Between reproductive rights and access to reproductive healthcare services: Narratives of reproductive rights activists in South Africa

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ABSTRACT

The motivation behind the research paper, "Between reproductive rights and access to reproductive healthcare services: Narratives of reproductive rights activists in South Africa" stems from the notion that civil society groups have often played a critical role in addressing social justice issues concerning women's rights. Since 1996 after implementation of the Choice on Termination of Pregnancy (CTOP) Act, South Africa has frequently been praised for its progressive abortion laws that formally recognises women's need for reproductive autonomy and equality. However, ineffective implementation has resulted in many women facing a combination of barriers to accessing reproductive healthcare services. Thus, resulting in some women opting for unsafe, illegal abortion services and placing their health and lives in danger. The purpose of the study, therefore, is to capture the perceptions of contemporary South African based reproductive rights activists and NGOs who engage in campaigns that seek to highlight the complex relationship between reproductive rights and access to such rights. Data for the study was collected through open-ended questionnaires in which participants provided their unique opinions as activists who regularly engage with the abortion and access issues in South Africa. Results from the study suggest that ineffective implementation of the CTOP Act can be attributed to a lack of political will to prioritise women's sexual and reproductive rights, thereby further marginalising women in society. Results also point to the need for widespread support from civil society on women's rights matters so that the State can more effectively be held accountable for catering to the most marginalised women in South African society.

Keywords: reproductive rights, abortion, civil society, activists, NGOs, campaigns, CTOP Act, Reproductive Justice

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Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the Sociology Department or Rhodes University.

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CHAPTER 1

INTRODUCTION

1.1 Background

Abortion is not solely about the termination of pregnancy or about a rights framework relating to whether woman can or cannot legally procure an abortion. Nor is it simply limited to a medical procedure (Klausen, 2015; Dlamini, 2014; Ross, 2006). On the contrary, abortion is much more complex than that as it deals with issues that relate to the human context. For example, women using abortion as a means to determine their own life situations by eliminating unwanted pregnancies that may otherwise restrict their self-determination (Ross, 2006; Dlamini, 2014, Albertyn, 2015). History portrays women as largely been censored and restricted to express themselves in the public sphere (Butler, 1999; Klausen, 2015; Albertyn, 2015; Friedman, 2003; Hodes, 2016; Jewkes *et al*, 2005). This was often achieved through using the law and traditional practices embedded in patriarchy to marginalise women from participating in the social, political, economic and legal spheres. Influenced by patriarchal ideologies, those who hold power such as (white) male legislators and other politicians often feel that women are less-capable and therefore should not be allowed to make decisions regarding their own bodies (Silliman *et al*, 2004; Klausen, 2015; Jewkes *et al*, 2005; Hodes, 2016). Restrictive abortion laws are then put in place so as to take away women's control of their bodies, and thus control over their lives.

These have consequences for women as their human rights are not considered. Leaving women further marginalised as they experience a combined loss of human subjectivity, autonomy, self-determination and choice (Klausen, 2015; Ross, 2006; Silliman *et al*, 2004. To a large extent, this still applies even in cases where abortion is legalised and women are allowed to procure abortions for any reason. However, this may just be a façade, especially when liberal laws are in place yet various difficulties pose further restrictions on marginalized women to access the provisions of the law. Hence, with these restrictions it becomes difficult for already-marginalized women to benefit from sexual and reproductive health rights and enjoy their human rights (Hodes, 2016; Klausen, 2015; Albertyn, 2015.

The issue concerning reproductive rights and abortion laws in South Africa is one that is widely addressed both by South African and internationally-based authors, researchers, interest groups and organisations (Horn, 2003; Albertyn, 2015; Althaus, 2000; Cooper *et al*, 2004; Guttmacher *et al*, 1998; Human Rights Watch, 2011; WHO, 2003). However, very few of these thoroughly engage with interest groups such as campaign activists, non-governmental organisations (NGOs), and other known civil society groups. This research will accordingly explore an area less commonly or comprehensively investigated in the South African context, that is, the issue of access to abortion services and the unique influence and understanding which civil society groups and NGOs bring to this issue. This is different to other studies which focuses on the 'access issue' in that it does not render its primary focus the post-Apartheid shift from restrictive abortion laws to the more liberal abortion law, currently in effect and known as the CTOP Act of 1996. In addition, the current study seeks to contribute exclusive information from the viewpoint of civil society groups such as activists who have direct engagement and expertise on matters relating to reproductive rights issues that impacts on women's human rights, autonomy, dignity and freedom of choice. This information is then analysed to give insight into what can be done differently to improve the conditions of marginalised women in South Africa.

The role played by activists and NGOs is most often a complex one (Klugman, 2011; Albertyn, 2015; WHO, 2001). This is because in order to influence more effective change in social justice issues such civil society groups need to decide on shrewd, robust strategies that would bring about a strong base of support from the general public including building alliances with other interest groups and organisations (Klugman & Mokoetle, 2010; Klugman, 2011). Moreover, encouraging those most affected to be part of a movement that seeks to address and influence policy change that would bring about social justice is not often an easy task, due to individuals having little faith in movements promising effective social justice when they are used to being disappointed in such matters (Klugman, 2011). However, where activists and NGOs succeed in mobilising for civil society support and funding, accompanied with effective and pragmatic objectives and good strategic leadership, chances of holding government accountable and demanding more effective social justice policies are increased (Klugman, 2011; Klugman & Mokoetle, 2010; WHO, 2001).

Twenty years after implementation of the celebrated CTOP Act many women in South Africa continue facing various barriers to accessing safe, legal abortion and other reproductive health services as afforded by the Constitution (Rebouche, 2011, Guttmacher *et al*, 1998;

Lomelin, 2014; Klausen, 2015; Hodes, 2016). Therefore, the access problem in this regard can be considered an unresolved issue or a gap in the knowledge of providing effective solutions to dealing with the 'access issue' beyond armchair reflections of authors or individuals not involved in the direct efforts of mitigating the gap between rights and access. It is for this reason that this study's chosen topic is "*How reproductive rights correspond with access: A case study of South African advocacy groups*". This is because the often complex yet critical role played by civil society groups such as activists, NGOs, and other interest groups in effecting changes through social justice policies has been well documented, and thus considered important for achieving the objectives of this study (Klugman, 2011; Albertyn, 2015; Klugman & Mokoetle, 2010; WHO, 2001; Center for Reproductive Rights, 2003). The term "advocacy" encompasses a broad range of activities that can influence public policy. From research and public education to lobbying and voter education, advocacy is the number one way non-profits can advance the issues they care about and help bring about systemic, lasting change. In the next sub-section, I will attempt to address the need to engage this unresolved issue.

1.2 The Research Problem

The access issue is addressed from a variety of standpoints as previously mentioned (Klausen, 2015; Hodes, 2016; Albertyn, 2015). This remains important because in spite of formal acknowledgment of women's capacity to make binding life-choices regarding their reproductive life and health, in reality many women face conditions similar to a country where abortion is completely illegal because they simply face too many barriers to accessing their rights (Hodes, 2016; Klausen, 2015; Mhlanga, 2003; Albertyn, 2015; Jewkes *et al,* 2005).

The exclusionary and often harsh reality of the past has changed in significant, constitutional ways that deserve to be celebrated. But the introduction of the new laws in and of itself has not been a panacea for the problems of the past because women and their rights continue being subordinated in society. Patriarchal ideologies have long ensured that women's freedom of choice and reproductive rights are not seriously considered in society (Butler, 1990, Ross, 2006; Silliman *et al*, 2004; Klausen, 2015). This presents a social issue, and ultimately a human's rights issue since reproductive rights, particularly in South Africa, form part of human rights (Mhlanga; 2003).

With that said, this study recognises the crucial role played by civil society groups such as activists and NGOs etc. in addressing human rights matters especially that of the most marginalised groups such as, for example, vulnerable women. Therefore, the main objective of this study is to capture the perceptions of contemporary South African-based advocacy groups and organisations who engage in campaigns that seek to highlight the complex relationship between reproductive rights and access to such rights as granted by the CTOP Act.

1.3 Purpose of the study

The chosen research design for this study is the qualitative research paradigm as it is best suited for achieving the objectives of this research. The population used as respondents for the study are contemporary South African based advocacy groups and NGOs who are or have previously been directly involved in campaigns addressing the reproductive rights and access issue. The reason for focusing specifically on reproductive rights campaign activists and NGOs is because of their direct and daily professional and social engagement with the issue of access. These respondents are all purposively selected. Furthermore, the data collection techniques used to obtain the relevant information from respondents is through open-ended questionnaires. This is discussed in more detail in chapter Three

1.4 Significance of the study

The purpose of this study is to add onto an existing body of information which inspects the barriers to safe abortion services. However, this study takes it a step further by investigating this issue from the perspective of activists and NGO role-players who have regular involvement on matters related to women's reproductive health rights and access. The desired outcome is to obtain information that can lead to pragmatic solutions to change the unfortunate realities facing many South African women. Some of these include: being systematically restricted from accessing safe, legal and discrimination-free abortion and reproductive healthcare at public health facilities due to various barriers (see Chapter 2); being forced to opt for unsafe and illegal abortion providers as a result of barriers and others factors such as, for example, lack of knowledge of South African abortion law, mistreatment by public healthcare providers and social stigma etcetera.

The health dangers, including death and other undesired outcomes faced daily by women due to the lack of access to abortion facilities in South Africa is a dismal injustice and social crisis

(Hodes, 2016; Lomelin, 2014; Althaus, 2000; Albertyn, 2015; Guttmacher *et al*, 1998; Stevens, 2011; Strydom & Humpel, 2014). Shocking statistics speak to maternal morbidity and other life-threatening health dangers experienced by many South African women. For example, the Department of Health's *2011-2013 Confidential Enquiries into Maternal Deaths in South Africa* reported that there were 4 867 maternal deaths recorded between 2008-2010. From these, 186 women died of septic miscarriage in public healthcare facilities and the death of 1119 women were the direct result of unsafe and illegal abortions (NCCEMD, 2012). Given the legal and political climate of South Africa since its democracy most of these unfortunate realities are avoidable and unnecessary (John, 2015; Hodes, 2015; Mhlanga, 2003; Lomelin, 2014). These avoidable health dangers faced by women who, for example, rely on remedial care due to septic and incomplete abortions (often from illegal providers) further strains the already limited and scarce resources in public healthcare (Hodes, 2015).

By adding to the existing body of literature examining barriers to access and the effects these have on women and society, this study hopes to further strengthen the goal of influencing policy-makers and other civil society groups to respect and support women's reproductive rights, and their autonomy over their bodies and lives.

1.5 Research aim and objectives

The objective of this study is to capture the perceptions of contemporary South African-based advocacy groups and organisations who engage in campaigns that seek to highlight the complex relationship between reproductive rights and access to such rights.

<u>Sub-goals include</u>:

a) Eliciting the way in which various activists and organisations understand the current tension between rights and access as well as their understanding of how this tension can be mitigated
b) Determining knowledge of the existing CTOP Act amongst advocacy groups and activists
c) Framing the most common concerns that campaigners identify as barriers to women gaining ease of access to reproductive health services
d) Understanding the nature of currently existing campaigns

1.6 Theoretical Framework

The chosen theoretical framework for this study is the Reproductive Justice framework. This concept of Reproductive Justice links reproductive rights with social justice (Ross, 2006; Silliman *et al*, 2004). The concept of Reproductive Justice was formed in 1994 in the United States of America (USA) as a movement that aimed to develop the rhetoric of reproductive rights beyond the sphere of women with the social means and economic resources to make the choice of having an abortion (Ross, 2006). Furthermore, it strove to make the discourse on abortion less elitist and more intersectional. Besides fighting for access to birth control, Reproductive Justice also provides a framework that concentrates on the social, political, and economic inequalities that face women of colour and which further contribute to infringements of reproductive justice (Ross, 2006).

Although the concept of Reproductive Justice was founded for black American women, for the purpose of this thesis the concept will be broadly applied, without specifically concentrating on the racial dimensions of women's reproductive politics, however these are held in consideration throughout the study.

Reproductive Justice is known as "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls", and will be "achieved when women and girls have the economic, social and political power and resources to make healthy decisions" about their "bodies, sexuality and reproduction for themselves, their families and their communities" in all areas of their lives. (Ross, 2006:1-7). Reproductive Justice is grounded on the understanding that the effects of race, class, gender and sexual identity oppressions are not additive but rather integrative, producing this paradigm of intersectionality (Ross, 2006). This study notes that the Reproductive Justice framework can also be applied to South African context as it can address the intersectionality of problems experienced by so many women who have been previously marginalised in South Africa.

This sentiment is supported by Minister of Social Develop, Bathabile Dlamini, in a speech in which she spoke about women's reproductive rights in South Africa and the need to urgently address the combined issues facing the most marginalised and poor women:

> "*Within the framework of reproductive justice, the ANC and the ANC government has always been and will always be pro-abortion in the sense that we realise that it is but one of the reproductive experiences of women that needs*

to be enabled. We are also concerned about improving other elements of women's reproductive experiences such as improving women's economic and educational statuses, we are concerned about whether women are in violent or abusive situations, whether their children have access to nutritious food, housing, clothing and other social protection services" (Dlamini, 2014).

We can therefore see that the Reproductive Justice framework can also be applied to South African context as the most marginalised and poor women are faced with similar issues that are intertwined and that need to be addressed together for women to truly be able to have full autonomy and choice over their reproductive lives.

1.7 Thesis Outline

This thesis tackles the difficult but often overlooked role of civil society groups such as campaign activists and NGOs in addressing the access issue faced by the most marginalised and vulnerable women in South Africa. Chapter one addresses the background for carrying out this particular study; Chapter Two outlines a review of the literature that is most relevant to the study; Chapter Three provides the research design and methodological approach for the study. These provide details of how the study will be carried out as well as some important ethical considerations when engaging with respondents. Chapter Four deals with the analysis and presentation of the data collected from fieldwork, and finally Chapter Five provides a conclusion of the entire study.

1.8 Conclusion

This chapter provided a basic outline of what the study entails, along with its objectives and the type of research design to be used. The purpose and significance of the study were also discussed. The population of the study and how these would be reached were briefly mentioned. I proceeded to discuss the theoretical framework that will be used and explained how it relates to the objective of the study. Lastly, I provided a brief overview of each chapter.

The following chapter provides a detailed review of the literature dealing with the reproductive rights access issue in South Africa, while at the same time making a case for the importance of the role played by civil society groups such as campaign activists and NGOs on the issue.

CHAPTER TWO

A REVIEW OF THE LITERATURE: THE ROLE OF CIVIL SOCIETY AROUND THE ACCESS ISSUE

2.1 Background

Reproductive rights and access to reproductive health services has long been a contested issue within the medical, religious, academic and political fields (Albertyn, 2015; Stevens, 2011; Griffin 2006; Klugman, 2011; Reagan, 1997; Labuschagne, 2013; Klausen, 2015). Many countries throughout the world have yet to implement reproductive rights for women. South Africa remains as one of the few examples of nations that have successfully implemented formal reproductive rights in its Constitution for all women irrespective of race, age and socioeconomic status. As a result, many have come to praise South Africa's efforts at rethinking and improving women's position in society as an integral part of democratic development, especially with regards to their reproductive lives. In the year 1996 the South African government passed the CTOP Act. Since then many have considered the CTOP Act as one of the most liberal in the world (Lomelin, 2014; Davis, 2013; Hoffman *et al.*, 2006). Hodes (2016:80) makes a compelling argument when she states "while South Africa's abortion laws have undergone profound changes, the practice of illegal abortion remains largely impervious to regulation" and that "over the course of decades, illegal abortion has, like pre-marital sex, been publicly condemned in South Africa. But it has been privately countenanced, so long as it is practised in ways that uphold the norms of secrecy and concealment". As Hodes (2016) certainly makes clear - while South African abortion laws are amongst the most liberal in the world, in practice abortion is condemned by religious groups, strict cultural beliefs and other pro-life supporters as though it were an illegal act. There is clearly a big gap between what the law allows regarding women's reproductive

rights and how those rights are practised (Griffin, 2006; Stevens, 2011; Davis, 2016; Harries *et al.*, 2016; Klausen, 2015; Heard 2016, Althaus 2000).

With this existing problem facing South African society at large, there must be alternative channels where individuals or groups seek to address and alleviate the issue of reproductive rights and access. One need not look far when considering how civil society often collectively respond to situations they feel has direct or indirect impact on them or society in general (Camay & Gordon, 2002). Civil society, often consisting of advocates of social justice and social change and non-governmental organisations (NGO's) are generally at the forefront of sparking interest and calling for support from communities regarding matters that affect society (Klugman, 2011; WHO, 2001). Lobbyists, for instance, are known for their habit of making use of several forms of advocacy to influence public opinion and policy (Albertyn, 2015, WHO. 2001). Lobbyists and NGO's have long played significant roles in addressing social justice issues affecting human rights all around the world. This has been particularly true in recent years with various NGO's, activists and advocacy groups fighting for women's reproductive rights on a global scale. Two prominent example include the International Conference on Population and Development (ICPD) in Cairo in 1994 and the United Nations Convention on the Elimination of Discrimination against Women (CEDAW) adopted in 1979 by the UN General Assembly. The ICPD and CEDAW are some examples of what influenced women's health and human rights activists to advocate for and achieve a legal right to terminate, women's bodily and psychological integrity and autonomy etc. (Griffin, 2011; Klugman, 2011; Rebouche, 2011).

In transitioning into the new democracy, South African civil society organisations played a significant role in securing women their reproductive freedom, the rights to bodily and psychological integrity and bodily autonomy to be formally realized in the final Constitution of 1996. This was largely possible due to "enabling political conditions, a positive global and national constitutional framework, committed support by key members of government and the ruling party" as well as effective activism from a small but well-organised ally of civil society groups (Albertyn, 2015:435; Klugman, 2011:150). The significant role of civil society's involvement in human rights matters such as reproductive rights cannot be stressed enough (Albertyn, 2015; Klugman, 2011). This is especially the case where there is a fight against restrictions placed on women to responsibly enjoy their human rights such as reproductive freedom and other reproductive health rights.

Therefore, having recognised the importance of civil society groups such as lobbyists and NGOs, it is this study's objective to interrogate those who are, or previously have been, directly involved in reproductive rights advocacy on how they address the perceived gap between reproductive rights and access.

2.1.1 The historical context of reproductive rights advocacy in South Africa

Partly what lends importance to my contemporary study on the political participation of abortion campaigners is that the history of South Africa shows not only the exclusion of black women, but also the related exclusion of reproductive justice activists from the conception of abortion rights (Klausen, 2015; Klugman, 2011). Very little is known about reproductive rights advocacy in South Africa prior to the transition into democracy. This is because during the apartheid era South Africans were faced with many restrictive laws and were barely allowed any freedoms of expression (Klausen, 2015). Moreover, during apartheid reproductive (particularly abortion) rights were very strict and less favourable for Black women (including Coloureds and Indians) since there were laws that fostered segregation between the different races (Mhlanga, 2003; Guttmacher *et al*, 1998). Furthermore, during this era there were very few South Africans who were brave enough to publically demand accessible medical abortion services for all women due to the racist policies of the ruling government of that time (Klausen, 2015). There were, however, very few individuals such as those considering themselves feminists and some doctors who publically called for accessible medical abortion services for all women. However, as a result of the political climate back then, coupled with the fact that the feminist group (known as the Abortion Reform Action Group or ARAG) consisted only of white middle-class women, these few activists failed at attracting widespread support (Klausen, 2015:93).

