ABORTION AND CONTRACEPTIVES: AN EXPLORATORY STUDY

Gladys Bathabile Bhuda
Lecturer, Department of Social work,
University of South Africa
bhudag@unisa.ac.za

Johannah Sekudu
Senior lecturer, Department of Social Work,
University of South Africa
sekudj@unisa.ac.za

ABSTRACT

The article presents the factors that lead to the increasing abortion rates amongst young women in South Africa, where contraceptives are said to be readily available at all state health facilities. The study employed a qualitative approach in order to gain an understanding of the beliefs and meanings attributed to abortion and contraceptives. The research strategy used in the study was phenomenology. Non-probability sampling, particularly purposive sampling was utilised to select research participants from whom data were collected by means of semi-structured interviews. The findings of the study, amongst others, have indicated that despite the considerable expansion of contraceptive services in South Africa, the use and accessibility to these services remains a challenge. The study also conclusively indicated that there is a need to improve service delivery at state health institutions with regard to abortion and to stimulate utilisation of contraceptive services.

Keywords:
abortion, contraceptives, health institutions, sexual intercourse, unplanned pregnancies

INTRODUCTION

The complexities regarding the provision of abortion and contraceptive services to young people continues to attract considerable research attention worldwide (Orner, De Bruyn and Cooper, 2011; McPhail, Pettifor, Pascoe and Rees, 2007; Burgard, 2004; Mhlanga, 2003; Mfono, 1998). In South Africa, the promotion of family planning (contraceptive service) began as early as 1965 and it was significantly marked by the South African National Family Planning Programme in 1974, which at the time was instituted with the objective of giving couples the opportunity to choose the number of children they desired (Ferreira, 1984). The same year, the apartheid regime changed the policy and introduced a vertical family planning programme under which patients paid fees for all health services except contraceptives, sterilisation, and medical exams of victims of rape or assault (Knudsen, 2006). Detractors, however, quickly pointed out that the programme was also intended to control the black population growth which was at a time thought to be draining the country's resources and which was also used as a means to hold onto white minority rule (Knudsen, 2006; Kaufman, 1998).

During this tenure, the rates of contraceptive use rose dramatically in the country. They were estimated to have reached 44% amongst black women in the late 1980's, the highest recording in sub-Saharan Africa at the time (Kaufman, 1998). These statistics were, however, lower compared to the use by white women; this was because racial residential segregation influenced the availability and quality of family planning services for non-whites resulting in services provided for black women, particularly in the homeland areas, being of uneven quality (Burgard, 2004; Kaufman, 1998). Consequently in later years, despite the availability of contraceptives, unwanted pregnancies amongst young women reached epidemic proportions worldwide (Henshaw in Bowers, 1994) and South Africa was not spared.

With regard to abortion, in 1975 the 99% male, all white South African parliament passed the Abortion and Sterilization Act (Act No.2 of 1975), which made abortion illegal except when continued pregnancy threatened both the woman and/or the life of the foetus, if the woman was classified as 'imbecile' and when the pregnancy was a result of rape or incest (Knudsen, 2006). This act meant that women could not choose to terminate an unwanted pregnancy. As a result, South Africa together with the rest of the world, experienced major dilemmas concerning abortion, particularly unsafe abortion, which was prevalent amongst young and unmarried women.

In the coming years strides were thus made internationally and nationally to deal with the increase in unplanned pregnancies and abortions. The International Conference on Population Development (ICPD) in 1994, wherein the question of abortion was one of the most prominent, resulted in countries committing to deal with the health impact of "unsafe abortion" as an integral aspect of their commitment to women's health (Department of Economic and Social Affairs, 2001). During the 21st Conference of Health Ministers for East, Central and Southern Africa (ECSA) held in Maseru, the Health Ministers adopted a resolution in which they identified unsafe abortion as a major cause of maternal morbidity and mortality in the region (Kinoti et al. in Benson, Nicholson, Gaffikin and Kinoti, 1996). At the 2012 Global Family Planning Summit held in London, the importance of contraception to human development, gender empowerment, HIV, sexual and reproductive health was re-emphasised (World Health Organization (WHO), 2012). The United Nations (UN), amongst other policies, formulated the following conventions on reproductive health:

the Millennium Development Goals (MDGs), with goal 5, target 5b focused on achieving universal access to reproductive health by 2015 (UN, undated); the 1994 ICDP Programme of Action (UN, 2014) and the Global Strategy for Women and Children's Health (UN, 2010). The South African Government as a member state of the UN ratified the afore-mentioned conventions.

