REPRODUCTIVE HEALTH RIGHTS OF WOMEN IN RURAL COMMUNITIES

by

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DECLARATION

I declare that :

THE REPRODUCTIVE HEALTH RIGHTS OF WOMEN IN RURAL COMMUNITIES

Is my own work and that all sources that I have used or quoted have been indicated by means of complete references.

FHUMULANI MAVIS RALIPHADA-MULAUDZI

11 day of 12 1997

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SUMMARY

THE REPRODUCTIVE HEALTH RIGHTS OF WOMEN IN RURAL COMMUNITIES

Reproductive health is very important as it shapes a woman's whole life. Currently there are a lot of obstacles which deny women their rights to reproductive health. The aim of this research was to find out what obstacles deny women the freedom to enjoy their reproductive health in order to establish a contribution which can be used by the Department of Health to improve their services. Descriptive research was conducted, using a survey approach. Convenience sampling was utilized. Participants were selected from a sample of people attending the reproductive health clinic at a hospital and a clinic in the Northern Province. The findings indicate that women are not enjoying reproductive health rights due to low educational level, cultural and societal constraints, low socio economic status and the negative attitude of the providers, of reproductive health services.

Key terms:

Contraceptives; Family planning; Health and gender; Health rights; Reproductive choice; Reproductive health; Reproductive rights; Reproductive health care; Women's rights; Rural women.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

Orientation to the study

1.1 INTRODUCTION

Health is inseparable from individual rights and freedoms, and from the right to development. The World Health Organization considers the health status of women to be one of the most sensitive indicators of progress in social development. The reproductive health of a woman shapes the quality of her whole life. It also offers potential liberation for women as it can free them from the obligation of ongoing pregnancies. This indirectly frees women to operate as equals to men at social, political, and economic levels. According to Whitty (1996:231), the International Conference on Population Development held in Cairo in September 1994, which focused on population policy, sustainable economic development and environmental protection, shifted the emphasis of population development to the empowerment of women by the improvement of their social, political, economic and health status.

Women were marginalized from "human rights". The very notion that women could have a claim to distinct and legally cognizable human rights was virtually unheard of in mainstream international dialogue. Article 12 (1) of the International Covenant on Economic, Social and Cultural Rights (ICESR) protects the right to a reasonable standard of physical and mental health under the guise of being gender neutral. The right to health in the Economic Covenant lacks sensitivity to women's health needs. This is also evident in the international human rights system, which is male biased, as it provides the right to health in gender neutral terms (Whitty 1996:225-228).

Women in South Africa have played a prominent role in shaping the human rights culture as most of their aspirations and needs are embodied in the Bill of Rights chapter 2 of the Constitution of the Republic of South Africa, Act 108 of 1996. It is

significant that women in South Africa have developed a woman-centered approach to health by combining public health and human rights principles in the concept of reproductive health rights entrenched in section 12 (2)(a) and section 27 (1)(a) of the country's Constitution.

South Africa has entered into a new Constitutional era with the enactment of a supreme Constitution with a justiciable Bill of rights. Parliamentary sovereignty was replaced with what is generally referred to as 'constitutional supremacy'. The courts are now in a position to test the constitutionality of legislation or regulations and infringement of human rights. This is an important change as women's reproductive health are often compromised by an infringement on specific human rights, such as the right to life, to liberty and dignity, which are now specifically protected.

According to Searle and Pera (1995:45), human rights can be grouped into two types: first-generation (political and civil rights) and second-generation human rights (socio-economic rights). First-generation human rights are those human rights that the government may not violate. These rights comprise the basic needs of life, such as the right to life, the right to human dignity, to language and culture and the right to privacy. In second-generation human rights the government has an obligation to render assistance, for example the right to work, the right to education, the right to medical care and others. Verschoor, Fick, Jansen and Viljoen (1997:35) argue that in contrast to first-generation human rights, which forbid government interference, second-generation human rights demand positive action from the government to ensure that people can realize certain rights. Chapman (1996:23-226) maintains that in the international community socio-economic rights (for example the right to health care) are often not taken as seriously as first generation or civil/political rights, despite frequent affirmations that all human rights are universal and indivisible. Instead of treating socio-economic rights as full fledged rights, they are often perceived as mere aspirations. She goes further by indicating that sufficient consideration is not given to the fact that civil/political and economic, social and cultural rights are interrelated, interdependent and indivisible. Thus if a person is denied access to proper health services, it could result in his or her death

invalidating the protection of the right to life and liberty - the most fundamental of human rights.

Respect for human rights is an integral part of nursing ethics. The right to privacy, human dignity and equality has been honoured by the nursing profession from the outset. The ethics of the nurse are thus now supported by a bill and applied more widely than just to nursing practice. A high degree of control over reproductive behaviour, including contraceptive usage, can only be achieved when women experience themselves as having the right to privacy, information and dignity.

Access to knowledgeable practitioners as well as the right to freedom of choice in relation to their health and lives in general are just as essential. The abovementioned rights are not new or foreign to nursing practice, but because they are mentioned in the bill of rights they have greater legal force (Pera & Van Tonder 1996:44). Reproductive health rights improve women's status, specifically a woman-centered approach to promoting contraception. It also contributes to heighten self-esteem, making women believe they are now in greater control over their sexuality and reproductive capacity, as well as over other aspects of their lives. All this should put women's health and women's control over their bodies as the primary goal of the state's reproductive health programme (Dixon-Mueller 1993:159; Klugmann & Weiner 1992:27-29).

1.2 OUTLINE OF THE PROBLEM

According to the bill of rights section 12(2), everyone has a right to bodily and psychological integrity, which includes "the right - (a) to make decisions concerning reproduction; (b) to security in and control over their body; (c) and not to be subjected to medical or scientific experiments without their informed consent." Currently the right to decide when to have a child and to practice safe birth control is not readily accessible to millions of women, especially in rural areas. Pitted around women are a number of obstacles, such as economic discrimination, subordination within the family, religious and cultural restrictions as well as the

distortions of family planning programmes to serve the end of population control (Hartmann 1987:38): These obstacles shape and control women's lives, thereby affecting every aspect of their experience, including family life, sexuality and exercising reproductive health rights.

According to Dixon-Mueller (1993:164), abortion as a method of fertility regulation falls clearly and logically under the right to family planning. Women use abortion like other methods of family planning to regulate the timing and number of their children, that is, to try to ensure that a child is born into circumstances where it will be welcomed and cared for. However, abortion opponents argue, that because the constitution guarantees women the right to reproductive health and to make decisions about reproduction, the constitutional principles of democracy, privacy and right to life are denied the unborn child.

Women's rights reflect a high level of choice and control over their bodies and over their lives in general. Choice and control which most women in rural areas, being both working class and subject to patriarchy, do not experience (Klugman 1992:98; Ngwenya 1994:25). Women are also subjected to more suppression by cultural and community values. In addition to that, most women in the rural areas are illiterate, leading to poor understanding of reproductive issues discussed in the media as well as in pamphlets distributed for their information.

There is a clash between public policy and reproductive behaviour. In the past international demographic goals, such as the goal of lowering fertility rates, were meant for population control rather than to improve the quality of life of the population as a whole. In addition to that, the goals of population control contributed to the assumption that women are impersonal demographic agents whose wombs must be controlled in order to reduce the population (Hartmann 1987:289). The effect of this is that many providers of contraception have been misinformed and hence promote contraception as part of population control and not as a response to the personal needs expressed by women or men themselves. Rather, health providers are motivated by a missionary zeal to lower the population growth rate, guided by an

incorrect analysis (Klugman 1988:102). A study conducted by Klugman and Weiner (1992:104) revealed that women working in factories reported that they have been told to have regular contraceptive injections to avoid pregnancy which, in turn, influences productivity. This is encouraged by the Department of Health's promotion directorate, which offers factory-based services free of charge.

One of the factors which compounds these problems, is the extent to which medical services have become distanced from the people they serve. Nurses and doctors carry an aura of authority about them which may cause women to feel extremely vulnerable and unable to question decisions made by these professionals and thereby to assert fully their reproductive needs and rights (Klugman 1988:103).

"Section 10 of the South African Bill of Rights provides that everyone has inherent dignity and the right to have their dignity respected and protected." In a study conducted by Mernissi in Morocco in 1975 a woman complained bitterly of dehumanizing treatment by clinic personnel. She recalled it as follows: "If you make a mistake and mispronounce a word, the name of a syrup or a pill, the nurse laughs at you, calls her colleagues to tell them the story and they laugh at you. You feel the floor crumble away under your feet." Another woman showed that there is no respect for human dignity. She indicated that when women were waiting to get into gynaecological services, health providers would shout at them to take their undergarments off before going into the hall where they are left with no underwear and thus feel degraded and dehumanized (Dixon-Mueller, 1993:159).

1.3 BACKGROUND TO THE PROBLEM

The nature of South African society itself contributed to the problems confronting rural communities of which reproductive health is one. For instance, there is maldistribution of resources and access to health services between rural and urban areas (Ngwenya 1994:25). Clinics in urban areas outnumber those in rural areas. They are also scattered kilometres away from each other. These institutions are also understaffed, leading to inadequate provision of services. According to our bill

of rights section 24(a), everyone has the right to an environment that is not harmful to their health or well-being. The main argument is whether the health services in rural areas will be improved to create a good environment as professed by the African National Congress's national health plan for South Africa.

According to the Abortion and Sterilization Act 2 of 1975, women were not allowed legal abortion except in specified circumstances as prescribed by the act. This has been viewed as a form of bureaucratic regulation by the present government. The former abortion policy discriminated against the majority of South African women in terms of access to safe, legal abortions. The provision of safe legal services for voluntary pregnancy termination is an essential ingredient of the personal freedom of individuals and couples to determine the number and spacing of their children, and of the social entitlement to the information and means to do so safely and effectively.

According to Dixon-Mueller (1993:5), patriarchal families also contribute to the state of women's reproductive health rights because their institutions are built on power hierarchies of age and gender. The bill of rights (section 9 (3)) emphasizes that no person may unfairly discriminate directly or indirectly against anyone on the ground of race, sex, gender, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. The critics of the Bill or rights fear that it will interfere with private relationships, which in this case is the private sphere of marriage relationship.

Women in patriarchal communities have limited role options and are still bound by assumptions of male superiority and women's subordination. These women have a limited experience and choice of control over their lives. Some studies on nuptiality patterns revealed that, traditionally, lobola gave a man sexual and reproductive powers over his wife (Dominique 1994:6). According to Klugman (1988:99), it is difficult and sometimes even impossible for these women to take control over their bodies, their sexuality and reproductive capacity, in a conscious manner. This is not to say that all oppressed women are total sexual objects unable to act in terms of their own perceived interests. Rather, it is to recognize that where women are

subject to male domination, total control over conception may not be imaginable and, even if it is, it may be difficult since they will remain answerable to men (Klugman 1988:99). As a result, women in rural communities find themselves in a predicament because men must first give consent to allow them to attend reproductive health clinics. Many women leave their patient cards in the clinic, and some resort to using injectable contraceptives which are not visible, although it may not be the treatment of their choice or the best medical option in a specific case. In most instances, health providers find themselves in a difficult situation because they are to blame if husbands find out the truth. Some of the husbands or partners may even go to the clinic themselves and threaten health providers in a violent manner. This is the worst insult to women; because it gives the impression that they are ignorant and totally helpless in deciding how many children they should have. Moreover, section 14 of the bill of rights states that everyone has the right to privacy, which includes the right not to have their person or home searched, their property searched, their possessions seized or the privacy of their communications infringed.

Certainly between partners consultation is necessary but men should not have the final say in reproductive health issues, especially since the responsibility of raising children falls mainly on the woman. In addition, personal choice of reproductive health may be unimaginable to women from cultures in which motherhood and conception are considered a woman's pride. In rural communities children are used as a source of power. The birth of a child, especially a son, provides a woman with automatic status, which other domestic roles such as cooking and cleaning are unable to do. A child pleases a woman's husband and her in-laws, the people who control her life. Children are a woman's constituency within the narrow political world of family in rural communities: the more she has, the stronger her clout. If she is infertile, her status plummets and she often falls victim to polygamy, desertion, ridicule or divorce (Hartmann 1987:43). In this situation, personal choice of reproductive health becomes difficult. Why would a woman prevent pregnancy when motherhood is seen as the only valid role for a woman?

On the other hand, according to Spector (1991:200), it appears that some African

men perceive birth control as a degrading and humiliating experience and also as a form of black genocide and a way of limiting the growth of the community. Moreover, since most males are migrant workers, they assume that if a woman uses any form of contraception, it may lead to infidelity on the part of the woman as she then does not need to fear being pregnant from another man.

Women in rural areas are economically deprived because most of them are unable to fend for themselves. This increases their dependency on men and confirms their status as child bearers. The home is the major source of oppression. Women are not given credit for work in the home and are not paid for it. Even if a woman earns money for outside work, the home chores still await her on her return and she is expected to do the same amount of work for those who are left at home. In addition, domestic workers are not paid adequately because this type of work is not valued.

Similarly, educated women find themselves in the same predicament, given the state of gender discrimination in the job market/workplace. Women study and pass the same examinations as men to gain employment and perform the same jobs but end up earning less than their male colleagues (Ngwenya 1994:26). According to Dixon-Mueller (1993:8), a woman's capacity to make independent choices regarding marriage, divorce and childbearing is linked to her capacity for economic and social self-sufficiency. Thus women who are financially insecure, lack assertiveness, become withdrawn and cannot voice their concerns, preferences and/or aspirations.

Furthermore, some researchers perceive education as important in determining attitudes towards reproductive health rights. Several studies show that women who have received education, particularly at high school level and above, know more about their reproductive rights in contrast to women with no education. In addition, women who have access to education and meaningful employment, tend to bear fewer children than their uneducated counterparts (Agyei 1988:106; Ngwenya 1994:34). Most women in rural areas cannot read or write and as a result health awareness in such areas appears to be very low. According to Ngwenya (1994:25),

the Chartbook of 1992 reflects that only three out of ten women have gone to secondary school and only one has attained a profession. The high illiteracy level contributes to undermining the status of women in society thus exposing women as baby-making machines.

The problem is compounded by the fact that there is little or no investment at all in the education of female children. Girls' first and foremost obligation to their parents is getting married and bearing as many children as nature can provide, which in turn elevates the status of their parents within the community. Education is therefore of little or no value.

Health care providers have a professional duty under the code of their professional conduct to recognize and protect the rights of their patients. In this sense, they have an advocacy role (Dimond 1993:5). Nurses as health care workers have been criticized by Searle and Pera (1995:41), who maintain that nurses call themselves patients' advocates and yet when it comes to keeping patients informed about their treatment and their rights to self-determination in care, nurses are in the forefront in ensuring that patients are denied these rights. This is contradictory to section 12 which protects bodily integrity and autonomy and section 32 (1) of the bill of rights which provides that everyone has the right of access to any information held by the state and by another person that is required for the exercise or protection of any rights.