This failure was due to two factors. First, this white feminist group was considered too radical to attract other white women for support and secondly, they were too middle-class to attract other women of colour who were facing a combination of pressing issues as a result of apartheid's unjust policies (Klausen, 2015;) Therefore, the attempt to reform abortion law at that time proved ineffective because of the hostile attitude of government towards abortion in general, and to passing liberal abortion policies for all women. Another factor according to Albertyn (2015:433) is that most women were predominantly concerned with fighting against the system of apartheid so much that gender issues were not an immediate priority at the time. Furthermore, during the struggle against apartheid the topic of abortion was regarded as

controversial and 'divisive' hence there was little engagement with it (Albertyn, 2015; Klausen, 2015; Klugman, 2011).

Fortunately, however, this, changed in the early 1990s when South Africa started transitioning into a new democracy. Political negotiations for a democratic South Africa allowed for discussions relating to sexual reproductive health rights for women and gender equality to be considered while drafting the new democratic constitution (Albertyn, 2015; Klugman, 2011; Rebouche, 2011). Such discussions were largely possible as a result of collective engagement by advocates from women's rights and civil rights groups, key figures within the ANC, feminist political advocates, public health experts, lawyers and ordinary women who realized the need for reproductive freedom in a new democratic South Africa (Albertyn, 2015; Rebouche, 2011, Klugman, 2011, Klausen, 2015; Hodes, 2016). Thus, a strong alliance was formed among lobbyists in the fight for women's emancipation, reproductive freedom and gender equality. One of the most notable interest group during this period was the Reproductive Rights Alliance (RRA). The RRA was a combination of thirty organisations started in 1995 to lobby for 'acceptable, accessible, affordable, cost-effective and user-friendly termination of pregnancy services for women … integrated into comprehensive health services' (Hodes, 2016:85; Cooper *et al* 2004:76).

Although significant changes in the Constitution over the years promised a positive future for all South Africans, the mere implementation of the CTOP Act to formally allow women reproductive freedom was not sufficient on its own. As various studies have shown, this is partly because the CTOP Act failed in its effectiveness to fully afford women the reproductive freedom and ease of access to the reproductive healthcare they need (Osman and Thompson, 2012; Harries *et al*., 2009; Guttmacher *et al*, 1998; Lomelin, 2014; Davis, 2013; Mosley *et al.*, 2016; Hodes 2016).

Various organisations such as the Reproductive Rights Alliance, Planned Parenthood of South Africa, the Progressive Primary Health Care Network and The Women's Health Project were in full support of the ANC government's decision to respond to the reproductive health needs of women by legalising abortion and making it more accessible (Guttmacher *et al*, 1998; Klugman, 2011; Hodes, 2016; Albertyn, 2015). These various organisations played their part in securing reproductive rights for women through engaging in public hearings, campaigns, research, involvement in court proceedings and the drafting of reproductive rights and abortion policies etc. (Albertyn, 2015; Rebouche, 2011). After the government

successfully passed and enacted the new liberal abortion Act known as the CTOP Act of 1996, this was regarded as a success for those who have long yearned for a liberal abortion legislation (Mhlanga, 2003; Hodes, 2016).

However, this 'success' would not go unchallenged. Those who aligned themselves with the pro-life movement and others who were generally discontent with provisions of the Act formally challenged the Act in court. Fortunately, claims against the CTOP Act were unsuccessful. This formal challenge against the CTOP Act is discussed under sub-section 2.4.3. *Religion and morals*. Part of this triumph for the pro-choice movement can be attributed to the support of various interest groups (such as the RRA) who were actively involved in these legal cases and helped keep the liberal abortion law of 1996 in place (Klugman, 2011). Sadly, in recent years some of these major organisations have closed shop and stopped operations. Some authors make the claim that this can be attributed to these organisations feeling that the CTOP Act was a success and that the mission for liberal sexual and reproductive health rights was complete (Klugman, 2011; Klugman & Mokoetle, 2010; Albertyn, 2015). In some cases some of these organisations lost funding and other means of support to stay in existence (Klugman, 2011; Klugman & Mokoetle, 2010; Albertyn, 2015). There are however some recently established organisations that also continue the fight to strengthen women's reproductive rights through campaigns, research and other means (Klugman & Mokoetle, 2010).

2.1.2 The importance of public participation in the promotion of rights

This sub-section attempts to show that civil society groups, through NGOs, and lobbyists, can play a critical role in holding local municipalities, government and legislators accountable for failures of policies that were implemented and which civil society does not benefit from, and ultimately demand the right to public participation where this is not effectively allowed (Albertyn. 2015; Klugman, 2011; Klugman & Mokoetle, 2010).

In South Africa, public-participation is a relatively new phenomenon. This is because the previous apartheid government passed segregation policies that would ensure that different races have very limited power to challenge the decisions of government (Nyalunga, 2006). In addition, these racist and exclusionary policies were in place to facilitate and regulate the suppression of participation by non-white communities (Nyalunga, 2006). Houston *et al* (2001) define public participation as 'participation in various political behaviours which the public can legally enact. These acts range from undemanding activities such as seeking

information and being interested in politics, discussing politics and voting to more demanding forms of participation such as attending public hearings, contacting politicians and campaigning for a political organisation'. From this definition we see that civil society organisations have the freedom to engage in these various platforms on behalf of their fellow community members to address their needs, hold government accountable and demand good governance and quality service delivery.

Having learned from lessons of the past, the new democratic government and its leaders realised the need to change how the state interacts with its citizens. Adopting the principles of *Batho Pele* (People First) and public-participation, state leaders recognised that it is important to allow those who would be affected by a decision to be part of the decision-making process (Mosadi, 2004; Rowe & Frewer, 2005). The *Batho Pele* approach is aimed at getting public servants committed to serving people and to find ways to improve service delivery and be held accountable by civil society (Mosadi, 2004; Khosa, 2011). Nyaluma (2006) thus asserts that the new government regards public-participation as a cornerstone of democracy.

Thus, public-participation is often regarded as a way of empowering communities (Czapinskiy & Manjoo, 2008; Nyalunga, 2006). Ackerman's (2004:448) holds that 'the opening up of the core activities of the state to societal participation is one of the most effective ways to improve accountability and governance'. Although the principle of public-participation is a celebrated one in South Africa, Friedman (2003; 2004) argues that the new democratic era has only rid South Africans from the rule of a small minority of a racist white government. Friedman (2004) goes on to argue that the democratic constitution order has not been very effective in affording South African citizens participation in government decisions. What we can take away from Friedman's analysis is that although South Africa has implemented progressive, democratic policies to ensure a better future for the new South Africa, in reality government is still struggling to provide effective implementation of such policies. Therefore, not all of civil society is experiencing the empowering sentiment of being involved in the decision-making process that would affect their lives. The importance of inviting public-participation for legislative matters is well-captured by Czapinskiy & Manjoo (2008:3-4) when they assert that "*…in the interest of promoting human rights and democracy, the legislative duty to facilitate participation is an important one*".

Activists and NGO role-players are known to stir awareness and influence in the political arena such as encouraging changes in legislation or influencing governments to be more

accountable and transparent to citizens regarding politics and other decision-making processes (Albertyn, 2015; Klugman, 2011; Klugman & Mokoetle, 2010; Czapanskiy & Manjoo, 2008; Camay & Gordon, 2002).With public-participation being a human right in democratic South Africa, civil society organisations play a critical role when it comes to participation (Nyalunga, 2006). Civil society's participation in the democratic process of decision-making remains an important one because of their ability to hold local municipalities and government accountable to its citizens (Friedman, 2004). Close involvement by civil society groups can also lead to government being more transparent. Civil society has been an effective advocate of social change and has led to improved governance before and after the democratic transition (Camay & Gordon, 2002). However, with Friedman's (2004) contention that the State has not been very effective in affording South African citizens participation in government decisions, this clearly remains an issue demanding attention and action.

One way of achieving this and allowing South African citizens to enjoy their right to public participation in matters that affect them such as, for example, ease of access to reproductive health services is for civil society groups such as lobbyists and NGOs to strengthen their objectives or plans of action to holding local municipalities and governments more accountable. This is possible when considering that advocacy groups and NGOs generally garner plenty support through donor funding and expertise when their objectives are strong and are aimed at improving human rights and civil society's living conditions (Klugman & Mokoetle, 2010; Nyalunga, 2006). Another important factor adding to this possibility is that, unlike in non-democratic States, South African civil society has the advantage of a largely enabling legal, political and institutional environment (Camay & Gordon, 2002). The one limitation of this, however, is the issue of resource-scarcity - where the State may not be able to cater for all the demands of civil society at once (Camay & Gordon, 2002).

Similar to Friedman (2004), I argue that comparisons with the past can evoke only limited celebration since massive implementation issues hampers the progressive status of the CTOP Act. For example, nearly half of pregnant women in South Africa still opt for illegal abortion services due to a variety of barriers to safe and free reproductive services despite liberal laws (Hodes, 2016; Lomelin, 2014; HEARD, 2016). This statistic is a staggering indictment of the reality of women's (reproductive) rights in South Africa.

The issue of the lack of access to reproductive health services as afforded by the South African Constitution is a serious social matter that needs to be addressed with a sense of urgency because it presents many serious social, economic and political implications. There is a long history of women being marginalised and mistreated in various spheres of life and this is largely attributed to the system of patriarchy (Butler, 1999). Furthermore, patriarchal ideologies have ensured that women's freedom of choice and reproductive rights are not considered in society and this, according to Butler (1999) presents a social issue and as Mhlanga (2003) captures it, a 'human rights' issue. Moreover, Mhlanga (2003:124) highlights that "women's rights are human rights" and with this contention, it is of utmost importance to make sure women's rights are realized in our society (Pickles, 2012). Therefore, there appears to be a disjuncture between the law and access to the services provided by the CTOP Act for women. Hence, the need for increased activism and involvement by various lobby groups and NGO role-players.

2.1.3 The everyday realities of limited access

Through the Constitution, the CTOP Act gives effect to various constitutional rights for women that can be grouped together as 'female reproductive rights' and these include the rights to life, privacy, bodily and psychological integrity, dignity, equality, access to information and healthcare and pregnant minors' rights (O'Sullivan, 2011). Furthermore, these rights are acknowledged as key elements in the promotion of reproductive rights. We therefore see what Mhlanga (2003:124) has asserted resonates well with the Constitutional rights afforded to all humans in that, reproductive health rights afforded to women through the CTOP Act are to be acknowledged and respected as no different or less than other important human rights enshrined in the South African Constitution. In 2011, the Human Rights Watch published a report that focused on the public health care system in the Eastern Cape. This report details the gruesome experiences faced by women when seeking health care at various EC public health facilities. Some women have expressed that they are verbally and physically abused and often turned away while in labour and without any examination or advice (Hodes, 2016; Mapumulo, 2015; Human Rights Watch, 2011). Nurses would ignore women asking for assistance and accuse them of faking being in labour. Where some patients are lucky to be attended to they would often face mistreatment such as having to make their own beds or left unattended for several hours after having given birth and without being given sound advice regarding issues that are important to their obstetric care (Human Rights

Watch, 2011). This delayed and intentional neglect of maternity patients often leads to serious health dangers to both mother and foetus (in some cases, live infants) and sometimes lead to maternal and infant mortality when these could have been easily prevented (Mapumulo, 2015; Gaede & Versteeg, 2011; De Waal, 2012). This is more an issue of a lack of governmental accountability rather than the South African legal framework failing to attend to and address the reproductive rights of women (Human Rights Watch, 2011; Gaede & Versteeg, 2011; Mapumulo, 2015).

While the Human Rights Watch (2011) report acknowledges that "failures in health system accountability affect *all* patients" it makes it clear that its focus specifically pertains to the "experiences of patients seeking maternity care" since the improvement of maternal health care is "a top priority for the national and Eastern Cape governments". Important to note from this report is its finding that government has failed to address recurrent health system failures that largely contribute to poor maternal health outcomes and furthermore, that government is "failing to provide oversight and accountability to ensure implementation of existing reproductive and sexual health-related laws and policies that could greatly improve maternal health care and overcome abuses" that are documented in the report and other texts (De Waal, 2012; Mapumulo, 2015; Gaede & Versteeg, 2011). Human Rights Watch (2011) has appealed to national and Eastern Cape governments in South Africa to "take immediate steps to strengthen health system accountability to ensure that women have access to the healthcare they need." The report also provides comprehensive recommendations to improve the services needed by women for good reproductive health care.

The Human Rights Watch (2011) report is a good example of how non-profit NGOs and activists are able to exert influence and direct attention to the various atrocities women continue facing today despite liberal reproductive legislation. Concerned with justice and human rights issues, the Human Rights Watch (2011) worked closely with other local, national and international organisations, United Nations agencies, experts, other civil society groups while also reviewing laws, policies, official health strategies, and reports by academics and researchers. This was done with the objective of investigating setbacks in women fully enjoying the benefits of their reproductive health rights and to come up with strategies and recommendations that would hold those accountable for these setbacks. Those held accountable would then have to consider these recommendations or adapt such recommendations in a pragmatic manner that would change the mistreatment of women at

maternity wards and other healthcare facilities when attempting to access reproductive health services so that all women can fully enjoy their human rights and reproductive freedom.

In a previous study I researched social perceptions on abortion where I interrogated how abortion is viewed and what reasons people gave in support of, and against, abortion matters including people's knowledge of South African abortion law (Jacobs, 2015). Results revealed that the majority of respondents were against abortion based on moral reasoning, but were accepting of it in extreme cases such as rape, incest and socio-economic reasons. Another factor that stood out was that most respondents were not certain about the status of abortion and very few knew about the CTOP Act. Those who knew of the Act were not fully familiar with some of the most important conditions of the Act such as up to how long pregnancies can be terminated and what age groups are allowed to access abortion services. The results were very alarming as it speaks to the general assumptions as cited in various studies regarding the lack of knowledge about women's reproductive rights and stigma based on false information that was learned within their communities(Stevens, 2011; Osman and Thompson, 2012; Hodes, 2016; Griffin, 2006; Althaus, 2000; Harries *et al.*, 2009; Mosley *et al.,* 2016) . The conclusions derived from the research basically leaned towards the need for increased awareness and educational programmes and campaigns that would help correct people's ill-informed beliefs regarding abortion and other reproductive rights. This needs urgent attention as those women who face various barriers to safe reproductive healthcare facilities tend to seek illegal abortion providers out of desperation while sometimes unknowingly putting their own lives in severe danger.

The disjunction between law and access to reproductive health services is a longstanding and unresolved issue, and due to it being unresolved I came to the conclusion that it requires further insight. There are many responses from various stakeholders and role-players on the unresolved question of abortion in society. Civil society widely defined as "a wide array of non-governmental and not-for-profit-organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations" has played an especially important role in how abortion is constructed in the public mind as both a choice, as right and as political controversy (World Bank, 2010). Activists and NGOS, through campaigns, projects and other channels that involve civil society, can thus help reduce the gap between law and access to reproductive health services by comprehensively tackling those factors such as, for example, ill-perceptions of women's reproductive rights, social stigma against

abortion, negative provider attitudes against young women seeking abortion etc. This could be done alongside the goal of seeking social and financial support to increase resources that can aid those most in need but who, due to distance and other limitations, are unable to have quick access to emergency contraceptives (Althaus, 2000).

Based on other conclusions that stemmed from my previous study I decided to focus the current research on engaging with activists who have been, or are currently, involved in campaigns that address the major issues around women's reproductive rights such as barriers, issues of justice and inequality, power dynamics, illegal abortions and potential solutions to these issues, among others. In most societies it is generally considered taboo to speak about these issues although most of these have implications for the rest of society. It is for this reason that it is imperative to look closely at campaigns that publically highlight these matters and shed light on issues that most people are often sceptical to discuss. I therefore hope to capture the unique insights of those individuals who are directly involved in running campaigns that deal with the above-mentioned issues since they are regularly involved in the politics of access.

2.2 Women's Reproductive Lives *During* and *After* Apartheid

Klausen's (2015) *Abortion under Apartheid* provides a rich, well-researched text that can help broaden the understanding of reproductive politics in South Africa. It provides a picture of how abortion rights were historically regulated in such a way as to maintain white power and the class ideologies of the apartheid era. Therefore, Klausen's (2015) work provides the current study with a backdrop to the historical context of abortion politics that led the new incoming party to start discussions around turning over a new leaf with transition to democracy in 1994.

Prior to the CTOP Act as we know it today, South African abortion law was ruled by the Abortion and Sterilization Act of 1975. And before the 1975 Act, abortion law in South Africa was governed by Roman-Dutch common law under which the right to abortion was *only* extended in situations where the mother's life would be threatened by the continuation of a pregnancy. Other than that, abortion was considered a common law crime (McGill, 2006:197; Hodes, 2016:81). According to McGill (2006:200) in terms of case law, it remains unclear as to why exactly abortion was considered a punishable crime at that time. That is, whether it was to 'protect women from dangerous practices, or to protect unborn children

from death'. McGill (2006:200) then posits that, at the time, South Africa did not apply itself to question the criminalisation of abortion but rather just applied its inherited common law as is. We see, therefore, that during this period women were severely oppressed as they were completely denied choice and autonomy over their own bodies and reproductive lives (Mhlanga, 2003: 116).

As a result of increasing numbers in maternal deaths and maternal morbidity in all races, the National Party (ruling government at that time) introduced the Abortion and Sterilization Act of 1975. The conditions under this new Act in which legal abortions could be obtained included the following: when the continued pregnancy endangered the woman's life; when the continued pregnancy constituted a serious threat to the woman's physical or mental health; when there was a serious risk that the child to be born would suffer from a physical or mental defect of such a nature as to be irreparably seriously handicapped; and when the pregnancy was the result of unlawful intercourse such as rape (had to be documented) or incest (The Abortion and Sterilization Act, 1975). Furthermore, under this Act, in order for any woman to be allowed to have an abortion procedure three doctors had to first agree that the woman indeed needed a legal abortion (McGill, 2006:201; Mhlanga, 2003:116; Guttmacher *et al.*, 1998).

Again, we see that women continued to have limited say in a matter that would affect their lives directly. In the past women were not able to consider legal abortion as an option even when confronted by circumstances outside of their individual control, such as poverty. Moreover, such restrictive laws would ultimately affect some women's desire for life and other future plans they might have had. For example, some women who fell pregnant unintentionally while studying or looking for employment opportunities would be affected by being forced by circumstances to carry the unwanted pregnancy to term. This would especially be the case in instances where such women do not have the financial means to obtain safe abortion elsewhere or are unaware of alternative options such as giving the baby up for adoption etc. In addition, this situation would be worsened where women receive no form of support from the partner or other parties. As some studies have shown, some women were affected more than others on the basis of race and class under these restrictive laws during the apartheid era (Klausen, 2015; Althaus, 2000; Hodes, 2016). For example, as a result of the strict conditions of the Abortion and Sterilization Act it was generally middle- or upper-class women from well-resourced areas who were able to make use of the Act. When they needed abortions for other reasons than what the Act stipulated, they would fly overseas

to obtain abortions. Unfortunately, however, less-privileged women would have no other choice but to make use of 'traditional methods', resort to illegal abortions out of desperation or carry the unwanted pregnancy to term (Klausen: 2015; Mhlanga; 2003:116; Stevens; 2011; Althaus; 2000:84; Davis, 2013). It is important to trace the historical impact from past to present of class and race inequality on women's capacity to access the option of abortion.