Nationally, the most liberal action taken to address the abortion matter in South Africa was the enactment of the Choice on Termination of Pregnancy Act (Act No. 92 of 1996). The Act stipulates the circumstances and conditions under which a pregnancy maybe terminated. South Africa's commitment to the provision of reproductive health is also inextricably embedded in Section 27 of the Bill of Rights which stipulates that everyone has access to health care services, including reproductive health care (Act No. 108 of 1996). Other policies to advance reproductive health care include the following: in 1997, the Ministry of Health re-emphasised the importance of contraceptives when they revised the guidelines and strategies for providing contraceptive services to both women and men alike so that they could all decide for themselves the most appropriate methods of contraceptive services to use (White Paper on the Transformation of the Heath Systems in South Africa, 1997). The National Adolescent-Friendly Clinic Initiative was launched in 1997 (Dickson-Tetteh and Foy, 2001). In 2003 the National Contraception Policy Service Delivery Guidelines: Republic of South Africa was also launched (Department of Health, 2003a). Section 134 of the Children's Act (Act No. 38 of 2005) as amended also makes provision for children over the age of 12 years to have access to all forms of contraceptives. The Choice on Termination of Pregnancy Amendment Act (Act 38 of 2004) was also enacted. This act makes it easier to designate facilities and allows for registered nurses to be trained for termination of pregnancy (TOP). The Strategic Plan for Maternal, Neonatal, Child, Women's Health (MNCWH) and Nutrition 2012-2016 was also formulated (Department of Health, 2012a). The National Contraception and Fertility Planning Policy and Service Delivery Guidelines as well as its companion the National Contraception Clinical Guidelines were reformulated, re-launched and their aim was re-visioned, with an emphasis on dual protection (Department of Health, 2012b, 2012c).

PROBLEM STATEMENT

It is estimated that every year in sub-Saharan Africa, approximately 14 million unintended pregnancies occur (Hubacher, Mavranezouli and McGinn, 2008). Kaida, Laher, Strathdee, Money, Janssen, Hogg and Gray (2010) also estimated that 50-84% of pregnancies occurring amongst HIV infected women in sub-Saharan Africa were unintended. In South Africa, the 1998 South African Demographic and Health Survey (SADHS) found that by the age of 19 years, more than one-third of women (35.1%) had been pregnant (Department of Health, 1999). Kaufman, De Wet and Stadler (2001) confirmed that in 1998, more than 30% of 19-year-old South African girls had given birth at least once. Most recently, the South African Department of Health statistics suggests that the percentage of 19 year olds that have given birth at some point in their lives is closer to 25% (Chiumia, 2014), suggesting a decline in the number of young women becoming pregnant.

Approximately 26 million legal and 20 million illegal abortions have been performed worldwide since 1995, resulting in a worldwide abortion rate of 35 per 1,000 women aged 15-44 (Henshaw, Singh and Haas, 1999). Globally, there are 28 abortions for every 1,000 women of child bearing age (Olson, 2007). At the end of the 20th century, the overall abortion rate in Africa was estimated 33 per 1000 pregnancies (Henshaw et al., 1999).

According to Williamson, Parkes, Wight, Petticrew and Hart (2009), in Southern Africa and South East Asia, one quarter of the estimated 20 million unsafe abortions and 7 000 abortion related deaths each year occur among women aged 15-19 years. The findings of the 2nd South African National Youth Risk Behaviour Survey revealed that the national prevalence rate of learners who reported an abortion was 8.2% with no significant variation by gender, race or age (Medical Research Council, 2008).

The 2011/2012 South African District Health Barometer (Massyn, Day, Barron, Haynes, English and Paradath, 2013) reported the following abortion trends in South Africa without data from the Western Cape, Limpopo and North West province.