According to Dimond (1993:5), difficulties which usually arise between patients and health care providers are due to conflict of rights and duties. The health care provider has a duty to take care of the patient and yet the patient has a right to autonomy and the right to freedom of choice. It may be difficult for the health care provider to decide where her duty lies if there is an apparent conflict of rights and interests. A nurse may, for instance, refuse to give contraceptives to a sexually-active teenager because of her own religious beliefs and moral values. This may lead to conflict with the patient's right to self-determination.

Contrary to the views of Spicker, Bondeson and Engelhardt (1987:xx1), it is not the duty of the health care provider to deliver lectures on moral behaviour while on duty at a reproductive health clinic. While the provider may disapprove of the sexual activity of minors, it is not appropriate to display disapproval by withholding services or delivering lectures. Health care workers are not *in loco parentis* (in the place of parents). Health providers may find themselves in moral and legal dilemmas as a result of religious views, moral views, ethical expectations, cultural pressures, on the one hand and fundamental rights of patients, on the other (Spicker et al 1993:5).

1.4 SIGNIFICANCE OF THE STUDY

Although the problems of fertility and reproductive health rights have been well researched, it remains an issue of major concern to the broader society. One of the present study is to bridge the imbalances caused by gender inequalities which violated the reproductive rights of women. In addressing these problems, it is hoped that this study will be beneficial in various ways. Possible Benefits of the study are to

- raise women's awareness of reproductive health issues and rights

- directly or indirectly influence government policies on reproductive rights and women's health issues and to create an awareness of the states' responsibility to protect reproductive rights of women and to secure access to health care and services

- raise the status of women by creating public awareness of the needs of an individual woman, stressing that it should take precedence over fewer concrete notions of what is good for society (Moen, 1981:53)

- help health care providers to provide the necessary information when offering treatment alternatives and to share it with their clients

- enable patients to decide whether they need contraceptives or not, thus improving their accountability and quality care (Collier 1994:50)

- encourage women to break their silence about their sexual and reproductive problems and to relate their individual experiences with health care systems by challenging notions of cultures, policies, the family, religions and community control that limit women's freedom.

1.5 AIMS OF THE STUDY

The specific objectives of this study are to

- determine whether women in rural communities are aware of their reproductive health rights

- assess to what degree they can exercise these rights

- determine the relationship between reproductive rights and women's rights in other spheres, such as education, employment, the family, community, culture and other socio-economic structures.

1.6 RESEARCH QUESTIONS

As this study is descriptive by nature, it proceeds without a hypothesis. The researcher proposes to obtain answers to the following questions:

(1) What are reproductive rights?

(2) Are rural women aware of their reproductive health rights?

(3) Do they enjoy or fully exercise their reproductive health rights?

(4) Are reproductive rights of rural women adequately protected?

(5) To what extent are reproductive rights of rural women related to the exercise of women's rights in other spheres of life?

1.7 DEFINITION OF KEY CONCEPTS

The present section is intended to avoid misconceptions and misinterpretations of important concepts used in this study. For the purpose of this study the following definitions will apply.

1.7.1 Reproductive health

Building on the World Health Organization's definition of health, the Cairo Programme explains that Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed {about} and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (Cook 1996:1).

1.7.2 Reproductive rights

Reproductive rights are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of their choice for regulation of fertility which are not against the law (Hartmann 1987:289). In this study "reproductive rights" refer to reproductive freedom, reproductive choice and women's right to control their bodies. It also includes the rights of a woman to decide freely and responsibly on the number and spacing of their children, and to have the information and means to do so (Pretorius in Joubert 1995:141).

1.7.3 Reproductive health care

Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, as well as counseling, and care related to reproduction, cancer and sexually transmitted diseases (Handwerker 1992:1246).

1.7.4 Reproductive choice

Reproductive choice means offering women a broad range of birth control methods from which they can choose freely.

1.7.5 Providers of health care

In this study the term "providers"and "nurses" are used as synonyms, referring to health care workers who are rendering care and issuing contraceptives to clients in clinics, health care centers and hospitals.

1.8 OUTLINE OF THE STUDY

The first chapter of the dissertation is devoted to the orientation to the study. The problem is stated, and the background to the problem analyzed. The aims and significance of the study are discussed. Research questions are posed, the key concepts defined and the essential elements of the dissertation are detailed.

Chapter 2 reviews books, articles and other sources relevant to the rights of women, reproductive health and reproductive health rights.

The methodology used in the research is outlined in chapter 3.

Chapter 4 deals with the analysis, description and interpretation of the research findings.

Chapter 5 details the limitations of the study, summarises the research findings and presents conclusions and recommendations for further research.

The list of references represents those used throughout the dissertation and a list of works consulted, whether reference were made to these or not.

The appendices contain the questionnaire and letters requesting and granting permission for conducting the research.

1.9 SUMMARY

There is a need for women to enjoy their freedom in matters concerning their reproductive health and that can only be achieved if all obstacles to their rights are removed. Giffin (1994:45) indicated that reproductive rights networks can help women to achieve greater empowerment in terms of improved standards of self-care and increased power in the use of health services.

CHAPTER 2

Literature review

2.1 INTRODUCTION

Numerous ethical, legal, social, psychological and policy questions have been raised since new reproductive technologies were developed over the last two decades. These technologies were aimed at expanding women's reproductive rights as well as their right of freedom to choose so as to enable them to overcome the biological limits and dysfunction. Women around the globe are insisting on a new agenda for reproductive health. Jacobson (1991:38) maintains that reproductive health programmes must meet women's needs and solve problems like unwanted pregnancies, reproductive tract infections, and infertility conditions that the majority of women face. Moreover, reproductive rights incorporate elements of conceptual approaches to health and family planning service delivery while broadening their scope and deepening their impact (Dixon-Mueller 1993:104).

Nzovu (1996:2) indicates that reproductive health is one of the key areas of major concern in the world today because of its implications for society and its development. It has been observed that sexual and reproductive rights elude many people in the world today and so people bear the consequences socially and economically both at family and national level. Hiroshi Nakajuma of the World Health Organization made a very important and valid statement during the establishment of the global commission on women's health in 1993. He stated that "Health is a fundamental human right which we must uphold, fight for and do so with peaceful but powerful weapons, care, compassion, mutual respect and education". He also indicated that health is inseparable from individual rights and freedoms and from the right to development (Kadandara 1994:2)

Nakajuma's view is supported by Cook (1996:1), who maintains that the 1994 United Nations Conference and the 1995 fourth World Conference on Women's Health held in Beijing have both emphasised the need to empower women and protect their

human rights and promote reproductive health. Pera and Van Tonder (1996:43) agree with Nakajuma and Cook's views. They indicate that nursing may encroach upon aspects of human life that are protected by the law and, in particular, the Constitution, which protects physical integrity, human dignity and privacy. Pretorius in Joubert (1995:140) agrees with the above statements but she emphasises that, rights are not absolute and have to be weighed and balanced against public interests and that individual rights can at times be in conflict, for instance a woman who requests an abortion, thus exercising her reproductive rights and a medical practitioner refusing to do so because of a conscientious objection.

Berthhold in (Davis and Aroskar 1983:104) maintains that the right of an individual to dignity, self-respect, and freedom of self-determination has been in conflict with the rights and interests of society on various issues. He goes on to state that this conflict can be characterised as involving humanitarian, libertarian and scientific values. Humanitarian values relate to respect for the sanctity of human life and the safeguard needed to protect the subject from physical and emotional harm. Libertarian values relate to the individual's political, civil and individual rights to self-respect, dignity, freedom of thought and action, as well as the safeguards needed to protect the individual from invasion of his or her privacy without his or her knowledge and consent. Scientific values relate to the extension of knowledge's sake and the safeguards needed to protect the right to know anything that may be known or discovered about any part of the universe.

The Constitution of the Republic of South Africa, Act 108 of 1996 includes the reproductive health rights of women (Section 12(2) (a) and (6) and Section 27(1) (a). It is specified in the new Constitution that any alleged violation or threatened violation of any fundamental right entrenched in chapter 2 (the bill of right) can be challenged for constitutionality. The bill of rights is a weapon and shield that can be used by women to raise their voices. The transition from individual liberty to social entitlement carries new obligations for all South African citizens. For instance, the "RIGHT" to an education becomes a moral obligation on parents to send all their children of a certain age to school. Similarly, the "RIGHT" to health becomes an

obligation to vaccinate one's children against certain infectious diseases; the "RIGHT" to decide "freely" on the number and spacing of one's children becomes an obligation to decide "responsibly as well".

2.2 REPRODUCTIVE RIGHTS

According to Spicker et al (1987: xx) the right to use contraception, in this century, was one of the rights guaranteed under the right to privacy, and it was guaranteed first as a basic and fundamental right of a married person and later of unmarried persons. It is asserted that in the political context of today, in which women's reproductive health rights are an issue of great controversy, there are many obstacles which constrain such ideologically based freedoms.

Women must always remember that they are mirrors to their children and should try to preserve the following rights that they are entitled to:

- The right to a safe working place and environment for all, so that nobody is exposed to hazards that threaten their ability to bear healthy children or force them to choose between sterilisation and occupation.

- The right to make abortion and contraceptive choices (reproductive/procreation rights).

- The right to reproductive education, so that women and men are better able to control their own bodies and make responsible choices. Women also have a right to decent medical care which is not only necessary to ensure contraceptive safety but becomes a basic human right.

Reproductive rights include the right to choose how to give birth and have control over the development and use of new reproductive technologies. Reproductive rights presuppose an end to discrimination so that all people, regardless of race, sex, or class, can lead healthy and responsible reproductive lives and exercise real

control over their own reproduction. Reproduction rights can only be exercised effectively if the male partner participates as an equal partner in childbearing, housework and birth control so women should no longer shoulder the "double burden" (Hartmann 1987:53).

2.3 REPRODUCTIVE HEALTH

Applying the World Health Organization's definition of health, reproductive health can be defined as the state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions. Section (27) (1) (a) of the Constitution (Act 108 of 1996) indicates the right to have access to health care services, including reproductive health care. According to Hartmann (1987:55-56), reproductive health includes the following:

- the freedom to decide how many children to have and when to have them;
- entitlement to family planning information and services;
- a wide choice of contraceptive methods with full information on benefits and risks and supportive counselling on how to use them;
- good screening and medical follow up;
- a full range of reproductive health services, including treatment of infertility, ante-natal and post-natal care, prevention of sexually transmitted disease and support for breastfeeding;
- counselling on male as well as female responsibility for contraception;
- freedom from pressure and coercion;

- respect from the local culture and local health providers, and the incorporation of traditional fertility control methods practised by the community, if they are safe and

- freedom from pressure and coercion.

2.4 REPRODUCTIVE CHOICE

Reproductive choice entails offering women a broad range of birth control methods, from which they can freely choose. Good screening, counselling, follow-up and genuine consent depend on the needs of an individual woman. She must be the ultimate arbiter in the decision of whether or not to use contraception and which method to use, as her womb belongs to her (Dixon-Mueller 1993:26 and section 12 (2) (b) of Act 108 of 1996).

2.5 STATUS OF WOMEN IN RURAL AREAS

To get a clear picture of women in rural areas, there is a need to understand what they are faced within different spheres like education, politics, employment, culture, community and socio-economic structures. According to Ngwenya (1994:26), the traditional norms of socialization contributed greatly to the oppression of women. Initiation schools, marriage and the way children are reared affect women's behaviour. They are taught to be subservient, a servant to their husbands, men in general and their in-laws.

Marriage is taken as a form of security, the main aim being to bear children and to protect the family lineage. For the rural majority, children in particular a male child, remains the main source of security in old age. Spicker et al (1987:92) maintain that women strengthen their informal status by creating male progeny, upon which they can centre a family that would be tied to them throughout life. This informal network has been termed the uterine family. Nowadays people are beginning to realize that

having a big family, with no financial stability, may affect the children's quality of life, as the cost of living is very high. In dire financial constraints children won't be able to get proper education and economic security. Instead they remain a financial burden and responsibility until the death of the provider. Most of the aged in rural areas are suffering. They are unable to enjoy their pension fund as they are expected to support their children's families with the little that they have.

In rural areas, the small-scale community has a real effect by urging conformity with the traditional norms. The extended family structure is common. The man as the head of the family is the guiding principle of social structures. This has resulted in most areas of politics and economics and legal, social and religious institutions being dominated by men. This state of affairs influences women to believe that decision making must lie with the head of the household as he is more valuable and capable than they are (Kadandara 1994:12). Women have little or no say in community affairs, which remain the domain of men. Although the Constitution provides for gender equality, few women are visible in local, regional and national organizations. Women need to be informed about changes taking place in their own communities and their own country. According to Klugmann and Weiner (1992:6), women's social and political status leaves them disempowered. It causes women to suffer material disadvantage as well as physical burdens and psychological pressure.

In many cases women are expected to report their pregnancy to their mother-in-law, who will tell her own son the "great" news. The fact that an adult, mostly the mother-in-law, act as a referee or a means of communication between husband and wife often inhibits discussion between spouses, especially relating to contraception, more especially, because the elders prefer sexual abstinence to modern contraception (Agyei 1988:52). Women are expected to sleep with the mother-in-law after delivery. They are expected to be faithful and culture doesn't allow them to have sex, even with their husband, when breastfeeding. However, men are given the freedom to have extra marital affairs with other women. It is important to note that the husband's attitude is also subjected to constant and subtle pressure from other family members. The educational and socio-economic status of the husband, his

knowledge and the amount of respect he is accorded by other family members is significant in shaping existing values or modifying new ones. Educated husbands are able to resist pressure from the more conservative party of the family (Agyei 1988:109). On the other hand, women seldom get the chance to further their education. Girls are usually burdened with an excessive workload, which makes them unable to cope physically and mentally with the demands of attending school. They end up entering into premature marriages and become second or third wives. The lack of a reasonable standard of education leads to their inability to develop self-confidence and self-worth.

Another stumbling block to women's reproductive choice is African customary law, which entrenches subordination to men. Customary law has allowed legislation and practices which prevent women from owning property, including decisions about their own bodies. The system of lobola gives a husband rights over his wife's body, both sexually and in terms of her physical labour. Lobola also gives him the right to have the number of children that he wants. Some people even argue that lobola gives the husband the right to his wife's income (Klugmann and Weiner 1992:6; Spicker et al 1987:92). Bennet (1995:80) explains the term "patriarchy" as the control exercised by senior men over the property and lives of women and juniors. He argues that the legal system that endorses patriarchy as customary law denies women the essential power to realise their autonomy. This also has far-reaching implications as women cannot occupy positions of high authority, cannot directly negotiate their marriage, terminate it or claim custody of their children.

Norries (1991:61) disagree with traditional concepts in African customary law when he states, "Although sex has a central role to play in marriage, and sexual relations are often described as matrimonial rights, marriage does not in fact give either party the right to insist that the other reproduce, or take steps to avoid reproduction". Section 15 (3) (a) of the Constitution (Act 108 of 1996) entrenches a system of choice of personal religious and traditional laws, as long as it is consistent with other sections of the constitution. Religious, cultural and traditional practices which might be gender discriminatory may therefore be considered unconstitutional.

According to Dixon-Mueller (1993:111-112), in most African countries in which hierarchies of age and gender, patriarchal regimes and male domination operate, women experience many problems in reproductive choice. One might ask how much control rests with the woman herself and how much with males or females within the household or with elders or others. And also, who makes decisions about women's sexuality, childbearing, schooling, labour allocation and so on?