When the African National Congress (ANC) came into government at the end of apartheid, having been influenced by various groups who lobbied for women's liberation rights, equity and the legalisation of abortion as a result of the many dangers presented by illegal, clandestine abortions, they passed the COTP Act in 1996 (Mhlanga, 2003:117; Osman and Thompson, 2012; Klausen, 2015). The struggle of these various groups finally paid off, leading sexual and reproductive rights to form part of the final Constitution of 1996. Then on 1 February, the CTOP Act came into effect. The new law on abortion promotes reproductive rights and extends freedom of choice by allowing every woman the right to choose whether to have a safe and legal termination of pregnancy according to her own individual beliefs (CTOP Act, 1996). One of the major differences between the CTOP Act and those before it lies in the fact that, now, women are able to demand a safe and legal abortion for *any* reason during the first twelve weeks of pregnancy (own emphasis; Choice on Termination of Pregnancy Act, 1996). From the thirteenth to the twentieth week of pregnancy, an abortion may be performed only in extreme circumstances due to health risks. After the twentieth week of pregnancy, an abortion may be performed if two medical practitioners or one medical practitioner and a midwife are of the opinion that the continued pregnancy would endanger the woman's life, and would result in severe malformation of the foetus or would pose a risk of injury to the foetus (Choice on Termination of Pregnancy Act, 1996).

In terms of women's empowerment, many have come to consider the implementation of the CTOP Act as a great step forward for allowing women to finally have autonomy over their own bodies and reproductive lives (Hodes, 2016; Mhlanga, 2003; Althaus, 2000; Lomelin, 2014). We can therefore agree that the exclusionary and often harsh reality of the past has changed in significant, constitutional ways. However, illegal abortions continue to be a profound issue prevalent throughout South Africa. There are various reasons for most women continuing to opt for illegal abortions in South Africa and various parts of the world. The following section takes a specific look at the South African context regarding the dilemma of illegal abortion.

2.3 The Scourge of Illegal Abortions in South Africa and the Promise of Campaign Work

2.3.1 The Harmful Effects of Illegal Abortions

According to the World Health Organisation (WHO, 2003:12) unsafe abortion or illegal abortion is defined as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both".

As previously mentioned clandestine abortions that, more often than not, result in serious health complications, are a major problem in South Africa (Althaus, 2000; Mhlanga, 2003; Osman and Thompson, 2012; Klausen, 2015; HEARD, 2016). One of the most serious of these complications include high maternal deaths, especially among teenagers. Often these are women who are not aware of the law, suffer financial constraints or who fear stigmatisation from healthcare workers and the community (Klausen, 2015; Hodes, 2016; Guttmacher et al., 1998; Mhlanga, 2003). Complications arising from illegal and unqualified abortionists all too often end up in women having to be admitted to, and treated at, public health care facilities (Osman and Thompson, 2012; Hodes, 2016; Harries *et al* 2009). Speaking on the complications presented from the strict abortion laws under the apartheid era, Hodes (2016:82) notes that "Treating the harmful effects of illegal abortion consumed scarce human and health resources in emergency and gynaecology wards throughout the South African health sector". Although Hodes' comment addresses an issue from a few decades back, the exact same problem is relevant today two decades after implementation of the Choice Act. This is so because due to various barriers (to be discussed in the following section) to safe and free access to reproductive health services at public health facilities, many women still opt for illegal abortion providers. As a result of unsafe abortion practices, most women tend to suffer from serious illness and other health complications which illegal abortionists refuse to treat and are generally unable to do so since they lack the necessary medical equipment and medicines (John, 2015; Lomelin, 2014). Abortions which do not follow medical procedure have often led to the deaths of many women. According to the Department of Health's *2011-2013 Confidential Enquiries into Maternal Deaths in South Africa* there were 4 867 maternal deaths recorded between the years of 2008-2010. Out of these, 186 women died of septic miscarriage in public healthcare facilities and 23% or the death of 1119 women were the direct result of unsafe and illegal abortions (NCCEMD, 2012). It is important to highlight that the number of maternal deaths caused by unsafe

abortions are most likely far higher than what has been recorded since the NCCEMD (2012) report only took into account those cases that were officially recorded at public health facilities.

Despite the legality of abortion at public healthcare facilities, access remains a significant issue. The dilemma arises in that access to legal, safe abortion is difficult to obtain due to resource constraints as well as social stigmatisation whereas access to unsafe, illegal abortion providers is comparably easier, cheaper and arguably more discrete (Hodes, 2016; John, 2015; Masinga, 2016). The ease of access to unsafe abortion in South Africa is manifest in the abundance and style of its advertising (Nkwashu, 2013; Masinga, 2016, Hodes, 2016). These illegal providers generally take advantage of women's lack of knowledge regarding South Africa's abortion laws. In cases where some women are aware of the legal status of abortion, illegal providers prey on their vulnerability and fear of stigma and discrimination at public health facilities. Due to some of these factors illegal abortionists use colourful advertising with captions such as "100% pain-free, affordable/cheap, quick/same-day abortions".

DAILY SUN

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'Nothing to say' about Madiba's condition

By SIMONE HERADIEN

THE presidency could not give the people of Mzansi any new information about Madiba's condition yesterday afternoon.

"There is nothing to say," said spokesman Mac Maharaj.

He said the Presidency was waiting for an update on the condition of former President Nelson Mandela.

The 94-year-old former struggle icon and Mzansi's first democratic president was admitted to a hospital in Tshwane in the early hours of Saturday morning.

Later that day, Maharaj described his condition as serious but stable.

"During the past few days Madiba has had a recurrence of a lung infection.

"This morning at about 1.30am his condition deteriorated and he was transferred to a Pretoria hospital.

"He remains in a serious but stable condition," Maharaj said.

"The former president is receiving expert medical care and doctors are doing everything possible to make him better and comfortable," it added.

The statement also said that President Jacob Zuma, on behalf of government and the nation, wished Madiba a speedy recovery.

Zuma also requested that the media and the public respect the privacy of Madiba and his family.

Mandela's lung problems stem from his time spent working in the quarries on Robben Island, where he developed tuberculosis in 1988.

His increasingly frequent hospital visits have left Mzansi fearing the worst.

On 6 April this year he was discharged from hospital after spending nine days receiving treatment for his lung problems.

In March this year he was admitted to hospital for a scheduled check-up and was discharged the following day.

In December last year he underwent

CONTINUED ON PAGE 2

GRIM . . . The dirty apartment that was used to perform illegal abortions. RIGHT: The bogus doctor's 'official' certificate. *Photos by Yuri Madonsela*

Bogus doctor bust giving pills to heavily pregnant teen!

Certificate

HOUSE OF ABORTION HORROR!

OFF TO JAIL . . . The bogus doctor (right) and his assistant are cuffed by Soweto cops.

By GLACIER NKHWASHU

COPS came into the flat and found a filthy room equipped for the bogus doctor to perform illegal procedures.

But the desperate 19-year-old girl never got to swallow the killer pills to abort her five-month old foetus.

THE MAN AND HIS ASSISTANT WERE TAKEN AWAY IN THE BACK OF A COP VAN!

It was a race against time for Jabulani cops in Soweto when the girl's boyfriend arrived at the cop shop.

He knew that his girlfriend had gone to the man's Jabulani flat to kill the five-month-old foetus inside her.

The 29-year-old so-called "doctor" from Uganda was bust on the spot in the room.

CONTINUED ON PAGE 2

PASTOR DANIEL KEEPS EVIL SPIRITS OFF THE SCENE – TURN TO P13!

Figure 1. The *Daily Sun* newspaper front page on 10 June 2013.

Figure 2. Lamp-post adverts of illegal backstreet abortion in the streets of Johannesburg.

Figure 3. Placards used during a campaign to fight against illegal backstreet abortions.

Figure 1 (*Daily Sun*, 10 June 2013) depicts the room in which a bogus doctor and his assistant perform an illegal abortion under unhealthy and filthy circumstances (Nkhwashu, 2013). On the same front-page, another picture illustrates the fake medical certificate that the illegal provider uses to convince desperate patients that he is 'qualified', another image shows the two men being arrested by cops and taken away to jail (Nkhwashu, 2013). According to the article, police were able to track down and arrest the fake provider and his assistant with help from a would-be client's boyfriend who reported to cops that his girlfriend went for an illegal abortion service and reported the bogus doctor (Nkhwashu, 2013). *Figure 2* shows the type of advertising backstreet abortionists are known for, that is, lamp-post

advertising. This type of advertising is used nearly everywhere to prey on the desperation of women seeking immediate and secret abortions at the expense of endangering their reproductive health and lives (Lomelin, 2014; John, 2015). *Figure 3* portrays activists and NGOs using campaigns with the aid of placards and rallies to garner support from other civil society groups to call for action against illegal abortion providers.

Lobby groups and NGOs who dedicate themselves to engaging in campaign work for society in addressing and fighting the widespread issue of illegal abortion play a role so significant that it can never be overstated (Albertyn, 2015; Klugman, 2011). What previous and current campaigners have done in relation to the plight of illegal abortion in South Africa is not, and cannot be, a once-off engagement. On the contrary, there is rather a need for continuous, committed, combined and long-lasting efforts at dealing with the issue of illegal abortion in South Africa. In recent years, however, some authors have pointed out that advocacy has become weaker on sexual reproductive health rights issues, including the fight against illegal abortion. It has been pointed out that this has largely been due to competition and conflict among organisations (Klugman & Mokoetle, 2010; Klugman, 2011; Albertyn, 2015).

It is critical, therefore, for advocacy groups and NGOs to combine efforts and reach out to other organisations to form coalitions as did the Reproductive Rights Alliance in the early and mid-2000s when they were very successful in influencing positive legislature and social change Mokoetle, 2010; Centre for Reproductive Rights, 2003) . Part of the success of the RRA was as result of it being a coalition of thirty organisations who worked towards achieving common goals and shared expertise, funding and the demanding workload among their members (Albertyn, 2015; Klugman, 2011). Nonetheless, current attempts by existing campaigns, advocates and NGOs on the issue of illegal abortion present a port of hope for democratic South Africa and its most vulnerable women who have to face the disturbing health risks accompanied by the shocking ease of access to illegal abortion providers.

Distressed women of all age groups generally prefer privacy and confidentiality in circumstances of being victims of unwanted pregnancies and public healthcare facilities are not well-known for privacy and confidentiality since many patients wait in long lines in public waiting rooms, coupled with the fact that patients' personal information has to be recorded (Hodes, 2016; Harries *et al*, 2009). Unfortunately, however, illegal providers easily offer privacy and confidentiality based on the nature of their business (being illegal). Moreover, these pamphlets advertising illegal abortions can be seen on almost every other

lamppost in towns, cities, at taxi ranks, at educational facilities, nearly everywhere where people are dwelling (Masinga, 2016; John, 2015, Osman and Thompson 2012; Davis,2013). It is clear that these illegal abortion providers are only in the business to exploit the access issue for financial gain, with no care whatsoever of the vulnerable women's health (Osman and Thompson, 2012). This is an alarming issue as we must account for all of those women who see the access issue as so insurmountable that they would rather fall victim to potential health dangers then be subjected to the difficulties involved in accessing their legal right to abortion.

2.3.2 The importance of campaign work

Various campaign groups, activists and NGOs need to work together and come up with an effective plan that can hold those who are involved in, or aid in, creating and distributing illegal abortion flyers, responsible for their actions and be given a fitting punishment. Reproductive rights activists and NGOs concerned with public health and women's rights issues are generally against illegal abortion advertising because of the seriousness of health risks unqualified abortionists are known for (Osman & Thompson, 2012). Many illegal abortion providers have no care or consideration for the vulnerable women seeking immediate abortion and thus use illegal abortion advertising as a means to get quick, desperate money (Hodes, 2016; Osman & Thompson, 2012). In addition, little is known about what the State, advertising authorities and South African Police Services (SAPS) are doing to stop illegal abortion advertising and apprehending illegal, unqualified abortionists who put the lives of desperate and vulnerable women in jeopardy on a daily basis (Osman & Thompson, 2012.

This has long been a target for campaigners and NGOs. However, without sufficient support from the public to report illegal provision of abortion and State intervention this remains a major problem throughout South Africa. Ironically, with little known intervention from the State, the complications from incomplete illegal abortion procedures end up at public healthcare facilities where the State has to use its already limited resources to help save women's health and lives from septic abortions etc. (HEARD, 2016; Hodes, 2016). This has further consequences on the rest of the community members who present to public healthcare facilities for various healthcare needs but who have to wait in long queues for attendance (HEARD, 2016; Hodes, 2016). This is partly due to the high number of women being treated

for emergencies resulting from septic abortions and other health complications from unsafe, illegal abortions (Mhlanga, 2003; Hodes, 2016).

Therefore, these issues speak to the need for increased public-participation from civil society to collectively fight against illegal abortion advertising and practices. Since illegal abortion practice in a democratic country like South Africa can negatively impact almost entire communities, it is of utmost importance for the fight against illegal abortion providers to be one of the top priorities on lobbyists, NGOs and local government's agendas (Hodes, 2016; Osman & Thompson, 2012, HEARD, 2016).

One such example is from the Kwazulu-Natal province where an anti-illegal abortion campaign was launched in November 2015 by the KZN Department of Health (John, 2015). This campaign was led by KZN Health MEC Dr Sibongiseni Dhlomo in the UMgungundlovu District with a march around the city. In an interview, Dr Dhlomo expressed concern about avoidable maternal deaths and increasing numbers of women who continue to opt for illegal abortions despite South Africa having "one of the most progressive laws in the world" with "widespread available government-sanctioned abortion centres" (John, 2015). According to the KZN Department of Health (2016) the campaign would call for support of women's autonomy to make their own decisions on reproductive health rights, and access to the means of acting on those decisions without risk to their health and lives.

Some of the campaign's goals include: promoting the legitimacy of the right to safe termination of pregnancy and also promote initiatives on safe motherhood and family-planning; promoting the provision of youth user-friendly health services; fighting stigma against safe and legal abortions; bringing together groups, networks, movements and organisations from around the province to work together in anti-illegal backstreet abortion campaign; building strategic partnerships with health professionals, governments, civil society officials and human rights bodies; promoting young women's leadership in the campaign at all levels; and developing and disseminating key messages to counter the influence of the anti-choice movement and reclaim the language of abortion as a moral decision (KZN DoH, 2016). With this campaign involving civil society and other interest groups to be part of the fight against illegal abortion in the province, much can be achieved in mitigating the plight of illegal abortion in the KZN province. It requires dedication and full support from civil society groups. However, as mentioned before, attempts against illegal

abortion cannot be a once-off effort. It requires time and a lot of dedication from various interest groups to eventually do away with widespread illegal abortion.

NGOs and activists can also play a major role in encouraging other provincial health departments to re-evaluate and strengthen their efforts to do away with illegal abortion in their provinces. These combined efforts can ultimately present favourable changes that can ensure illegal abortion providers face the consequences of the law and are done away with.

Unlike in the past, many individuals now have an array of access to information such as the internet, and the production of 'fact sheets'. In recent years there have been various activists and NGOs who make use of such platforms to reach out to the masses. Many well-known campaigns and activists have also started blogs, Facebook, Twitter and Youtube accounts from where they disseminate important information regarding their campaign objectives and important points on the reproductive rights and access issue (WHO, 2001; Centre for Reproductive Rights, 2003). In addition, with growing support from local departments of health MEC's such as the KZN example, there seems to be growing support for campaign work related to fighting the plight of illegal abortion in South Africa.

An example of a campaign that addresses and fights the disjuncture between abortion law and practice is the #ShoutYourAbortion campaign (Buchanan, 2015; Pearson, 2015). This is largely an online-based campaign that encourages women all over the world, who had legal abortions, to break the silence on abortion-related issues which they generally would keep quiet about out of fear of being victims of stigma and discrimination (Buchanan, 2015). According to Buchanan (2015) "tens of thousands of social media users have taken to Twitter to share their experiences of abortion and counteract the stigma surrounding the medical procedure". Twitter users all over the world would "tweet" their abortion experiences explaining that they are no longer ashamed or haunted by what they have done because they are in control of their own lives and bodies and that they will no longer be victim to society's stigma and judgmental attitudes (Buchanan, 2015). However, due to the pro-life vs pro-choice stances, it comes as no surprise that there were many individuals who were displeased with this campaign and addressed their opinions using the #ShoutYourAbortion title on Twitter so as to, perhaps, delegitimize the cause of why #ShoutYourAbortion was started in the first place and, in effect, push forward a pro-life view (Pearson, 2015). Regardless of some negative responses to the campaign, this thesis recognises that there is a pressing need for more campaigns like that which tackle the secrecy around abortion-related issues and do

away with the stigma and ill-perceptions of societies in which abortion is legal yet frowned upon. This could bring about significant changes in doing away with the common barriers to safe and legal abortion. It is for this reason that my fieldwork has a particular focus on reproductive rights activists, NGOs, and campaigners to find out what their objectives and policies are in addressing the disjuncture between abortion law and practice.

It would thus be ignorant of NGO role-players, civil society groups and campaign activists to only focus combined resources on getting rid of illegal abortionists without sufficiently tackling the cause of what they consider as the problem. Indeed, it is important to note that some women regard illegal abortion/abortionists as a solution to a problem (of having an unwanted pregnancy). It is a job of campaigns to tackle the symptoms of the problem like backstreet abortions, but also ultimately to dismantle the factors defining the problem. These will be discussed below:

2.4 General Barriers to Ease of Access

In the context of South African reproductive rights, barriers to abortion services inevitably limit the effectiveness of the law. As argued in the previous section, if enough resources can be dedicated to mitigate and fight these barriers along with working with campaigners and activists then we could ultimately make reproductive services more accessible to those women who need it most and thus bring about more empowerment for women while also saving vital public healthcare' resources.

When it comes to the concept of "access" there is no universally accepted definition of what it entails (Griffin; 2006:2) The WHO, however, has come up with a working definition in which universal access includes prevention, diagnosis, counselling, treatment and care services relating to:

- Antenatal, perinatal, postpartum & new-born care
- Family planning services including infertility and contraception
- Elimination of unsafe abortions,
- Prevention & treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc.
- Promotion of healthy sexuality

We see that this definition of access is one which focuses not only on treatment or prevention only, but incorporates a broader inclusion of other services closely related to reproductive

health. For example, looking at 'family panning services', if healthcare providers have the relevant training and fully adhere to the conditions of the CTOP Act they would be equipped with the counselling aspect of abortion. This means that instead of just helping with, or refusing abortion to women they would be able to give these women sound advice regarding their available alternative options such as (for example) adoption. Many distressed women sometimes are unaware that they have alternative options available with which they can be assisted with at no cost from public healthcare facilities (COTP Act, 1996). Thus, through fighting for universal access to reproductive rights services it would be a step in the right direction for reproductive rights activists, healthcare providers and legislators to adapt the definition supplied by WHO and ensure that it is applied at all times.