Table 1: Trends in termination of pregnancy, illustrated by unmet need for contraception (2011/2012)

Data element	FY 2008/2009	FY 2009/2010	FY 2010/2011	FY 2011/2012
Termination of pregnancy performed	75 292	77 147	71 548	77 780

During the 2013/2014 financial year, the South African District Health Barometer (Massyn, Day, Peer, Paradath, Barron and English, 2014) reported the following abortion prevalence rate:

Table 2: Trends in termination of pregnancy, illustrating the unmet need for contraception (2013/2014)

Data element	FY 2012	FY 2013	FY 2014	Percentage change
Termination of pregnancy performed	77 693	82 910	90 160	16.0

Contrary to the Department of Health's 2014 statistics, the increasing abortion rates suggests the continued increase in the number of unwanted pregnancies that end up being terminated. It is therefore against this backdrop that the concern for this study was that there continues to be increasing rates of unplanned pregnancies amongst young women in South Africa despite contraceptives having been made readily available at all state health facilities, as shown above. These occurrences continue despite South Africa having been recorded as having the highest contraceptive prevalence rate in sub-Saharan Africa (Sharan, Ahmed, May and Soucat, 2011). The second concern for the study was that some of the unwanted pregnancies end up being terminated hence the necessity to uncover the factors behind this situation.

RESEARCH METHODOLOGY

The study was located within the qualitative research paradigm because its aim was to gain an understanding of the beliefs and meanings that women attribute to abortion and

contraceptives. The approach was appropriately suited for the study because, as stated by Yegidis and Weinbach (2009) and Rubin and Babbie (2010), the approach elicits a deeper understanding of the meanings of the phenomenon under study from the perspective of those who experience it.

Because the study was qualitative in nature, the phenomenological research strategy was employed to understand the participant's subjective experiences by exploring, understanding and interpreting the meaning that they attached to the phenomena under study (Fouché and Schurink, 2011; Rubin and Babbie, 2010). The population of the study consisted of the women who had approached the Termination of Pregnancy Clinic (TOP) at Kalafong Hospital located in Atteridgeville, West of Pretoria, for pregnancy termination. Purposive sampling was used to select participants who possessed the most characteristics or attributes typical of the population. The sample thus consisted of married and unmarried women aged between 13 and 35 years who were either waiting to undergo pregnancy termination and/or who had already undergone pregnancy termination and were being observed for possible complications. The participants were interviewed at the hospital after being identified in the waiting room and agreed to participate. Data were collected over a period of 6 months.

Ethical issues were also considered in the study. Amongst others, the following ethics were adhered to: Informed consent, avoidance of harm to subjects, avoidance of violation of privacy/anonymity/confidentiality and debriefing of participants (Strydom, 2011). Informed consent was obtained from each participant and the forms were available in four languages, i.e. in English, IsiZulu, SePedi and in Setswana, to ensure that participants were not deceived in any way due to language barrier. Efforts were also taken to avoid emotional harm to participants; prior to data collection a briefing session was conducted with the participants. Debriefing was also conducted with the participants after data collection sessions were completed. Participants who needed long term therapeutic intervention were referred to the social worker at Kalafong Hospital. Privacy, anonymity and confidentiality were upheld throughout the study. The interviews were conducted individually and the raw data from the tape recordings was placed in a safe place for safe keeping. The study was ethically approved by the Department of Social Work and Criminology at the University of Pretoria and by the Medical Research Council of South Africa.

Data from the participants was gathered by means of semi-structured interviews aided by an interview schedule as suggested by Greeff (2011). A total of ten participants were subsequently interviewed and the number thereof was determined by the principle of 'data saturation'. Data saturation was achieved when the researcher began to hear from the participants the same information being repeated (Greeff, 2011).

Data from participants was gathered by means of semi-structured interviews. The collected data were then analysed by means of integrating Creswell's analytic spiral data analysis process with the process described by Marshall and Rosman cited by De Vos (2005). The process took place in the following series of steps:

- Planning for recording of data: during this phase arrangements were made that interviews with participants would be conducted in the waiting room of the clinic so as not to intrude on the ongoing flow of daily events at the clinic as stipulated by De Vos

(2005). Participants were also informed of the use of a tape recorder on the informed consent, which they signed.

