responses	90	6.61
Total	**514**	**100**

24.12% of the participants thought that EC have long-term side-effects. Over 60% of the participants were not sure of the long-term side effects of EC or did not respond. Only 10.12% of the participants indicated that EC does not have long-term side-effects.

6.2.7. Results of the chi-square

The above section was to give a numerical representation of the data. Thus the following section is on inferential statistics which goes beyond what has been illustrated above. The tables of the following section demonstrate whether there were any significant relationships between various variables. It is worth noting that only the results with a significant difference will be included in this chapter. This section will only be divided into two subsections namely: sex analysis and schools analysis due to the fact that there are no significant relationships between sexual activity of the participants in the last 12 months and knowledge concerning EC.

6.2.7.1. Sex analysis

This section examines whether knowledge concerning Emergency Contraceptive pills is sex specific or if one's sex is not necessarily related to their knowledge of EC. Table 60 demonstrates relationships between sex and knowledge of EC.

Table 60. Relationship between Sex and knowledge of emergency contraceptives.

Variable one	Variable two	Chi-square
Sex	Knowledge regarding emergency contraceptives pills being used to prevent pregnancy after unprotected sex	$X^2(2, N = 487)=1.30, p =.521$
	Knowledge regarding emergency contraceptive pills causing abortion	$X^2(2, N = 472)=4.78, p =.916$
	Knowledge regarding emergency contraceptive pills being taken within 72 hours of unprotected sex	$X^2(2, N = 476)=3.59, p =.166$
	Knowledge regarding emergency contraceptive pills being obtainable for free in public hospitals and clinics	$X^2(2, N = 478)=2.91, p =.234$
	Knowledge regarding emergency contraceptive pills being bought over the counter	$X^2(2, N = 478)=24.42, p =.000**$

	Knowledge regarding the requirement of parental consent	$X^2(2, N = 478)=2.83, p =.245$
	Knowledge regarding the requirement of spousal consent	$X^2(2, N = 480)=12.03, p =.002$**
	Knowledge regarding emergency contraceptive pills having long-term side-effects	$X^2(2, N = 479)=13.49, p =.001$**

* indicates significant relationship at the 0.05 level

** indicates significant relationship at the 0.01 level

The following tables present the cross-tabulations of those variables with a significant relationship.

Table 61. Cross-tabulation: sex of the participants and knowledge of EC being bought over the counter.

Sex	EC being bought over the counter YES	EC being bought over the counter NO	EC being bought over the counter NOT SURE	Missing responses	Total
Female	68.80%	4.96%	19.53%	6.71%	100%
Male	49.41%	14.71%	28.82%	7.06%	100%

Chi-square results indicate that there is significant relationship between sex and knowledge of whether Emergency Contraceptive pills can be bought over the counter at a pharmacy. A higher proportion (68.80%) of female participants knew that EC can be bought over the counter than male participants. A higher proportion of males were unsure or thought that EC cannot be bought over the counter.

Table 62 illustrates data concerning relationships between sex and the requirement of spousal consent for emergency contraceptives.

Table 62. Cross-tabulation: sex of the participants and knowledge of the requirement of spousal consent for obtaining EC.

Sex	Requirement for spousal consent YES	Requirement for spousal consent NO	Requirement for spousal consent NOT SURE	Missing responses	Total
Female	32.07%	32.07%	29.74%	6.12%	100%
Male	47.06%	23.53%	22.35%	7.06%	100%

According to the chi-square results, these two variables are dependent. That is, knowledge of whether a married woman who wants Emergency Contraceptive pills must get her husband's permission is dependent on one's sex. A higher proportion of female participants (32.07%) compared to that of male participants (23.53%) knew that spousal consent is not required for a married woman to obtain abortion. A higher percentage of males than females thought that spousal consent is required.

Table 63 outlines data concerning the relationship between sex and emergency contraceptive pills having long-term side effects.

Table 63. Cross-tabulation: sex of the participants and knowledge of EC having long-term side-effects.

Sex	EC has long-term side-effects YES	EC has long-term side-effects NO	EC has long-term side-effects NOT SURE	Missing responses	Total
Female	21.87%	7.58%	64.14%	6.41%	100%
Male	28.82%	15.29%	48.82%	7.06%	100%

A significant relationship was found between sex and knowledge of whether emergency contraceptives have long-term side-effects. In other words, these two variables are dependent. Interestingly, only 7.58% of female participants in contrast to the male participants (15.29%) knew that EC does not have long-term side-effects. A higher proportion of females than males were uncertain concerning the long-term side effects of EC.

6.2.7.2. School analysis

Our geographical location influences our perceptions and the knowledge we may have about certain topics, particularly topics that are often referred to as being 'taboo' or controversial. The

following table demonstrates the relationship between schools and knowledge of whether emergency contraceptives are used to prevent pregnancy after unprotected.

Table 64. Relationship between School and knowledge of emergency contraceptives.

Variable one	Variable two	Chi-square
School	Knowledge regarding emergency contraceptives pills being used to prevent pregnancy after unprotected sex	$X^2(8, N = 488)=69.64$, $p=.000$**
	Knowledge regarding emergency contraceptive pills causing abortion	$X^2(8, N = 473)=12.54$, $p=.128$
	Knowledge regarding emergency contraceptive pills being taken within 72 hours of unprotected sex	$X^2(8, N = 477)=36.59$, $p=.000$**
	Knowledge regarding emergency contraceptive pills being obtainable for free in public hospitals and clinics	$X^2(8, N = 479)=67.73$, $p=.000$**
	Knowledge regarding emergency contraceptive pills being bought over the counter	$X^2(8, N = 479)=14.54$, $p=.069$
	Knowledge regarding the requirement of parental consent	$X^2(8, N = 479)=9.99$, $p=.266$
	Knowledge regarding the requirement of spousal consent	$X^2(8, N = 481)=44.98$, $p=.000$**
	Knowledge regarding emergency contraceptive pills having long-term side-effects	$X^2(8, N = 480)=3.57$, $p=.892$

* indicates significant relationship at the 0.05 level

** indicates significant relationship at the 0.01 level

The following tables demonstrate the cross-tabulations of those variables with a significant relationship listed in Table 64.

Table 65. Cross-tabulation: schools and knowledge of EC preventing pregnancy after unprotected sex.

Schools	EC prevents pregnancy YES	EC prevents pregnancy NO	EC prevents pregnancy NOT SURE	Missing responses	Total
HOR	74.16%	7.87%	13.48%	4.49%	100%
DET-rural	48.20%	15.83%	33.81%	2.16%	100%
DET-urban	44.29%	17.86%	29.29%	8.57%	100%
Private	80.25%	4.94%	9.88%	4.94%	100%
Model C	87.69%	1.54%	6.15%	4.62%	100%

There is a significant relationship between these two variables. This means that, one's knowledge of whether emergency contraceptive pills also known as 'the morning after pill' is used to prevent pregnancy after unprotected sex is dependent on one's school. DET-urban and DET-rural had the highest percentages compared to other schools of participants who thought that EC does not prevent pregnancy after unprotected.

Table 66 illustrates the relationship between schools and knowledge of the time frame within which EC must be taken after unprotected intercourse.

Table 66. Cross-tabulation: schools and knowledge of EC being taken within 72 hours after unprotected sex.

Schools	EC taken within 72 hours YES	EC taken within 72 hours NO	EC taken within 72 hours NOT SURE	Missing responses	Total
HOR	33.71%	5.62%	53.93%	6.74%	100%
DET-rural	20.86%	13.67%	64.03%	1.44%	100%
DET-urban	19.29%	13.57%	56.43%	10.71%	100%
Private	38.27%	8.64%	40.74%	12.35%	100%
Model C	50.77%	3.08%	40.00%	6.15%	100%

A significant relationship was found between schools and the knowledge of whether emergency contraceptives must be taken within 72 hours of unprotected sex. That is, HOR, private and model C schools had the highest percentages of participants (33.71%, 38.27% and 50.77% respectively) compared to both rural and urban DET schools who knew that there is a time limit to EC.

Table 67 demonstrates the relationship between schools and knowledge of EC being free of charge in public hospitals and clinics.

Table 67. Cross-tabulation: schools and knowledge of EC being free of charge in public hospitals and clinics.

Schools	EC free at public hospitals and clinics YES	EC free at public hospitals and clinics NO	EC free at public hospitals and clinics NOT SURE	Missing responses	Total
HOR	42.70%	21.35%	31.46%	4.49%	100%
DET-rural	71.94%	5.76%	20.86%	1.44%	100%
DET-urban	60.00%	7.86%	20.00%	12.14%	100%
Private	32.10%	14.81%	43.21%	9.88%	100%
Model C	24.62%	26.15%	43.08%	6.15%	100%

Chi-square results indicate that there is a significant relationship between schools and the knowledge of concerning emergency contraceptives being obtainable for free at public hospitals and clinics. A higher proportion of participants from DET-rural and DET-urban schools (71.94% and 60.00% respectively) knew that EC is obtainable for free at public hospitals and clinics compared to other schools.