I will now proceed to look at some of the most common barriers facing women who seek safe and legal abortion services in South Africa.

2.4.1 Knowledge and Attitudes

Lack of knowledge, negative social attitudes and ill-perceptions regarding abortion generally plays a major role in the formation and strengthening of barriers to women seeking reproductive health services (Hodes, 2016; Klausen, 2015; Harries *et al,* 2009). Reproductive rights activists and NGO role-players are able to play an especially important role in redressing commonly held ill-perceptions of a society in which abortion has been legal for over twenty years. For example, through health promotion and information exchange, NGO role-players and activists can help shift social attitudes where communities are ill-equipped to understand the importance of reproductive health rights and access to public healthcare to make use of such rights (Stevens, 2011; WHO, 2001). For example, this can be achieved through public gatherings and the use of campaigns that distribute flyers and fact sheets in towns and communities which can include information regarding women's reproductive rights and some points to encourage others to respect and support women's reproductive rights as human rights. Also, civil society organisations can also "make other important inputs to health such as transforming public understanding and attitudes about health; promoting healthy public choices; building more effective interactions between health services and clients; and enhancing community control over and commitment to health interventions" (WHO, 2001:7). Another important avenue to make use of is through the targeting of schools (Stevens, 2011:31). , NGOs and campaign activists are documented as

playing a key role in encouraging sexual responsibility aimed particularly at those most prone to risky sexual behaviours that may end up in unwanted pregnancies (Stevens, 2011).

Social stigmas (in addition to economic material barriers) makes free and safe abortion even more inaccessible to the women who need it the most (Lomelin, 2014). In my previous study when I interviewed tertiary students on their knowledge of the legality of abortion in South Africa about at least half of those students knew that abortion is legal in South Africa but were not familiar with the details of their rights. When explained what the CTOP Act entailed, some were very impressed with it referring to it as '*empowering women*' whereas others expressed, '*it is a step in the right direction but it is crazy to allow girls who are under sixteen years to be allowed abortion when they themselves can't even make big and serious life decisions*'. Other authors and researchers have also noted how lack of knowledge of abortion law is a major hindrance to safe abortion (Grimes, 2006; Ludman, 2012; Stevens, 2011; Althaus, 2000; Davis, 2013; Mhlanga, 2003).

Healthcare providers' attitudes can also pose a problem. In a study on healthcare provider attitudes to abortion, Harries *et al* (2009) look at how the personal and professional attitudes of healthcare providers shape how they interact with individuals seeking abortion and other reproductive healthcare services. If abortion providers were to strictly obey the stipulations of the COTP Act then the woman seeking abortion would have her bodily and psychological integrity and reproductive rights honoured (Honikman *et al,* 2015; Pickles, 2012; Harries *et al.*, 2009). Although medical professionals are obliged by law to adhere to the HPSCA code of conduct and to respect patients and their health needs, it is well documented that in South Africa this is not entirely the case. Healthcare providers often treat patients with disrespect by abusing them verbally and physically and at times refuse them immediate treatment even in cases of emergency (Jewkes *et* al, 1998; Human Rights Watch, 2011, Harries *et al,* 2009; Pickles, 2015; Jewkes *et al,* 2005; Honikman *et al,* 2015). In the process of fighting barriers of access to reproductive health services, activists and NGOs can also aid in addressing the importance of mutually-respecting patient-provider relationships in ensuring good provision of reproductive health services and good maternal health. Inspiring confidence in public healthcare service provision can partly help reduce women opting for clandestine, illegal abortion services. This in turn can reduce the number of women presenting to public healthcare facilities for treatment of septic abortions etc. (Harries *et al*, 2009; HEARD, 2016).

The result of the study undertaken by Harries *et* al (2009) shockingly revealed that where some abortion healthcare providers were aware of the CTOP Act, they were not fully familiar of the contents of the Act. Others who were non-providers of abortion were not sure of the conditions under which a woman could request an abortion, or if females of all ages were allowed and whether or not there was a requirement to have a guardian or parent involved (Harries *et al.,* 2009). This is alarming when one considers the shortage of qualified and willing abortion providers (Human Rights Watch, 2011; Gaede & Versteeg, 2011; De Waal, 2012). This lack of knowledge of the CTOP Act from abortion providers is a matter that needs to be urgently addressed and handled by the national department of health. Other healthcare workers gave personal reasons in support of, and against, providing termination of pregnancies. Some were against providing it or being involved in the direct provision of abortion based on moral and religious grounds. Some of these healthcare workers who preferred not to be directly involved in abortion services were understanding and respected the fact that a woman's decision to terminate is her own and that she needs to be helped accordingly (Harries *et al.*, 2009).

Another shocking result was how some providers expressed disapproving commentary from their fellow workers who call them "murderers" and "baby killers". Such commentary largely came from pro-life religious healthcare workers (Harries *et al*., 2009). What also stood out was that whether healthcare workers were providers or non-providers some would often turn women away without referring them to willing providers or counsel them on alternative options. This is a very important aspect of the abortion process because some women are already under severe stress, particularly if they have run out of options and think that abortion is the only way out or that it will have serious health implications in her reproductive life after the abortion.

In such instances it is important for qualified healthcare workers to assist the woman by counselling her on all available options and explain the entire abortion process and the possible effects to follow should she opt for abortion as opposed to, say, adoption. This is also captured by Strydom and Humpel (2014) when they argue that it is very important to have abortion providers and counsellors be as helpful as possible to ensure good health and safety of the woman who opts to undergo an abortion at any given abortion facility. Therefore, to hold public healthcare service providers accountable for being intentionally (or otherwise) negligent to patients and their health needs, this pressure can ultimately lead to healthcare supervisors intervening and demanding better healthcare service provision from

healthcare providers. If not, civil society such as NGOs and activists, interest groups etc. can take to the media to alert the general public and local government regarding the failure of service provision from particular health institutions etc. (Human Rights Watch, 2011; De Waal, 2012; Centre for Reproductive Rights, 2003). Hence, we can conclude that lack of willing legal abortion providers undermines the effectiveness of the law and that healthcare provider attitudes to patients is also an important aspect that needs to be publically addressed through campaigns in which involvement of reproductive rights activists and NGO role-players can produce fruitful results.

2.4.2 Socio-economic Reasons

People's socio-economic status tends to play a major role when it comes to their reproductive lives and the choices they have to make regarding their current and future life prospects, including that of the unborn child. South African abortion law had never previously allowed individuals to legally obtain abortion services for reasons relating to their socio-economic status. This means that financially unstable women did not have the freedom to access legal abortion services for unwanted pregnancies which they would struggle to maintain, or afford to raise a child. This, however, only changed when the CTOP Act came into effect after 1996 when women would be allowed to terminate unwanted pregnancy for various personal reasons, including her socio-economic status. Moreover, the CTOP Act is based on a time-frame model. Meaning that, abortion on demand is only available up until the twelfth week.

From the thirteenth week, all other personal reasons for wanting a legal abortion at public health facilities falls away and doctors would only provide abortion in the most extreme cases as it was under the Sterilization Act during Apartheid i.e. under conditions where the continued pregnancy endangered the woman's life; when the continued pregnancy constituted a serious threat to the woman's physical or mental health; when there was a serious risk that the child to be born would suffer from a physical or mental defect of such a nature as to be irreparably seriously handicapped; and when the pregnancy was the result of unlawful intercourse such as rape (The Abortion and Sterilization Act, 1975). However, the only difference is that a woman's socio-economic status continues to be considered between the thirteenth up until the twentieth week of gestation, especially in the instance when continued pregnancy would result in severe social or economic conditions (CTOP Act, 1996; Mhlanga, 2003:118; Lomelin, 2014).

As liberal and accommodative as that may appear, there are other barriers faced by less privileged women to be able to make use of their reproductive rights as offered in the CTOP Act. Those most affected are women who live far away in rural areas that can be several hours away from the nearest public clinic or hospital (Althaus, 2000:85). One of the immediate problems faced by such individuals is the burden of traveling costs to get to-and-from public healthcare facilities. Furthermore, South African rural areas have a tendency of being occupied by individuals who receive little to no income (Althaus, 2000; Hodes, 2016). Also, with most rural areas generally being resource-poor and very distant, some operating mobile clinics never get to some rural areas and when they do it is not on a regular basis. Some of these factors play a part in being responsible for many rural women not having access to safe, readily available contraception. Hence, when these women become victims of unplanned pregnancies, they face multiple burdens and barriers to make use of the provisions of the CTOP Act (Lomelin, 2014; Davis, 2013 Osman and Thompson, 2012; Hodes, 2016).

Due to limited resources at public healthcare facilities to cater for the large numbers of women presenting for abortion services and treatment of septic abortions from illegal unsafe providers, private reproductive clinics have opened up to help with the growing demand for abortion services in the country. One of the most notable private providers around major South African cities and towns is the Marie Stopes International Reproductive Clinic. Though some would consider it a big help that private providers such as Marie Stopes have opened and thereby helping lessen the burden of having to cater abortion services to thousands of women daily Althaus (2000).

The problem that remains is that such private providers charge fees for their services as opposed to free abortion services offered at public healthcare facilities because they are "too business oriented" (Althaus, 200:86). Moreover, these fees are generally unaffordable by the less financially-privileged women in South Africa. Hence, those women who need free, accessible and safe abortion services the most continue to be at a disadvantage (Althaus, 2000:86). With South Africa already facing various issues of access despite liberal abortion laws that guarantee all women safe and free access to public health facilities, 'abortion apartheid' is reinforced by private providers who charge high fees (Hodes, 2016; Althaus, 2000). The CTOP Act was implemented to cater for all women, especially the previously disadvantaged, hence distance and financial limitations ought to be the least of a woman's troubles when needing to access reproductive rights services from public healthcare facilities. Therefore, reproductive rights activists and NGOs can combine resources to address such

inequalities and also call for further assistance from willing donors to aid in increasing access to women most in need of reproductive health services but who are faced with financial and physical constrains such as distance.

2.4.3 Religion and morals

Religion is one of the most significant determinants of social opinion, and policy justifications regarding abortion. For example, those against abortion generally hold the view that life begins at conception and that because all life is sacred, any act of abortion is immoral and sinful because the foetus is considered as a human being (Hetsroni, 2001). In South Africa, the most prominent case based on religious grounds was that of the Christian Lawyers Association (CLA) versus the Minister of Health in 1998 where the CLA brought a claim against the provisions of the CTOP Act (Christian Lawyers Association v. Minister of Health, 1998). Soon after the CTOP Act was formally passed, pro-life groups together with the Christian Lawyers Association challenged the government with the claim that by approving the 'taking of life', the Act violated the right to life of human beings, which they proclaimed, starts at conception. They had based their claim on Section 11 of the South African Constitution which holds that "*everyone has the right to life*". Moreover, they argued that the phrase "*everyone*" refers to an unborn child whose 'life' is ended during an abortion'.

The Reproductive Rights Alliance being one of the key civil society organisations that played a crucial role in the late nineties and early 2000's continued to play a major role during the fight for a liberal abortion legislation which turned out to be the CTOP Act of 1996 (Albertyn, 2015; *Christian Lawyers Association v. Minister of Health,* 2005). When the provisions of the CTOP Act were challenged in court, the RRA continued playing a significant role in protecting the liberal abortion Act and thereby ensuring that it stays in place *Christian Lawyers Association v. Minister of Health,* 2005). This is another example of how civil society organisations and interest groups can help society in maintaining or improving women's reproductive, and ultimately, human rights in South Africa.

Speaking on the history of abortion laws in South Africa and the influence of religion and moral reasoning based on the Bible McGill (2006) largely writes from a religious perspective in which she occasionally points out to abortion as a 'crime'. Under a section titled "*Fundamental reasons for criminalising abortion*", McGill (2006:200) posits that "… society may criminalize abortion to protect women from dangerous medical practices, to protect the

lives of all unborn children and as a matter of justice out of a sense of fear of God. This is undeniably a pro-life/anti-abortionist stance that disregards the pregnant woman's life circumstance and reproductive freedom on the basis that an unborn child has 'personhood' and the fear that God would punish such acts. Moreover, according to McGill it was "*dubious* arguments about deaths from backstreet abortions and equality" that "were used to justify the legalisation of abortion on demand". Throughout the article McGill (2006) shows a general disapproval to abortion in general, especially with democracy's move to adopt the Choice Act and allow abortion on demand. She further romanticises reasons against legal abortion based on Biblical scripts and old law cases that challenged the practice of abortion and encourages religious leaders and other pro-life supporters to continue challenging the legality of abortion laws.

South Africa has generally been a country with majority of its citizens belonging to some religious group, comprising mainly of Christians, Muslims and other religions. However, using such moral and religious tactics while blatantly choosing to ignore the history of South African women (especially women of colour), their socio-economic status and history as an oppressed group of individuals, including the current health dangers many still face, this can only be described as ignorant and frightening to the future of women's reproductive rights. Reproductive rights activists and NGOs that support women's reproductive health rights are generally aligned with pro-choice movements. This immediately places them at odds with religious groups who are pro-life and against liberal abortion and reproductive rights (Smith-Christopher, 2009). This is evident in legal cases where pro-life religious groups have challenged legislation that is responsible for South Africa's liberal abortion rights (Christian Lawyers Association v. Minister of Health, 2005; Christian Lawyers Association of SA and Others v Minister of Health and Others, 1998). Examples of such civil society groups that have supported the quest to do away with liberal abortion rights range from various religious groups and organisations that form counter campaigns basing their pro-life stances on moral and religious reasoning. Clearly this is a tension that will possibly be around for a very long time. However, while such individuals and groups often use moral reasoning and stigma to prey on women's consciousness to produce guilt so that they rather choose not to abort unwanted pregnancies as planned, this can have various negative effects on a woman's future life and psyche (Yang *et al*, 2007). This is so because due to a guilty conscience sparked by moral manipulation, such women lose out on their freedom of choice to shape their own future and could end up faced with various burdens (Smith, 2005; Ross, 2006). It is for such

reasons that reproductive rights activists and NGOs are key actors who can play a crucial role in helping women become empowered and be able to enjoy the reproductive freedoms afforded by the constitution so that they can have autonomy over their own lives.

2.5 Concluding Remarks

As argued throughout this paper it is clear that there most certainly are some problems between implementation of the CTOP Act and the provision of the services in reality as per the legislation. With that being said, there is an urgent need to implement more pragmatic solutions that can lessen and eventually close the large gap between rights and access. Another major issue that is both directly and indirectly linked to the issue of access to safe and free reproductive health services and abortion is that of the growing business of illegal abortion providers throughout South Africa. Left unchecked, these problems will continue to consume public healthcare resources which have already been described as being scarce or limited (Hodes, 2016:82; Althaus, 2000:85 Osman and Thompson, 2012; Lomelin, 2014; Haries *et al.* 2009). The key players involved in investigating and addressing the issue of access and barriers to provisions of the CTOP Act are reproductive rights campaigners, activists and researchers (Albertyn, 2015; WHO, 2001; Klugman, 2011; Klugman & Mokoetle, 2010). These parties need to work closely with legislators, healthcare providers and other interest groupswhose objectives align with improving implementation of the CTOP Act and making reproductive services more accessible to all women in South Africa, especially those women who are most disadvantaged.

It is no doubt that making reproductive services more accessible for all by fighting barriers is not an easy task as it requires a lot of support, resources and time investment. However if all these various parties can combine all relevant resources and focus on pragmatically doing away with the most common and biggest barriers then that would be a great start to securing women's reproductive rights, health and freedom. Since knowledge and attitudes, along with religious beliefs play a significant barrier to access, there must be particular task teams delegated to address these and find a way to work with departments of education, religious leaders etc. to discuss the various benefits involved for women's health and South Africa in general. The ideal outcome here would be their willingness to help fight stigma and correct ill-perceptions commonly held in society through both formal and informal education. In addition, with issues such as illegal abortion being a widespread phenomenon throughout

South Africa that impacts nearly entire communities in negative ways, there is an urgent need for civil society to engage with this issue as a collective.

CHAPTER THREE

RESEARCH DESIGN

3.1 Introduction

This following chapter will outline the methodological approach used for this study. The nature of the research instruments applied to this study, their applicability and use will be discussed. Furthermore, a detailed description of participants and the mandatory ethical considerations which guide data collection are included. Finally, both the data collection process and the resultant data analysis are examined.

The study on "How reproductive rights correspond with access: a case study of South African advocacy groups" employs the qualitative paradigm or 'worldview'. According to Hancock *et al* (2007:7) "Qualitative research is concerned with developing explanations of social phenomena". They further go on to explain that research that is qualitative helps us understand the social world in which we live and also why things are the way they are. Ritchie *et al* (2013:4) consider qualitative research as "aims and objectives that are directed at providing an in-depth and interpreted understanding of the social world of research participants by learning about the sense they make of their social and material circumstances, their experiences, perspectives, and histories". They also point out that qualitative research provides rich, detailed and complex data. We see therefore that researchers adopting a qualitative paradigm rely heavily on the views of the participants, their perceptions and interpretations.

3.2 Rationale and Aims

The current research seeks to interrogate the unique viewpoints of reproductive rights activists and organisations who are or have been previously involved in campaigns that have tackled the issue of access faced by many women when trying to enjoy the benefits of their reproductive rights as enshrined in the CTOP Act. Moreover, through working with these activists the current study aims to look at prospective solutions to overcoming the common barriers to access.

Sub-goals include:

a) Eliciting the way in which various activists organisations understand the current tension between rights and access as well as their understanding of how this tension can be mitigated

b) Determining knowledge of the existing CTOP Act amongst advocacy groups and activists

c) Framing the most common concerns that organisations and campaigners identify as barriers to women gaining ease of access to reproductive health services

d) Understanding the nature of currently existing campaigns

3.3 Selection of Respondents

According to Sargeant (2012) in qualitative research the selection of participants is 'purposeful' and that those selected are the respondents who can best inform the research questions and enhance understanding of the phenomenon under study. Sargeant (2012) further points out that decisions regarding which participants to select will often depend on research questions and evidence informing the study. For the purpose of this study, individuals over the age of eighteen at the time of interviewing and administering of questionnaires were selected. Prospective participants were recruited through searching for South African reproductive rights campaigns and activists on the "Google" search engine. Contact details on particular websites were then used to contact prospective respondents. Some referred me to other activists they knew of. All participants identified as either current campaigners or as having previously been involved in campaigns that addressed the various issues of access to reproductive rights. All those who participated in this study have direct experience of reproductive rights campaigns.

Respondents have been either purposively selected, or selected via snowball sampling. Purposive or judgmental sampling is particularly useful in cases where the information needed for research is held only by certain members of the community (Tongco, 2007:151). In the case of this study, the objective is to obtain information from reproductive rights advocates. According to Hancock *et al* (2007:22) 'snowball sampling' relies on referrals. Meaning that one or more participants helps the researcher recruit other individuals who are suitable as respondents for the research.

3.4 Sampling

About ten prospective respondents were contacted for research and from that total only three ended up being part of the research due to others showing disinterest in being part of the study. The number of campaigns that respondents have worked on vary from one to four campaigns in which some played the role of leading a particular campaign or simply being part of a campaign as a supporting activist.