Under such circumstances it is difficult to know whether a woman is making a "free decision" because her preferences have been shaped by group norms, economic constraints and the influence of partners or elders. Norries (1991:60) states that as it is the woman's body which may be affected by contraceptive pills or the implantation of an IUD, it may be argued that she should have sole decision-making power.

According to section 24 of the final Constitution (Act 108 of 1996), everyone has the right to an environment that is not harmful to their health or wellbeing. Cachalia, Cheadle, Davis, Hayson, Maduna and Marcus (1994:98) maintain that the term "environment" should be interpreted broadly to mean any setting, whether in an urban or rural area. The environment can harm a person physically or mentally. The state is therefore responsible for removing potential health hazards. The national health plan for South Africa is aimed at changing the status of women in rural areas by playing the advocacy role in activities such as job creation, income generation, land redistribution, education and community development.

Cultural and religious beliefs which are in conflict with reproductive health rights, can be considered detrimental and harmful to the individual's environment. Section 31 of the Constitution guarantees the right to freedom of cultural and religious practices. This section could be interpreted as protecting vested and patriarchal interests and denying women equality. Freedom of religion can allow fundamentalists to perpetuate the oppression of women, for example the Roman Catholics deny women the right to use contraceptives and to abort. These are typical examples of conflicts of rights between individuals and groups or between groups themselves.

2.6 INFORMED CONSENT

Informed consent implies that a patient has full knowledge and has given permission for surgery/ medical treatment or to be used as a research subject in morally permissible procedures and experiments. Seaman (1993:43) indicates that informed consent enables clients to acquire full knowledge and understanding about the procedure they are to undergo. According to Searle and Pera (1996:143) patients must grant consent for all procedures performed in health care settings which involve some kind of invasion of the person's physical or psychological independence. Informed consent in this case involves full disclosure to enable clients to make informed and free choices. Thus the doctrine of informed consent, the legal support for individual decision making, mediates the allocation of responsibility and authority to the individual (Spicker et al 1987:168). Section 12 (2) of the Constitution provides everyone with the right not to be subjected to medical or scientific experiments without their informed consent.

In all forms of medical and paramedical practice, the principle of autonomy and respect for persons is protected by the important rule of informed consent. Patients' rights to informed consent are clearly outlined in the document approved by the Medical Association of South Africa (1996). The charter states that patients have the right to

- adequate information necessary to give or withhold consent
- request a second opinion at any stage should it be considered necessary
- know about health services in the area and how best to use them
- give informed consent to any diagnostic procedure or therapy
- refuse any procedure or treatment, even if the doctor considers this to be in the patient's best interest

- expect that a previously expressed decision will continue to be respected even if they lapse into unconsciousness, or is otherwise unable to express their will and

- give informed consent for participation in clinical or academic teaching, which may be implicit by attendance at an academic institution for treatment

Makhubela-Nkondo (1996:17) agrees with the patient's charter as approved by Medical Association of South Africa (MASA) when she stresses that every person is supposed to be "guaranteed the right to receive health information that will facilitate informed decisions or choices during hospitalization or when using health services". Informed consent helps the health care worker to recognize clients as individuals and people who deserve their dignity as well as their personal freedom. It also provides a fulcrum of power to the individual, permitting him or her to accept or reject an offer of expertise and skill (Spicker et al 1987: 168; Norries 1991:169).

The rule of informed consent is of fundamental importance to the patient's freedom of choice for not only does it protect the patient from unwanted bodily interferences, but it also ensures that it is the patient rather than the nurse who makes the decision about whether to accept treatment or medication, and, if so, which type. For this reason, the requirement for consent ought more properly to be termed "the right to choose" (Norries 1991:168). The issue of consent forms becomes complicated when dealing with written consent forms and who should sign them. Normally every person from eighteen years and above is authorized to sign a consent form, unless he or she is mentally disturbed, unconscious, mentally retarded or very ill. According to Mellish and Lock (1987:204), married women although under age may give consent to treatment, but in the case of operations which involve childbearing or fertility, Mellish feels it is advisable to obtain the husband's consent. Norries (1991:62) indicates that this attitude is sometimes justified by doctors and nurses, who refer to their professionals ethics and also to the fact that they are afraid of legal consequences. However, he criticizes those fears as generally unfounded, for law does not give one spouse the rights over the other. This view is supported by Pera and Van Tonder

(1996:156), who maintain that spouses may grant informed consent independently of one another, even if they are married in community of property.

This issue is causing much debate as women feel they are adults with responsibility and in order to maintain their self-dignity, privacy as well as their right to human dignity, men shouldn't have a say in their decision making about reproductive health. Pera and Van Tonder (1996:44) maintain that the right to human dignity, the right to privacy, and the right to equality fall under first-generation human rights that neither government nor anybody else is allowed to violate.

2.7 THE RIGHT TO INFORMATION REGARDING CONSENT

The issue of informed consent embraces the right to "full disclosure" or the right to "information". The latter is also protected in the Constitution. Section 32 (1) (a) (b) gives everyone the right of access to information held by the state or another person that is required for the exercise or protection of any rights (subject to the enactment of national legislation). The right to full disclosure regarding informed consent consists of setting before the client various options and describing all the details of each [*see the case of Castell v de Greef 1994 (4) SA 408 (C)*]. The right to full disclosure also includes giving advice as to what course should be followed. There is a need to have knowledgeable practitioners who have full information about all kinds of contraceptives as well as their side effects. According to the national health care plan of the African National Congress, the health information system will gather universal, opportune, reliable, simple and action-oriented types of data to inform the entire system and increase its effectiveness.

Providers must give information about the number of options available for the achievement of the desired end result. Much time will have to be spent ensuring not only that the particular method of contraception selected is suitable for the client, but also that it is actually chosen by the client on proper advice. According to Dixon-Mueller (1993:71), reproductive health programmes must include a description of the affectiveness and risks of all major methods of family planning and an agreement to

provide other methods preferred or requested. According to Davis and Aroskar (1983:103), maldistribution of power and information may occur in a situation where health workers give complex information using medical terms. Most contraceptive methods depend on the patient's comprehension and cooperation for their proper efficiency. For example, the use of the "safe period" as a method can only be used by a woman who knows her menstrual cycle, but she needs to be given clear instructions as to how the method works, when the risk period is, and fundamental matters like how long the sperm is capable of fertilizing an egg. It follows that if the provider fails to ensure that the woman understands, she or he will have failed in the duty of full disclosure and maybe subjected to an action for damages if pregnancy occurs. According to Norries (1991:183-184), the provider must give unambiguous instructions. The user's comprehension must be checked. Any method of contraception that requires a high level of patient cooperation would therefore inappropriate if the client does not or cannot understand what the method entails. The provider will have to ensure that the patient understands not only how to use the method, but also how it works.

The nature of the risks involved in a method must be explained clearly to clients. There is no method which is 100% safe. Clients must be informed about the side effects of the treatments. Proper advice involves making clients aware of the fact that certain methods are unreliable, for example that a condom can burst or that the method of coitus interruptus may be unreliable. The health care worker is violating the health principle of trust and justice if he or she deceives or tells lies to the client, whose trust has been granted on the basis of role expectations (Davis & Aroskar 1983:98).

2.8 THE RIGHT TO AUTONOMY AND DIGNITY

Autonomy involves the right of an individual to take individual actions. According to Husted and Husted (1995:59), respect for autonomy is the necessity placed on health care professionals of accepting the uniqueness of a patient. From this perspective, providers in the reproductive health clinic are obliged to respect clients'

decisions even in those situations with which they disagree, like issuing contraceptives to an eighteen-year-old teenager when the nurse feels that she is still too young to have sexual relations.

Janet Richards in Spicker et al (1987:202) remarks that the "passion to decide to look after your fellowmen, to do good to them in your way, is far more common than the desire to put into everyone's hand the power to look after themselves". It has been argued that the increase in the availability of contraceptive information and devices can lead to an increase in autonomy only in the absence of countervailing pressures, either from those who dispense this information or from a culture of fellow-users of that information which can be coercive. This view is supported by Husted and Husted (1995:60), who maintain that recognition of one's autonomy involves willingness of not interfering with actions towards goals that are not one's own. They also emphasise that health care professionals have no right to attempt to frustrate a patient's purposes, no matter how much they differ or clash with her own.

Autonomy consists of discretion, control and self-determination. Therefore clients attending reproductive clinics deserve to be respected and advised so that they can act accordingly. Providers and nurses are equally in their own rights, and the one should not dominate the other. Providers must bear in mind that no agent has the ethical freedom to violate the rights of others (Pera & Van Tonder 1996:145).

Husted and Husted (1995:60) agree with Pera and Van Tonder (1995:145) when they indicate that " to be possessed of superior rights is an absurdity as no human is more human than the other". They all agree informed consent, autonomy as well as freedom of choice can never be separated, that is neither can it be understood without the other. Freedom of choice is the doctrine that nothing should be done to the patient without his or her consent. At the same time, the patient's right to freedom means that he or she has a right to bodily autonomy.

A study conducted in Bangladesh revealed that women were given incentives if they agreed to sterilization. Women had no choice but to agree as they didn't have food

and clothing. Clients were not fully informed about the permanent nature of the operation and did not consent freely. Providers were also given incentives if they recruited a specified target number per month. There was competition between providers to vie for clients. The government was also interested in reducing population growth at the expense of the dignity and autonomy of poor women (Hartmann 1987:216-217).

According to the green paper for public discussion on health (1995:26), a similar situation existed in South Africa. Family planning providers used to give women contraceptive injections without their knowledge. They even went to the extent of giving women incentives such as money and clothes. Such service providers were only interested in meeting the target numbers instead of respecting people's autonomy by giving them information so that they could make their own choices. In conclusion, the green paper indicates that the setting of goals for fertility reduction can lead to human rights abuses.

2.9 THE RIGHT TO PRIVACY AND CONFIDENTIALITY

The right of patients to confidentiality is phrased solely in terms of law in the nurse's code. The right to confidentiality of information is also clearly outlined in a document for patients' rights by MASA. MASA (1996) indicates that patients have a right to the protection of all confidential data which may identify them, including all substances of the human body. A brief factual written report regarding the patient's health status may only be made available if requested on reasonable grounds. National legislation is about to be enacted regulating access to information in the form of the open democracy Bill. It remains to be seen how confidentiality will be influenced/affected. In the health care setting confidentiality of information is viewed as the right of a patient to be protected against any form of intrusive contact from others. The relationship between nurses and clients is expected to be one of trust and mutuality. The client may share intimate previously hidden facts unrelated to current problems on a confidential basis and this must be kept confidential. However, members of the health team may share relevant data for the health needs of the individual (Husted

& Husted 1995:63).

There is general consensus that if one takes autonomy seriously as a right to self-determination, made possible by individual freedom, then there can also be a right to privacy which enables individuals to control the presentation of aspects of themselves to others. The right to privacy encompasses both the right to respect for the dignity of the patient, namely physical privacy, and to respect for the patient's secrets, namely confidentiality (Pera & Van Tonder 1996:177).

According to Pera and Van Tonder (1996:26), conflicts often arise as health professionals often deal with more than one patient at a time. For example conflict of rights may occur between parents and sexually active teenagers if they are attending reproductive health clinics together. Neither will they feel free hence their privacy will be threatened. Health professionals have a duty to prevent such situations, because the patient's right to privacy is one right that they ought to be especially careful to protect. Violation of such a right involves the insupportable implication that the patient has no human rights (Husted & Husted 1995:63).

Dixon-Mueller (1993:13) maintains that the right to reproductive health involves a right to use rather than to have access to different methods, the right to learn about, obtain, as well as to use modern methods within the ordinary limitations that a state may impose to protect the consumers of health. According to this formulation, government, cultural and religious values as well as social norms do not have the power to intervene to prevent people from obtaining contraceptives as people have "rights to privacy".

The right to privacy falls under first-generation human rights, and should be protected. Norries (1991:106) emphasises that in nursing, breach of contract has historically always been considered a serious professional misdemeanour. Therefore, for a person seeking help in this intimate area of medicine, confidentiality must be guaranteed as a fundamental right. Moreover, the contours of this right are shaped by growing respect for autonomy and individual choice and by increasing

recognition of the private nature of sexuality (Spicker et al 1987:169). Section (14) of the Constitution (Act108 of 1996) provides everyone with the right to privacy. In the next section the right to abortion is considered.

2.10 THE RIGHT TO SAFE AND LEGAL ABORTION

The word "abortion" is ambiguous because it means different things to people of differing ethical, cultural, religious and legal standpoints. For the purpose of this study, the question analysed is whether women have the right to abort or not. Fundamentally, abortion is a form of termination of pregnancy - that is bringing of a pregnancy to an end or terminating a pregnancy.

Section 14 of the Constitution provides the right to privacy, which includes the right not to have one's person, home and property searched; one's possessions seized or the privacy of one's communication infringed upon. Cachalia et.al (1994:43) contend that the right to privacy is the protection of the freedom of the individual from unwarranted Government intrusion in matters affecting a person. To add to that, Pretorius (in Joubert 1995:141) argues that reproductive rights are grouped under the right to privacy as decisions regarding reproduction are of a private nature. Spicker et al (1987:170) agree with these authors by adding that the ability of the state to regulate these private and fundamental rights is regarded with Constitutional skepticism and held to a strict scrutiny.

The Abortion and Sterilization Act 2 of 1975, which has been repealed in respect of the abortion provisions, provided for legal abortion only for medical reasons and only if there was a risk to both mother and child, or if pregnancy occurred due to incest or rape. The Act also provided that two physicians must confirm that grounds for a legal abortion exist. This Act was discriminatory, particularly against poor and rural women, who lack access to doctors and facilities. Moreover, it was an infringement of women's rights to privacy and equality (Section 9). Given that women have the right to reproductive health care, this restrictive abortion policy has been replaced by the Choice on Termination of Pregnancy Act 92 published on 22 November 1996

and implemented on 1 February 1997.

The preamble of the Act defines the reasons of the new law and these can be summarised as the restoration and protection of women's health and rights. The Act gives women the right to termination on request or on demand up to 12 weeks' fetal age. Between 13 and 20 weeks gestation a consultation with a doctor is required and abortion will still be available under broad circumstances as specified by the Act. Up to 20 weeks gestational age abortion is also now available where there is a substantial risk to the fetus of severe physical or mental abnormality (Act 92 of 1996).

Dwyer (1997:3) maintains that a significant improvement on the 1975 Act is the inclusion of the availability of terminations where the pregnancy would significantly affect a woman's social or economic circumstances. She indicated that a survey of incomplete abortions conducted by the Medical Research Council in 1994 revealed that the majority of illegal abortions are due to social and economic circumstances like desertion by partners, unemployment, having other children to support in poorly paid employment, schoolgirls who wish to complete their education and women with careers under threat.