Table 68 outlines data concerning the relationship between schools and knowledge about the requirement for a husband's permission for a married woman to obtain EC.

Table 68. Cross-tabulation: schools and knowledge of the requirement of spousal consent for a married woman to obtain EC.

Schools	Requirement for spousal consent YES	Requirement for spousal consent NO	Requirement for spousal consent NOT SURE	Missing responses	Total
HOR	22.47%	42.70%	31.46%	3.37%	100%
DET-rural	49.64%	19.42%	30.22%	0.72%	100%
DET-urban	42.86%	18.57%	26.43%	12.14%	100%
Private	35.80%	38.27%	16.02%	9.88%	100%
Model C	18.46%	44.62%	30.77%	6.15%	100%

There is a significant relationship between schools and knowledge regarding a married woman requiring her husband's permission to obtain emergency contraceptive pills. HOR, private and

model C schools had the highest proportion of participants (42.70%, 38.27% and 44.62% respectively) who knew that spousal consent is not required compared to DET-rural (19.42%) and DET-urban schools (18.57%) who thought that spousal consent was required.

6.3. Discussion

6.3.1. Introduction

In the previous chapter results were presented with regard to what adolescents know and do not know about CTOP Act and its stipulations. This chapter examines their knowledge concerning the consequences of abortion and methods of legal and illegal termination of pregnancy. Furthermore, this chapter explores where the participants get their information (i.e. their primary sources of information) and whether they feel that they have sufficient information. Lastly, this chapter examines the participants' knowledge concerning EC. It is worth noting that due to the fact that the questions are interrelated, some points might overlap.

6.3.2. Discussion of the results of the frequency tables

This section discusses the results obtained from the frequency tables in the chapter. The discussion will be divided into the following sections: the knowledge of the consequences of abortion, methods of legal and illegal abortion, whether participants think they have sufficient information concerning abortion, their knowledge of Emergency Contraceptive pills and their sources of information

6.3.2.1. Knowledge of the consequences of abortion

As previously mentioned there is a possibility that many adolescents do not accurately distinguish between legal and illegal abortion. Thus the knowledge they may have concerning the consequences play a pivotal role in whether they are speaking about legal or illegally performed abortion. 69.65% of the participants thought that legal abortion is a medically safe procedure. Ironically however, 47.86%, 63.81% and 58.37% thought that legal abortion is a leading cause of infertility, is medically more dangerous than giving birth and frequently causes death of the woman respectively. This irony illustrated in the participants' knowledge regarding the consequences of legal abortion may stem from the 'half-truth', stigma embedded information

that adolescents are continually given and having 'danger' and 'disease' as guiding metaphors for sex education (Macleod, 2009). In addition to this stigma embedded 'half-truth' information that adolescents are given, there is a wide-spread belief in the unsubstantiated psychological and emotional aftermath of abortion. The primary aim of these stated but unsubstantiated psychological and emotional consequences of abortion is to either prevent a woman from having an abortion or to dictate how she should feel after having an abortion (Charles et al., 2008; Cooper et al., 2005). These unfounded consequences of abortion have created a reality whereby there are certain emotional and psychological experiences that a woman who had an abortion is expected to have. Hence only 31.52% of the participants thought that abortion is associated with positive feelings of relief while 74.32% thought that abortion will almost certainly lead to feelings of guilt and depression.

The following section discusses the participants' knowledge concerning methods of legal and illegal termination of pregnancy.

6.3.2.2. Knowledge of the methods of legal and illegal termination of pregnancy

Lack of accurate knowledge is evidently causing adolescents to develop new yet more perilous methods for terminating an unwanted and/or unintended pregnancy. These methods are hazardous with fatal consequences but the 'half-truth' that adolescents are told, the stigma and the negative connotations attached to teenage sexuality, contraceptives and abortion is encouraging and facilitating the development and use of these 'new' death-defying methods.

That is, the various hazardous methods mentioned above are evidence that lack of accurate knowledge may be contributing to maternal morbidity and mortality amongst women, particularly adolescents. Women, including adolescents, are engaging in desperate and potentially fatal activities in an attempt to solve unwanted and/or unintended pregnancies.

What is more disconcerting is that, in some instances they did not know the difference between how legal and illegal abortion is performed. Unless adolescents are equipped with accurate comprehensive information, one can only assume that dangerous methods of how to terminate a pregnancy will be developed and maternal morbidity and mortality amongst adolescents are to be expected.

The following section discusses adolescents' primary sources of information because they play a fundamental role in the kind of information adolescents receive.

6.3.2.9. Sources of information and sufficient information

The media (TV, movies and radio), friends, family relatives, teachers and the clinic serve as primary sources of information for most of the participants. It has been argued in the literature how sources of information influence the information that young people receive. As a result, looking at these primary sources of information, taking into account the various controversies mentioned in previous chapters and the fact that IEC takes place within a context, it is difficult to determine whether or not adolescents are given objective comprehensive information particularly in matters such as abortion and contraceptives, as these topics are still seen as 'taboo' and 'controversial' by most people. This incomplete information is primarily due to two factors. Firstly, as discussed in the literature, not all adults have accurate and comprehensive knowledge about such matters.

Secondly, teenage sexuality, abortion and the use of contraceptives are still tabooed and heavily stigmatized, so nurses, teachers, relatives and parents may share or give information regarding these matters with the aim of scaring teenagers from engaging in any sexual activities, for example through the use of words such as "murder", "infertility", "blockages of the tubes" when talking about abortion and contraceptives (Varga, 2002; Woods & Jewkes, 2006, p. 112). Information targeted at adolescents is often insufficient or vague (Wood & Jewkes, 2006). As a result of this lack of detailed information, most of them tend to rely on friends and the media as primary sources of information. It is acknowledged that the media does display or distribute accurate information but the information is not filtered at all times and it is often meant to serve a particular agenda.

There is a crucial need for more information and this is made evident by the 43.58% of the participants who thought that they did not have sufficient knowledge and the 29.57% who were not sure if they did. These percentages were higher compared to the percentage of those who thought they had sufficient information. These high percentages were in spite of teachers, family relatives and clinics being ticked as some of the major primary sources of information. As mentioned above and demonstrated by the level of knowledge that many adolescents have, the

end product of the inadequate information given to adolescents in an attempt to fallacious or 'half-truth' information that most adolescents are given with the intention (be it consciously or not) of delay or prevent them from engaging in sexual activities, may have also contributed to the recently developed methods of performing abortion.

6.3.2.10. Knowledge of Emergency Contraceptive pills

Emergency Contraceptive pills serve as an effective alternative to preventing unwanted and/or unintended pregnancy after unprotected sex. Similar to abortion, emergency contraceptive pills are time-sensitive. The only fundamental difference is that the time period for emergency contraceptive pills is very short. That is, emergency contraceptive pills are effective for 72 hours after unprotected sex. Thus, having accurate knowledge is crucial because time is of the essence.

61.67% of the participants had accurate knowledge concerning the fact that emergency contraceptive pills prevent pregnancy after engaging in unprotected sexual intercourse. 51.36% also knew that emergency contraceptive pills can be obtained for free at public health facilities and that they can be bought over the counter. However, most of the participants were not sure of the time-frame within which emergency contraceptive pills must be taken after unprotected sex or whether emergency contraceptive pills are abortifacients or have long-term side-effects or whether parental or spousal consent is required for obtaining them. Similar trends of lack of knowledge were found in various studies (Ebuehi, Ebuehi & Inem, 2006; Netshikweta & Ehlers cited in Mqhayi et al., 2004; Smit et al., 2001) which were conducted using average people and people in health care.

6.4. Discussions of the results of the Chi-square

This section discusses the significant relationships that were found between sex and EC and between schools and EC. It is worth noting that, no significant relationships were found between sexual activity in the last 12 months and EC. In other words, the participants' knowledge concerning EC is independent of their sexual activity in the last 12 months.

6.4.1. Sex x knowledge of EC

Significant relationships were found between sex and EC being obtainable over the counter at a pharmacy, requirement of spousal consent and EC having long-term side-effects.

A high proportion (68.80%) of females knew that EC can be bought over the counter at a pharmacy which is important information to have as it broadens one's knowledge of services. A higher percentage (47.06%) of male participants compared to female participants (32.07%) thought that a married woman needs her husband's permission to get emergency contraceptive pills and a higher percentage of males erroneously thought that EC has long term side effects. In general, it appears that females have better knowledge than males regarding these particular issues.