In their capacity as activists these individuals have previously worked for or are currently working for various organisations such as the Sexual Health & Reproductive Justice Coalition (SRJC), Global Doctors for Choice, The Gender Health and Justice Research unit, International Campaign for Women's Right to Abortion and the Women's Health Project. Respondents did not provide permission to have their real names used in this study. Therefore, pseudonyms will be used instead.

3.4.1 Eve runs the International Campaign for Women's Right to Safe Abortion which is a network of international, regional and national organizations, and consists of groups and individuals in over 100 countries who support safe abortion as a woman's right on both public health and human rights grounds. This is a large online-based organisation that comprises of various pro-choice campaigns/organisations whose objective includes promoting universal access to safe, legal abortion as a women's health and human rights issue and to support women's autonomy to make their own decisions of whether and when to have children and have access to the means of acting on those decisions without risk to their health and lives. Eve has been part of the Safe Abortion Rights Campaign which was launched in May 2012. The primary focus of the Campaign is to build capacity to advocate for the right to safe abortion at national level

3.4.2 Jill has experiences as an academic, activist and donor. She also works freelance to strengthen the strategic and evaluation capacity of organisations and individuals with social justice objectives. Jill takes on sexual and reproductive health and rights research and has published various books and journals that addresses women's right matters including the role NGOs play in addressing social justice issues. Jill has worked for Urgent Action Fund-Africa, Ford Foundation, Women's Health Project, and Global Doctors for Choice. While working as director at the Women's Health Project, Jill was part of the Sexual Rights Campaign and prior to implementation of the CTOP Act worked on identifying what policies women needed in a new South Africa. She also participated in shaping the Green and White papers on

population policy, the Department of Health's gender and health policy, the South African delegations to the Cairo and Beijing UN conferences.

3.4.3 Ivy is a 33 year old medical doctor who currently runs a Reproductive Health Clinic in Sandton. She currently serves as the Vice-Chairperson of the Sexual Health & Reproductive Justice Coalition (SRJC). Ivy has particular interests in Women's Health and Rights, Reproductive Justice, Comprehensive Sexual Health Education and Content production. She is a public speaker, facilitator and also contributes to various print publications as well as radio and television productions. She is also an Organising Committee Member and Chair of "Track 3: Social, Political, Economic and Health Systems" at the upcoming 8th National AIDS Conference to be held in June 2017. Some of the campaigns she has worked on include #RedMyLips2016 and #AbortionProviderAppreciationDay. Ivy led the international "No to rape and no to victim blaming" campaign in April 2016 in which they galvanized a national dialogue on social media and solidarity with victims of sexual assault. She pointed out that this campaign originated in the USA but its themes are "just as real and relevant in South Africa". The #AbortionProviderAppreciationDay is observed annually on March 10, the date in 1993 when abortion provider Dr David Gunn was murdered by a pro-life activist. . On this day, reproductive rights advocates mobilise and visit as many providers as possible and show gratitude to them for the courage, respect and dignity willing providers offer their patients.

3.5 Data Collection

Initially, data was supposed to be obtained from respondents by way of in-depth interviews and open-ended questionnaires. However, due to various respondents indicating unavailability for interviews due to it being "time-consuming" for their "busy schedules" and for "personal reasons", this technique was unfortunately not possible. Therefore, the only other method used to obtain data from respondents was through open-ended questionnaires.

According to Mathers *et al* (2007) and Reja *et al* (2003) open-ended data collection is characterised by allowing the respondent the freedom to answer in their own words uninfluenced by the researcher and, further, does not constrain possible responses. In-depth face-to-face interviews would have been ideal for this study as it would garner relevant information regarding reproductive rights issues from the unique vantage of activists through their own words (Wengraf, 2001; Rowley, 2012; Opdenakker, 2006). These interviews

would have particularly been useful for this study because it would give the participants the chance to fully express their own opinions in their own words regarding how they perceive the reproductive rights and access issue. Moreover, face-to-face interviews are extremely helpful as it makes it much easier to pick up social cues (visual aids) such as the interviewee's body language and intonation etc. (Opdenakker, 2006). Being able to pick up social cues in face-to-face interviews can be very helpful as it can add extra information on top of what activists would verbally provide throughout the interview. Furthermore, such interviews allow for personal communication between interviewer and interviewee and make it much easier to gather more information for the study (Olson & Muise, 2009). This has the advantage of allowing both parties to ask follow-up questions or ask for clarity where questions or responses are vague (Olson & Muise, 2009; Opdenakker, 2009). However, one shortfall is that interviews can be a time-intensive evaluation activity because of the time it takes to conduct interviews (Roulston, 2013). Another disadvantage of face-to-face interviews, according to Olsen & Muise (2009:3), is "stage-fright". This could be another possible explanation why some respondents preferred to fill out questionnaires in their own space and comfort as opposed to sitting in on face-to-face interviews.

Open-ended questionnaires were distributed to willing respondents through email and Facebook attachments to their personal inboxes. Completed questionnaires were then returned through the same electronic platforms. These were sent to those respondents who were too far to reach for face-to-face interviews and those whose schedules were too busy to be available for interviews (or who were unavailable for other reasons) but rather opted to complete the questionnaire at a time most convenient for them (Moerdyk, 2009). Open-ended questions are exploratory in nature as a result of them allowing for the respondent to provide any answer they choose without forcing them to select from concrete options as is the case with close-ended questions. A major shortfall of open-ended questionnaires includes difficulty for the interviewer to intervene should a respondent find a question to be vague (Reja *et al* 2003). In such instances, respondents can easily choose to ignore a question that could potentially be important for the study (Reja *et al* 2003). Hence, it is important for the researcher to ensure that all questions are clear and concise before administering the questionnaire (van Teijlingen & Hundley, 2002). These shortcomings may be overcome by conducting pilot studies. A pilot study refers to pre-testing of a particular research instrument, e.g. Questionnaires or interview schedules. It is the mini-version of a full-scale study (van Teijlingen & Hundley, 2002). Pilot studies are also known as 'feasibility' studies.

Furthermore, they are considered to be a key element of a good study design (van Teijlingen & Hundley, 2002). For the current research a pilot study was conducted before questionnaires were administered to other respondents. The wording and order of some questions were changed, whereas some questions were completely omitted based on results and suggestions from the pilot study. Moreover, since questions that are open-ended ask for the critical thinking and honest uncut opinion of the respondent, they are perfect for gaining information from specialists in a field that the researcher is less qualified in. Information on issues such as reproductive rights and access can be best obtained from those who have expertise on the topic such as activists, campaigners and NGO role-players since they deal with such issues directly on a more regular basis. As explained above, in terms of the benefits face-to-face interviews would yield from engaging with activists and NGO role-players, it would have been ideal to use in this study. Unfortunately however, the study now has to rely solely on in-depth open-ended questionnaires. But, considering the advantages with open-ended questionnaires, there is a good likelihood that the questionnaires will yield sufficient information since follow-up questions have been added after the pilot-study. Proposed open-ended questionnaires can be found attached under Appendix Two.

3.6 Data Analysis

The analysis of data in any research project is generally aimed at providing a summary of the mass of data collected and presenting the results in a way that communicates the most important features (Hancock *et al*, 2007). Thematic analysis is applied to this study to make sense of, and explain, data collected from respondents. Within the qualitative research paradigm, thematic analysis is used with the goal of examining various themes from available data (Braun & Clarke, 2006; Creswell, 1994). In explaining what constitutes a theme, Braun and Clarke (2006:82) point out that "A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set". However, just because a theme surfaces more often than others this does not necessarily make it more important to understanding the data (Braun and Clarke (2006). Using thematic analysis, data can be well-organized while providing the researcher the benefit of providing a rich description of collected data (Guest & MacQueen, 2012). Data analysis can be quite a demanding task as the data collection technique stated above characteristically generates extensive information (Miles & Huberman, 1994).

There are six known phases when conducting thematic analysis (Braun and Clarke, 2006; Guest & MacQueen, 2012; Saldana, 2009). These will not be discussed in great detail. Instead, each phase will be briefly summarized.

Thematic analysis starts with the researcher familiarising themselves with the data after it has been collected. This is the first and one of the most important phases in which *transcription* takes place whereby data is transcribed into written form. The second phase deals with generating initial codes where the researcher looks for patterns. This is done through *data reduction*. Data is put into labels so as to create categories that relate to the research question. The various codes formed in the previous phase are combined into possible themes that would better depict the data. This is known as phase three where the analyst comes up with a list of possible themes for further analysis (*thematization)*. The themes that emerge in this stage will be used to make sense of respondent's narratives. Phase four deals with reviewing existing themes to see if supports the data. If not, the researcher needs to look back at the data and/or rework the theme so that it fits with the given codes. In the fifth phase, themes are defined and refined where the analyst must explain what the theme deals with and what its significance is in relation to the data. The sixth and final stage deals with writing up the final report. Here, researchers need to make a careful decision on what themes to use that can make a meaningful contribution to understanding the research question. The outcome of this phase need to provide a 'thick description' of the results so as to provide a comprehensive report (Braun & Clarke, 2006).

According to Grounded Theory the inductive nature of qualitative research means that as open-ended research is carried out new ideas or theories constantly surface from newly gathered information (Hancock *et al* 2007; Scott, 2005). Because of this it is important to verify the emergent conclusions from the data collected throughout the study. The multiple meanings induced from the data have to be tested for their plausibility/validity. The importance of this is to prove that conclusions drawn from the data are indeed credible (Braun & Clarke, 2006). It is thus crucial to conduct "member checking" so as to ascertain *validity*. This can be achieved through requesting respondents to comment on the accuracy of the data and conclusions at the end of the study (Brink, 1993; Braun & Clarke, 2006). Reliability on the other hand is much difficult to prove for qualitative research than quantitative (Brink, 1993). According to Brink (1993:35-36) threats to validity and reliability are limited when data is obtained from respondents where there is no direct contact with the researcher.

3.7 Ethical Considerations

Ethical considerations or measures are extremely important in any research involving participants so as to protect them from any harm or injury that may possibly occur during or after research as a result of their participation (Richards & Schwarts, 2002). The fieldwork is foregrounded by an explicit acknowledgement of the sensitive nature of the topic of abortion and reproductive issues related to it. Therefore, it adheres strictly to the Rhodes University ethical guidelines for research. Moreover, ethical issues observed in research studies generally include informed consent, rights to privacy, justice, anonymity and confidentiality, including respect for persons (Brink & Wood (1998).

3.7.1 Permission to conduct the Research

In order to conduct research ethical clearance is required because ethics are the norms of conduct that distinguish between acceptable and unacceptable behaviour (Shamoo & Resnik, 2015; Moerdyk, 2009). For this study, permission was obtained from the Sociology departmental committee from where I had to complete ethical standards research protocol forms. Thereafter, the final clearance to conduct research was successfully obtained from the Humanities Higher Degrees Committee (HHDC).

3.7.2 Informed Consent

Pedroni *et al* (2001:4) refers to informed consent as "the kind of authorization made by a person with decision-making capacity who has a substantial understanding of the relevant information and who is free from controlling influences in making the decision". After having thoroughly explained the objectives of the research to the prospective respondents I administered informed consent forms with all relevant details in order to get formal permission from interested activists. This form basically gave the respondents a clear appreciation and understanding of the facts, implications, and consequences of taking part in the research and ensure that participation is informed and completely voluntary (Richards & Schwartz, 2002; Moerdyk, 2009). A copy of the informed consent form can be found under Appendix One.

3.7.3 Confidentiality and Anonymity

Research ethics is fundamentally concerned with protecting the wellbeing of the research participants (Brikci & Green, 2007; Moerdyk, 2009; Elliot, 1997). Due to the nature of the

research on abortion and reproductive rights participants were well-informed about their personal information remaining anonymous and that the research would instead make use of pseudonyms rather than use real names so as to lessen any risks to participants and their views. In this instance it is extremely important to maintain and respect the privacy and confidentiality of campaign activists because they can easily fall victim to harm from anti-supporters of abortion and reproductive rights or other parties who simply disagree with their views and actions. Having borne this in mind, participants were explicitly reminded that they could, at any time, choose not to engage with matters which they either found very sensitive or which they preferred to not make available and that they also have the right to stop participation at any moment in the research without need to provide any reasons for such withdrawal (Moerdyk, 2009).

3.7.4 Dissemination of the Research Findings

In the informed consent form distributed to participants, they were all guaranteed access to the findings of the study upon request. Furthermore, confidentiality will be strictly maintained throughout the study and participants' identities will be kept private. The final dissertation will only be stored on the Rhodes University Library archives.

3.8 Challenges and Limitations

One of the main challenges that stood out in this study was that some of the respondents who agreed to be part of the study later decided to not respond or avail themselves for interviews or the completion of questionnaires. It thus became clear that in expert communities my pool of interviewees was more limited than anticipated. According to Adler & Adler (1987) one of the limitations to the sample pool size can be that researchers have little time available for data gathering since research can generally be a time-consuming process. However, this does not only extend to researchers but also to potential participants who may withdraw even after having agreed to be participants. Furthermore, this also slowed down the process of data collection as I now had to spend more time finding willing participants who would replace the few who seemed to no longer be interested in being respondents. Although most campaign activists were contacted well in advance to request participation, many of them only confirmed at a later stage after having been repeatedly asked and reminded. This was certainly interesting when considering how so many academic texts and campaigns highlight a shortage of support, exposure and dedication to the reproductive rights and access issue in

and around of South Africa (Van der Merwe, 2016; Guttmacher *et al* 1998; Lomelin, 2014; Griffin, 2006; Hodes, 2016; Stevens, 2011). This led me to the tentative conclusion that some reproductive rights activists are perhaps mainly responsive to well-known and established researchers and research organisations. At its extreme, this limitation with regards to access to expert communities for new researchers could stand to deepen the problem of awareness and support for issues of reproductive rights and access.

In the context of knowledge production around reproductive rights, qualitative studies have inherent shortfalls in that it involves a relatively small number of participants. This can then further present difficulty in influencing policy-making decisions for reproductive rights and access due to it not being representative of the entire population (Travers, 2009).

3.9 Conclusion

This chapter outlined the research methodology for the qualitative paradigm as well as ethical considerations pertaining to the study. The following chapter will present the data analysis and interpretation of the findings.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF FINDINGS

4. 1 Introduction

Findings in this chapter are presented and discussed using a thematic approach. The themes that will be discussed developed from the fieldwork and were formulated in relation to the objectives of the study including its theoretical framework. Data analysis is described as the process of bringing order, structure and meaning to the mass of collected data (Marshall & Rossman, 1999:150). Furthermore, qualitative data analysis is the process of making sense from research participants' views and opinions of situations, corresponding patterns, themes, categories and regular similarities (Cohen *et al,* 2007:461). Therefore Chapter Four will reveal the unique influence and understanding brought by civil society groups to the abortion and access issue faced by women in South Africa as well as how young black women remain the most marginalised. What is more important is how reproductive rights activists propose solutions to existing sexual and reproductive rights issues in South Africa. The thematic approach begins by looking at the 'demographic data' of the respondents in which some descriptive information is specified. Thereafter, I proceed to discussing the 'Unique vantage point of activists'. Under this theme some of the key reproductive rights issues are engaged from the unique perspectives of those directly involved in lobbying around the 'access' issue.

'Challenges to reproductive rights advocacy' is an important theme which emerges from the research and deals with the enduring battle between individuals fighting to increase access to sexual and reproductive rights for women and those who are anti-abortion. Other challenges include the lack of academic texts that speak to the South African experience of provider-abuse, and the lack of appreciation by the general public for the services provided by those involved in abortion care (Harries *et al*, 2009). However, it must be noted that this section does not intend to provide a comprehensive description of general challenges faced by reproductive rights advocacy, but rather to those relating directly to opposition campaigners and to other issues raised by respondents on this theme. There is a long history of tension between advocates for abortion rights and anti-abortion advocates (Manninen, 2014; Staggenborg, 1991; Lopez, 2012). Surrounding this ongoing tension is the controversy around the moral and legal status of induced abortion. These two movements, often referred

to as ‘pro-life and pro-choice’, have sought to influence public opinion to gather legal support for their diverse positions. The abortion discourse in many countries’ political and legal arenas often includes debates between anti-abortionist advocates fighting for strict anti-abortion laws while abortion-rights advocates fight for more liberal abortion laws that would expand access to abortion laws (Dubinsky & Morton, 1994; Manninen, 2014). The outcome of these debates often influence legal policies that has direct consequences for many women, be it positive or negative (Grisanti, 2000; Manninen, 2014).

Under this theme the discussion is centred on what different activists experience as ‘disruption’ from oppositional campaigners who often attempt to delegitimize their cause. This is discussed while bearing in mind that these particular ‘challenges’ may not be the only ones faced by all reproductive rights advocates in South Africa, but rather those observed and experienced by respondents in this study. Given the context of South African history regarding marginalised groups of people, especially black women, oppositional campaigners such as anti-abortionists can be considered a problem if their actions could result in threating the human rights of others as provided for by the Constitution (Camay & Gordon, 2002; Dlamini, 2014; Albertyn, 2015). Opposition campaigners largely refers to those groups of individuals or organisations who are dissatisfied with the CTOP Act or some of its provisions. For example, these opposition campaigners would then publically engage in anti-choice or pro-life campaigns and explain why they are against a particular abortion issue. Alternatively, such groups would formally challenge provisions of the CTOP Act (see *Christian Lawyers Association v. Minister of Health, 1998; Christian Lawyers Association v. Minister of Health, 2005*).

The next central theme which emerged from the research, ‘Shaping attitudes and knowledge’ broadly looks at knowledge production, education and the sharing of information publically on the issue of abortion and on the various avenues for accessing abortion services which women and communities may otherwise be unfamiliar with for a variety of reasons to be discussed. Central to the question of attitudes and knowledge is the intersection between private family spheres and public spheres of knowledge, and how these two spheres influence social attitudes. The theme ‘Illegal abortion: the major problem’ discusses the plight of illegal abortion in South Africa. Given the South African legal context, activists explain and elaborate on whether or not they regard illegal abortion as a problem. The discussion then proceeds to look at what activists consider to be the answer to mitigate the reproductive rights access issue in South Africa. Finally, under ‘Application of theoretical framework’ I evaluate

how the realities of the fieldwork correspond to the chosen framework i.e. *Reproductive Justice*.

4.2 Unique Vantage point of Activists

The role played by activists, NGOs and other interest groups in the sexual and reproductive rights discourse is understood as being a significant one in that, through fighting for women's access to sexual and reproductive health rights, other human rights are also recognised such as the rights to human dignity, equality and freedom (Matthews & Nqaba, 2017; Goolam, 2001; Albertyn, 2015; Klugman, 2011). This significant role has particular prominence in South Africa's transition to a new democracy in the early 1990s where activists and NGOs along with other civil society organisations aided in reforming previous restrictive abortion laws in a manner that would consider and include women's reproductive emancipation and other human rights, human dignity, equality and freedom etcetera in the new abortion legislation (Pickles, 2013; IPAS, 2014; Klausen, 2015; Goolam, 2001). It remains clear therefore that such lobby groups have the ability to bring about social transformation given South Africa's social, political, and legal climate South Africa being a democratic nation allows for social justice issues to be addressed by concerned interest groups. However, the success of NGOs and lobbyists in bringing about social justice can be dependent on a variety of factors, which due to constraints I am unable to discuss here.