Section 5 (3) provides that only the woman's consent will be necessary, even if she is a minor. Although the Act specifies that she will be advised to discuss her situation with an adult family member, guardian etc, it goes further by making a provision that termination of pregnancy shall not be denied to a minor even if she choses not to consult. There has been reaction to this clause. According to Verschoor et al (1997:9), the Child Care Act 74 of 1983 section 39 (4), a minor aged 14 years or over is allowed to give consent to his or her own medical treatment, and from 18 years of age he or she can also consent to surgery. Dwyer (1997:4) supports Act 92 of 1996 by indicating that one third of the births in our country are by teenagers, who become pregnant accidentally, leading to poverty, dependence on social services as well as social and economic effects.

This new Act is opposed by many groups. The groups which are against abortion

("pro life") argue that the Constitutional principles of democracy, privacy and the right to life are denied the unborn child. These arguments pertain to the question: When does life begin? Norries (1991:29) maintains that the question of when life begins as a matter of morality or biology is not the same as when pregnancy begins according to the law. According to Dixon-Mueller (1993:165), even a live birth may not be the event that fully defines life. Moreover, in some societies, a newborn child is not considered a full member of society until some form of ritual or naming ceremony has been performed. In the case of abortion whose constitutional rights are violated: the mother's or the unborn child's?

Davis and Aroskar (1983:102) argue that if one defines the foetus as possessing humanity at any point along the continuum prior to birth, then who represents this human being? Which criteria are used? Who guards the rights of the unborn child in a matter which is so vital to his or her existence? They go on to indicate that if foetuses could speak for themselves under these circumstances, they would probably consent to abortion. If the parents do not want the child what quality of life can the child expect to have? People must realise that for children to lead a better life and fulfil their potential, They should be born wanted and planned, not unwillingly and accidentally.

Christians and Muslims oppose abortion on moral and religious grounds. Although cultural and religious beliefs are protected in the Constitution, there is a clause which specifies that they must be consistent with other provisions of the Constitution. What about the equality principles and gender rights? If indeed there are moral principles why must so many women continue to face death and anguish due to backstreet abortion? What about their right to life?

Health workers maintain that abortion is as moral a decision for them as it is for a pregnant woman. Nurses are supported by the Draft Position Paper of the Democratic Nursing Organisation which indicate that nurses may not be coerced to participate in direct termination of pregnancy. They also indicate that professionals have rights to freedom of conscience and must not sacrifice their personal integrity

and must never be required by policies, laws or societal expectations to do so. Nurses are also protected by the common law and the Constitution. Nurses are protected by section 9 (equality) as well as section 15(1), which also protects clients by providing the right to freedom of conscience, religion, thought, belief and opinion.

No institution agency, or Government legislation may force a nurse or medical practitioner, for that matter to participate in abortions against his or her will. Moreover, people in authority may not discriminate against any person who performs or who refuses to perform or assist in abortion. A nurse may not abandon abortion patients in the middle of the treatments, but must see to it that the health and safety needs of patients are met. The obligation of one patient relates directly to the right of another. As citizens, nurses have an obligation to respect the legal rights of other citizens, including their decisions to abort and the legal right to privacy.

According to David (1994:345), psychological stress is one of the potential complications of abortion. This stress is usually greatest during the decision-making period when the patient is concerned with the question of how to resolve an unwanted pregnancy. For most women, abortion is followed by feelings of relief, often tinged with regret, but to some it may cause post-abortion syndrome and depression, which may last for years. Counselling is very important to avoid mental health problems, especially for minors. Coliver (1995:315) suggests that physicians and nurses who are planning to help assist women in abortion should receive clinical training in counselling and abortion care.

2.11 THE ROLE OF PROVIDERS

Providers have a pivotal role to play in reproductive health clinics, the most important one being that of contraceptive education and counselling. It is through these actions that the providers convey to the clients their contraceptive philosophy. Unlike aspirin and vitamin C, which can easily be dispensed over the counter, birth control pills and other contraceptive methods are the vehicle for teaching personal and moral responsibility (Spicker et al 1987:186).

In her counselling and educative role, the provider must be able to provide reliable and up to date information, and she must be careful not to make moral judgements. Knowledge of colloquial names for contraceptive methods and parts of the body is desirable because some clients may need advice about the risks associated with their sexual life style. Providers in England have undergone specialist post registration courses in order to have expert knowledge (Bennet & Brown 1989:244).

Providers must communicate with clients using language that everybody can understand. The use of interpreters must be discouraged or avoided, especially in procedures like sterilization where the operation is irreversible. The Government can be held liable for violating a patient's right to information needed for informed consent by using doctors from abroad who don't know the languages used in South Africa. Pera and Van Tonder (1996:102) state that the " South African Medical and Dental Council has made it clear that sterilization operations may only be performed if the full implications are known to the patient".

In order to achieve good communication, providers must know the norms and values of the cultures of people they are serving. A woman's religious and cultural background can have a profound effect on how she regards family planning, and if the provider is aware of the various cultural and religious aspects this can have significance, mostly in methods on which differnt cultures have widely opposing views (Norries 1991:187). The attitude of both providers and clients must be conducive for the discussions. Spicker et al (1987:191) remark that providers become fulfilled in their educator and counselling roles if the clients show eagerness to learn. That will be indicated when the clients respond by asking questions to show that she understood and has absorbed the instructions. On the other hand, there are providers who don't want to be asked questions, they are easily irritated and don't have time to listen. Such a situation is frustrating for a client who usually leaves the clinic uninformed. Failure to respect a person's constitutional rights, especially the right to reproductive health care, can be challenged in terms of the constitution. Providers usually blame such behaviour on the shortage of staff, which they claim leads to tensions and stress due to work overload. This is particularly true in rural

settings because professionals are unwilling to work there due to lack of incentives.

The most important aspect of the nursing system, which is based on rights is that the patient always forms the core of all ethical decision making and the fact that the patient's autonomy is always recognized (Pera and Van Tonder 1996:173). According to Spicker et al (1987:191), the bureaucratic systems in the clinics oppose the above view as clients are only given three packets of pills at each visit. In addition, only a few clinics accept clients without a scheduled appointment and less than a third hold evening clinics. Under these circumstances it is easy for a client to run out of pills, miss appointments and to request an emergency visit at unscheduled times.

Who is at fault if pregnancy occurs? Is the provider responsible for choosing the amount of packets suitable for the patient's use? Was the client's autonomy taken into consideration? Providers are responsible for giving clients their due respect in order to retain the patient's integrity as a unique individual. Clients in reproductive health clinics must not be subjected to torture, inhuman and degrading treatment either physically, mentally or emotionally. Cruel, inhuman or degrading treatment must be avoided at all cost (Constitution section 12 (1)(d)(e). According to Norries (1991:171) to force contraceptive treatment, either hormonal or mechanical, upon a client without consent is considered an assault and is punishable by law. Providers may also be guilty of negligence if they fail to satisfy a duty of care, such as failing to give the necessary information and advice to the patient under the circumstances.

Ngwenya (1994:28) made a call on providers to change their negative attitudes towards women who seek their services. They must show empathy, provide proper counselling and allow clients to voice and express their anxieties.

2.12 ADVANTAGES OF REPRODUCTIVE HEALTH RIGHTS

According to Dixon-Mueller (1993:116-118), women have a lot to gain if their reproductive health rights can be recognized. Teenagers can enjoy sex and avoid pregnancy thus delaying marriage and placing them in a good position to choose a spouse or not to marry at all. Effective birth planning can make it easier for couples to exercise their rights to marry without incurring the cost of having children right away. Fertility limitation within a marriage improves a woman's ability to terminate an unsatisfactory relationship with less personal cost if she has the social, economic and legal option. Fertility control can enhance the right to education and the right to economic advantage. A study conducted in Denmark revealed that successful fertility regulation heightens adaptive capacities and coping abilities, furthermore good conceptive control makes for good family health and thus good mental health (David 1994:344).

Coliver (1995:126) maintains that improving the status of women means increasing the range of their choices. He goes on to indicate that reproductive choice empowers women and reduces women's dependency on men and children for status and support. Reproductive health is a major contributor to saving women's lives and defending their human rights.

Sellers (1993:860) agree and emphasizes the fact that reproductive health improves the life expectancy of the mother. In addition, the availability of contraceptives allows a couple to have a sexual relationship freed from the anxiety of an unwanted pregnancy, to plan childbirth and child rearing for a time when they have the resources to cope with the increased responsibility.

2.13 SUMMARY

Women should be treated with the utmost care and respect as they are the ones who make the world go round. Since a woman carries the child and cares for it for about eighteen years, the rights of women should be respected absolutely when it comes

to reproductive health. Women need to be educated on their reproductive health rights. They also need the support to enable them to make decisions pertaining to their health and development (Kadandara 1994:32). The Constitution now provides for the protection of women' s rights. The onus is left on women to stand firm and learn to be advocates of their own health.

CHAPTER 3

Research methodology

3.1 RESEARCH DESIGN

Descriptive research was conducted using a survey approach. The survey method was chosen because Treece and Treece (1986:176) describe it as a non-experimental study or any research activity in which the researcher gathers data from samples of subjects, whose responses will be representative of the population, for the purpose of investigation and probable solution of the research problem. This chapter presents, the methods and procedures employed to accomplish the purpose of the research.

3.2 TARGET POPULATION

The target population was women in their reproductive stage of life in the rural areas of the Northern Province. One hospital and one clinic in region four of the Northern Province were selected as they serve the largest number of people in rural areas. In addition their accessibility kept travelling expenses to a minimum.

3.3 POPULATION AND SAMPLE

Convenience sampling was utilized. Participants were selected from a sample of people who attended the reproductive health clinic when the researcher was present. Every fifth client was interviewed to avoid delaying the respondents.

3.4 RESEARCH INSTRUMENT

The interview method was used for data collection. Although structured questionnaires were utilised, research participants were interviewed directly to avoid misinterpretation and to ensure clarity on certain issues. Woods and Cantanzaro (1988:130) maintain that an interview is the best method of collecting data, especially

if the respondents cannot read and write.

The questionnaire consists of eight sections;

The purpose of section A is to obtain data about the participants' personal details, their educational status, economic status, marital status and the issue of lobola.

The purpose of section B is to determine whether participants had relevant information about the contraceptives that they are using.

Section C is aimed at obtaining data about the maintenance of privacy in the reproductive health clinic

Sections D & E were drafted to determine the role played by the employer, the husband, relatives and society in the woman's decision making about the use of contraceptives.

Section F was structured to obtain information on women's views on abortion.

Section G was structured to obtain information about the women's awareness of their reproductive health rights.

The questionnaire was mainly composed of closed questions.There were also a few open-ended questions to enable respondents to express their views and clarify statements, where necessary. The questionnaire is given as appendix A.

3.5 VALIDITY AND RELIABILITY

Leedy (1993:41) defines face validity as the type of validity that relies upon the subjective judgement of the researcher, and content validity as the accuracy with which an instrument measures the factors or situations under study. In other words,

content validity would be concerned with how accurately the questions asked tend to elicit the information sought. The research instrument was tested for face and content validity by giving the questionnaire to the supervisors for acceptance, and to detect ambiguities in wording and repetition of items. Professional statisticians were also consulted to establish whether the instrument was sufficiently comprehensive in seeking the proper range of responses, was appropriate in terms of space and length, and was adequate. As a result of this pretesting to ensure the validity of the tool, some questions were discarded and others reworded to give greater clarity.

Reliability of the tool was ensured by phrasing each question carefully to avoid leading the respondents towards a particular answer. Respondents were also informed of the purpose of the interview and asked to respond as truthfully as possible to discourage the tendency of responding to questions with desirable answers only (Brink & Wood 1988:267).

3.6 ETHICAL CONSIDERATIONS

Ethical considerations are vital in a study concerned with personal data, emotionally and potentially affective to the physical status of a human subject (Reid 1993:4).

The research proposal, the instrument, the letter from the ethical committee and the covering letter were sent to the Director of Health of the Northern Province requesting permission to undertake the study at a hospital and clinic under his control. Permission to undertake research was obtained (see appendix C). The instrument and the covering letter were then sent to the medical superintendent of the relevant hospital. The researcher undertook not to identify the hospital's name or the participants involved in the study. Clients were reassured that they would get their normal treatment and care even if they refused to participate. Respondents were informed that their names would not be disclosed and the confidentiality of the information they gave would be maintained.

3.7 PILOT STUDY

A pilot study was carried out. The hospital and clinic used in this study were visited and ten respondents were interviewed. The same questionnaires were used. The questionnaire was subsequently changed, some questions discarded and others reworded to give greater clarity. Despite this, the findings were similar to the final study. The results of the pilot study were not included in the final study.

3.8 DATA COLLECTION

Data was collected in October 1996 from the relevant hospital and clinic. Clients were chosen randomly during their visit to the reproductive health clinic. The interview was conducted in a special room given to the researcher. Sixty (60) respondents were interviewed. Questions were asked in the language of the respondents to make it easier for them to respond with ease and to understand questions clearly. An explanation of the research was given to them. A covering letter requesting their cooperation and explaining the nature, relevance and importance of the research was also explained to the clients. Clients were requested to append their signatures to indicate that they are willing to participate in the study (see appendix D).

Nurses who attended the clinic were reluctant to spend time being interviewed and requested permission to fill in the questionnaire in their own time. They also indicated that they would feel free to record their feelings more truthfully without them being recorded by the researcher. Questionnaires were returned and clarity was given where there was misunderstanding of the questions.

Clients responded spontaneously and some were inquisitive to know more about the whole process. Most of the clients felt free to express their views as well as their problems. Consequently the researcher had to refer some clients back to the providers for help and more information for instance, clients who wanted sterilisation.

to repeat questions if the interviewees did not understand them. Depth of response was also assured since the researcher was able to pursue any questions of special interest.

3.9 DATA ANALYSIS

Questionnaires were coded to help intensive data analysis. They were sent to the Statistics Department and processed by the Computer Services Department. The statistical package for social science's program was used to analyse the data. Data was displayed in tables which indicated frequencies and percentages. This data constituted the material needed to analyse the results, present findings, draw conclusions and make recommendations for further research, as indicated in chapters 4 and 5.

CHAPTER 4

Analysis and presentation of data

This chapter is devoted to the analysis, interpretation and discussion of the responses to the questionnaires. The purpose is to present the information obtained from the responses and from this to answer the research questions as outlined in chapter 1(see section 1.6).

4.1 SECTION A: INTERVIEWEE'S DEMOGRAPHY

This data is very important as it gives the researcher valuable information about the respondents. Analysing this data statistically indicated any deviation from the expected norms, which lead to the conclusion finally drawn from the responses.

Section A Question 1: Age in years

The first item examines the age structure of the respondents.