- Data collection and preliminary analysis: during this phase data were collected from the research site and away from the research site (De Vos, 2005). At the research site data were gathered from participants by means of semi-structured interviews and compiling filled notes. Away from the site, data were preliminary analysed by revisiting the recording and ensuring that correct field notes are kept against each participant.
- Managing or organising the data: in this phase the recordings were transcribed. The field notes were merged with the relevant transcriptions. The said data were then organised into file folders. Reading and writing memos occurred next whereby the catalogued data were read in its entirety, several times to gain a deeper understanding of the meaning it exhumes.
- Thereafter salient categories and themes were identified.
- The data were then coded. Herein key thoughts were highlighted and first impressions recorded.
- The processes that followed next was testing emergent understandings and searching for alternative explanations. During this phase the coded data were reread to ensure that it was correctly compartmentalised and to establish its relevance and usefulness in each theme. Plausible explanation to data were also sought.
- The preceding processes made it possible for the research report to be compiled. In the report findings were presented. The findings were categorised into themes that were substantiated by the participant's responses and the meaning exhumed corroborated by literature.

PRESENTATION OF RESEARCH FINDINGS

The findings are presented according to the following themes which were outlined in the interview schedule.

Table 3: Themes emerging from the qualitative data

Theme	Subthemes
• Having shared the information about the pregnancy	
• Knowledge of contraceptives and their utilisation	
• Attitudes towards utilisation of contraceptives	
• Number of the current pregnancy	
• Reasons that led to the decision to terminate the pregnancy	• Unwanted/Unintended pregnancy • Having other children • Economic stratus • Medical problems • Pressure from family • Marital and educational status
• The impact of pregnancy on their lives	

The themes are substantiated by the participant's responses and supported by literature.

Having shared information about the pregnancy

The majority of participants, nine participants from the ten, indicated that they had told someone about the pregnancy; some told their friends, some their siblings and others their partners. There was however, one participant who underwent the procedure without telling anyone.

"*I told the baby's father about the pregnancy and he was happy. I also informed him of my plans to terminate and he did not have a problem but encouraged me to think through my decision and make a decision that is best for me".*

"I was afraid to tell anyone about the pregnancy especially my boyfriend because he would have insisted we keep the baby and I'm not ready".

The studies by Moreau, Trussel and Bajos (2011) and Larsson, Aneblom, Odlind and Tydén (2002) also revealed that almost all the women had discussed the abortion decision with someone, their partners, their mothers, their friends, their fathers and some with other family members. The latter, however, also reported that 2% of young women included in their study had not discussed the issue with anyone.

It would seem that a decision to terminate a pregnancy is mostly from within irrespective of the views of the significant others.

Knowledge of contraceptives and their utilisation

The Participants acknowledged that they were aware of contraceptives. The most widely-known and used methods amongst the participants were the pill, the injectables, and barrier contraceptives as shown below:

"Contraceptives prevent unwanted pregnancies and help to plan children appropriately. After the birth of my first child I used pills but they were not effective because I conceived my second child whilst using them. After the birth of my second child I changed to an injection. When I used the injection my menstrual cycle stopped so I decided to discontinue and told myself I would use a condom."

"I only started using contraceptives this year. I went to the clinic where they told me about deppo and the different time intervals it can be administered. I then chose a three month cycle and I am surprised why I became pregnant".

There were also participants (three participants) who had never used contraceptive before. The following response represents their views:

"I know a lot of information about contraceptives because I was once part of the Love Life youth club. I know that they prevent pregnancy but have never really considered using them because I never thought I would fall pregnant."

The aforementioned statements have evidenced that participants were aware of at least one contraceptive method. The responses are also validated by Sharan, Ahmed, May and Soucat (2011) in their study of family planning trends in 45 sub-Saharan African countries between

1986 and 2009, which revealed that Southern Africa has the highest levels of contraceptive use, with South Africa having the highest prevalence rate at 60.3%.