As noted elsewhere in the study, the reason for choosing reproductive rights advocates was to capture how they perceive the reproductive rights and access issue based on their experience on the matter. This important and distinctive role played by activists in the reproductive and abortion rights issue has been expounded throughout Chapter Two. Civil society organisations such as NGOs often possess many of the crucial elements needed to address and bring about social justice matters (Centre for Reproductive Rights, 2003; Albertyn, 2015; Matthews & Nqaba, 2017; Ulleberg, 2009). Some of these include NGOs acting as knowledge creators conducting original research and analysis on various issues. NGOs can also be important contributors to the process of implementing policy and delivery services and strategizing to garner public support from communities and donors. They can also be major providers of important public information. Education, motivation and engagement. One example of the influence of NGOs in social justice matters such as reproductive rights is evident in the works of organisations such as the Reproductive Rights Alliance and Women's Health Project who helped with deciding on and drawing up of policies that would enable

women's reproductive rights to form part of the final Constitution of 1996 (Albertyn, 2015; Klugman, 2011; Klugman & Mokoetle, 2010).

As Matthews & Nqaba (2017:2) point out, while there may be various forms of NGOs that often exist with distinctive focuses, these "tend to be involved in one way or another with development initiatives that are concerned with service delivery, capacity building or policy influencing". Also important to note is how Matthews & Nqaba (2017:5) refer to NGOs as the "mouthpieces of the excluded and marginalised". This reference reinforces the idea of how NGOs and activists play a critical role in social justice issues by representing and fighting for the human rights of the most "excluded and marginalised" groups of people. We can also refer to NGOs as the 'go-between' or representatives of civil society in political matters. While NGOs have been praised for their dedication in addressing social issues that government neglects to prioritise despite having resources to do so, others have come to critique their efficiency in addressing social justice issues and lasting development policies while also pointing to the lack of continuity of many NGOs in recent years (Piotrowicz & Ciancara, 2013; Zhang, 2005; Matthews & Nqaba, 2017)

The main objective of garnering these unique and experienced perspectives from activists and NGOs is to assess important ways in which reproductive rights issues can be addressed and mitigated in ways that can bring about pragmatic solutions to creating more accessible, safe and legal abortion for South African women (Albertyn, 2015; Klugman, 2011). In the following sub-sections we take a look at how activists view some of these issues based on their expertise.

4.2.1 Reproductive rights and access: Most important concerns

Women throughout the world have a long history of being marginalised and censored from public participation as a result of patriarchal ideologies. However, in recent decades women's movements, civil society organisations and global conventions on human rights have led to significant constitutional changes that have resulted in making way for women to enter the political arena and help implement further changes that would promote equality, autonomy, dignity and other women's rights (Blee & France, 2001; Geisler, 2004). This is particularly true for South African women. For example, women are celebrated and commemorated annually in the month of August (City Press, 2011). However, even when women are the centre of attention for that short space of time, the combination of problems they face are not sufficiently addressed.

The most commonly discussed topics include gender-based violence, HIV/AIDS, maternal mortality with little to no discussion on sexual and reproductive health or related socio-economic matters that affect women's lives in making reproductive health decisions etcetera (City Press, 2011). This problem, coupled with an ineffective liberal abortion law that has repeatedly failed to cater for the most marginalised women in South Africa, can hardly lead us to say that all South African women have experienced full reproductive autonomy. This view is supported by the following quote. "Freedom cannot be achieved unless women have been emancipated from all forms of oppression ... unless we see in visible and practical terms that the condition of the women of our country has radically changed for the better, and that they have been empowered to intervene in all aspects of life as equals with any other member of society". (Mandela 1994, cited in Baden, Hassim & Meintjies, 1999:4). While various NGOs have disappeared over the years after implementation of the CTOP Act, some remain in the battle of addressing social justice matters that affect women in South Africa (Klugman, & Mokoetle, 2010).

On the topic of reproductive rights civil society groups, authors and researchers may have a general agreement on what they consider to be the central problems facing women regarding the 'access issue' in South Africa (Hodes, 2016; Lomelin, 2014; Althaus, 2000; Guttmacher *et al* 1998; Klausen, 2015, Davis, 2003). However, *how* these are posed in relation to the general reproductive rights access issue is what is most important as this could be an indication of why such problems exist in the first place, why exactly it should be considered a social problem, what exacerbates these and how these could be overcome etcetera.

What stood out among respondents when they expressed their opinion on what exactly it is they are most concerned about when it comes to the reproduction rights and access issue was their expression of strikingly similar concerns. This revealed that despite NGOs and activists 'competing' for resources, and often having 'conflict' amongst each other or lacking funding from donors, they consider the most common or serious issues in a similar light (Zhang, 2005; Piotrowicz & Siancara, 2013). What this further reveals is that some reproductive rights matters such as the plight of illegal abortion, lack of public health information, lack of service provision and the discrimination and marginalisation of black young women are all too common throughout South Africa. While women in general were considered to be an oppressed social group as a result of patriarchal structures in the past, in South Africa during Apartheid black women were the most marginalised (Donchin, 2015). Although it is often noted that 'blacks' during Apartheid suffered a "triple yoke of oppression" through gender,

race and class, black women were victims of additional oppressions relating to law and custom (Nolde, 1991:203-204). This means that black women were more oppressed than other 'inferior' groups such as black men and white middle-class women. Restrictive and discriminatory laws under the Apartheid regime such as the Abortion and Sterilization Act of 1975 put many black women's health and lives in serious danger and twenty years later, reformed 'liberal' abortion laws are ineffective in catering for black women's reproductive and socio-economic needs (Nolde, 1991; Klausen, 2015; Poinsette, 1985). Thus, leaving black women as a marginalised social group facing similar problems as a result of past injustices that largely remain unresolved more than two decades after democracy (Veeran, 2000; Nkosi, 2014).

In addition, when considering how long it has been since reforming of restrictive abortion laws, this clearly points to an enduring problem of a lack of implementation on the part of the State. This then raises the question of why the State has not yet effectively been held accountable by civil society groups to address these matters. This area requires further attention, research and more effective and lasting solutions so that even the most marginalised women are catered for and thus doing away with restrictions faced by these women from fully achieving reproductive autonomy (Dlamini, 2014; Ross, 2006; Smith, 2005). For example, Albertyn (2015:448) points out that "At present, the gap between rich and poor in access to healthcare in general, and reproductive healthcare in particular, is significant. Women with means access private services. Poor women rely on the state or illegal providers, to the detriment of their health and lives". The same observation resonates with realities faced by marginalised black women under the Apartheid regime (Nkosi, 2014; Poinsette, 1985; Maharaj and Rogan, 2007). Ivy expressed her concern regarding the reproductive rights and access issue as follows:

The fact that there is absolutely no activism; no public health information regarding abortion services as provided by the state facilities is a form of violence.

There are women who still think abortion is illegal yet for more than 20 years they have had the right to have the procedure.

Lack of information on what to expect, how to tell a bogus facility or provider, all these are important details that are needed in order to counter all the dangerous lies being advertised over lampposts, internet and newspaper ads.

The other issue is the continued lack of services (contraception, counselling etc.) and discrimination of specifically young women, in most cases black, based on their location or that they are in school uniform when they come to clinics. They remain vulnerable and are unable to afford private healthcare therefore are further violated by the system (Questionnaire, Ivy*).*

Ivy's argument of there being "absolutely no activism" has the implication that there are no current civil society organisations and campaigns actively involved in addressing sexual and reproductive rights and access issues. This is not entirely true as there is evidence of currently active advocacy on the matter in South Africa. Some examples include the Reproductive Health Research Unit, the anti-illegal abortion campaign launched in 2015 by the KZN Department of Health, the #EndAbortionStigmaInitiative by the WISH associates and Make Women Matter by Marie Stopes (Klugman & Mokoetle, 2010; John, 2015). However, the strong impression that Ivy like so many others have of the near total absence in the representation of women's issues is itself interesting. It shows the serious concern of the evidently unsympathetic and impervious attitudes of society to women's health and women's rights.

A better expression on the state of activism in South Africa should perhaps be expressed in a manner that speaks to the little support and limited effective results emanating from existing organisations and campaigns for reproductive rights and access (Zhang, 2005; Matthews & Nqaba, 2017; Hendrickse, 2008). In their work, these authors speak to the decline of previously efficient organisations and activists involved in sexual and reproductive health rights work. This area also requires further research as to why exactly in post-democracy we experience a decline in reproductive rights advocacy. NGOs are currently described as being in deep crisis. Some of the reasons for many NGOs facing difficulties in being effective in achieving their objectives while providing lasting change is attributed to many NGOs struggling to adjust to a rapidly changing society, inability to raise funds, lack of leadership and management capacity, and many facing attacks from government leaders (particularly the ANC) for their constant criticism of poor service delivery by the government (Gumede, 2015; Matthews & Nqaba, 2017; Hendrickse, 2008). This was different prior to South Africa's democracy where civil society groups such as NGOs played key roles during the struggle in fighting for the rights of the most disadvantaged, marginalised groups when the Apartheid government intentionally neglected to cater for the needs of non-whites (Gumede, 2015).

During this time many NGOs were very strategic in challenging the Apartheid State's *modus operandi* and this was largely due to widespread support from donors and other interest groups who simply wanted to end the repressive reign of apartheid (Matthews & Nqaba, 2017; Zhang, 2005). A few years into successfully achieving this objective NGOs started suffering a loss of continued support from previous donors, hence playing a major role that lead to the decline of many NGOs in South Africa. A more recent example of this is seen from the plans of United States President Donald Trump in which he revealed that his administration fully intends to shut down all forms of support for U.S-funded organisations around the world on abortion issues (Wulfhorst, 2017; Aizenman, 2017). This means that various NGOs and campaigns supporting reproductive rights and abortion (including those in South Africa) that previously received financial support from the United States will now suffer as a result of President Trump's overtly anti-abortion stance. Not only will these organisations suffer, but many women's hopes of experiencing reproductive freedom and autonomy will now be destroyed.

On the matter of there being a lack of public health information regarding abortion services, Ivy's view is supported by various studies that found that South Africa faces problems of information barriers regarding women's reproductive rights, health information, and where abortion facilities can be accessed including information on when and under what circumstances abortions can be obtained etcetera (De Pinho & Morroni, 198; Althaus, 2000; Maharaj & Rogan, 2007). Hodes (2016:79) refers to this as a 'paradox' in pointing out that while abortion may be legally sanctioned, it is often publically condemned by political authorities and healthcare workers. This observation resonates with that of Varkey's comment in an interview with Althaus (2000:86) when he points out that "the government says 'do it', but provides no funding". This contradiction indicates that despite liberal abortion laws on paper, without strong political will and support from interest groups on matters pertaining to women's reproductive health rights that women – especially the most marginalised – are facing tough times ahead with a discouraging battle for true reproductive freedom and empowerment.

In addition, Ivy's comment on the lack of activism or governmental support for women's reproductive rights issues is well-captured in Klugman & Mokoetle's (2010:12) work where it is pointed out that "…the strong political and governmental support for a human rights approach to sexuality and reproduction, and to gender equality, are decreasingly evident in government choices as to what issues are and are not addressed in provincial, national and

international forums" and further that "…the decline in civil society voice has enabled politicians to speak and act with impunity". Clearly, in order to address observations such as Ivy's, there is an urgent need for growing civil society support and action (Hendrickse, 2008; Albertyn, 2015; Matthews & Nqaba, 2017). This could include coming up with more pragmatic solutions to suggest to legislators as was the case during the transition into democracy or alternatively hold the State accountable for failures of policies that were implemented and which civil society, especially marginalised women, do not benefit from (Maharaj & Rogan, 2007; Human's Rights Watch, 2011; Setou, 2015). Griffin (2006:3) points out that "In many countries systems are not in place for the population to demand accountability of the government to provide quality services, and there are limited opportunities for civil society groups to participate in policy debates". In countries where there are such systems in place, the problem may sometimes be that the platforms on which civil society groups aim to hold government accountable are inadequate or inefficient (Griffin, 2006).

An example of how civil society can effectively position themselves can be found in an 'advocacy guide' provided by The Centre for Reproductive Rights (2003) entitled *From Rights to Reality: How to Advocate for Women's Reproductive Freedom Worldwide*. Once civil society organisations possess the knowledge and skills of holding the State accountable they could go a step further and demand that government or legislators create task groups that will be committed to working with activists and organisations in addressing reproductive rights issues. This could yield far better results as it incorporates the idea of "public participation" where civil society advise their leaders on how they could best be served, and it also speaks to a bottom-up approach that has been shown to empower communities and build good relationships between State and society in general (Nyalunga, 2006; Houston *et al*, 2001; Human Rights Watch, 2011; Centre for Reproductive Rights, 2003; Rowe & Frewer, 2005)

However, another important observation found throughout studies on the barriers to effective implementation of the CTOP Act is that the issue of HIV/AIDS is regarded by government and NGOs as a top priority under the sexual and reproductive health discourse with reproductive rights issues largely remaining neglected (Maharaj & Rogan, 2007; Griffin, 2003; Mosley *et al,* 2016). Where reproductive rights are mentioned in the sexual and reproductive health discourse it is generally in passing and not thoroughly engaged.

4.2.2 “Best abortion law in the world”

Despite being generally described as ‘liberal’ some authors often critique the CTOP Act for some of its contents and usually point out that it has not yet been successfully implemented to cater for all - especially the most marginalised –women, whereas some are simply against it being ‘too liberal’ based on religious, moral and cultural grounds (McGill, 2006; Hodes, 2016; Klausen, 2015; Osman & Thompson, 2012; Pearson, 2015; Griffin, 2006; Rebouche, 2011). By expressing dissatisfaction toward the CTOP Act being ‘too liberal’ on moral and cultural grounds points to such individual’s stance of not considering women’s health or lives as a priority or the deaths of so many women being a social issue in South Africa. However, part of the reason for reforming previously restrictive abortion laws was to make abortion more liberal so that women can stay away from putting their lives in danger by accessing unsafe, illegal abortion facilities throughout South Africa (Klausen, 2015; Guttmacher *et al*, 1998; Hodes, 2016; Albertyn, 2015; Mhlanga, 2003; Althaus, 2000). This further has the implication of such individuals showing no regard for the Constitution which formally recognises women’s rights. Contrary to some authors’ dissatisfaction with the CTOP Act, one respondent celebrates it for being liberal formally but notes that there is room for improvement in terms of implementing it to widen access:

> *I think it’s probably the best abortion law in the world from the point of view of giving women the right to make decisions about if and when they want to terminate a pregnancy. The fact that adolescents don’t need parental consent is very very significant since so many are pregnant because of violence in the extended or immediate family or in schools and are not supported by their parents, or even able to talk to their parents about this. The fact that nurses, with appropriate training, can conduct abortions in principle means that abortions could be available to poor, rural women. Of course the government’s failure to seriously implement the law means that this access is not always there* (Questionnaire, Ivy)

Ivy makes it clear that she is satisfied with the legal provisions of the Act when she highlights how it gives women the power of choice to decide “if and when they want to terminate a pregnancy”, the absence of parental consent and that rural residents can also now be catered for even by qualified nurses. However, her concern regarding the Act is that some realities such as, for example, the barriers discussed in Chapter Two often make accessing abortion and other reproductive health services extremely difficult for many women (Hodes, 2016; Klausen, 2015; Harries *et al,* 2009; WHO, 2001; Lomelin, 2014; Grimes, 2006; Mhlanga, 2003). However, the problem - and a common observation throughout the literature in the

study – is that not all women have the power of choice of being able to decide "if and when they want to terminate a pregnancy" since many have poor knowledge of the CTOP Act and its contents or in some instances possessing no knowledge of the legality of Abortion in South Africa (Hodes, 2016; Buchamnan, 2015; Cooper et al, 2004; De Waal, 2013; Davis, 2013; Harries et al 2009). When asked if they ever refer to the CTOP Act in campaigns or try to make others aware of its contents one participant expressed the importance of having this knowledge as a reproductive rights advocate and that of making the public, for whom the Act is supposed to benefit, aware of their rights.

Indeed my time and public health education drives have been online, on social networks and also when I am invited to facilitate and often speak at events, I always refer to the Act as it is the guiding document. [Many people do not know what a facility that offers abortions should have, they still have lack of information regarding the process at different gestations etc. the only way we can truly have people that need terminations make informed decisions is by giving them the information to do so] (Questionnaire, Ivy).

Referring to the Act as "the guiding document" is an indication that this activist regards the CTOP Act and the knowledge of its provisions as crucial, not only for advocates of reproductive rights but also for those women who would need to make use of its provisions at some point, as well as abortion providers (Harries e*t al*, 2009; Honikman *et al*, 2015). In their study, Harries *et al* (2009) have found that in some cases where healthcare providers often turn women presenting for abortion services away, these healthcare providers are not fully aware of the provisions of the CTOP Act. This then adds to the various complications and barriers women often face when falling victim to unwanted pregnancies. When considering this common occurrence at health facilities being one of the factors regarded as barriers to accessing safe and legal abortion, it becomes clear that knowledge of the CTOP Act is crucial to the effective provision of abortion services and, equally important, for respecting women's dignity, bodily and psychological integrity (O'Sullivan, 2011; Griffin, 2006; Albertyn, 2015). This needs to be considered an important aspect as the attitudes and knowledge of abortion providers often play a very significant role in determining whether women go through with obtaining safe, discrimination-free and legal abortion at health facilities (Harries et al, 2009; Honikman et al, 2015). Therefore, it is also important for this to be incorporated into campaign work, or where it is already part of some campaigns, that its focus be strengthened.

4.2.3 The 'gap' between rights and access

The overarching lynchpin of the study is the problematisation of the perceived gap between 'law' and 'access' for women's reproductive justice in South Africa. As discussed in Chapter Two under *2.3.1 The Harmful Effects of Illegal Abortions* advocacy has become weaker on sexual reproductive health rights issues in recent years (Hendrickse, 2008; Klugman & Mokoetle, 2010:12). This is partly due to the decline of major organisations who played a role in the success of changing previously restrictive abortion laws to a more liberal one. Research on this decline of major organisations is generally attributed to "lack of leadership and management capacity and lack of funds". (Gumede, 2015; Matthews & Nqaba, 2017; Klugman & Mokoetle, 2010:13-16; Klugman, 2011:151).

Where there are 'new' organisations formed there is often the inability to grow efficient leadership and support from donors, the inability to properly manage resources and finances as well as to the failure to "continually adjust strategies in a rapidly changing political, economic, cultural and donor context" (Klugman & Mokoetle, 2010:16). It can thus be concluded that part of the reason for the ineffectiveness of various campaigns and organisations on reproductive rights access issues is that since previously restrictive abortion laws were successfully reformed since apartheid many of the "major" organisations for reproductive rights matters such as the Reproductive Rights Alliance, Women's Health Project, the Progressive Primary Health Care Network felt that the struggle was complete and successful (Gumede, 2015; Zhang, 2005; Klugman & Mokoetle, 2010). Kihato (2001:12) makes the argument that in South Africa support from many NGOs for social justice issues "declined after 1997 because of growing confidence in the government and the reduced threat of violent upheaval". However this is not entirely the case as government shows little interest in prioritizing women's matters in the political agenda.

The following is a response from Ivy on the question of whether there is a disjuncture between the CTOP Act and access to making use of the services as provided for in the Act.