EC is a time-sensitive service with the potential of preventing an unwanted and/or unintended pregnancy after engaging in unprotected sex, thus having accurate and comprehensive knowledge is fundamental to women's reproductive health. For instance 68.80% females know that EC can be bought over the counter at a pharmacy but lack of accurate knowledge they have concerning other factors may render the accurate knowledge they have insignificant.

6.4.2. School x knowledge of EC

Significant relationships were found between schools and knowledge of EC being used to prevent pregnancy after unprotected sex, time frame within which EC must be taken, EC being free at public health facilities and the requirement for spousal consent.

With regard to having accurate knowledge concerning EC being used to prevent pregnancy after engaging in unprotected intercourse, EC being taken within 72 hours of unprotected sex, and EC not needing spousal consent, HOR, private and Model C schools fared better than DET-rural and DET-urban schools. Interestingly though, DET-rural and DET-urban schools had better knowledge about EC being free at public hospitals and clinics. This may be an indication of learners from these schools accessing clinic facilities more regularly for other kinds of services than learners from the other schools.

Across all the schools, DET-rural and DET-urban (19.42% and 18.57% respectively) had the lowest percentage with regard to a husband's permission not being required for a married woman if she wants EC. It is interesting that the requirement for spousal consent for obtaining emergency contraceptive pills is dependent on one's school but the requirement for parental consent for minors is independent of one's school. This means that most of the adolescents have the same knowledge with regard to the requirement of parental consent for minors to obtain EC.

6.5. Conclusion

Despite the fact that many adolescents had accurate knowledge concerning legal abortion being a medically safe procedure, emergency contraceptive pills being used to prevent pregnancy, EC being available for free at public health facilities and being obtainable over the counter at a pharmacy, erroneous and insufficient knowledge still persisted. That is, misguided information especially about the requirement for parental and spousal consent, may have rendered legal abortion and/or using emergency contraceptive pills as an unfeasible option for many of the adolescents. The level of inaccurate knowledge concerning EC and the consequences of abortion displayed in this chapter is the end-product of insufficient information that many adolescents are continuously given. This insufficient information is made explicit by the paradoxical nature of abortion being thought of as a medically safe procedure and by the same token as a leading cause of infertility and frequently resulting in the death of the woman.

One cannot adequately and comprehensively address issues relating to reproductive health without taking into account the impact that sex and schools or rather geographical location might have on how one relates and perceives the world. Knowledge or rather lack thereof regarding the consequences of abortion and EC were not specific to a particular school or sex. That is, there are certain facts regarding EC that a higher percentage of males are accurately informed about compared to that of females for e.g. a higher proportion of males had accurate knowledge concerning EC not having long-term side-effects. Similar results were found with regard to schools and knowledge of the consequences of abortion and of EC. Thus, it is difficult to say that a particular school or sex has more accurate knowledge concerning the aftermath of abortion and/or EC.

However, it can be argued with a certain degree of conviction that may be information is not disseminated in the same way. As a result may be it is not taught and understood the same way because the top 6 sources of information, were mentioned by more than half of the participants implying that it was across sex and schools (geographical location). The following chapter is a detailed conclusion of this study including limitations and recommendations.

Chapter 7

Conclusion

7.1. Introduction

When South Africa implemented the Choice on Termination of Pregnancy Act in 1996, it was praised for its progressive move towards the recognition of women's productive health and reproductive health rights. Comparable commendations were expressed when it introduced the *National Contraception Policy Guidelines* in 2001 and the *National Contraception Service Delivery Guidelines* in 2003 (Maharaj & Rogan, 2007). Despite all these commendations and praises, abortion and emergency contraceptive pills services remain inaccessible to many women especially adolescents. Many women, particularly adolescents, still opt for clandestine 'back-street' abortion or inducing the pregnancy themselves by using hazardous methods (Moodley & Akinsooto, 2003; Oye-Adeniran et al., 2005; Seutlwadi, 2007). Hence the aim of this study was to examine adolescents' knowledge concerning the CTOP Act, emergency contraceptive pills, consequences of legal abortion and their sources of information. This research was based on a reproductive health perspective. As a result the following sections will summarise the main points of reproductive health and reproductive rights.

7.2. Reproductive rights

As mentioned in previous chapters, many adolescents engage in sexual activities with little or misguided reproductive health information (Alubo, 2001). This often results in several reproductive health problems, such as unintended pregnancies, unsafe abortions, maternal morbidity and maternal mortality. These reproductive health problems formed one of the topics at the 1994 *International Conference on Population and Development* which took place in Cairo. The following section will summarise these reproductive health rights and the elements that are associated with them.

7.2.1. Reproductive rights paradigm

According to the International Conference on People and Development, both men and women have the right to "decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so"; and they "have the right to make decisions

concerning reproduction free of discrimination, coercion and violence" (ICPD, 1994, p. 60). From the given definitions, it is evident that the provision of adequate, affordable, acceptable and accessible health services, and information, education and communication programmes to women across all ages and socio-economic status are fundamental to the effective recognition of women, including adolescents' reproductive health and rights.

Various interventions were implemented in response to further recognition of both men and women's reproductive health and reproductive rights, particularly the youth. Sex education is one of the components of Life Orientation that was made compulsory and examinable in all the schools in South Africa and over the years there has been an increase of multi-media and multi-dimensional intervention programmes aimed at promoting awareness about reproductive health matters amongst the youth. However, adolescents are still not given comprehensive accurate information. Sex education manuals used in Life Orientation and interventions such as loveLife or IEC, rarely discuss abortion or contraceptive pills without stigmatizing them from a social, religious, moral, psychological and traditional point of view (Lithur, 2004). 'Danger' and 'disease' are used as guiding metaphors together with unfounded physical, psychological and emotional consequences of abortion and contraceptive pills (Macleod, 2009).

Despite the open dialogue that is created by these interventions, there are various controversies and barriers that may hinder the successful recognition of women, including adolescents' reproductive health and reproductive rights. Consequently, inhibiting women, including adolescents, from exercising their reproductive health rights effectively. These controversies are:

- Religion

Although the CTOP Act has been implemented in South Africa for over a decade, religion still plays a vital role in the shaping of societal views and attitudes towards abortion but it also structures women's experiences of abortion and their consequent behaviour. Despite the role that religion still plays on abortion, some religious bodies are tolerant of abortion performed for traumatic reasons rather than elective reasons. As a result, IEC on traumatic abortion is seen as unproblematic, whereas IEC on abortion upon request is opposed.

- Morality

Religion is the only language of morality for many people. Thus, what is condemned by religion is automatically seen as immoral. Moral sanctions are instituted against extramarital pregnancies and abortions, with the latter being seen as a morally repugnant act. Thus, provision of IEC on abortion may be viewed as advocating for morally reprehensible acts.

- Informed consent and parental involvement

The fact that minors do not need parental consent to obtain an abortion has evoked much controversy. This controversy has become a debate of parental involvement *versus* adolescents' competency and hence their ability to act upon full reproductive rights. The underlying principle for this debate is whether adolescents are competent to make adequately informed choices. This debate has shifted the focus away from the fact that accurate and comprehensive information forms the crux of one's ability to make informed decisions. In addition, making parental consent mandatory may have detrimental effects for adolescents (Ganatra & Hirve, 2002). Although applications to make parental consent mandatory by the CLA have failed, some health care providers may share the same sentiments as the CLA consequently serving as additional barriers to reproductive health services. Other barriers to service accessibility are:

- Legal aspects

The legal status of abortion plays a vital role in women's health and reproductive health, particularly since abortion is regulated by the state. That is, although the legal status of abortion does not necessarily guarantee service accessibility and availability (South Africa being a perfect example of this), it does however, have immeasurable impact on women across all ages enjoying and exercising their reproductive health and reproductive rights.

- Stigmatization

Stigmatization is one of the barriers that have hindered the effective implementation of the CTOP Act. Abortion stigmatization is a silent and ignored contributor to statistics of maternal mortality and morbidity (Lithur, 2004). Abortion is available upon request for 12 weeks in South Africa. However, many women, including adolescents still opt for 'backstreet' abortion due to stigmatization amongst other factors (Varga, 2002; Seutlwadi, 2007). Providing IEC on abortion

remains difficult and abortion services continue being inaccessible to many women, including adolescents due to stigmatization.

- Attitudes of staff

The attitude of health-care providers is pivotal to service accessibility especially since counselling is the key component of the IEC programme. However, many health-care workers are against abortion (Walker, 1996; Harrison et al., 2000; Wood & Jewkes, 2006), making abortion services more inaccessible.