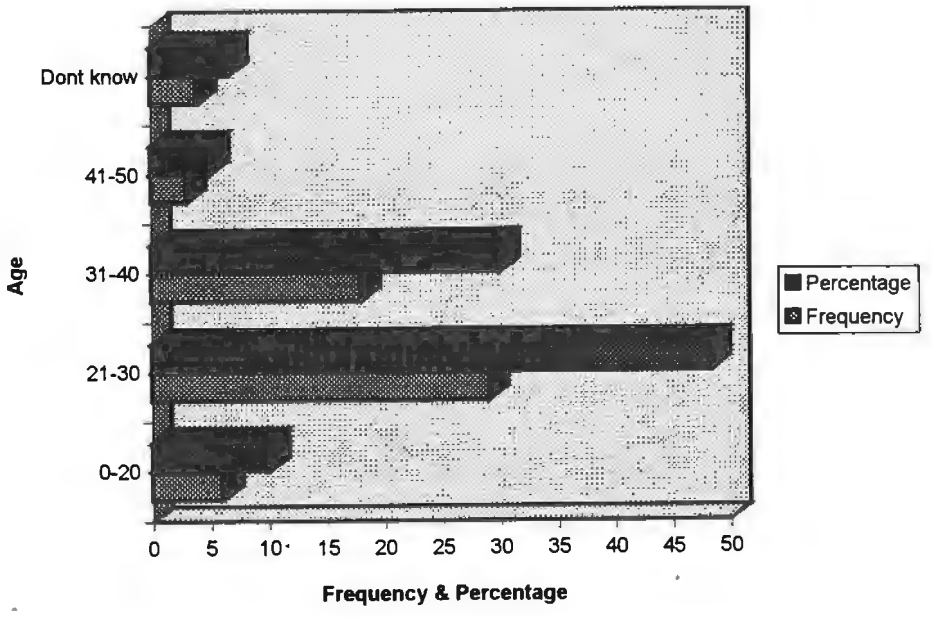

Figure 4.1: Bar graph indicating age distribution (N = 60)

Figure 4.1 shows the age distribution of the respondents. The ages of the respondents were grouped into intervals of ten years except in the first category where an interval of 20 years was used (This was done since the age of reaching puberty and that of being sexually active cannot be specified). The "don't know" option was included for those who are uncertain about their age. The ages of the respondents ranged from 0 to 50 years, with only 6,7 percent who didn't know their age. An uneven age distribution in the sample is apparent with 48,3 percent of the respondents being between 21 and 30, 10 percent being between age 0-20. From figure 4.1 it is clear that 58,3 percent of the respondents fall within the age group 0 to 30 This indicates a very young group who are still in their reproductive stage. Only 5 percent were in the age group 41 to 50.

Section A Question 2: Present occupation

The purpose of this item was to establish whether the respondents were employed and, if so in what capacity.

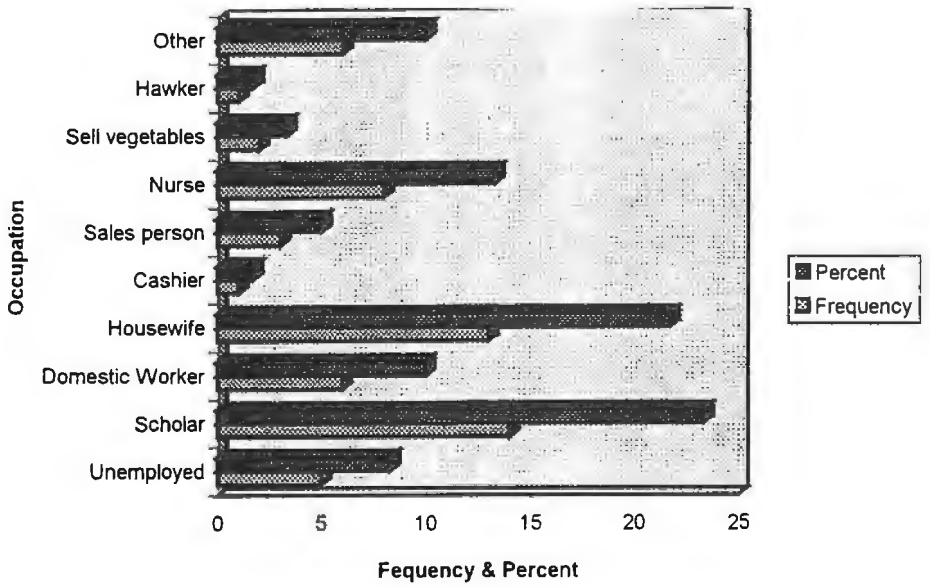

Figure 4. 2: Bar graph indicating occupational groups(N=60)

The results as displayed in figure 4.2 show that students represented the highest percentage of the respondents (23,3%), followed by housewives (21,7%), nurses (13,3%), and domestic workers (10%). Hawkers, cashiers, salesperson, the unemployed and those selling vegetables comprise the remaining 21,7 percent. With 23,3 percent of the respondents being students, it is important that they should receive the necessary information on reproductive rights. They are future wives and mothers responsible for the health and education of children.

Section A Question 3: Monthly income

This question was included to determine the socio-economic status of the respondents. The results indicate that most of the respondents have a low socio-economic status.

Table 4.1: Average income of respondents (N=33)

Salary in Rands	Frequency	Percentage
0-100	9	27,2
101-300	14	42,4
301-500	5	15,2
Other	5	15,2
TOTAL	33	100
Missing	27	

A substantial number (27,2%) earn less than R100 per month. Of the respondents, 42,4 percent earn between R101-300 per months, and only 15,2 percent earn between R301-R500 per month. Of the respondents, 84,8 percent earn below the bread line. The other 15,2 percent earned a living wage. One may assume that these **other** are nurses and other professionals. A frequency of 27 was missing, indicating that out of 60 people interviewed, 27 didn't answer the question. Dixon-Mueller (1993:8) emphasizes that a woman's capacity to make independent choices

regarding marriage, divorce and childbearing is tied to her capacity for economic and social sufficiency. Ngwenya (1994:26) maintains that women who are not earning a good income lack assertiveness as they cannot think independently without consulting the husband who is usually the breadwinner.

Section A Question 4: Church affiliation

This question was asked to determine the denominations to which the respondents belong. Churches have norms, values and beliefs which can influence respondents' views on reproductive health rights.

Table 4.2: Church affiliation of respondents (N=58)

Church denomination	Frequency	Percentage
Lutheran	4	6,9
Apostolic	14	24,1
Presbyterian	7	12,1
Born Again Church	22	38,0
Dutch Reformed	4	6,9
Z.C.C.	6	10,3
Other	1	1,7
Total	58	100
Frequency missing	2	

Table 4.2 indicates that most of the respondents (38,0%) were from born again churches. The remaining percentages were from other Christian churches as shown in the table above. The frequency missing was 2 meaning that those were not church goers (non-Christians) or didn't want to respond. Most Christian churches have ethical objections to abortion. This could influence the respondents' attitudes to using abortion as a method of birth control.

Section A Question 5: Highest standard passed

Education is very important in determining attitudes to reproductive health. This question was included to determine whether educational status has an influence on reproductive health rights.

Table 4.3: Educational Standard of respondents (N=60)

Standard passed	Frequency	Percentage
None	5	8,3
Grade 1-4	2	3,4
Grade 5-7	9	15,0
Grade 8-11	24	40,0
Grade 12	11	18,3
Post matric	9	15,0
Total	60	100

Of the respondents, 40 percent indicated that their highest standard passed was between Grades 8 and 11. Only 8,3 percent of the respondents had no education at all and 18,4 percent had not reached Grade 8. The results indicate a low educational status as only 15 percent of the respondents have passed matric or higher qualifications. Education is very important in determining attitudes to reproductive health. Several studies show that women who have received some education (particularly high school level and above) know more about reproductive health and that they practise contraception in contrast with women with little or no education (Agyei 1988:106).

Section A Question 6: Marital status of respondents

The marital status of the respondents is shown in table 4.4. This question was included to see whether marital status influenced the approach to reproductive

health.

Table 4.4: Marital status of respondents (N=60)

Marital Status	Frequency	Percentage
Single	9	15.0
Married	37	61.7
Widowed	2	3.3
Divorced	1	1.7
Separated	11	18.3
Total	60	100

The results indicate moderate to good marital dominance as 61,7 percent of the respondents were married, and 3,3 percent widowed. Only 18,3 percent were separated and 1,7% divorced. Of the 15% who are single, one may assume that 8,3 percent of the students are married. As figure 4.2 indicates that 23,3 percent of the respondents are scholars, it may be assumed that a significant number of the scholars are married. Being from the same background as the respondents, it is common practice that young teenage girls who fall pregnant are forced to go and stay with the in-laws to preserve the family status. In the study conducted by Nzovu (1995:7) in Ghana, it was discovered that early marriages are common due to the fact that if a girl becomes pregnant before marriage, she must be accompanied to the boyfriend's home to avoid dishonour to the girl's family.

* **NB**: In questions 7 to10 the frequency missing refers to 9 unmarried respondents and 1 divorcee.

Section A Question 7: Type of marriage

As the area of research is rural and traditional customs are still very prominent, the results shown in table 4.5 can be expected. The results indicate that most of the

respondents (74%) are married in terms of customary law. The rest (26%) are married in community of property.

Table 4.5: Type of marriage of respondents (N=60)

Type of marriage	Frequency	Percentage
Customary marriage	37	74
In community of property	13	26
Frequency missing	10	
Total	60	100

Being married in terms of customary law could have profound complications for reproductive health, as one of the characteristics of customary marriage is to bear children. If a husband or wife is not able to have children, a substitute may be found to bear children for the family. This puts pressure on women to have children without proper planning.

Section A Question 8: Payment of lobola and its influence on reproductive health

Questions 8, 9 and 10 were combined as they all deal with the issue of lobola. These questions were asked to determine the extent to which the payment of lobola can affect decision making regarding reproductive health.

Table 4.6: Payment of lobola and its influence on reproductive health rights (N = 60)

Question No	Question	Yes	No	Total
8	Paid lobola	78%	22%	100%
9	Right to sex	55,3%	44,7%	100%
10	Right to No of children	42,6%	57,4%	100%

It is clear from table 4.6 that the husbands of some of the respondents who were not married in terms of customary law did, however, also pay lobola. This is verified by the fact that 78 percent of the respondents indicated that their husbands had paid lobola for them whereas only 74 percent were married in terms of customary law. Lobola was not paid for 22 percent of the respondents. Of the respondents, 55,3 percent indicated that they are of the opinion that paying lobola gives their husbands the right to have sex with them whenever they want, while 44,7 percent disagreed with this. Of the respondents, 42,6 percent indicated that the husband has a right to decide on the number of children they should have as he had paid lobola for them, while 57,4 percent disagreed on this point. The responses to the above three questions confirmed to a certain extent the way in which Klugmann and Weiner (1992:6) view the system of lobola. They indicate that it gives a husband rights over his wife's body, both sexually and in terms of physical labour. It is interesting to note, however, that the results indicate that not all women in rural communities agree with the above view. Of the 39 respondents whose husbands had paid lobola, only 26 agreed that lobola gives a husband the right over his wife's body.

4.2 SECTION B: CONTRACEPTIVE METHODS AND INFORMATION

This section was included in the questionnaire to establish the respondents' knowledge on contraceptive methods and information. This is important as knowledge of different methods, their side effects as well as their action can help clients to make wider choices, thus helping them to enjoy their reproductive health rights.

Section B Question 1: Number of children

This question was asked to find out the parity of the respondents. This is important to determine whether respondents have small or big families. The results are displayed in table 4.7.

Table 4.7: Parity of the respondents (N=60)

No of children	Frequency	Percentage
1	13	21,4
2	14	23,4
3	22	36,6
4	11	18,6
Total	60	100

The results indicate that 36,6 percent of the women in this sample have three children while only 18,6 percent have more than three. This indicates that most of the respondents have less than four children. This should also be seen against the fact that 23,3 percent of the respondents are scholars and that 58,3 percent are under the age of 30 years. If these respondents become fully aware of their reproductive health rights they could have well-planned families.

Section B Question 2: Child spacing

The question was asked to establish whether the respondents are aware that a woman needs rest between consecutive pregnancies.

Table 4.8: Child spacing (N=60)

Spacing in years	Frequency	Percentage
1	3	5
2	5	8,3
3	40	66,8
4	12	24,4
Total	60	100

Most respondents (66,8%) indicated that the youngest child must be three years old before the next child is born. This is very interesting as it indicates that the respondents are aware that spacing is important. Only very small percentage (5%) indicated a spacing of one year. Cook (1996:6) indicates that a lack of effective means of birth spacing and fertility control endangers women's survival and health. She indicates further that although pregnancies and birth carry some health risks, these are usually higher when pregnancies are too early, too late or too closely spaced or unwanted.

Section B Question 3: Methods of family planning already heard of by respondents

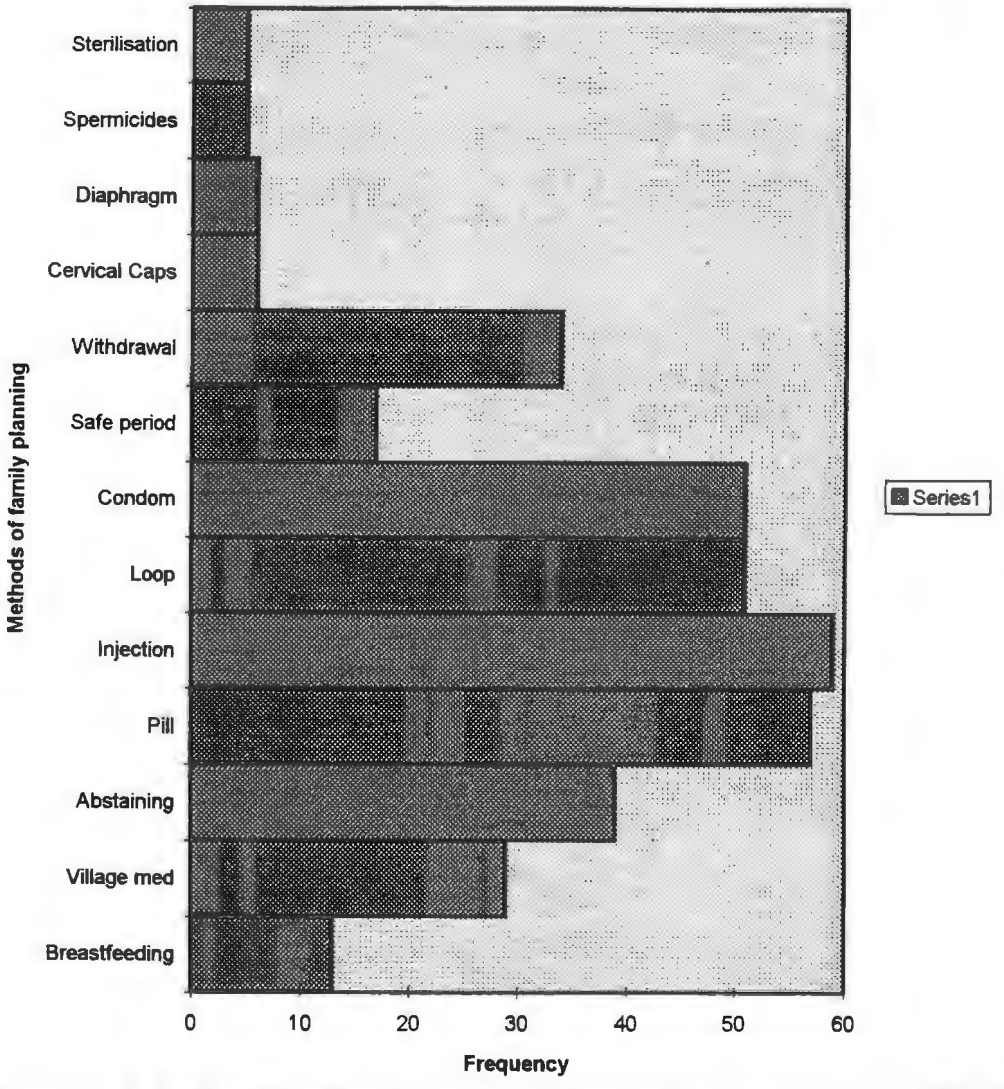

Figure 4.3: Methods of family planning known by respondents (N = 60)

Different methods of family planning are available to women. To make choice, it is therefore important that they have knowledge of the methods available. The question was included to determine which methods of family planning are known to the respondents as that can help them to make an informed choice. In figure 4.3 only frequencies have been used because respondents were allowed to tick more than one method.