Absolutely there is a major gap with what is literally accessible and available and to what is provided for in paper. The ACT is in need of ongoing analysis and improvement because it has to serve the people it intends on assisting well. The legal framework has to be one that can be used to hold implementers accountable for failures of service provision and really be more than an academic document.

The Act, as we have proof with the statistics, has not translated into literal access and reproductive rights of people continue to be violated, especially those who depend on the state to provide services. The Act may be used in court, perhaps someday when

legal firms or movements can afford to force the government through the court to provide what is set out in law; much like the Limpopo textbook case. And we know in South Africa, funding will come for many causes but not much in the area of abortion access, due to the highly stigmatised area of work it is. (Questionnaire, Ivy)

This quote highlights the perceived disjuncture and also speaks to accountability in that the legal framework needs to allow for certain provisions so that civil society groups can adequately hold legislators accountable in instances where there is evidence of failure to provide services to the general public. Ivy also hints to the hope that should civil society groups be effective and thoroughly prepared with sufficient support and resources someday, that they would hopefully be able to successfully challenge and hold the State accountable in court to ensure better delivery of services relating to reproductive health. Through specifically referring to the Limpopo textbook case on how government has been held accountable in other departments such as Education through the actions of NGO intervention, Ivy seeks to highlight how, using similar or different avenues of action, civil society groups can influence change and hold government accountable for reproductive rights policy failures so that service provision can be improved and be made more accessible to marginalised women.

Lastly, the respondent addresses a sad reality in South Africa – that "funding will come for many causes but not much in the area of abortion access, due to the highly stigmatised area of work it is". In a similar vein, Washington & Tallis (2012:8) point out how "inadequate funding for family planning is a major factor" behind some governments being unable to fulfil commitments to improving the reproductive health of women. More research is required here to go back to investigating those "major" organisations that were involved during the transition into democracy and who played a key role in reforming the restrictive abortions laws from the Apartheid era. Some important questions needing to be looked into is what the particular objectives were at that time, how - and which - donor sponsors were involved, why these stopped supporting campaigns and organisations, why certain organisations closed down, and why those in leadership positions retired from the reproductive rights movement in South Africa etcetera. Research into these areas of inquiry can produce some information that can help improve the access to reproductive services for women in South Africa.

4.2.4 Abortion campaign advocacy vs. other gender-based campaigns

Gender-based campaigns and abortion campaigns are surprisingly treated with some modicum of separation by governments and some civil society organisations in that they tend to focus more on addressing gender-based issues such as violence against women as separate from other forms of violence experienced by many woman in South Africa such as emotional and psychological abuse in reproductive rights matters etcetera (Mosley *et al*, 2016; Albertyn, 2014; Maharaj & Rogan, 2007) This is impactful because the separation operates within a hierarchy , which often places concerns such as sexual violence and HIV/AIDS related matters as priorities over reproductive health services and consequently bypassing an intersectional approach with a framework such as, for example, Reproductive Justice. (Ross, 2006; Smith, 2005; Griffins, 2006; Klugman & Mokoetle, 2010). Furthermore, since these are often treated as separate from each other, donor support is sometimes more focused on some campaigns more than others, if any support is provided at all – creating an environment of fierce competition for funding between different campaigns and organisations (Matthews & Nqaba, 2017; Klugman & Mokoetle, 2010). This competition for limited resources places abortion rights matters at odds with other gender-based campaigns. Some activists, however, recognise the interconnectedness of these varying yet similar women's rights issues. Here is an example:

They are the fight for the same marginalised person. We all know the horrid statistics of sexual violence that women face and many of those women do get pregnant from being raped.

It makes no sense to fight on the one hand against GBV during16 days of activism and go on to neglect the same women when dealing with the repercussions of that violence. Women in different stages of their reproductive lives require different services and I have seen this so often when people judge others and later find themselves in situations where they are the one in need of services and find it difficult to ask for help. (Questionnaire, Jill).

The observations Jill makes about engaging in the fight against Gender Based Violence or supporting the cause only for a certain period yet "neglecting the same women when dealing with the repercussions of that violence" is a problem that is evident throughout South African society (Mosley *et al*, 2015; Maharaj & Rogan, 2007). The "16 Days of Activism" campaign generally garners quite a lot of support nationwide from both men and women, politicians, religious organisations, and other civil society groups (Govender & Fever, 2016; Klugman & Mokoetle, 2010:11). Unfortunately, the same cannot be said about support women who

require help regarding their reproductive health needs (Hodes, 2016; Klugman & Mokoetle, 2010). For example, there are many adverts on various media platforms i.e. television, radio, newspapers etcetera which speak to Gender-Based Violence, yet very little (if at all) about the reproductive rights and access issue in South Africa.

Were there not so much gender-based violence, fewer women would become pregnant unintentionally. In general you seldom hear people who are talking on the radio about gender based violence, or who are raising the profile of cases of murders of women, bringing abortion into the discussion. (Questionnaire, Jill)

While supporting the cause of 16 Days of Activism, societies could simultaneously bring widespread attention to unwanted abortion matters as unwanted pregnancies can also be considered a violation of South African women's human rights (Mosley et al, 2016; Maharaj & Rogan, 2007). Activists can play a remarkable role in eliciting the connections between gender-based violence and abortion issues in the public imagination (Mosley *et al*, 2016). Suffice to say, till now this has been a blind-spot in the discourse of violence against women.

4.3 Challenges to reproductive rights advocacy

The post-Apartheid transition offered to women and civil society organisations a social climate favourable to the construction and defence of new ideas of change (Albertyn, 2015; Klausen, 2016; Hodes, 2016). Over the years, the State and other civil society groups such as NGOs and reproductive rights advocates managed to successfully defend formal claims against the contents of the CTOP Act in court (Albertyn, 2015:441:442). However, challenges against women's reproductive rights and access has not been limited to formal spheres. Several reproductive rights movements and advocates, along with desperate, vulnerable clients often face different forms of attack for their pro-choice stance. This is an example of what one reproductive rights health activist has encountered:

Like every other safe abortion rights Campaign, we encounter anti-abortion movements who try to delegitimize what we do. Anti-abortion groups try to spin false information in every way possible: through websites that claim to 'help' pregnant women, but in fact only tell cruel lies; by standing outside abortion clinics and intimidating people seeking abortions, and staff; by setting up their own 'clinics' that may refuse to treat women with complications due to miscarriage/unsafe abortion; to taking legal action and pushing through unconstitutional bills that create barriers to access (such as compulsory waiting periods).

As the [name of campaign] is mostly a web-based network of groups, we mainly encounter anti-abortion groups 'trolling' our social media pages. We have to be careful how and when we publish news, especially requests for international solidarity, as anti-groups will often take our information and try to protest it. (Questionnaire, Eve).

Challenges from anti-abortion movements is evidently a common occurrence in South Africa (Albertyn, 2015; Klugman & Mokoetle, 2010; Hodes, 2016; *Christian Lawyers Association v. Minister of Health, 1998; Christian Lawyers Association v. Minister of Health, 2005*). Moreover, it seems to grow stronger with the increase in avenues of communication e.g. blogs, social sites e.g. Twitter, Facebook etcetera (Mattison, 2011; Centre for Reproductive Rights, 2003; Murray, 2008:260). As suggested by Eve quote above, anti-abortion groups are now adapting their tactics and targeting pro-choice movements through their websites whereby they hijack information and use it to strategize against pro-choice groups. Eve also refers to the act of 'trolling' on their website. The term is slang used to refer to internet users who intentionally pass false and aggravating information to start quarrels. Clearly the aim here is to hinder and delegitimise the reproductive rights and pro-choice movements from helping vulnerable women. One would think it should be easy for such individuals to be reported for harassment, however, many people get away with it as they often create and use fake accounts that in most cases cannot be traced back to them. Although this particular respondent largely speaks to harassment through the internet, this extends beyond cyber harassment against reproductive rights activists and organisations as some individuals get physically harassed or threatened for seeking abortion or for helping women obtain abortions. This generally takes place outside abortion healthcare facilities. For example, as noted by another respondent:

The abortion provider abuse by people is a much more evident and spoken about from the USA perspective and not much is written about the South African experience. My friends, colleagues and Marie Stopes' clients in Cape Town are constantly harassed by people who do not respect the laws and women's right to make decisions regarding their bodies (Questionnaire, Ivy).

This is an unfortunate and bitter reality that is all too common throughout public and private healthcare facilities providing abortion services in South Africa. However, as highlighted in the quote, "not much is written about the South African experience". This speaks to the daunting reality of how the media has little involvement in addressing women's rights issues (Hodes, 2016; Smith, 2005). But, the media's silence is arguably reflective of the weight given to women's abortion issues in society as a whole, in the academy, within communities

and by the government. The issue of abortion and the social difficulties it presents for women needs to be more visible in the mainstream. It is with the hope of achieving a new and dedicated discourse on abortion that pro-choice campaigners continue in their work.

4.4 Shaping attitudes and knowledge

The attitudes and knowledge of individuals or societies is a common feature in many texts investigating barriers for women seeking safe abortions (HEARD, 2016; Harries *et al*, 2009; Hodes, 2016; Griffin, 2011). Authors generally highlight how negative attitudes and ill-perceptions or lack of knowledge are shaped by cultural and traditional influence, religious beliefs, education etcetera. One of the ways to fighting barriers to accessing reproductive health service provisions is through dealing with perceptions around abortion (Griffin, 2006; Klausen, 2015; Hodes, 2015). As recommended by Jannat *et al* (2016) one of the avenues of doing this is through including sexual and reproductive rights in the curriculum of education in schools, colleges and universities . When asked if they think it is better for parents to teach their children from a young age about reproductive health and women's rights or rather that this would work best when taught in a comprehensive manner at a formal institution such as at school, Ivy had the following to say:

We cannot separate these two forms of learning and discovery. The learning in the home begins as early as when the toddlers play and soon ask about their body parts. Often because parents and caregivers are ill prepared for these moments they tend to react harshly and with negativity or even scolding. Children do not learn well under these types of conditions and worse some go on to smack children and accuse them of being forward or fast.

These reactions to children and young people set the tone for future engagements and they learn to not go to the adults or care givers for clarity out of fear. This is how children and young people end up relying on the internet, magazines, other adults (which you may not know what values they have) and other children.

School curricula must definitely have comprehensive sexuality and reproductive health education for every learner. This should not be reserved for those who do biology, which is not adequate, and only focuses on anatomy or those who do Life orientation as this subject is very poor when it comes to content. We have seen the questions in the exam papers in Life orientation as well as textbooks which promote rape victim blaming and is frankly criminal to be teaching and asking children to describe how someone's dress code could have contributed to them being raped. (Questionnaire, Ivy).

This articulate and straightforward response provides reasons as to why both forms of learning are crucial to teaching young South Africans about reproductive and women's rights

(Horn, 2003; Klausen, 2015). Ivy also offers an astounding critique of how contemporary curricula in particular subjects such as Life Sciences and Life Orientation neglect education about reproductive health and rights. These are supposed to be the very subjects for critically engaging such matters. Instead the content and learning material is described as "very poor".

Ivy observes that exam questions set up by the Department of Education which do speak to gender tend to be about violence and are posed in ways that promote "victim-blaming" when it comes to rape and how women are dressed. Clearly, this is a serious problem in South African education in that department(s) of education show little comprehensive understanding of the sex-specific trials faced by women in our society. By neglecting to thoroughly engage women's issues through a constructive light in their academic syllabus they add to the marginalisation of women's issues in society. (Stevens (2011:24) quotes how at the International Conference on Population and Development in 1994 government representatives agreed that "Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality". It is evident that not much dedication and effort has been put into realising this agreement (See NCCEMD Report, 2012). Furthermore, Stevens (2011:26) highlights that, "research further indicates that teenage pregnancy is as a result of a complex set of varied and inter-related factors, largely related to the social conditions under which children grown up". Therefore, these issues cannot be addressed in isolation to the larger social problems that heighten or increase the chances of teenagers or vulnerable women falling victims to unwanted pregnancies.

4.5 Illegal abortion: the major problem

The most commonly discussed issue regarding abortion in South Africa is the dilemma of why and how illegal providers continue to thrive in a country that is frequently described as possessing one of the 'greatest', 'most liberal' abortion laws in the world (Orner, 2011; Hodes, 2016; Lomelin, 2014; Albertyn, 2015; Klausen, 2015; Althaus, 2000). The answers arrived at to these questions through the review of literature, more often than not, speak to the various barriers to accessing safe, legal and discrimination-free abortion services as a major cause for the existence of widespread illegal, unsafe abortion. What is clear is that an industry of illegal abortion practitioners has thrived on the existence of said barriers to access. For example, we see colourful adverts on lamp-posts, walls, taxi stations and many other places

promising "quick, same day, pain-free and cheap" abortions. This shockingly widespread visibility is captured by one of the respondents:

The illegal posters are present on lampposts outside the National department of health's offices in Pretoria. That's how easy and without consequence illegal people move. (Questionnaire, Ivy)

Many illegal providers position themselves in such a way that it is not always obvious to women that they are not trained professionals (Lomelin, 2014; Althaus, 2000; Orner, 2011). Sadly, at times some women are well aware of their reproductive rights and the dangers of illegal abortion providers but due to mistreatment at public healthcare facilities, lack of finances to visit private legal providers such as Marie Stopes or out of desperation they are forced to put their lives and health in danger by opting for illegal, unsafe services (WHO, 2003; Althaus, 2000; Osman and Thompson, 2012; HEARD, 2016). As discussed under Section 2.3 of Chapter Two, opting for such services has various health consequences and, in worse cases, even death. While unsafe, illegal abortion may be regarded as a problem by some, in the context of difficulties in accessing safe, legal abortion some desperate and vulnerable women may regard the abundance and privacy of illegal providers as a solution to their unwanted pregnancies. Hence, during data collection, activists were asked if they consider illegal abortion as a problem and why they thought so. Two responses stood out:

The issue is with unsafe procedures as well as illegal abortion pill sellers and providers. It cause not only death from vaginal bleeding and uterine rupture but immense morbidity due to injuries and sometimes complications that lead to hysterectomy and therefore infertility (Questionnaire, Ivy).

Yes. Untrained abortion providers endanger women's health and dignity. Trained providers can of course provide them illegally without danger, but they are likely to charge women who can ill afford the expense (Questionnaire, Jill).

From both responses we see that activists are primarily concerned with the health dangers associated with untrained providers as they generally only induce abortion and tell women to present to public healthcare with severe complications. However, while Ivy focuses only on the health aspect, Jill points out that trained providers can provide safe abortions legally and these are likely to be without the common serious dangers as with untrained providers. Moreover, Jill goes on to argue that in this instance chances are that trained providers would charge women who are unable to afford to pay. This is a good observation. However, should any trained providers consider this option of "providing illegally without danger" they must bear an important factor in mind – that as history has shown, it is often the most marginalised

and poorest of women who opt for abortions that should be free or affordable since in some instances they opt for abortion particularly as a result of low socio-economic status (Klausen, 2015; Althaus, 2000; Osman and Thompson, 2000). This is supported by Hodes (2016:86) where she argues that the most frequently cited reason for abortion in South Africa falls under the category of "socio-economic grounds".

4.6 The Way Forward

Having set out to base the fieldwork for this study on engaging with activists who have previously been or are currently involved in various campaigns and organisations that deal with the reproductive rights issue on a more regular basis, it became clear that of the most important data to be captured from their unique perspectives would be their ideal proposed solutions to the access issue. One respondent had a few suggestions to make which are as follows:

- *Training during medical school and nursing college must be pro-choice and supportive, empathetic to people who require the service.*
- *Continued medical training for those in practise to keep clinicians updated*
- *Information on the fact that abortion is legal in RSA as well as the supporting Legal framework, for example, CTOP act needs to be disseminated and provided to lay people as part of a public health communication national strategy.*
- *Continuous quality checks of existing facilities and maintenance of good clinical standards and protocols*
- *Ensure medication stocks are up to date.*
- *Network mapping of available facilities and flow charts of referral systems*

(Questionnaire, Ivy)

The suggestions provided by the respondent shows a clear focus on changing or improving some of the provisions within the Act in ways that would lead to improving healthcare provider's experience and tasks in dealing with women seeking abortions. Furthermore, the respondent also proposes ways in which the quality of service provision can be bettered at public healthcare facilities. However, what is important to note here is that it can be relatively easy to pinpoint where service provision can be improved, but without political will the issue of reproductive rights may long remain lip-service to women's rights discourse with no actual engagement to effectively improve services (Maharaj & Rogan, 2007; Hodes,

2016). One of the issues that was omitted from this response, however, was that the most marginalised groups of women was not addressed. For example, those women of low socio-economic status who are faced with many other intertwined problems such as poverty, discrimination, staying at far distances from the nearest health facilities, victims of gender-based violence and so forth. A different response by Jill was as follows:

Get a new Minister of Health who is not anti-abortion; Get those in government responsible for women's rights to hold government accountable for safe and equitable service provision; build a strong movement for sexual and reproductive rights with young black women in its leadership. The Sexual and Reproductive Justice Coalition is an important step in that direction (Questionnaire, Jill)

This can be interpreted as a call to civil society to make more significant use of their right to public-participation and have government representatives who are part of the task-team for women's rights to address the issue with government by holding them accountable for lack of service provision (Houston *et al*, 2001). What stands out in this contribution is the reference to empowering young black women into leadership positions of the sexual and reproductive rights movement. This would be a ground-breaking move as young black women, being a marginalised group, would be empowered to lead the way and steer the movement into a direction that will ensure catering especially for the generally most marginalised groups of women (Ross, 2006; Dlamini, 2014). This speaks to a bottom-up approach that can inspire high self-esteem and a sense of empowerment and autonomy for previously marginalised women (Amroussia, 2016).

4.7 Application of Theoretical Framework

"Equality Does Not Always Mean Justice" - Unknown

Data from the fieldwork regarding women and the difficulties they face when accessing reproductive health services often highlights that some women are more affected as a result of past injustices. It was black, young women" who were often referred to as the most marginalised. Furthermore, fieldwork data including literature reviewed led to the conclusion that black young women still being marginalised today as a result of past injustices is a clear indication that simply changing a previously discriminatory law does not outright remedy those past injustices.

Rather, while planning legislation for a liberal abortion reform during the transition into a new democracy, legislators, civil society groups and the State may have built a very different

foundation by applying a framework such as that of 'intersectionality' and/or reproductive justice which aims to specifically improve previously marginalised women's social conditions. However, since these concepts were relatively new and specific to the USA at that stage one cannot blame legislators for not having adopted intersectionality and Reproductive Justice as frameworks for inclusion in the CTOP legislation. Nevertheless, it is not too late to consider adopting these frameworks. It has been argued that the South African historical context is much like that of the USA's where black women were marginalised and experienced various interconnected injustices (Albertyn, 2015:439; Dlamini, 2014). Similarly, due to South Africa's cruel and racist history black women suffered the triple oppression of race, gender and class, positioned at the bottom rung of the social hierarchy (Klausen, 2015).

Findings in the study indicate that current activists are in support of Reproductive Justice Framework in addressing the interrelated problems facing marginalised women such as racism, discrimination, poverty, ill-health, abuse lack of education, insecurity and culture etcetera (Ross, 2006, Albertyn, 2015 Smith, 2005). Authors such as Albertyn (2015) and the Minister of Social Development, Bathabile Dlamini (2014) have also pointed out the need for South Africa to adopt the Reproductive Justice Framework to better address the various interconnected social problems that remain part of marginalised black women's lives long after the end of Apartheid. This will require various activists, NGOs, legislators, and especially political will from government and other interest groups to come together and share resources and ideas on how to effectively adopt the Reproductive Framework within the CTOP policy to cater for the most vulnerable and marginalised women.