- Knowledge of and attitudes towards contraceptives

Negative social and cultural connotations attached to contraceptives have possibly made many adolescents sexually and reproductively vulnerable to unwanted pregnancies and HIV amongst other factors. That is, lack of knowledge, misconceptions and contradictory messages sent to adolescents have made it difficult for many adolescents to use contraceptives to prevent unwanted and/or unintended pregnancies that may result in abortion.

The following section is brief summary of the Sterilization Act, CTOP Act and stipulations of the CTOP Act.

7.2.2. Context: CTOP Act

The Abortion and Sterilisation Act of 1975 was the first legislation in South Africa to permit abortion (Dickson-Tetteh & Rees, 1999). However, abortion remained inaccessible to many women, particularly Black women due to the fact that abortion was granted under strict conditions. Only about 40% of applications for abortion were approved each year (Dickson et al., 2003). As a result, many of the women faced with unwanted and/or unintended pregnancies opted for 'backstreet' abortion. In 1996, new abortion legislation was passed as part of the new government's effort to promote safe, accessible abortion services to all women especially poor and previously disadvantaged woman (Dickson et al., 2003).

South African Parliament implemented the Choice on Termination of Pregnancy Act, making abortion legal upon request for all women, including minors, up to 12 weeks gestation period. Up to this point trained midwives can provide the service and abortion can be performed at primary

health facilities (Choice on Termination of Pregnancy [CTOP] Act, 1996). The Act further provides for abortion from 13-20 weeks gestation on physical and mental health grounds. Much debate, controversy and opposition was evoked by the implementation of the CTOP Act, particularly because minors do not need parental consent to obtain abortion.

The CTOP Act has made abortion more available and this is made evident by the decreased number on maternal and mortal morbidity related to abortion compared to prior to its implementation (Cooper at al., 2004). Despite this steady increase of legal abortion, accessibility, including information on available services, remains a problem for some women especially adolescents (Berer, 2004).

7.2.3. Emergency Contraceptives

The post-apartheid South African health legislature has developed a reproductive health policy package that is widely accepted as one of the most progressive in the world (Maharaj & Rogan, 2007). This included the introduction of the Emergency Contraceptive pills which are clinically defined as "the use of a drug or device, as an emergency measure to prevent or reduce the risk of an unwanted pregnancy" (Cheng et al., as cited in Maharaj & Rogan, 2007). EC is a time-sensitive service that must be taken within 72 hours of unprotected sex. EC does not cause abortion, it prevents an unwanted pregnancy. EC is currently the only method used post-coitally. Lack of promotion of EC, which has consequently contributed to lack of accurate knowledge about EC, has rendered it ineffective

7.3. Summary of results

This is a bullet point summary of the major trends found in this study. It is divided into two subsections, namely: knowledge of the CTOP Act and its stipulations and significant relationships found between various variables. The following subsection is a brief summary of the kind of knowledge that the participants had concerning the CTOP Act and its stipulations.

Knowledge of the CTOP Act and its stipulations:

- The majority of participants did not know the name of the CTOP legislation or the date when it was passed;

- A substantial minority of the participants have accurate knowledge of the circumstances under which abortion may be performed;
- Only half of the participants knew that minors could obtain abortion and only a quarter of the participants knew that minors do not need parental consent to have a legal abortion;
- Over two thirds of the participants knew that unmarried women can obtain abortion, but less than a third of the participants knew that spousal consent is not required for a married woman to have an abortion;
- A substantial minority of the participants have accurate knowledge concerning the gestation period under which abortion can be obtained upon request, and over a third of the participants knew abortion may occur under specified circumstances after 12 weeks of pregnancy;
- A substantial minority of the participants thought that TOP clinics are not obliged to provide *pre-* or *post*-termination of pregnancy counselling to the woman or to the woman's partner;
- Just over a third of the participants knew that preventing a woman from obtaining an abortion is an offence, and almost half of the participants knew that the state has designated various sites as Termination of Pregnancy clinics;
- Just over two thirds of the participants knew that abortion can be obtained for free at government Termination of Pregnancy clinics;
- A little over twenty percent of the participants have accurate knowledge concerning nurses not being obliged to insist on the partner accompanying the woman to the Termination of Pregnancy clinic;
- Over two thirds of the participants had accurate knowledge on abortion being a medically safe procedure, and a substantial minority of the participants knew that legal abortion is not the leading cause of infertility;

- Less than a third of the participants indicated that legal abortion is associated with positive feelings of relief, and three quarters of the participants thought that legal abortion will almost certainly lead to feelings of depression and guilt;
- Just over a third of the participants knew someone who has undergone a legal abortion, and a quarter of the participants knew someone who has had an illegal abortion;
- Less than a quarter of the participants felt that they had sufficient information concerning Termination of Pregnancy;
- Over half of the participants knew that Emergency Contraceptive pills also known as 'the morning-after pill' are used to prevent an unwanted pregnancy after unprotected sex but less than twenty percent of the participants knew that Emergency Contraceptive pills cannot cause abortion;
- Less than a third of the participants have accurate knowledge concerning the time frame within which Emergency Contraceptive pills must be taken after unprotected sexual intercourse;
- A little over half of the participants knew that Emergency Contraceptive pills are free at public hospitals and clinics, and just over two thirds of the participants knew that Emergency Contraceptive pills can be bought over the counter at a pharmacy;
- Only a little over a third of the participants knew that parental consent is not required for a minor to obtain Emergency Contraceptive pills, and less than a third of the participants knew that a married woman does not need her husband's permission to get Emergency Contraceptive pills;
- Only less than 11 percent knew that Emergency Contraceptive pills do not have long-term side-effects;

The following is an outline of significant relationships found between the various variables in the study.

A significant relationship was found between the following:

- The participants' sexual activity in the last 12 months and knowledge of the requirement of parental consent;
- The participants' sexual activity in the last 12 months and knowledge concerning the requirement of spousal consent;
- The participants' sexual activity in the last 12 months and knowledge concerning Termination of Pregnancy clinics being obliged to provide *pre*-termination of pregnancy counselling to the woman;
- The participants' sex and knowledge concerning minors being allowed to have an abortion is dependent on the sex of the participants;
- The participants' sex and knowledge of abortion being obtainable up to 12 weeks of pregnancy;
- The participants' sex and knowledge of Termination of Pregnancy clinics being obliged to provide *pre*-termination of pregnancy counselling to the woman's partner;
- The participants' sex and knowledge concerning nurses insisting on a partner accompanying the woman to a Termination of Pregnancy clinic;
- The participants' schools and knowledge of the circumstances under which legal abortion can be obtained;
- The participants' schools and knowledge of minors being allowed to have an abortion;
- The participants' schools and knowledge of the requirement of parental consent for minors to have an abortion;
- The participants' schools and the requirement of spousal consent for a married woman to have a legal abortion;
- The participants' schools and knowledge concerning abortion being obtainable upon request up to 12 weeks of pregnancy;

- The participants' schools and knowledge of Termination of Pregnancy clinics being obliged to provide *pre*-termination of pregnancy counselling to the woman;
- The participants' schools and knowledge of Termination of Pregnancy clinics being obliged to provide *post*-termination of pregnancy counselling to the woman;
- The participants' schools and knowledge of the state having designated various sites as legal Termination of Pregnancy;
- The participants' schools and knowledge of nurses insisting on the partner accompanying the woman to the Termination of Pregnancy clinic;
- There is significant relationship between sex of the participants and knowledge of Emergency Contraceptive pills being bought over the counter;
- The participants' sex and knowledge of the requirement of spousal consent for obtaining Emergency Contraceptive pills;
- The participants' sex and knowledge of Emergency Contraceptive pills having long-term side-effects;
- The participants' schools and knowledge of Emergency Contraceptive pills also known as 'the morning-after pill' being used to prevent pregnancy after unprotected sex;
- The participants' schools and knowledge of Emergency Contraceptive pills being taken within 72 hours after unprotected sexual intercourse;
- The participants' schools and knowledge of Emergency Contraceptive pills being free of charge at public hospitals and clinics;
- The participants' schools and knowledge of the requirement of spousal consent for a married woman to obtain Emergency Contraceptive pills.

7.4. Conclusions from data

As illustrated in previous chapters, there are high levels of lack of accurate knowledge concerning the CTOP Act, its stipulations, the consequences of abortion, and EC. It has been illustrated that some participants have accurate global knowledge regarding abortion and EC but lack knowledge concerning the specifics. That is, adolescents may know that abortion is available upon request but have inaccurate knowledge with regard to the procedure such as whether parental or spousal consent is required or not. This global knowledge may be due to the participants' primary sources of information. That is, teachers and clinics form part of the top 6 of the participants' primary sources of information, but evidently this does not necessarily mean that the participants are given quality or comprehensive information. Hence it has been argued that when teachers, nurses, parents and/or relatives give information about matters such as sex, abortion, contraceptives etc., they may give it in such a way that the information is not detailed or clear (Warenuis et al., 2006; Woods & Jewkes, 2006).