Various studies including the World Health Statistic (WHO, 2011) and Dickson-Tetteh, Pettifor and Moleko (2001) have, however, found that women do not always adhere to the correct use of contraceptives. This was confirmed by some of the participants who openly admitted to failing to take the contraceptives according to instructions.

"*I was told that I needed to take the pill daily and at the same time intervals because if I didn't I would become pregnant but I did not believe that something like that could happen; as a result I took the pill at different times and sometimes I would even forget to take it. I was not consistent.*"

Failure to use contraceptives appropriately contributes to increased unwanted pregnancies, some of which end up being terminated as it was the case with the preceding participant.

Attitudes towards utilisation of contraceptives

Participants demonstrated a positive attitude towards contraceptives. They believed that contraceptives are important because they prevent both sexually transmitted diseases and unwanted pregnancies, as one said:

"I think contraceptives are good, especially the condom, because it not only prevent pregnancy but also sexually transmitted diseases".

There were two participants who, even though they had reported to having a positive attitude towards contraceptives, did not fully trust contraceptives, arguing their ineffectiveness and shared the following:

"*After the birth of my first child I used pills, but they did not work well because I conceived my second child whilst on the pill".*

"I like using contraceptives but at the same time I think they are not effective for me because I became pregnant while using deppo."

The participants who previously used contraceptives cited side effects as one of the reason for being discouraged from further use. They complained that when they reported the side effects, the practitioners did nothing to alleviate or minimise them. Secondly, they reported that poor service delivery by the medical personnel deterred them from further using contraceptives. Studies by Cullwell, Vekemans, De Silva, Huwitz and Crane (2010); Jewkes, Gumede, Westaway, Dickson, Brown and Rees (2005) and Dickson-Tetteh et al. (2001), also revealed that health care providers often impose unnecessary barriers to the provision of contraceptive services. In this study, one of the participants said:

"I know that contraceptives prevent unwanted pregnancy. I used to consult at the local clinic every month where I received an injection but my foot had a bad reaction to it. This is because every time after receiving the injection my foot became sore and it wouldn't get better. Whenever I consulted I always told the nursing sister about it but she never attended to my problem, instead she kept telling me that the pain would stop but it never did. I then decided to stop and my foot has not been sore ever since."

Responses also showed that culture plays a major role in influencing individual's attitudes towards contraceptive use:

"The thing is I'm originally from KwaZulu/Natal and as a Zulu girl we are taught not to engage in sexual intercourse before marriage and I have always told myself that I would never engage in pre-marital sex. Therefore it is a shame in my culture and my father would be disgraced by the act".

The above responses raise the question of whether contraceptives are safe or not, effective or ineffective? The responses also evidence barriers within the system that discourage women from accessing contraceptives.

In the study, cultural beliefs and practices concerning sexuality and the use of contraceptives played a role in some of the participant's decision to either use or not use contraceptives. This issue is particularly imperative for South Africa because the country has one of the most diverse populations' worldwide, which affects contraceptive utilisation. Strategies should thus be sought to address cultural issues impacting on reproductive health issues.

Number of the current pregnancy

The majority of participants (7 participants) reported that the current pregnancy was not their first. Of these, some had two children and others had more, with some children born within marital relationships whilst others were born out of wedlock. This finding is consistent with studies by Lim, Wong, Yong and Singh (2011), Okonofua, Omo-aghoja, Bello, Ogushe and Agholor (2010), Jewkes et al. (2005), Schuster (2005) and Uygar and Erkaya (2000). Those who had children out of wedlock further reported shock, anger and disappointment on the part of their families to their first pregnancies, whilst they reported shock, being scared and disappointed in themselves with the current pregnancy.

"I have two children who are staying with their father; we are separated. The first born is 8 years old and another is 5 years old."

"I have five children with my deceased husband".

"When I was pregnant with my first child I was 17 years old. I didn't know the symptoms of pregnancy nor notice any changes in my body. My mother and sister had suspicions though and for a long time kept asking me if I was pregnant and I denied it until they forced me to consult. I was ashamed at first when the pregnancy was confirmed, I was ashamed because I was the only one amongst my peers who had been pregnant; moreover I was shocked to discover that I was already six months pregnant. My mother and sister were also shocked but eventually accepted the situation as there was nothing else anyone could do.