4.8 Conclusion

Based on literature reviewed and information revealed through fieldwork it is clear that South Africa faces various problems that require immediate attention and change. Some of these include: the abundance of illegal abortion providers in a country with liberal abortion policies, serious lack of service provision at healthcare facilities, lack of public health information distributed to wider audiences needing abortion services the most, lack of support for organisations and campaigns dealing with reproductive health rights issues, general lack of respect for black young women at public abortion facilities etcetera (Hodes, 2016; Albertyn, 2015; Guttmacher *et al*, 1998; Osman & Thompson, 2012; Hodes, 2013; Pickles, 2013).

These various problems, left unchecked, will continue to worsen the issue of access, particularly for the most marginalised women. If we look to active reproductive rights advocates to help mitigate these problems and aid in widening access to safe, legal and discrimination-free abortion then there is an urgent need to involve a wider audience in civil society for support. For this to occur, the topic of sexual and reproductive rights need to be thoroughly addressed and included in the discourse of violence against women when addressing issues such as gender-based violence, HIV/AIDS, poverty etcetera (Griffin, 2006; Maharaj & Rogan, 2007; Hodes, 2016). What has been observed rather is that sexual and reproductive health rights is treated as a sub-category when talking about problems facing women in South Africa (Maharaj & Rogan, 2007). This can explain the lack of in-depth discussion to address the intertwined problems faced by vulnerable women. Also, with the State showing little public support for women's reproductive rights issues in the political arena other NGOs supporting government tend to invest resources in more prioritised issues such as HIV/AIDS when these are supposed to be dealt with, not separately, but rather as interlinked social justice matters.

The current government, as with the previous one, operates within a patriarchal symbolic and political order (Geisler, 2004). This is evident in women's matters being largely neglected when addressing health, economic, social and political issues in South Africa. Despite laws formally recognising women's rights as a social group, attitudes and actions continue operating under patriarchal ideologies (Weideman, 2004; Haffajee, 1999). Geisler (2004:9) accounts how in the 1980s, in spite of patriarchal power structures having been hostile towards the entry of women into politics, they (women) "managed to force their way into the almost exclusively male domain with amazing speed and determination". Today we see a fair representation of women in parliament, however, the power and influence women possess as having only recently entered the political arena is very limited in effectively pushing women's matters to the top of the political agenda (Bathembu, 2010). This is further limited by government's particular focus on curbing poverty, unemployment and HIV/AIDS related issues that are overwhelmingly regarded as more urgent matters than women's sexual and reproductive health needs (Bhorat, 2012).

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Discussion of findings

While South Africa boasts one of the "most liberal" abortion laws in the world in comparison to its previous restrictive laws that largely discriminated against Black women, many observers have pointed to the ineffectiveness of the CTOP Act to cater for the most marginalised women (Althaus, 2000; Mhlanga, 2003; Hodes, 2016; Guttmacher *et al* 1998; HEARD 2016; Harries *et al*, 2009). Some of the realities faced by Black women under the Apartheid regime continue to manifest in the new democratic South Africa today, particularly among Black young women. Some of these realities include discrimination at healthcare facilities, lack of support from members of the community or government, maternal morbidity and maternal mortality, lack of service provision, rurality, stigma, lack of dissemination of information regarding health and rights etcetera (Poinsette, 1985; Hodes, 2016; Donchin, 2015; Klausen, 2015; Griffin, 2006). These are but some of the many difficulties women continue to face today. Some of these factors or a combination thereof often leave women with no choice but to opt for illegal abortion providers to help them get rid of unwanted pregnancies. The dangers associated with unsafe and untrained providers has been discussed in this thesis (see Chapter Two).

Illegal abortion has long been an important part of the abortion discourse in South Africa. Due to the restrictive and discriminatory abortion laws prior to democracy women who could not afford to consult private doctors or travel to other countries for abortion consulted illegal providers in large numbers, often leading to high maternal deaths (Hodes, 2016). When civil society groups, feminist movements, NGOs and other interest groups lobbied for abortion reform in order to improve the health of women and prevent deaths among women, after much deliberation with government restrictive abortion laws were reformed and replaced with a more liberal law. The aim of this new abortion law was to improve service provision, improve access to services and the health of the most marginalised women and encourage responsibility and autonomy (Mhlanga, 2003; Hodes, 2016; Albertyn, 2016; Cooper *et al*, 2004). However, studies show that the objectives of the CTOP Act has not been achieved as women continue facing barriers to accessing reproductive healthcare at public facilities (Harries *et al*, 2009; Hodes, 2009; WHO, 2010; Osman & Thompson, 2012; Guttmacher *et al*

1998). Furthermore, these studies show how some healthcare providers are not thoroughly trained and have a lack of knowledge of the CTOP Act and thus fail to treat women with dignity and respect or help them when seeking emergency healthcare. Instead young women are often ridiculed and turned away, forcing these vulnerable women to seek clandestine illegal abortions.

Nearly all respondents, engaged with in their capacity as reproductive rights activists, highlighted that illegal abortion is a major concern in terms of the various health dangers (including infertility and death) they present to vulnerable women who may or may not, beforehand, be aware of these dangers. Moreover, some expressed great concern regarding the ease with which illegal providers can be reached by anyone in need of their services. This refers to the abundance of flyers and posters promising women 'quick', 'safe', 'affordable' and 'pain-'free' abortions. One respondent went as far as to explaining that such posters of illegal abortion services can be found right outside on the walls of the National Department of Health's offices in Pretoria. Further noting, "That's how easy and without consequence illegal people move". This, without a doubt, points to the seriousness of the scourge of illegal abortion in South Africa.

The fact that illegal providers and those who aid in advertising their services can take the risk of placing their illegal services outside the National Department of Health building is a clear indication of how little is done nationwide to protect young vulnerable women and their health from the severe dangers posed by the existence of illegal abortionists. There is little discussion in the media about this issue and about what advertising authorities and police are willing to do regarding the situation. Another problem is that community members may sometimes know those involved in the advertising and provision of illegal abortions but either feel too scared to report or do not see it as their place to. It rarely happens that individuals take action and report illegal providers and this often occurs in situations where they fear for the life of someone close to them who intends to make use of such services (See figure 1 and discussion thereof in Chapter Two). The concerns regarding illegal abortion and its harmful consequences as expressed by activists during fieldwork is an indication of how serious of a problem illegal abortion is. It can well be regarded as a social issue because of the high number of deaths and various health dangers it causes. In addition, the complications of illegal abortion most often becomes a problem to be taken care of at public healthcare facilities at the State's expense (Hodes, 2016; Osman & Thompson, 2012; Mhlanga, 2003).

With illegal abortion being such a major problem that threatens the life of many vulnerable women, and adding to the depletion of already limited public healthcare resources, one can only wonder how valuable the life of women and their reproductive rights mean to the State. However, considering how little women's issues are addressed in political discussions and in parliament it shows an indication of the lack of support for women and their reproductive rights in South Africa (Klugman & Mokoetle, 2010). Furthermore, this perpetuates the isolation of abortion from other social justice issues (Ross, 2006). With the decline of key organisations that played a significant role in reforming old abortion laws and fighting for the CTOP Act among other women's rights, government also appears to have lost interest in women's issues as though the struggle for women's reproductive rights was a once-off battle (Klugman & Mokoetle, 2010; Klugman, 2011; Albertyn, 2015). Another factor is that some of the leadership in government holds strong traditional values influenced by patriarchal ideologies and therefore do not consider women's issues as a matter of priority. Meanwhile, women continue being marginalised and stigmatised for making use of their reproductive rights to benefit from the CTOP Act in order to have control over their lives.

Based on literature reviewed that spoke to the critical role played by civil society groups like activists and NGOs, this study recognised the important stance of those directly involved in addressing various issues relating to sexual and reproductive health rights (Klugman, 2011). Hence, focusing the fieldwork on reproductive rights activists who are part of organisations that are interested in empowering women by increasing their access to reproductive healthcare. However, despite the insightful information provided by respondents what was of concern is how some expressed worry for the lack of support from civil society with regards to activism and donor support. The decline in activism and support from civil society shows a lack of concern for women's issues despite shocking statistics regarding maternal deaths and the dangers from illegal abortions.

However, a large part of this can be attributed to the lack of information disseminated to the public by the media and the State. As a guide to overcoming this one respondent suggested "Information on the fact that abortion is legal in RSA as well as the supporting Legal framework e.g. CTOP act needs to be disseminated and provided to lay people as part of a public health communication national strategy". What could be added to this are the dangers of illegal abortion, general tips on how to differentiate between legal and illegal providers, and statistics on maternal deaths. These can hopefully shock some people into action and

have them reconsider how they view women. Unfortunately, however, it could also prove very difficult since little information on women issues is covered and distributed by the media or government. Perhaps a more effective strategy would be for various activists and organisations to form alliances, as did those before them in the past to secure women's reproductive rights and implement the CTOP Act. These groups would then have to come up with good objectives and effective strategies to draw in and convince donor supporters to aid them. As pointed out by respondents, they often face challenges from anti-abortion movements and this is a hindrance to their cause of empowering and enabling support for women.

Hence by forming allies and combining resources, activists and their different organisations can share tasks and responsibilities, thereby making their jobs and achieving common objectives much easier. The issue of there being competition among activists and organisations for resources and funding is an obstacle on its own (Klugman, 2011; Klugman & Mokoetle, Albertyn, 2015). Therefore, these groups and individuals must urgently realise that the issue of fighting for the access of women to achieve their reproductive freedoms is what is of more importance and requires immediate attention and intervention by civil society. Those truly concerned with women's lives and health and their freedom can no longer stand by and hope the State, other activists, NGOs and other interest groups will intervene and solve the problem. Rather, this issue is one that requires society's undivided attention, combined support and resources to effectively change the dark, gruesome reality facing the most marginalised women in South Africa.

Information provided helped reinstate the acknowledgement of an existing gap between paper rights and access to those rights in reality, including the factors in play that are responsible for this gap. Activists also provided some ideal solutions that they think need to be taken into consideration (For some examples, see Chapter Four, section 4.7). They felt that these were likely to mitigate the various factors responsible for women experiencing difficulties in accessing reproductive healthcare and thus enabling women to experience autonomy, freedom of choice, growth and confidence as members of society (Ross, 2006; Silliman *et al*, 2004).

Speaking to the various combined social injustices faced by marginalised women, especially women of colour, the Reproductive Justice framework along with the intersectionality paradigm highlights that women's issues cannot and should not be addressed as separate but

rather as combined problems in order for marginalised women to truly experience freedom and empowerment (Ross, 2006; Silliman *et al*, 2004; Smith, 2005). As pointed out in the study and by the respondents, the women most affected by these reproductive rights issues are Black young women. The various problems they currently face shows a long history of mistreatment from the Apartheid era based on their sex and race. This history has unfortunately followed them throughout democracy where they continue to be marginalised. It is for such reasons that authors argue that the CTOP Act is poorly implemented since it continues failing to cater for such women. In working to address and solve these barriers faced by South African women, activists, NGOs, legislators and the State need to consider the history and interconnected issues facing young Black women and come up with solutions that can deal with these as, not separate, but connected injustices.

The completion of this study, like most others, was not without challenges. This study encountered a couple of challenges and limitations. Some of the main challenges faced throughout the study ranged from dealing with prospective participants to methods of data collection. When preparing and planning for fieldwork and how data would be collected, numerous prospective respondents were contacted to be part of the study. Initial contact with prospective respondents highlighted the purpose of the study and in all instances a copy of the informed consent form was distributed. Upon advising prospective participants to take enough time to consider participation at their own free will, they would respond back and agree to participate then questionnaires would be sent or, where relevant, face-to-face interviews would be planned according to their schedule. Where participation was not possible, they would often refer me to someone else through snowball sampling.

Near the agreed upon time to conduct interviews some respondents would ignore emails and calls, where some would express disinterest to participate despite being offered the alternative of completing a questionnaire instead. This left me with the pressure of having little time to find other willing participants to complete the study. Another challenged faced was that other willing participants would change from agreeing to conduct interviews to opting to fill out questionnaires due to “being too busy” and having “limited time to sit in on interviews” and other unexplained reasons. Hence this left me with open-ended questionnaires being the only tool of data collection and also engaging with a relatively small number of participants.

Limitations included having little time to complete the study as a result of delayed responses from participants. This can be overcome by other researchers through starting to seek prospective respondents as early as possible in the research process. If the study was able to conduct face-to-face interviews, the data collected and analysed could have provided much richer and detailed information (Wengraf, 2001; Opdenakker, 2006). This is because through face-to-face interviews one can easily pick up on social cues (visual aids) which can provide more information from a participant's body language and intonation etcetera (Opdenakker, 2006).Also, having a wide variety of reproductive rights activists as respondents could have helped provide a much better picture regarding how activists and NGOs perceive and engage the problem of reproductive rights and other women's issues.

5.2 Conclusion

Based on the discussion of findings it becomes clear that the existing gap between law and access to abortion services can largely be attributed to ineffective implementation. These further result in various barriers making it difficult for women to realise and enjoy their sexual reproductive health rights. In addition, what is more alarming is that a combination of these barriers often lead women to opting for easily accessible unsafe and illegal abortion services throughout the country. Despite campaigns, activists and healthcare providers often highlighting the serious health consequences of illegal abortion, very little is done on a national scale to investigate and eliminate illegal abortion and those who assist illegal providers and their businesses in thriving at the cost of desperate women's lives.

Having realised that marginalised women of colour often face a combination of social injustices due to their political history and that they are often the ones who fall victim to illegal abortion as a result of their history, the Reproductive Justice Framework was chosen as the best framework to be used in addressing marginalised women's combined social injustices and needs. What also stood out from the discussion is that activists often referred to a lack of support and competition for resources among various NGOs and reproductive health rights activists. On its own, this becomes a major barrier that limits activists and NGOs from successfully obtaining common goals such as making safe and legal abortion services more widely accessible for the most marginalised and eliminating illegal abortion services. These findings led to the suggestion that various NGOs and activists need to realise this problem and rather find more pragmatic ways of working together and sharing resources

working towards common goals in order to effectively deal with the problem of lack of access to safe and legal abortion healthcare services.

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APPENDICES

Appendix One: Informed Consent Form

Research Topic: *How reproductive rights correspond with access: A case study of South African advocacy groups*

Researcher: Marc Jacobs

This form will provide you with full information regarding the research study so that your participation is voluntary and informed.

I am inviting willing participants to be part of my research titled "*How reproductive rights correspond with access: A case study of South African advocacy groups*". This study is in fulfilment of a Master of Social Science degree in Sociology. Participation entails partaking in interviews or questionnaires.

The thesis will be read by both an internal and external examiner and the final dissertation will be made available publically only in electronic form. The study seeks to contribute to the already existing body of research which explores barriers to abortion and other reproductive health related services. Furthermore, the purpose of the study is to specifically obtain advocacy groups and women's reproductive rights activists' perceptions on abortion, reproductive rights and other reproductive health related issues as individuals who deal directly with such issues or cases.

All those who choose to participate in the research will be guaranteed the following:

1. Complete confidentiality and privacy. This entails total anonymity in the final write up where pseudonyms[1] will be used. Participant's names and identities will not be disclosed at any stage of the research process.

2. No deception will be employed in this research. If at any point a participant wishes to read the thesis during the course of writing up or before final submission, they are entitled to do so.

3. If at any time a participant wishes to withdraw from the research and make information that they have shared unavailable after interviews and/or filling out of questionnaires have taken place, they have the full right to do so.

In accordance with the Rhodes Ethical Guidelines, you are in no way forced to answer all questions. If you feel some questions are personal and would not like to answer them, you are free to do so. If at any stage, you feel uncomfortable or due to any other reason want to stop participating, you are free to do so without any consequence. What would be expected from wiling participants is that they sit in for a face-to-face interview which may take up to 15-20 minutes of their time, or either fill in an open-ended questionnaire in the participant's own time. Filling in the questionnaire will take approximately 10-15 minutes. The questionnaire can be emailed to the researcher.

There are no particular benefits that will arise from participation or from the research project itself during and after the final paper is completed. As mentioned above, this research is merely a requirement for obtaining a MSS degree from the sociology department. Also, there are no

[1] A fictitious/false name

particular conceived risks from participating. All information shared during this process by willing participants will be treated with strict confidentiality and privacy

If any clarification is required please feel free to ask any question pertaining to the research at the time of signing, or if any concerns arise later contact:

Marc Jacobs (Researcher): Cell: 0788 401 072; Email: marcemjay.jacobs707@gmail.com

Tarryn Alexander (Supervisor): t.alexander@ru.ac.za

Janet Chisaka (Chair of Ethics, Department of Sociology): j.chisaka@ru.ac.za

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant___________________________________

Signature of Participant _________________________

Date ______________________

Appendix Two: questionnaire

1. Please indicate your sex and/or gender?
2. Please indicate the organisation(s) you work for/previously worked for
3. In what Provinces are these organisations situated in?
4. Are you currently involved in any campaigns/activism?
5. What is the name(s) of the campaign(s) you are/have been involved in?
6. What are your campaign objectives?
7. During preparation and the running of campaigns, are there ever any opposition campaigners who try to disrupt and delegitimize your cause?
8. What, for you, is the most important concern regarding women's reproductive rights and the issue of access?

9. What can ordinary citizens do to contribute to the issue of reproductive rights and access?
10. How does the abortion campaign relate to other gender-based campaigns such as those on sexual violence?
11. Do you think that it is better for parents to educate their children from a young age about reproductive health and reproductive rights or that it is better to have it formally implemented and taught at schools?
12. As a campaigner, how familiar are you with the Choice on Termination of Pregnancy (CTOP) Act, and how do you feel about it in general?
13. Do your campaigns ever refer to the CTOP Act in any way or try to make others aware of what it is?
14. When it comes to women empowerment how significant would you say the role of the CTOP Act, and the reproductive rights it affords women, has been?
15. Do you think that all women's roles in both the private and public spaces of reproduction have improved since implementation of their formal reproductive rights after 1996?
16. Do you think that there is some tension or a gap that exists between reproductive rights on paper and access to such rights in the health services?
17. What are some of the most common barriers to women accessing reproductive health services?
18. Which do you consider to be the most serious of these?
19. How does an individual's socio-economic status affect their access to abortions or other reproductive health services?
20. How important is the concept of 'patriarchy' in understanding abortion access?
    a) How often does the concept surface in dialogues?
21. Abortion is overwhelmingly seen as a women's issue, can men be involved in women's issues?
    a) Is this important? Why/why not?
22. Do local cultural and social conditions influence the abortion issue in ways that are unique to South African context?
23. Traditional healers are often consulted with regards to well-being in South Africa, how do traditional healers and other alternative channels influence the abortion issue?
24. Is illegal abortion a problem? Why/why not?

25. Can you compare ease of access to legal and illegal abortion?
26. Have you ever had direct contact with illegal abortion as part of your campaign?
    a) What was the outcome?
27. What is your imagined ideal solution to existing abortion issues?