Misinformation and lack of information concerning the accessibility of abortion, how abortion is performed and the consequences of abortion may have paved a way for the development of 'new' methods of performing abortion as illustrated in the previous chapters. These 'new' methods are perilous and seem to be known across the various schools sampled in the project. Based on the erroneous knowledge that a high proportion of participants had concerning the requirement of spousal and parental consent (especially who claimed to have been sexually active in the last 12), these 'new' methods may progressively seem more accessible and available than legal abortion for many adolescents who are or know of a peer who is faced with an unwanted and/or unintended pregnancy.

There are some variables such as the participants' sexual activity in the last 12 months, knowledge of EC and CTOP Act that are also dependent on the participants' schools and sex. We still live within a social system where men (boyfriend/husband) assume the decision-making role and rural areas are still perceived as conservative while urban areas as liberal concerning adolescents' sexual activity (as made evident to a certain extent by the data, for e.g. a high proportion of the participants thought that nurses must insist on a partner accompanying the woman to a TOP clinic). Hence the above variables cannot be comprehensively dealt with in a

vacuum. The following section summarises the implications of the conclusions of data mentioned in this paragraph.

7.5. How do we understand the results: Implications

Lack of accurate knowledge about the CTOP Act, its stipulations and abortion in general continues to deny many women, particularly adolescents, the opportunity to exercise their reproductive rights. In addition, the fact that adolescents may not be aware of the difference between legal and illegal abortion continues to place many adolescents in harm's way.

EC serves as an effective option to prevent an unwanted and/or unintended pregnancy after unprotected sex. However, lack of knowledge about EC has rendered this service ineffective consequently failing to prevent unwanted and/or unintended pregnancies that may result in abortion.

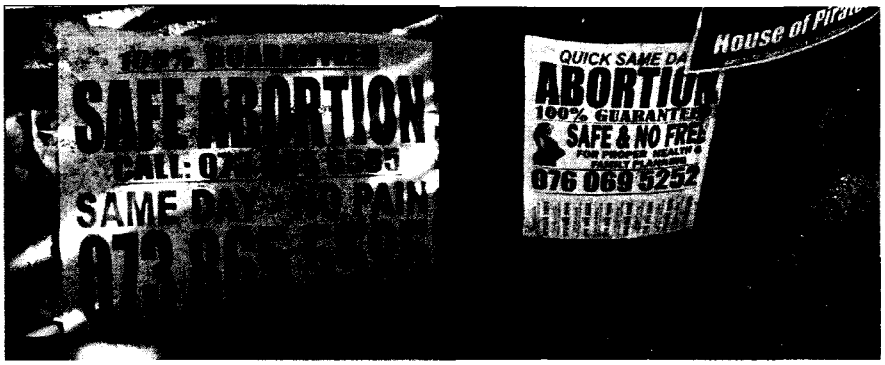
The use of 'scare tactics', 'danger' and 'disease' as guiding metaphors, fallacious statements and 'half-truth' information that may be given to adolescents is an attempt to delay them from having sex. However, based on the results of this study, they are not effective. The reality of the situation is that, adolescents are engaging in sexual activities and this is made evident by the fact that 50.19% of the participants in this study claimed to have been sexually active in the last 12 months. As a result, being in-denial of the fact that adolescents are sexually active may have irreparable and sometimes fatal consequences because at this point in time, most adolescents are engaging in sexual activities ill-equipped to prevent or deal with an unwanted and/or unintended pregnancy should it occur. It is worth noting that the school participants attend plays a role in their knowledge or lack thereof.

7.6. Conclusion

South Africa is one of the few countries globally that has such liberal abortion and contraceptives laws. Yet many of its women, particularly adolescents, still opt for 'backstreet' abortion or develop death-terrifying methods such as drinking pesticides or boiling steelwool and then drinking the water.

What is concerning about these dangerous methods is that knowledge about them is not specific or limited to a particular school or location. They are common knowledge including the

meticulous steps on how to use them. This illustrates how fast inaccurate knowledge is disseminated by informal channels. The situation is worsened by the fact that adolescents are being bombarded by these posters (see below) of 'backstreet' abortion everywhere they go, without any contrary information/posters in the clinics, health campaigns or even on the street about where they can go to obtain a legal abortion. Adolescents may not know the difference between legal and illegal abortion (as illustrated in the previous chapter). Thus the information given on these posters becomes the truth to them because firstly they are everywhere and secondly there are no other posters or sources of information that tell them differently.



Posters of 'backstreet' abortion everywhere in town particularly in places where there are a lot of people such as malls and taxi-ranks.[Photographs taken in Grahamstown; 17th March, 2011]

Adolescents may resort to these desperate and hazardous measures in an attempt to solve an unwanted and/or unintended pregnancy because stigmatization, attitudes of staff, religion, misguided information concerning the requirement of parental/spousal consent but most importantly because of lack of accurate knowledge.

All these barriers and controversies do not stop or delay adolescents from having sexual intercourse but they may be contributing towards the current teenage pregnancy rate and the maternal morbidity and mortality rate amongst women especially adolescents. In addition, they are in violation of basic human rights which are the pillars of democracy and reproductive health rights that South Africa was praised for recognising not so long ago. Abortion, teenage sexuality and contraceptives are far from being accepted or being seen as non-controversial or sensitive topics. However, adults such as family relatives, teachers, the clinic staff and the media (as they were amongst the top 6 primary sources of information chosen by the participants) cannot continue to give adolescents vague or inaccurate information irrespective of their views or attitudes towards these matters (Feldman & Clark, 1996; Warenuis et al., 2006; Woods & Jewkes, 2006; Macleod, 2009; Macleod, 2011).

Abortion and contraceptive pills are fundamental aspects of women's, including adolescents', reproductive health. Thus, adolescents have the right to control their own fertility free of discrimination and coercion, the right to comprehensive information so that they can make informed decisions and the right to attain the highest standard of sexual and reproductive health (ICPD, 1994).

Adler's definition of informed consent or choice has informed our understanding of informed consent or choice with regard to this research. Adler (1992, p. 289) defined informed choice or consent as "a) access to sufficient information b) understanding the information c) competence to evaluate potential consequences d) freedom to make a choice and e) the ability to make and express that choice". Based on the participants' primary sources of information and the fact that these sources of information do not necessarily speak to the quality of the information given, it can be said with a certain degree of conviction that participants do not have access to sufficient information. The level of knowledge that adolescents have illustrated in this research has demonstrated that they do not understand the information sufficiently and this is further made evident by their competence to evaluate potential consequences. As a result, adolescents' freedom and ability to make a choice and to express that choice is inhibited. South African women, including adolescents, are not powerless especially with regard to their reproductive health. However, lack of accurate and comprehensive knowledge may have resulted in many of them opting for 'backstreet' abortion or inducing the pregnancy themselves.

7.7 Limitations of the study

It is common knowledge that the response rate of a survey study plays a crucial role in the validity and reliability of the results and arguments/discussions made in the study. The level of the response rate was kept in mind throughout this study and measures were employed in an attempt to increase the level of the response rate. As mentioned in the methodology chapter, unforeseen problems with regard to non-responses were encountered. Non-responses were distributed across the questionnaires. They did not apply to particular questions.

This study was only conducted in Buffalo City Municipality. Thus it is not necessarily generalisable to other parts of South Africa. However, when disseminating information, specifics of abortion and EC are equally essential across regions. Thus sources of information such as teachers, clinics and the media need to ensure the comprehensive and accurate information concerning abortion and EC are provided throughout the country.

Everyone, including adolescents, has the right to factual comprehensive information about reproductive health, reproductive health rights and access to health care services, free from coercion, stigmatization and discrimination.

7.8. Recommendations

Similar research with a larger sample in and outside the Eastern Cape is recommended so as to increase awareness on the level of knowledge that adolescents have concerning contraceptive pills particularly emergency contraceptive pills, the CTOP Act and abortion in general.

That is, it must be ensured that adolescents are 1) aware of the name of the legislation and **all** its stipulations, in particular that abortion is **on request** up to **12 weeks**, but may be requested thereafter as well, 2) that parental and spousal consent is not required, 3) that the prevention of legal abortion is an offence and that it is not required for partners to accompany the woman to the TOP clinic.