There were also participants who had reported the current pregnancy as their first like 7.35% of respondents in the study by Okonafua et al. (2010) where they reported that they had been pregnant for the first time. In this study, most of these participants portrayed no emotional reaction to the pregnancy, they seemed detached. They offered a brief, similar response:

"Yes this is my first pregnancy".

Another participant was not sure if she was pregnant or not, but she made it clear that should she find that she is indeed pregnant she was definitely going to terminate the pregnancy. She reported the following:

"I am actually not sure if I'm pregnant or not. I did my first pregnancy test at Laudium Clinic where the results came out positive; I then went to Phomolong Clinic for confirmation and there I was told I'm not pregnant. I was then referred by Phomolong Clinic to check at the hospital using a sonar machine to make sure. If I find that I am pregnant I will definitely terminate the pregnancy".

It is evident that for most participants who already had other children, their current pregnancy was a traumatic experience because of the negative reactions they had had from their families with their previous pregnancies. The trauma was also brought by the feelings they had about themselves. Consequently, it was also evident that none of them wanted to go through the same emotional turmoil of disappointing their loved ones, hence the abortion. The responses further confirm that South Africa's state institutions are faced with an enormous challenge as far as rendering women's health services is concerned. This is exemplified by the participant who after consultation with two different clinics, was still not sure if she was pregnant or not.

Reasons that led to the decision to terminate the pregnancy

It was important to further explore the reasons that led to the decision to terminate the pregnancy.

Unwanted/unintended pregnancy

All the participants cited this reason; some said they were not ready to have a child or another child, some viewed the pregnancy as a mistake whilst others wanted to postpone child bearing because having a child at that time would hinder their future plans, and others reported financial dependence on their families as the major reason. In the studies by Lim et al. (2011) and Adanu and Tweneboah (2004), this was found as the main reason for seeking pregnancy termination as the pregnancy was not planned. In 2003, the former Minister of Health, the late Dr. Manto Tshabalala-Msimang, also acknowledged that a significant number of pregnancies in South Africa were still unplanned (Department of Health, 2003b).

The afore mentioned discussion thus gives a clear indication that, despite the availability of contraceptives, young people continue to engage in unprotected sexual intercourse which then puts them at risk of contracting sexually transmitted diseases as well as having to deal with the burden of unplanned pregnancies.

Having other children

Although the majority of participants had children, only four cited this as a reason behind their decision. These participants elaborated that the children they were having were either too young or too old to have a new born sibling, as shown below.

"A baby? Not now, my other child is still too young."

"I have other children, I do not want another."

In the study by Uygur et al. (2000) 46.7% of respondents also reported that they had requested abortion because they wanted no more children. Similarly, in the study by Okonofua et al. (2010) 28.9% respondents also reported that they had other children hence the need for pregnancy termination. It can thus be deduced that having other children does motivate women to seek pregnancy termination, especially if they feel they have the desired number of children.

Economic status

All the participants mentioned financial constraints as one of the major reasons for seeking pregnancy termination. A number of reasons were given with regard to this factor; the women reported that they came from impoverished families whilst others stated they were unemployed. Of these, some were employed and those stated that they earned too little consequent to which they would never be able to afford the costs associated with raising a child. Literature confirms that financial constraints serve as one of the major motivating factor for women to seek pregnancy termination. Poor economy was one of the major factors cited by women for seeking abortion in the study by Larsson et al. (2002) whilst Uygur et al. (2000) cited 27.2%; Adanu and Tweneboah (2004) cited 8.5% and Lim et al. (2011) cited 86.8%.

Rape

One woman cited rape as her reason for seeking pregnancy termination. In the study by Adanu and Tweneboah (2004) the figure was slightly higher at 2.4%. In South Africa, this group of women are supported by means of Section 2 of the Choice of Termination of Pregnancy Act (Act No. 92 of 1996), which stipulates that pregnancy termination maybe requested up to 20 weeks of the gestation period if a medical practitioner, after consultation with the woman, is of the opinion that the pregnancy was a result of rape or incest.