Injection, sterilisation, loop, condoms and pills are the methods best known to the respondents as they were known by fifty respondents and more. Only few respondents knew about spermicides, cervical caps and the diaphragm. The results in section A question 2 indicate that eight of the respondents are nurses. From this one can assume that the six respondents who knew about spermicides, cervical caps and the diaphragm are nurses. It is strange to note that not all nurses had knowledge of these methods. One wonders what type of health education they will give to the community when they themselves do not know all the methods. Coliver (1995:126) agrees with these results by indicating that there is very little information available, and in most cases none at all, about the intra-uterine device (IUD) and the diaphragm. She also highlights the fact that the chief barriers to effective communication include inadequate funding, inefficiency of the public health system, the isolation of rural women and in some cases, women's illiteracy or low literacy. In contrast to Colivers' view, fifty-one of the respondents in this study knew about IUD as a method of contraception.

Section B Question 4: Method of information

The ways in which the methods were learned was asked to determine what is the appropriate and easiest method of spreading information in rural areas. Frequencies were used to display the results as respondents were allowed to choose more than one method through which they received information.

Table 4. 9: Methods of obtaining information on the use of contraceptives (N = 60)

Communication method	Frequency
Radio	25
Newspaper	1
Church	0
Friends	29
Clinics	43
Initiation school	0
Older women	3
Other	2

Most of the respondents (43) indicated that they heard about the contraceptive methods at the health care units. This is followed by information received from friends (29). The radio (25) also seems to be a very powerful means of communication as compared to newspapers, which most women do not read or cannot even afford to buy. Friends also play a very important role in the dissemination of the information as compared to older women and relatives. Thus, indicating that peer groups feel free to discuss reproductive health issues amongst themselves, but discussing family planning with older women and relatives is not a popular practice. The church does not play a role in educating women about reproductive health. Initiation schools were not used as a method of conveying information.

Section B Question 5: Methods of contraceptives used in the past

This question was asked to find out the methods the respondents had used in the past. Frequencies were used because some of the respondents have already used more than one method, whereas others have never changed a method since they started using contraceptives.

Table 4.10: Methods already used by the respondents (N = 60)

Method	Frequency
Breastfeeding	0
Village Medicine	0
Abstinence	1
Pill	24
Injection	8
Loop	2
Condom	10
Calendar method	0
Withdrawal method	9
Cervical caps	0
Diaphragm	0
Spermicides	0

A substantial number of the respondents (24) have used the pill. Ten indicated that their husbands used condoms, which shows that men are also becoming responsible for reproductive health. Traditional ways of preventing pregnancy, like abstinence, breastfeeding, village medicine and the withdrawal method, are less popular and have been replaced by modern contraception. Diaphragms and spermicides are not known to most of the respondents as indicated in section B question 3, and this is also confirmed by the fact that none of the respondents used these methods. The fact that no one indicated the use of the calendar method can be attributed to the low literacy level in section A question 5, as this method needs someone with a thorough knowledge of the menstrual cycle. Although many women indicated that they know abstinence as a method, only one respondent indicated that she used the method. This shows that today's women are no longer keen to use this method. This view is supported by Cook (1996:4), who maintains that sexual abstinence is a natural way to prevent unwanted pregnancy, but sex is also a natural part of life.

Section B Question 6: Reasons for stopping the use of a contraceptive method

This was an open-ended question which was asked to determine whether respondents have valid reasons for stopping or changing a method of contraception, and also if they had experienced complications in the past. Different reasons were given for stopping or interrupting the use of contraceptives. The reasons can be summarised as follows:

Of the twenty-four respondents who indicated that they had previously used the pill:

- seven indicated that they missed the pill and fell pregnant
- twelve complained that they used to forget the pill and realised that it was not a good method for them to use
- five explained that they had experienced side effects like headache, migraine, nausea, vomiting and hypertension

All eight respondents who used the injection

- indicated that they stopped using the method because of irregular bleeding, which is one of its common side effects

Discontinuing other methods

- Respondents whose husbands used condoms indicated that the method is unreliable as husbands are not keen to use the method every time.
- Six respondents indicated that they fell pregnant because their husbands refused to wear the condoms at times.
- Most of the respondents who indicated that they were using the withdrawal method cited that the method was unreliable.
- Respondents who were using the intra-uterine device indicated that

they wanted to have a baby, and that they didn't continue with the method after delivery because of its side effect of concurrent infections.

- One respondent who used abstinence in the past cited that this method is unreliable.

Section B Question 7: Contraceptive method currently used

This was an open-ended question. Forty-eight of the respondents indicated that they were currently using the injection as their method of contraception; eleven are using the pill and one is using an intra-uterine device. This can be attributed to the fact that many women find the injection the only viable method to use for reasons of convenience, particularly because its use can be hidden from their husbands (Klugmann 1988:121). It is also clear from question 6 above that most of the respondents no longer used the pill as they had realised its disadvantages. Hartmann (1988:187) supports Klugmann when she stresses that the advantages of the injection lie primarily in the way it is administered, a single injection protects a woman from pregnancy for two to three months, freeing her from the need for continued responsibility for birth control unlike the pill, which must be taken every day.

Section B Question 8: Full information on how the method works

This question was asked to find out whether the respondents had full information on the action of the method they are using.

Table 4.11: Information on the way in which a method works (N=60)

Answer	Frequency	Percentage
YES	26	42,4
NO	34	57,6
Total	60	100

From table 4.11there is a clear indication that most of the respondents (83,3%) are using the method without the knowledge of its action whereas 16,3 percent indicated that they had information on the method. It is not known whether this has to do with the literacy level as only 15 percent of the respondents have post-secondary qualifications. Pamphlets with information about contraceptives are only available in English, and this makes it difficult for those who can only read their own language. Bennet and Brown (1990:244) suggest that to enable clients to understand different methods of contraceptives, the reproductive health clinic information services must produce pamphlets in ethnic minority languages.

Section B Questions 9 and 10: Awareness of the side effects of contraceptive methods

These questions were asked to determine whether the respondents were made aware of the side effect of the method so that they could seek medical aid early should they observe any side effects. Of the respondents, 42,4 percent were made aware of the side effects of the method whereas 57,6 percent were unaware as displayed in table 4.12. Respondents who indicated that they were made aware, were asked to list the side effects of the method.

Table 4.12: Respondents' awareness of side effects of contraceptive methods (N=60)

Answer	Frequency	Percentage
YES	26	42,4
NO	34	57,6
Total	60	100

Of the forty-eight respondents who are using the injection method, thirteen knew two side effects, namely amenorrhoea and excessive weight gain. Three knew about the prolonged return to fertility. Of the eleven respondents who are using the pill, three

knew about one side effect of the pill namely hypertension. At least the respondent who was using the intra-uterine device knew about three complications, namely infection, displacement and lower abdominal pains. Coliver (1995:136) maintains that people who dispense contraceptives should make the contraindications, the possible side effects and the measures a woman who suffers negative side effects should take very clear.

Section B Question 11: Using the contraceptive method of choice

As adults, respondents are expected to make their own choice of a method. This is only possible if they are equipped with full information and knowledge of how the methods work.

Table 4:13: Using the method of choice (N=60)

Answer	Frequency	Percentage
YES	49	81,7
NO	11	18,3
Total	60	100

The majority of the respondents (81,7%) indicated that they are using the method of their choice and 18,3 percent indicated that they are not. This implies that they may decide for themselves or are accepting the provider's choice.

Section B Question 12: Right to choose a method for another

This question was asked to find out whether there are individuals who have the right to choose a method for another. Figure 4.4 displays the answers to this question.

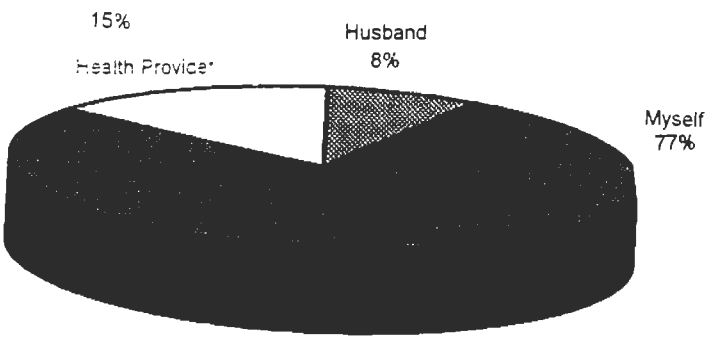

Figure 4.4: Pie chart on choice of method (N = 60)

Of the respondents, 77 percent indicated they chose the contraceptive method of their choice and 15 percent indicated that providers chose methods for them, while 8 percent indicated that their husbands did. When asked if it is right for someone to choose a method for another, most respondents (80%) disagreed, indicating that everybody is entitled to choose a method for her, while 20 percent agreed, indicating that it is right for someone to choose a method for you if she finds it suitable, especially the nurse as she has more knowledge.

Section B Question 14: Changing a method

This question was asked to determine whether respondents are free to change a method. Only 8,6 percent of the respondents mentioned that they are not allowed to change a method whereas 91,4 percent of the respondents indicated that they were allowed to change to another method. This indicates that the majority of respondents are free to exercise their freedom of choice in this regard.

Section B Question 15: Awareness of pap smear test

It was necessary to find out whether respondents are aware that they must go for a pap smear test once a year as indicated in the reproductive health programme.

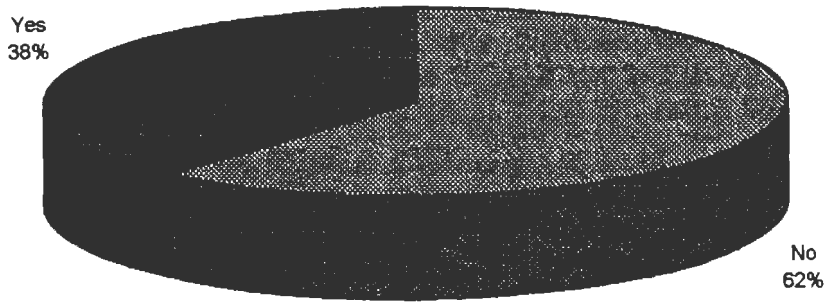

Figure 4.5: Respondents' awareness of the pap smear (N= 60)

According to figure 4. 5, 38 percent were aware of the pap smear test whereas 62 percent didn't know what a pap smear is. This shows a lack of information as well as poor services because women are supposed to be told that they must go for a pap smear as a screening test for cancer of the cervix once a year. The FDA (United States Food and Drug Administration) concluded in 1984 that the pill may increase the risk of cervical cancer. It was therefore recommended that women on the pill should be monitored carefully, using physical examination and the pap smear test (Hartmann 1987:185).

Section B Question 16: Periods of availability of contraceptives at the clinic

It was important to ask respondents how often they are able to obtain contraceptives from the clinic to determine the accessibility of services at the clinic. In table 4.14 the findings are given.

Table 4.14: Periods of availability of contraceptives at the clinic (N=60)

Periods	Frequency	Percentage
Daily	41	68,3
Twice weekly	0	0
Weekly	19	31,7
Other	0	0
Total	60	100

Of the respondents, 68,3 percent indicated that contraceptives were obtainable daily from their clinics, whereas 31,7 percent indicated that the reproductive health clinic operates on a weekly basis at their clinic. Accessibility of services is limited for clients who get contraceptives on a weekly basis, should they forget to get the contraceptive on the specific day. It could also be a problem if they do not have transport on the day the clinic is open.

Section B Question 17: Monitoring vital signs during visit to the clinic

Taking of blood pressure, weighing and breast examinations must be done every time clients visit the reproductive health clinics. This is a part of health screening that is usually dealt within a family planning clinic. Sellers (1993:866) indicates that it is necessary to measure blood pressure as oral contraceptives affect blood pressure. Screening helps providers to detect disease rather than treating people after they get sick. Breast examination, which is a screening test for breast cancer, is not done at all. The FDA recommended that routine breast examinations are very important for pill users to detect breast cancer early (Hartmann 1987:185). The results, as in table 4.15, show that examinations prior to issuing the contraceptives are not properly done.

Table 4.15: Examinations done during visit to the clinic

Vital signs	Frequency
Taking of blood pressure	40
Weighing	41
Breast examination	0
Issuing method only	20
Asks if any complaints about the method	15

Section B Questions 18 and 19: Becoming pregnant while on contraceptives

To determine the failure of certain methods of contraception, the respondents were asked who became pregnant while on contraceptives. This was necessary to see which method is most suitable for the majority of women. This can also help the provider in her counselling role as she must provide clients with enough knowledge and information on the reliability of a method.

Table 4.16: Method used when falling pregnant while using contraceptives (N = 15)

Method	Frequency
Pill	11
Injection	3
Intrauterine device	0
Other	1
Total	15

Most of the respondents who fell pregnant while on contraceptives were using the pill. This could be attributed to forgetfulness, indicated by most of the respondents in section B question 6 on page 56. Lack of information on how the method works may also be a contributory factor as shown by the results in section B question 8 on page 57. Coliver (1995:132) confirms this when she maintains that the wide availability of contraceptives over the counter, combined with inadequate access to information, has undoubtedly had negative consequences for women's health.

4.3 SECTION C: THE RIGHT TO PRIVACY

This section was intended to establish whether privacy is maintained in the reproductive health clinic and if clients are enjoying their rights to privacy. According to Spicker et al (1987:169), the right to privacy is the right which was proposed in *Grisworld v Connecticut 24* for married and unmarried persons to use contraceptive devices, and to be free from unwarranted government intrusion into matters so fundamentally affecting a person, for example the decision about the right whether to bear or beget a child. The Constitution of the Republic of South Africa provides the right to privacy (section 14) as well as the right to human dignity (section 10). Furthermore, women in reproductive health clinics are also protected by section 12 (e), which includes the right not to be treated or punished in a cruel, inhuman or degrading way.

Section C Questions 1 and 2: Entrance to the screening room

Of the respondents, 25 percent indicated that they entered the screening room alone without other clients, while 75 percent indicated that they do not enter the screening room alone. Almost all (90,6%) of the respondents who did not enter alone indicated that they enter the screening room with other clients. The rest mentioned that a nurse accompanied them, which is what is expected, as the nurse does the screening. The results, as indicated in figure 4.6, show lack of privacy.