Furthermore, it needs to be made certain that adolescents have accurate and clear understanding of the difference between legal and illegal abortion so that 1) they can be aware of the fact that, legal abortion does not cause infertility, it is not more medically dangerous than giving birth and it does not frequently cause death of the woman, and 2) they can have accurate knowledge

regarding legal and illegal methods of termination of pregnancy. Moreover, it needs to be ensured that adolescents have accurate and comprehensive knowledge about emergency contraceptive pills, especially that EC is to prevent pregnancy after unprotected sex and must be taken within 72 hours of unprotected sex, that EC does not cause abortion and does not have long-term side effects and that parental and spousal consent is not required.

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APPENDIX A

RHODES UNIVERSITY
Grahamstown • 6140 • South Africa

PSYCHOLOGY DEPARTMENT

Mr. Mpangazita Ngwanya
Dr WB Rhubusana Building
MdantsanePrivate Bag x9007
East London
5200

Dear Mr. Mpangazita M. Ngwanya

My name is Lebogang Seutlwadi and I am a Masters' student at Rhodes University. I am conducting research in fulfillment of my degree in Psychology. The aim of the study is to find out how accurate adolescents' knowledge concerning termination of pregnancy is. In addition, I wish to understand how the information is conveyed, whether there is a difference between those that are sexually active and those that are not, and between learners at different schools. Data will be collected through a survey. The research will be conducted within a reproductive health rights approach, which stresses that knowledge concerning reproduction is a fundamental aspect of reproductive health. It is envisaged that the research will assist in understanding current trends in termination of pregnancy amongst teenagers.

In this letter I am requesting permission to conduct this research in some of the schools in Buffalo city in East London. The schools that I am interested in are divided into five subpopulations namely: private schools, former Model C schools, former Department of Education and Training schools (DET) located in townships; former DET schools located in the rural areas and the former House of Representatives schools, which are commonly known as the former 'coloured' schools. Schools will be randomly selected from each subgroup.

The research will involve administration of questionnaires, which I will administer personally. This study is limited to Grade 11 learners, both male and female. There will be no discussions, thus the students are not expected to reveal any personal details to other participants.

The following ethical standards will be put into place:

* The administration of the questionnaires will be arranged so as not to disrupt the students' studies;
* The name of the school and the names of the participants will not appear in the raw data or in any publication;
* Permission from the principals, the learners' parents and the learners themselves will be obtained. All three sets of stakeholders will be fully informed about the purpose of the research and the nature of the learners' involvement;
* Learners' participation will be entirely voluntary;
* Should any learner feel uncomfortable during the study, they are free to leave. They will be informed of this;
* Only the researcher and her supervisors will have access to the raw data.

Permission to conduct the study on school property at a time convenient to the school will also be sought from the principal. The results from the study will be accessible to the Departments of Education and Health as well as the participating schools. It is envisaged that the research will result in a thesis, publications and conference presentations.

Should you have any queries that we are not able to address in the meeting we have set up with you, please feel free to contact me on [079 136 9169] or my supervisor, Prof. Catriona Macleod or co-supervisor Mr. Gary Steele on [046 603 8500], fax no. [046 622 4032]. This research has ethical clearance from the Department of Psychology, Rhodes University.

Your co-operation will be highly appreciated

Sincerely Yours

L. Seutlwadi

APPENDIX B

RHODES UNIVERSITY

Grahamstown • 6140 • South Africa

PSYCHOLOGY DEPARTMENT

The Principal

????? Secondary School

????? Location

Dear Sir/Madam

My name is Lebogang Seutlwadi and I am a Masters' student at Rhodes University. I am conducting research in fulfillment of my degree in Psychology. The aim of the study is to find out how accurate adolescents' knowledge concerning termination of pregnancy is. In addition, I wish to understand how the information is conveyed, whether there is a difference between those that are sexually active and those that are not, and between learners at different schools. Data will be collected through a survey. The research will be conducted within a reproductive health rights approach, which stresses that knowledge concerning reproduction is a fundamental aspect of reproductive health. It is envisaged that the research will assist in understanding current trends in termination of pregnancy amongst teenagers. In this letter I am requesting permission to conduct this research in your school.

The research will involve administration of questionnaires, which I will administer personally. This study is limited to Grade 11 learners, both male and female. There will be no discussions, thus the students are not expected to reveal any personal details to other participants.

The following ethical standards will be put into place:

* The administration of the questionnaires will be arranged so as not to disrupt the students' studies;

* The name of the school and the names of the participants will not appear in the raw data or in any publication;

* Permission from the learners' parents and the learners themselves will be obtained;

* Learners' participation will be entirely voluntary;

* Should any learner feel uncomfortable during the study, they are free to leave. They will be informed of this;

* Only the researcher and her supervisors will have access to raw data.

Permission to conduct the study on school property at a time convenient to the school is also sought. The results from the study will be made available to the Department of Education and Health as well as to your school. It is envisaged that the research will result in a thesis, publications and conference presentations.

Should you have any queries that we are not able to address in the meeting we have set up with you, please feel free to contact me on [079 136 9169] or my supervisor, Prof. Catriona Macleod or co-supervisor Mr. Gary Steele on [046 603 8500]. This research has ethical clearance from the Department of Psychology, Rhodes University.

Your co-operation will be highly appreciated

Sincerely Yours

L. Seutlwadi

APPENDIX C

RHODES UNIVERSITY

Grahamstown • 6140 • South Africa

PSYCHOLOGY DEPARTMENT

Dear Sir/Madam

My name is Lebogang Seutlwadi and I am a Masters' student at Rhodes University. I am conducting research in fulfillment of my degree in Psychology. The aim of the study is to find out how accurate adolescents' knowledge concerning termination of pregnancy is. In addition, I wish to understand how the information is conveyed, whether there is a difference between those that are sexually active and those that are not, and between learners at different schools. Data will be collected through a survey. The research will be conducted within a reproductive health rights approach, which stresses that knowledge concerning reproduction is a fundamental aspect of reproductive health. It is envisaged that the research will assist in understanding current trends in termination of pregnancy amongst teenagers.

Permission is sought for your daughter/son to participate in the research. The research will involve filling in questionnaires and it will be limited to Grade 11 learners. There will be no discussions, thus the students are not expected to reveal any personal details to other participants.

The following ethical standards will be put into place:

* The study will be arranged so as not to disrupt your son's/daughter's' studies;

* The name of the school and the names of the participants will not appear in the raw data or in any publication;

* Permission from your son/daughter to participate will be obtained;

* Your son's/daughter's participation will be entirely voluntary;

* Should your son/daughter feel uncomfortable during the research, they are free to leave.

Should you have any queries, please feel free to contact me on [079 136 9169] or my supervisor, Prof. Catriona Macleod or my co-supervisor Mr. Gary Steele on [046 603 8500]. This research has ethical clearance from the Department of Psychology, Rhodes University. Please return this signed letter to the school with your son/daughter, who will give it directly to me.

Sincerely Yours

L. Seutlwadi

I_____agree/do not agree that my son/daughter_____, may participate in the above mentioned research.

Signed_____ Date_____

APPENDIX D

RHODES UNIVERSITY

Grahamstown • 6140 • South Africa

PSYCHOLOGY DEPARTMENT

Dear Respondent

I am a Masters' student from Rhodes University conducting a survey study. The aim of the study is to find out how accurate adolescents' knowledge concerning termination of pregnancy is. Your school was selected randomly but you were purposively selected due to the fact that you fit the purpose of the study. You are requested to participate in this research.

You will be handed a copy of a questionnaire. The questionnaire will require 15-20 minutes to complete. I hope you will take the time to complete it and put the completed questionnaire in the box. The information that you provide will contribute significantly to an important study.

Your anonymity will be protected. This means that your name will not be revealed or associated with your response nor will anyone outside of this study be allowed to see your responses. The name of your school will not appear in the report. If you do agree to participate, and then feel uncomfortable when completing the questionnaire, you are free to withdraw from the research.

I appreciate your willingness to participate and help me in my research efforts. Please complete the attached consent form should you agree to participate.

I_____, agree to participate in the research of Lebogang Seutlwadi concerning the adolescents' knowledge about abortion.
Signature_____ Date_____

Sincerely yours

Lebogang Seutlwadi

APPENDIX E

ENGLISH

Demographics

❖ Please tick the **appropriate** option

1) Sex:

Female	Male

2) Age:_____

3) Have you had sex in the last 12 months?