Medical problems

Only one participant cited this as the reason for terminating her pregnancy.

"I am HIV positive and I am concerned with the negative impact the pregnancy may have on my health and the health of the baby".

The study by De Bruyn (2012) also found that whilst the reasons for seeking pregnancy termination coincided with those of women without the virus; HIV positive women also had reasons specific to the status which, amongst others, included fear of transmitting the virus to the baby, fear of exposing the child to later stigma and discrimination whilst others cited a need to use socioeconomic resources for their own health care and that of their existing children.

Pressure from family

Only two participants cited this as their reason for pregnancy termination.

"I wouldn't know how to raise the baby. Amongst my family I would also be the only one at my age with a child. I am born from a royal family and my father is well respected in the family, so this would be an embarrassment for him."

"My family would be shocked to hear that I am pregnant. They don't expect me to have another child."

In the study by Larsson et al. (2001) 13% of the respondents also cited this reason. Based on the fact that these women were somewhat pressured to terminate one may wonder if they will be able to deal with the aftermaths of this action. It is therefore also arguable to state that women who are forced whether directly or indirectly to terminate their pregnancy may experience greater difficulties in dealing with the emotional impact and even the physical implications that may occur later in life.

Marital and educational status

Eight of the ten participants who were not married cited marital status as one of the major reasons for seeking pregnancy termination, while the need to acquire a qualification at the institutions of higher learning was cited by the younger participants who were three participants of the ten. From the findings, it has been evidenced that young single women are more likely to seek termination compared to married women who have support from their spouses.

The impact of the pregnancy on their life

For most participants (seven participants), the pregnancy did not have any major impact on their lives but they felt that carrying it to term would definitely hinder the realisation of their dreams such as acquiring a tertiary qualification and/or securing employment. The positive factor as far as the participants were concerned in this regard is that they took the experience as a learning curve and maintained a positive outlook on life and the following response captures succinctly their views:

"Keeping the baby would have changed my life dramatically. I have won two bursaries for next year, so it would mean that I wouldn't go to tertiary and I couldn't allow that."

CONCLUSIONS AND RECOMMENDATIONS

The study explored factors that lead to the increasing abortion rates amongst young women in South Africa, where contraceptives are said to be readily available at all state health facilities. Participants in the study have attested to the availability of contraceptives in South Africa with some also attesting to having used them. It was thus interesting to discover that participants became pregnant whilst they knew of contraceptives. Logically the view that should follow is the question of why then did the participants not use contraceptive to prevent the unwanted pregnancies? What cannot be disputed in this regard is the discrepancy that has been evidenced; that despite the considerable expansion of contraceptive services in South Africa, the use and accessibility to these services remains a challenge. The discrepancy is further exacerbated by the fact that there was a woman who used contraceptives incorrectly. It was thus established in the study that side effects and poor service delivery by medical personnel deterred participants from continuing contraceptive usage. Cultural beliefs and practices concerning sexuality and the use of contraceptives also played a role in the women's decision to either use or not use contraceptives.

The aforementioned discrepancy points to a need for a multidisciplinary approach to the provision of abortion and contraceptives services in South Africa consisting of the Department of Health, the Department of Social Development, the Department of Education and the Department of Cooperative Governance and Traditional Affairs. These departments should collaborate and streamline the reproductive health policies of the country. In their collaboration, these departments should also encourage culturally sensitive reproductive health practice by service providers.

The fact that study participants sought pregnancy termination although being aware of the availability of contraceptive services at state health facilities also signals that the current strategies aimed at promoting contraceptive use are ineffective. And as a result, the identified ministries also need to embark on the revision of prevention strategies; they need to develop culturally specific and culturally sensitive prevention strategies to promote contraceptive use.

Moving forward there is another need to explore the current phenomena focusing on males to highlight the critical role they play and to identify the gaps in service delivery in the whole scenario of unplanned pregnancies. The findings of such a study would strengthen the proposed revision of prevention strategies. It would also enhance the culturally specific and sensitive service provision.

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