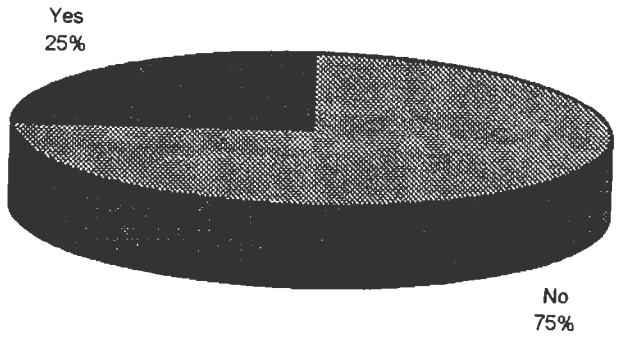

Figure 4.6: Pie chart on who accompanies respondents when entering the screening room (N = 60)

Section C Question 3: Freedom to verbalise fears

In question 3 respondents were asked when they felt free to verbalise their fears and problems. The findings are presented in table 4.17 indicating frequencies only, as respondents could respond to more than one question.

Table 4. 17: Freedom to verbalise fears (N= 60)

Verbalising fears	Frequency
When alone	57
When with family	0
When with husband	3
In front of others	4

The majority of respondents (57) indicated that they feel free to verbalise their fears and discuss problems related to reproductive health when alone with the provider.

Only four respondents mentioned that they could discuss their problems even in the presence of other clients. This indicates that clients have a lot of problems and fears that are not attended to due to lack of privacy.

Section C Question 4: Attending clinic with same age group

This question was asked to determine whether adults and teenagers object to attending the clinic at the same time.

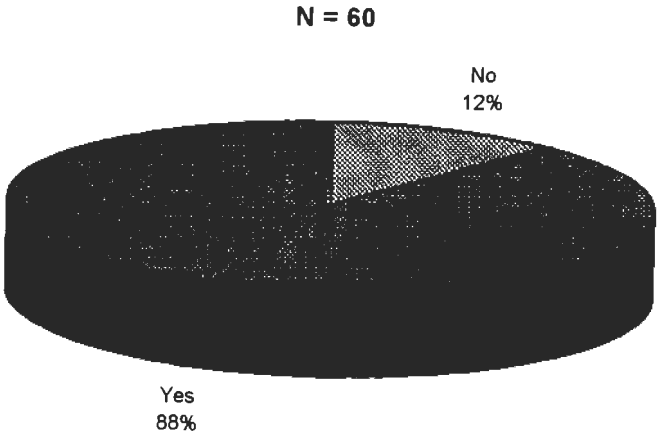

Figure 4.7: Pie chart on attending clinic with the same age group (N = 60)

According to figure 4.7, 88 percent of the respondents indicated that it is preferable to attend the clinic with people of their own age group. This has also been shown by section B question 4 on page 53 where one of the best means of spreading and source of information was found to be friends.

Section C Question 5: Description of services at the clinic

Spicker et al (1987:185) maintain that clinics can vary tremendously in atmosphere, from rushed, harassed and harassing to cheerful and relaxed, depending on the size of the premises, the number of patients waiting to be seen, the number of staff

available to see them and the manner in which staff go about their business. This question was asked to determine the atmosphere of the reproductive health services at the clinic.

Table 4.18: The atmosphere at the clinic where services are rendered (N = 60)

Description	Frequency
Embarrassing	7
Friendly	10
Professional	46
Other	3

Most of the respondents (46) indicated that the services were professional, ten indicated that the services were friendly, and seven indicated that they were embarrassing. Of the respondents, only four chose other and specified that the services are unfriendly and unprofessional. They indicated that they are treated like kids and no respect is shown by the providers.

Section C Question 6: Suggestions on the improvement of services

Suggestions were made on how to improve the services. Most clients indicated that the space is too small and made the following suggestions:

- Twelve respondents suggested that more space should be provided to help in the maintenance of privacy.

- Fifteen respondents indicated that teenagers must be informed on reproductive health at schools.

- Six respondents indicated that nurses must get further training in reproductive health and must also change their attitudes to clients.

- Ten respondents suggested that there must be a separate clinic for teenagers. There were women from faraway places who indicated that their sons and daughters are already teenagers, they will therefore feel embarrassed if they meet at a reproductive health clinic.

- Ten respondents indicated that consent from the husband must no longer be a prerequisite as it denies women the right to use contraceptives.

- Five respondents suggested that men must be taught the importance of contraception.

4.4 SECTION D: REPRODUCTIVE HEALTH RIGHTS AND EMPLOYMENT

The aim of this section was to find out about problems in the employment sectors which deny the respondents the chance to attend reproductive health clinics.

Section D Question 1: Time granted by employer to attend reproductive health clinic

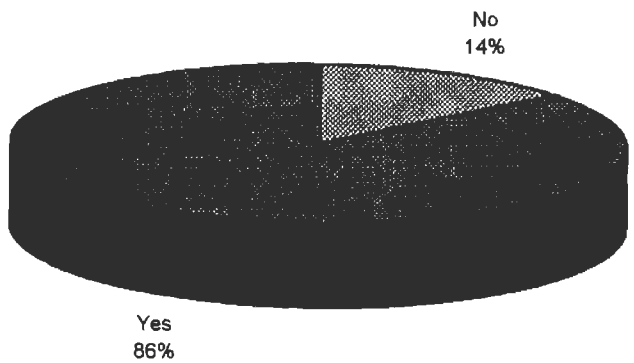

Figure 4.8: Pie chart on time granted by employer to attend reproductive health clinic (N =29)

It is encouraging to note that 86 percent of the respondents indicated that employers grant them time to attend reproductive health clinic. Only 14 percent indicated that they were not granted time to attend a reproductive health clinic.

Section D Question 2: Provision of family planning clinic at workplace

Employers could make it easier for employees by providing a family planning clinic at the workplace. It is clear from figure 4.9 that most of the employers do not provide for a family planning clinic at the workplace. This can be attributed to the fact that most of the respondents are domestic workers, hawkers, housewives and vegetable sellers (see figure 4.2), which makes it impossible for the employer to provide such services compared to when people are employed by a big firm.

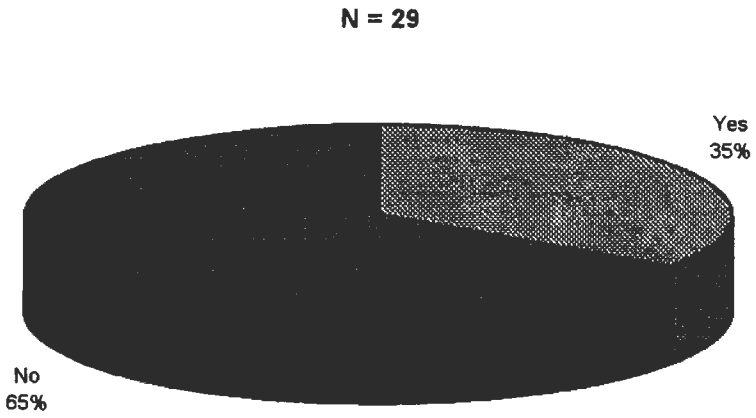

Figure 4.9: Pie chart on provision of family planning at the clinic (N =29)

Section D Question 3: Type of leave granted for attending clinic

In table 4.19 the types of leave granted to employees are given. Most of the respondents (87,5%) indicated that they were granted hours which do not affect leave days.

Table 4.19: Type of leave granted to attend the clinic (N=24)

Answer	Frequency	Percentage
Vacation leave	1	4,2
Sick leave	1	4,1
Special day	0	0
Hours not affecting leave	21	87,5
Other	1	4,2
Total	24	100

No one was given a special day's leave for reproductive health clinic reasons. Vacation leave was granted for 4,2 percent of the respondents. As family planning is not regarded as a disease, it is surprising to find that 4,1 percent of the respondents indicated that they were granted the day as a day's sick leave.

Section D Question 4: Policies set by the employer to attend reproductive health clinic

According to Klugmann (1988:103), employers in large factories make contraceptives available at work to avoid women conceiving which disturbs work production rather than for their own health. Surprisingly, 95,8 percent of the respondents indicated that there are no policies set by their employers pertaining to reproductive health. It can be assumed that this is attributed to the fact that they are not pregnant, as problems in the workplace usually affect pregnant women. This view is supported by Cobbet in Klugmann (1988:103) when he indicates that women working in factories view pregnancy as a burden because if you become pregnant, you are asked to stop working and you are not even sure whether you will get your job back after delivery.

4.5 SECTION E: THE ROLE PLAYED BY SOCIETY, HUSBAND AND FAMILY IN DECISION MAKING ON ISSUES PERTAINING TO REPRODUCTIVE HEALTH CARE

This section examines the role played by the husband, family members and society in reproductive health care and decision making.

Section E Questions 1 and 2: Discussing family planning with husband

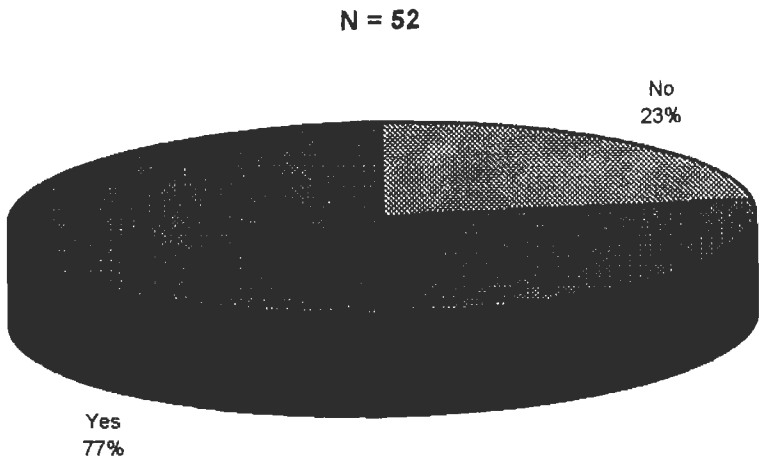

Figure 4.10: Pie chart on role played by society, husband and family in decision making on issues pertaining to reproductive health care (N = 52)

Most of the respondents (77%) indicated that they discuss family planning with their husbands. While 23 percent indicated that they do not discuss the subject with their husbands, the reason being that their husbands would not allow them to use contraceptives. They therefore find it difficult to discuss such issues.

Section E Questions 3 and 4: Husband's consent to use contraception

Hartmann (1987:48) indicates that a study conducted in Mexico revealed that husbands do not want their wives to go to the clinic as they are going to be examined

by doctors, who will see and touch them in areas where their husbands feel no man, except themselves are supposed to touch. Of the respondents, 78,4 percent indicated that their husbands are aware that they are using contraceptives, whereas 21,6 percent indicated that they do not have their husband's consent. All the respondents (78,4%) who indicated that their husbands were aware indicated that they had discussions with their husbands.

Section E Question 5: Consequences of using contraceptives without husband's knowledge

Respondents were asked how their husbands would react if they found out that they are using contraceptives without their consent.

Table 4.20: Consequences of not informing husbands about using contraceptives (N=21)

Answer	Frequency
Will let me continue	0
Will send me to my parents	6
Will hit me	8
Will ask me to stop	6
Will confront the providers	1
Total	21

Of the respondents who answered the question, six indicated that husbands may send them back to their parents if they discovered that they were using contraceptives, eight indicated that they could be beaten, six indicated that they could be asked to stop and one indicated that the husband may confront the providers. These results indicate that there are only a few women who are able to stand up for their rights and who feel that they have a right to control their own bodies. A doctor in a rural Mexican clinic explained that "when a wife wants to do

something on her own, such as trying to limit the number of children to feed in the family, the husband will become angry and even beat her. The husband thinks it is unacceptable that his wife is challenging his authority, his power over her, and thus the very nature of his virility" (Hartmann 1987:48).

Section E Question 6: Decision on the number of children

Family ties are very important in rural areas. Moreover, the extended family is still common. This question was asked to determine whether members of a family can influence the decisions on reproductive health care.

Table 4.21: Decision makers in deciding on the number of children (N=49)

Answer	Frequency
My mother	2
Mother in law	14
Husband's first wife	0
Sister in law	2
Nobody	31
Total	49
Frequency missing	1

Fourteen of the respondents indicated that the mother-in-law can decide how many children a woman may have whilst only two respondents indicated that their mother or sister-in-law may also have an influence. Slightly more than half of the respondents (31) indicated that nobody has a say in the number of their children except their husbands. This indicates that although mothers-in-law still play a big role in some families, about half of the respondents are now free to decide on their own or with the input of their husbands on the number of children they would like to have.

Section E Question 7: Responsibility for acquiring information on contraceptives

Couples are responsible for going to the clinic to get more information about contraceptives so that they are able to make informed decisions.

Table 4.22: Acquiring information on contraceptives (N = 60)

Answer	Frequency	Percentage
Wife	23	43,4
Husband	0	0
Both	30	56,6
Don't know	0	0
Total	53	100
Frequency missing	7	

Most of the respondents (56,6%) indicated that both husband and wife should go and get information if they want to learn something about contraception. Only 43,4 percent indicated that the wife should be the only one to go and get the information. This shows that less than half of the women feel that they are solely responsible for contraceptive measures.

Section E Questions 8, 9 and 10: Society's approval

Discriminatory attitudes and practices within the community can impede women's knowledge on reproductive health issues (Dixon-Mueller 1993:213). This question was asked to determine the attitude of society to women using contraceptives. As can be seen from table 4.23, 31,7 percent of the respondents agreed that society approves of women using contraceptives, while 53,3 percent disagreed and 15,0 percent were not sure.

Table 4.23: Society's approval for using contraceptives (N=60)

Answer	Frequency	Percentage
Yes	19	31,7
No	32	53,3
Not sure	9	15,0
Total	60	100

Those who agreed indicated that society approves the use of contraception for the sake of spacing children and limiting family size, only a few gave the reason of the wife having a small baby as the reason. The following reasons were given by the 53,3 percent who indicated that society does not approve of women using contraceptives: it makes women weak and sick, induces sterility and destroys libido in men.

4.6 SECTION F: ABORTION

As indicated by the analysis of question 19 on page 63 and question 6 on page 56 in section B, unplanned pregnancy may occur due to failure of a contraceptive method. In such a situation a woman may think of abortion. This section was included to find out how the respondents feel about abortion as it is a current issue, which is debated daily in our society, and moreover it is also part of reproductive health care. Dixon-Mueller (1993:170) argues that abortion is not only necessary as a backup for contraceptive failure or non-use. It is also a preferred method of family planning for some women.

Section F Questions 1 and 2: unexpected pregnancy

The respondents were asked whether they ever found themselves pregnant unexpectedly, and if so, what was the first thing they thought of.