Yes ☐

No ☐

4) The legislation dealing with abortion in South Africa is called:

_____

5) The Act was passed in_____

Knowledge of Act

❖ Choose **one** of the following

a. Abortion is **illegal** in South Africa under all circumstances	
b. Abortion may be legally performed **ONLY** in cases of rape, incest or sexual abuse	
c. Abortion may be legally performed **ONLY** in cases of potential physical or mental harm to the woman or foetus	
d. Abortion may be legally performed in cases of rape, incest or sexual abuse **AND** in cases of potential physical or mental harm to the woman or foetus	
e. Abortion may be **legally** performed upon request of the woman up to a certain date of pregnancy	

❖ Please tick **only one** option for each of the following questions

According to the legislation concerning abortion:	YES	NO	NOT SURE
1. Women under the age of 18 years are allowed to have an abortion			
2. Parental consent is needed for a woman under the age of 18 years to have a legal abortion			
3. Only a married woman can have a legal abortion			
4. If a married woman wants an abortion legally, she must have her husband's permission			
5. A legal termination of pregnancy can be obtained upon request up to 12 weeks of pregnancy			
6. After 12 weeks, abortion may occur only under certain specified conditions			
7. Termination of pregnancy clinics are obliged to provide voluntary *pre*-termination of pregnancy counselling to the woman			
8. Termination of pregnancy clinics are obliged to provide voluntary *post*-termination of pregnancy counselling to the woman			
9. *Pre*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic			
10. *Post*-termination of pregnancy counselling must be offered to the woman's partner at the Termination of Pregnancy clinic			
11. Preventing a woman from obtaining a legal termination of pregnancy is an offence			
12. The state has designated (chosen) various sites as legal Termination of Pregnancy clinics			
13. Abortion may be obtained free of charge at government Termination of Pregnancy clinics			
14. Nurses must insist on the partner accompanying the woman to the Termination of Pregnancy clinic			

Knowledge of legal and illegal abortion methods

1. At Termination of Pregnancy clinics, abortion is performed by using.....
   .....
   .....
   .....
   .....
   .....
2. When women attempt to terminate the pregnancy themselves or to use 'backstreet' (or illegal services), the abortion may be performed by using.....
   .....

.....
.....
.....
.....

Knowledge of consequences of legal abortion

❖ Please tick **only one** option for each question

	AGREE	DISAGREE
Legal abortion performed by a trained practitioner in a Termination of Pregnancy clinic:		
1. Is a medically safe procedure		
2. Is a leading cause of infertility		
3. Is medically more dangerous than giving birth		
4. Frequently causes death of the woman		
5. Is associated with positive feelings of relief		
6. Will almost certainly lead to feelings of depression and guilt		

Knowledge of somebody having undergone a termination of pregnancy

	YES	NO	NOT SURE
1. I know someone who had a legal termination of pregnancy			
2. I know someone who had an illegal termination of pregnancy			

Sources of information

❖ Please tick ***as many as*** apply

1. I heard about abortion from: Parents	
Family Relatives	
Friends	
Boyfriend or girlfriend	
Teachers	
Clinic	
Church	
Health campaigns	
Television	
Movies	
Radio	
Internet	

	YES	NO	NOT SURE
I feel I have sufficient information concerning Termination of Pregnancy			

Knowledge about Emergency Contraception

❖ Please tick **only one** option for each of the following questions

	YES	NO	NOT SURE
1. Emergency Contraceptive pills also known as 'the morning pill' is used to prevent pregnancy after unprotected sex			
2. Emergency Contraceptive pills can cause abortion			
3. Emergency Contraceptive pills must be taken within 72 hours of unprotected sex			
4. Emergency Contraceptive pills are free at public hospitals and clinics			
5. Emergency Contraceptive pills can be bought over the counter at a pharmacy			
6. Parental consent is needed for a woman under the age of 18 years to get Emergency Contraceptive pills			
7. If a married woman wants Emergency Contraceptive pills, she must get her husband's permission			
8. Emergency Contraceptive pills have long-term side-effects			

THANK YOU FOR YOUR TIME

AFRIKAANS

Demografiese Besonderhede

- ❖ Maak asseblief 'n kruisie by die **gepaste** antwoord

1) Geslag:

Vroulik	Manlik

2) Ouderdom:_____

3) Het u in die afgelope 12 maande seks gehad?

Ja: ☐

Nee: ☐

4) Die wetgewing aangaande aborsie in Suid-Afrika word genoem:

_____

5) Wanneer is die Wet deurgevoer?_____

Kennis van die Wet

❖ Kies **een** van die volgende

a) Aborsie is **onwetting** in Suid-Afrika onder alle omstandighede	
b) Aborsie mag wetting uitgevoer word **SLEGS** in die geval van verkragting, bloedskande of seksuele mishandeling.	
c) Aborsie mag wetting uitgevoer word **SLEGS** in die geval van potensiële fisiese of verstandelike skade aan die vrou of die fetus.	
d) Aborsie mag wetting uitgevoer word in die geval van verkragting, bloedskande of seksuele mishandeling **EN** in die geval van potensiële fisiese of verstandelike skade aan die vrou of fetus.	
e) Aborsie mag **wettig** uitgevoer word op aanvraag van die vrou tot op 'n sekere datum van swangerskap.	

❖ Maak asseblief 'n kruisie by **slegs een** opsie by elk van die volgende vrae

Volgens die wetgewing aangaande aborsie:	JA	NEE	ONSEKER
1. Vrouens onder die ouderdom van 18 jaar word toegelaat om 'n aborsie te hê.			
2. Vrouens onder die ouderdom van 18 jaar benodig die toestemming van ouers om wettig 'n aborsie te hê.			
3. Slegs 'n getroude vrou mag wettig 'n aborsie hê.			
4. As 'n getroude vrou 'n wettige aborsie wil hê, moet sy die toestemming van haar eggenoot kry.			
5. Die wettige beëindiging van swangerskap kan verkry word op versoek tot en met 12 weke van swangerskap.			

6. Na 12 weke mag 'n aborsie slegs gedoen word onder sekere spesifieke omstandighede.			
7. Klinieke waar swangerskap beëindig word, word verplig om vrywillige berading aan die vrou te verskaf voor die beëindiging van swangerskap.			
8. Klinieke waar swangerskap beëindig word, word verplig om vrywillige berading aan die vrou te verskaf na die beëindiging van swangerskap.			
9. Berading moet aangebied word aan die vrou se maat voor die beëindiging van swangerskap by die kliniek waar swangerskap beëindig word.			
10. Berading moet aangebied word aan die vrou se maat na die beëindiging van swangerskap by die kliniek waar swangerskap beëindig word.			
11. Dit is 'n misdaad om te verhoed dat 'n vrou 'n wettige beëindiging van swangerskap verkry.			
12. Die staat het verskeie gebiede uitgekies vir wettige Beëindiging van Swangerskap klinieke.			
13. Aborsies mag gratis verkry word by die regering se Beëindiging van Swangerskap klinieke.			
14. Verpleegsters moet daarop aandring dat die vrou se maat haar begelei tot by die Beëindinging van Swangerskap kliniek.			

Kennis van wettige en onwettige aborsie metodes

1. By die Beëindinging van Swangerskap kliniek word aborsies uitgevoer deur

.....

.....

.....

.....

.....

2. Wanneer vroue probeer om die swangerskap self te beëindig, of as hulle van "agterstraat" (of onwettige) dienste gebruik maak, word sulke aborsies uitgevoer deur

.....

.....

.....

.....

.....

Kennis van die gevolge van wettige aborsie

- ❖ Maak asseblief 'n kruisie by **slegs een** van die opsies vir die volgende vrae

	STEM SAAM	STEM NIE SAAM NIE
Wettige aborsie (soos uitgevoer deur 'n opgeleide praktiseerder in 'n Beëindiging van Swangerskap kliniek:		
1. Is medies 'n veilige prosedure.		
2. Is 'n leidende oorsaak van onvrugbaarheid.		
3. Is medies meer gevaarlik as om geboorte te skenk.		
4. Veroorsaak voortdurend die dood van die vrou.		

5. Word geassosieer met positiewe gevoelens van verligting/		
6. Sal amper sekerlik lei tot gevoelens van depressie en skuld.		

Kennis van iemand wat 'n aborsie ondergaan het

	JA	NEE	ONSEKER
1. Ek ken iemand wat hul swangerskap wetting beëindig het.			
2. Ek ken iemand wat hul swangerskap onwettig laat beëindig het.			

Bronne van informasie

- ❖ Maak asseblief 'n kruisie by alles wat van toepassing is

1. Ek het gehoor van aborsie by: Ouers	
Familie-lede	
Vriende	
Kêrel of meisie	
Onderwysers	
Kliniek	
Kerk	
Gesondheids-veldtogte	
Televisie	

Flieks	
Radio	
Internet	

	JA	NEE	ONSEKER
Ek voel ek beskik oor voldoende inligting aangaande die Beëindiging van Swangerskap			

Kennis oor noodgeval voorbehoedmiddels

- Maak asseblief 'n kruisie by **slegs een** van die opsies vir die volgende vrae

	JA	NEE	ONSEKER
1. Noodgeval voorbehoedmiddels, beter bekend as die "morning after pill", word gebruik om swangerskap te voorkom na onveilige seks.			
2. Noodgeval voorbehoedmiddels kan 'n aborsie veroorsaak.			
3. Noodgeval voorbehoedmiddels moet ingeneem word binne 72 uur na onveilige seks.			
4. Noodgeval voorbehoedmiddels is gratis by publieke hospitale en klinieke.			
5. Noodgeval voorbehoedmiddels kan oor die toonbank by 'n apteek gekoop word.			
6. 'n Vrou onder die ouderdom van 18 jaar benodig haar ouers se toestemming om noodgeval voorbehoedmiddels te			

verkry.			
7. As 'n getroude vrou die noodgeval voorbehoedmiddels will hê, moet sy eers haar eggenoot se toestemming verkry.			
8. Noodgeval voorbehoedmiddels het langtermyn newe-effekte.			

Dankie vir u deelname aan hierdie studie

isiXhosa

Isiniki ngcanciso ngokobumi

- ❖ Khetha impendulo ohambelana nayo

1) Isini

Owasetyhini	Indoda

2) Iminyaka:_____

3) Ingaba uke wazibandakanya kwezesondo kwezi nyanga zilishumi elinambini zigqithileyo?

Ewe ☐

Hayi ☐

4) Ubizwa ntoni umthetho ojongene nokukhutshwa kwezisu emZantsi Afrika?

_____

5) Lo mthetho waqulunqwa nini? _____

Ulwazi ngalo mthetho

- ❖ Ketha ibenye kwezi zilandelayo

a. Ukukhutshwa kwesisu emZantsi Afrika akuvumelekanga nangaphantsi kwayo nayiphi na imeko	
b. Ukukhutshwa kwesisu kuvumeleke kuphela, kwiimeko zodlwengulo, umbulo, okanye uhlukumezeko ngokwezesondo qha	
c. Ukukhutshwa kwesisu kuvumelekile kuphela xa isisu eso sinokubangela uphazamiseko emzimbeni, engqondweni okanye kusana lwalowo ukhulelweyo	
d. Isisu singakhutshwa kwiimeko zodlwengulo, umbulo okanye uhlukumezo ngokwesondo **KUNYE** nakwiimeko zobungozi ngokubhekiselele emzimbeni, engqondweni okanye kusana lwalowo ukhulelweyo	
e. Isisu singakhutshwa ngokusemthemthweni ngokuthi lowo akhulelweyo enze isicelo kwiintsuku eziqingqiweyo	

❖ Khetha impendulo ibe nye kule mibuzo ilandelayo

Ngokomthetho oqingqiweyo ngokuphathelene nokukhutshwa kwezisu	Ewe	Hayi	Andiqinisekanga
1. Abasetyhini abaneminyaka engaphantsi kwelishumi elinesibhozo bavumelekile ukuba bakuphe izisu			
2. Ukuze akhutshwe isisu ngokusemthethweni, kufuneka imvume yomzali xa owasethyini engaphatsi kweminyaka elishumi elinesibhozo			
3. Ngotshatileyo kuphela ovumelekileyo ukukhupha isisu ngokusemthethweni			
4. Umntu otshatileyo ukuze akhutshwe isisu ngokusemthethweni, kufuneka imvume yomyeni wakhe			
5. Isisu singakhutshwa ngokusemthethweni xa isicelo soko sithe senziwa ningakapheli iiveki ezilishumi elinambini			
6. Emva kweeveki ezilishumi elinambini isisu singakhutshwa kuphela phantsi kweemeko ezithile			
7. Amaziko empilo abucala anyanzelekile ukuba anike uthetha-thethwano lwabucala ngaphambi nasemva kokuba owasetyhini ethe wakhupha isisu			
8. Amaziko empilo abucala anyanzelekile ukuba anike uthetha-thethwano lwabucala ngasemva kokuba owasetyhini ethe wakhupha isisu			
9. Kufuneka iqabane lalowo uza kukhupha isisu lifumane uthetha-thethwano lwabucala kwiziko elo lempilo ngaphambi kokuba sikutshwe isisu			
10. Emva kokuba sikhutshiwe isisu iqabane lalowo wasetyhini kufuneka lifumane uthetha-thethwano kwiziko elo lempilo emva kokuba sikhutshiwe isisu			
11. Ukuthintela owasetyhini ukuba akhuphe isisu ngokusemthethweni kukwaphula umthetho			
12. Urhulumente ukhethe amaziko athile wawabeka bucala ukuba wona akhuphe izisu ngokusemthethweni			
Isisu singakhutshwa simahla kumaziko karhulumente okukhupha izisu			
13. Kuyimfuneko ukuba oonesi balicele iqabane lalowo ukhulelweyo ukuba limkhaphe xa esiya kukhupha isisu			

<u>Ulwazi ngokukhutshwa kwesisu okusemthethweni nokungekho semthethweni</u>

1. Kwi kliniki zokukhupha izisu, izisu zikhutshwa ngokusebenzisa:
   .....
   .....
   .....
   .....
2. Xa abasetyhini bezama ukukhupha izisu ngokwabo okanye besebenzisa indlela ezingalunganga okanye ezingekho mthethweni zikhutshwa ngokusebenzisa:
   .....
   .....

.....

.....

Ulwazi ngemigaqo ekufuneka ilandwelwe xa ubani efuna ukukhupha isisu ngokusemthethweni

❖ Khetha impendulo ibe nye kumbuzo ngamnye

	NDIYAVUMA	ANDIVUMI
Ukukhutshwa kwezisu ngokusemthethweni kusenziwa ngumntu okulungeleyo oko, kwiziko lokukhutshwa kwezisu:		
1. Ngowona mgaqo ukhuselekileyo		
2. Sesona sizathu sihamba phambili esingunobangela wokungabina nzala		
3. Kunobungozi ukogqitha ukuzala		
4. Ngamanye amaxesha kuyabulala kwabasetyhini		
5. Kubangela ukukhululeka ngokwasemoyeni		
6. Kubangela ukuba ubani azive enobutyala		

Ulwazi ngomntu osele ethe wakhupha isisu

	EWE	HAYI	ANDIQINISEKANGA
1. Kukho umntu endimaziyo osele ekhe wakhupha isisu ngokusemthethweni			
2. Kukho umntu endimaziyo osele ekhe wakhupha isisu ngokungekho semthethweni			

Indawo ofumana kayo ulwazi

❖ Khetha kangangoko impendulo ongqinelana nazo

1. Ndive ngokukhutswa kwesisu: Kubabazali	
Kwizihlobo	
Kubabahlobo	
Kwendincuma naye	
Kootitshala	
Esibhedlela	
Ecaweni	
Kumaphulo ezempilo	
Kumabonakude	
Kumboniso bhanya-bhanya	
Kunomathotholo	
Kwi-intanethi	

	EWE	HAYI	ANDIQINISEKANGA
Ndicinga ukuba ndinolwazi olwaneleyo malunga nokukhutshwa kwesisu			

Ulwazi ngokucwangcisa okungxamisekileyo

❖ Khetha impendulo ibe nye kule mibuzo ilandelayo

	EWE	HAYI	ANDIQINISEKNGA
1. Ipilisi yocwangciso olungxamisekileyo ekwaziwa njenge "morning pill"isetyenziswa ukuthintela ukukhulelwa emv kokuba ubani ethe wazibandakanya kwezesondo engazikhuselanga			
2. Iipilisi zocwangciso olungxamisekileyo zibangela ukuba siphume isisu			
3. Iipilisi zocwangciso olungxamisekileyo kufuneka zisetyenziswe zingekapheli iiyure ezingama-72 emva kokuba ubani ethe wazibandakanya kwezesondo engazikhuselanga			
4. Iipilisi zocwangciso olungxamisekileyo zifumaneka simahla kumaziko empilo karhulumente			
5. Iipilisi zocwangciso olungxamisekileyo ziyathengiswa kumaziko athengisa amayeza			
6. Xa ubani engaphantsi kweminyaka elishumi elinesibhozo kufuneka imvume yomzali ngaphambi kokuba asebenzise iipilisi zocwangciso olungxamisekileyo			
7. Xa owasetyhini etshatile kufuneka afumane imvume yomyeni wakhe ngaphambi kokuba asebenzise iipilisi zocwangciso olungxamisekileyo			
8. Iipilisi zocwangciso olungxamisekileyo zibangela uphazamiseko oluthile emzimbeni walowo uzisebenzisayo			

SIYAYIBULELA NGOKUTHI UTHATHE INXAXHEBA KOLU PHANDO