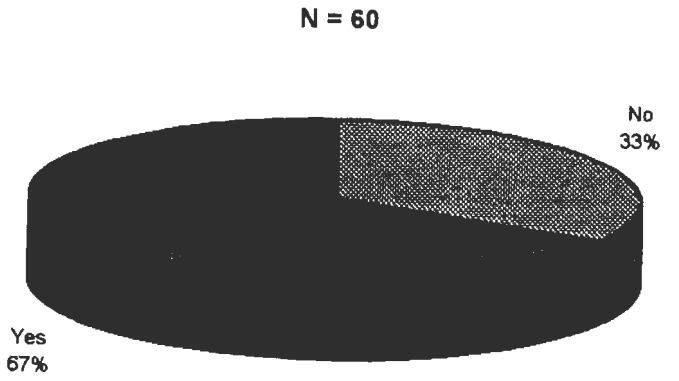

Figure 4.11: Pie chart on the rate of unexpected pregnancy (N = 60)

Of the 67 percent respondents who indicated that they once found themselves pregnant unexpectedly, 41,4 percent indicated that they thought of having an abortion. This percentage can be attributed to the fact that data was collected when abortion was still illegal except in cases of rape, incest, gross malformations of foetus and maternal health, therefore people were not willing to give out information related to abortion and a lot of secrecy was associated with the process.

Section F Question 3: Reasons for having an abortion

Table 4.24: Reasons for abortion

Answer	Frequency
I was not ready to have a child	13
My youngest child was too young	13
I didn't have money to support a child	5
It would have disturbed my school years	10

Frequencies were used in table 4.24 as the respondents were allowed to choose more than one option. These findings indicate that in many cases the reasons for abortion are social or economic, as already discovered in a survey of incomplete abortion conducted by the Medical Research Council in 1994 (see page 31).

Section F Question 4: Success of abortion

When asked about the success rate of abortion, 50 percent of the respondents who had opted for an abortion managed to abort while 50 percent failed. See figure 4.12 below.

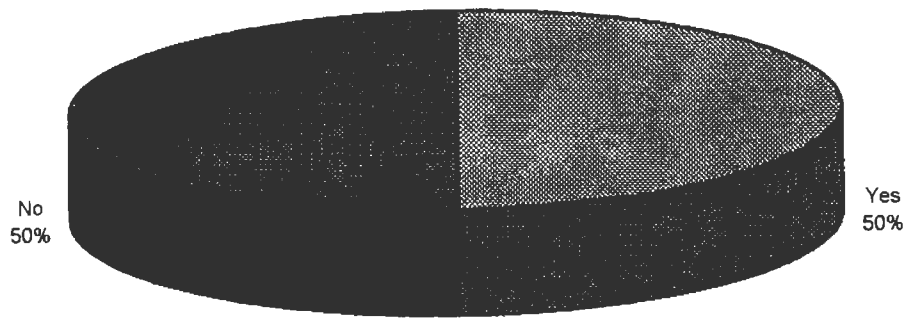

Figure 4.12: Pie chart on success of abortion (N = 24)

Section F Question 5: Reasons for failing to abort

Respondents who failed to abort were asked the reasons for failing to abort. The results as displayed in table 4.25 indicate that fear of death was the main reason for not aborting, followed by those who felt they must accept their responsibilities.

Table 4.25: Reasons for failing to abort (N = 60)

Reasons	Frequency
Afraid of death due to backstreet abortion	31
I did n't have money to pay for abortion	8
I felt I have to accept my responsibilities	13
It would have been against my religious beliefs	6

Hartmann (1987:47) indicated that in countries where abortion is illegal one fifth to one half of all maternal deaths are due to illegal abortion. This has also been confirmed by Price (1983:90) who stressed that self induced abortion and backstreet abortion are hazardous, and are usually performed under unhygienic conditions using crude instruments, caustic agents and toxic potions which lead to death and adverse complications.

Section F Questions 6, 7 and 8: Views about the termination of pregnancy Bill.

These questions were asked to determine the respondents' view about The Termination of Pregnancy Bill. For most of the respondents this was the first time they were hearing about the bill, but after a thorough explanation they understood what it was all about. Of the respondents, 48 percent indicated that Termination of Pregnancy Bill was good and 52 percent felt it was not good. The respondents who supported the bill indicated that it would reduce the mortality rate of women who died due to backstreet abortion, whereas those who were against the bill felt strongly that it denies the foetus the right to life with a few indicating that it is against their religious belief and is morally wrong.

4.7 SECTION G: AWARENESS OF REPRODUCTIVE HEALTH RIGHTS

The aim of this section was to determine the degree of awareness of reproductive health rights. All the respondents indicated that they are aware that they have the freedom to choose the method that they liked and the right to confidentiality.

Table 4.26: Awareness of reproductive health rights (N = 60)

Questions	Yes	No	Total
Freedom to choose	100	0	100
Right to confidentiality	100	0	100
Forced to choose a method	98,3	1,7	100
Information on a method	96,7	3,3	100
Short of pills during emergency	96.7	3.3	100
Right to adequate information	94,9	5,1	100
Right to refuse treatment	89,8	10,2	100
Decision by husband	86,7	13,3	100
Routine checkup	86,7	13,3	100
Knowledge of the pap smear	26,7	73,3	100

According to table 4.26 the majority (86,7%) indicated that they were aware that their husbands are not allowed to decide on their behalf in matters affecting reproductive

health. It is also encouraging that 96,7 percent indicated that they were aware that providers must give them full information on all methods of contraception before they choose and 98,3 percent indicated that they are not supposed to be forced to choose the method that they do not like. Of the respondents 96,7 percent indicated that they are aware that they must go to the clinic if they are running short of pills.

Of the respondents 73,3 percent indicated that they don't know what a pap smear is and 81,7 percent indicated that they are not aware that they are supposed to go for a pap smear once a year. A high percentage (86,7%) are aware that they must undergo routine checkups every time they visit the reproductive health clinic and 89,8 percent are aware that they have a right to information. All the respondents are aware that they have a right to confidentiality. Although the overall results indicate that there is a high rate of awareness, this is not always evident in the responses, for example, sharing the examination room with other clients as shown in section C question 1 and 2. This could be because respondents are not assertive in requesting their rights.

4.8 STATISTICAL ANALYSIS AND INTERPRETATION

According to the statistical significance as indicated in table 4.27, the one person who chose "newspaper" as her source of information on different methods of contraception is from group 6 which is post-secondary school education. This could be an indication that the literacy level influences the method used to get information and knowledge on the functioning of contraceptives.

The correlation was done between the following two questions:

Section B question 4: Where did you learn of these methods?
Section A question 5: What is the highest standard passed?

Table 4:27: The correlation between educational status and method used to get information on contraceptives

AQ5	Count / Row Pct / Col Pct / Tot Pct	BQ4 = 1	Row Total
6		1	1
		100,0	100,0
		100,0	
		100,0	
Column Total		1	1
		100,0	100,0

>Warning # 10307
>Statistics cannot be computed when the number of non-empty rows or columns
>is one.

Number of Missing Observations: 59

From table 4.28 it can be seen that 50 percent of the respondents who had full information on the method of contraception, which they were using, were from group 6 (Post- secondary education) and 100 percent had high school education. Of those who answered "NO" 50 percent were from the three lower educational groups. There is therefore a definite correlation between educational status and information on how the method works.

The correlation was done between the following two questions:

Section A Question 5: What is the highest standard passed?
Section B Question 8: Do you have full information on how this method works?

Table 4:28: Correlation between educational status and information on how contraceptive method works

AQ5	BQ8 1	BQ8 2	Row Total
1		5 100,0 10,0 8,3	5 8,3
2	.	1 100,0 2,0 1,7	1 1,7
3		9 100,0 18,0 15,0	9 15,0
4	2 8,3 20,0 3,3	22 91,7 44,0 36,7	24 40,0
5	3 27,3 30,0 5,0	8 72,7 16,0 13,3	11 18,3
6	5 55,6 50,0 8,3	4 44,4 8,0 6,7	9 15,0
8		1 100,0 2,0 1,7	1 1,7
Column Total	10 16,7	50 83,3	60 100,0

From table 4.28 it becomes clear that 73,3 percent, of the respondents, were not aware of the pap smear test and of the 26,7 percent who were aware of the test, 87,6 percent had high school education. This could be an indication that people of low literacy might not be aware of the test being done at the clinic.

The correlation was done between the following two questions:

Section A Question 5: What is the highest standard passed?
Section B Question 15: Are you aware of the pap smear test?

Table 4:29 Correlation between education and information about A pap smear

AQ5	Count / Row Pct / Col Pct / Tot Pct	1	2	Row Total
1		1 20,0 6,3 1,7	4 80,0 9,1 6,7	5 8,3
2			1 100,0 2,3 1,7	1 1,7
3		1 11,1 6,3 1,7	8 88,9 18,2 13,3	9 15,0
4		3 12,5 18,8 5,0	21 87,5 47,7 35,0	24 40,0
5		5 45,5 31,3 8,3	6 54,5 13,6 10,0	11 18,3
6		6 66,7 37,5 10,0	3 33,3 6,8 5,0	9 15,0
8			1 100,0 2,3 1,7	1 1,7
Column Total		16 26,7	44 73,3	60 100,0

4.9 SUMMARY

This chapter yielded findings from which one can deduce conclusions and recommendations which can form the basis for further research as indicated in chapter 5.

CHAPTER 5

Overview of findings, implications, limitations, recommendations and conclusions.

5.1 INTRODUCTION

This chapter includes an overview of the study with the emphasis on the limitations of the study, specific major findings, the implications of these findings, recommendations and conclusions.

The specific objectives of this study were to:

- determine whether women in rural communities are aware of their reproductive health rights

- assess to what degree they can exercise these rights

- determine the relationship between reproductive rights and women's rights in other spheres, such as education, employment, the family, community, culture and other socio-economic structures.

5.2 DISCUSSION OF FINDINGS ACCORDING TO THE INSTRUMENT

5.2.1 Awareness of reproductive health rights

The results indicate that women were aware of their reproductive health rights, although they lacked information on certain issues, such as pap smear tests and certain birth control methods. The degree of awareness also depended on the educational level, of the respondents. The higher the educational level the higher the degree of awareness.

5.2.2 Interviewee's demography

The ages of the respondents ranged between 0 and 50 years. Most of the respondents were in the age group 21 to 30. This is of significance as it indicates that most of the women are in their childbearing years. Most of the respondents were in the lower occupational groups and most of them earn salaries which are below the bread line. The results also indicate a low literacy level. Nowadays the chances of getting employment are rare, especially if one is not educated. It is not surprising to find that 23,3 percent of the respondents are students, who are intending to further their education in order to get better jobs, earn a good income, and be able to enjoy and exercise their reproductive health rights.

Women who are not earning a good income usually depend on their husbands for financial support. This dependency subjects women to submissiveness, lack of self confidence, assertiveness and self-worth. They are unable to decide on reproductive health issues on their own as they are not independent therefore they do not enjoy their reproductive health rights. Only 15,2 percent earned above R500 per month, which could be an indication that in the rural areas a high percentage of women are still dependent on their husbands.

More than 50 percent of the respondents were married in terms of customary law and 78% indicated that their husbands paid lobola. There were different views as to whether lobola give husbands the right to have sex whenever they want or whether it gives them the right to decide on the number of children the woman should have. Of the respondents, 44,7 percent disagreed, indicating that their husbands cannot decide on their behalf in matters concerning reproductive health. It is the opinion of the researcher that, in the days when lobola was used properly, different areas had different forms of payment, but its value was almost equal throughout. Nowadays a bride's price is determined by how educated she is. In some instances for a BSc graduate, one might part with up to R15 000. If the same BSc graduate were a medical school graduate, then one would pay a fortune. These values or price tags attached to women by their parents make the potential bridegrooms feel that they are

buying these women. Ultimately, the women, because of the high prices that their husbands paid, are regarded as the property of their husbands, and thus have no rights whatsoever.

5.2.3 Information and knowledge on contraceptives methods

The results indicate that the respondents know different methods of contraceptives, though most of them seem not to have any knowledge about cervical caps, diaphragms, spermicides and sterilisation. The results also show that less than 50% of the respondents knew or used breastfeeding, village medicine and the safe period, which is not surprising as these methods are not reliable. Most respondents indicated that they received information about contraceptive methods in health care units. Friends and the radio were also indicated as very powerful means of communication, see table 4.9 on page 54. Only one respondent indicated that she found out the information from reading the newspaper. This indicated that few women buy newspapers, which could be attributed to a lack of interest, illiteracy or socio-economic reasons. Although 47,4 percent of the respondents have only one child, it must be kept in mind that most of them are still in their reproductive stage of life. Therefore, if the spacing of children is to be 3 years, according to them many may still have more.

The pill was chosen as the method which most of the respondents had used in the past. The main reason given for stopping the use of the pill was forgetfulness, which for most of the respondents led to unplanned pregnancy. Most respondents indicated that they were currently using the injection method as it is more convenient to use, it can also be hidden from husbands who deny their spouses' using contraceptives, and moreover, unlike the pill, it relieves the woman of the responsibility of having to remember it every day.

Respondents indicated a lack of information on how the contraceptive method works. Only 10 (16,7%) (table 4.11, page 57) had knowledge about the action and side effects of the methods. Although 81,7 percent (table 4.13, page 59) of the

respondents indicated that they were using the method of their choice, there was also an indication that some of the respondents are of the opinion that providers have a right to choose the method for a client as they have more knowledge of how the different methods work.

Respondents lacked information about the pap smear test, which should be done yearly for early diagnosis of cervical cancer. It was also clear that vital signs and examinations which are supposed to be done before issuing the method are not properly done (see table 4.15 page 63). According to the correlation test in table 4.29 on page 83, respondents with higher education had more information about the pap smear test than those with a low educational status.

5.2.4 The right to privacy

The results indicated a lack of privacy as respondents indicate that they enter the screening room with other patients as shown in figure 4.6 on page 65, thus they are unable to verbalise their complaints. As reproductive health revolves around private issues, it is difficult to discuss personal matters in front of other clients.

Although most of the respondents described the services at the clinic as professional, few respondents described the services as unfriendly, unprofessional and embarrassing. Adolescents indicated that they feel providers do not respect them and they are just treated like kids, shouted at, harassed and looked down on.

Suggestions included having separate clinics for teenagers and also having enough space, which will enable the providers to maintain privacy. Respondents also suggested that consent forms from the husband must no longer be a prerequisite as it denies women the rights to use contraceptives. The attitude of providers was of concern and it was suggested that providers should also go for further training in reproductive health, ethics and human rights.

5.2.5 The right to reproductive health and employment

The findings show that some employers grant the respondents time to attend reproductive health clinics (figure 4.8 page 68), even though they do not provide reproductive health clinics at the workplace. The overall results show that there are no problems encountered by the respondents in attending reproductive health clinics. The majority of the respondents did indicate however that it would be more convenient if employers provided family planning at the workplace.

5.2.6 The role played by husband, family members, and society in reproductive health and decision making

Husbands are the main role players in reproductive health as they are supposed to grant consent for their wives to use contraceptives. This seems to be one of the stumbling blocks to women's reproductive health rights. Most of the respondents had their husbands' consent and are thus able to discuss family planning with their husbands. Women who did not get consent from their husbands are risking their marriages as well as their lives as some of them indicated that if caught they can be send back to their parents, assaulted or asked to stop. One of the respondents indicated that she is even putting providers at risk as her husband could even confront providers.

It was also found that mothers-in-law play a role in some families as they can decide on the number of children their sons may have, as indicated in table 4.21 on page 73.

Most of the respondents indicated that society does not approve of women using contraceptives as they say it induces sterility, makes women sick and weak and destroys libido in men. This has profound effects as society's views are very important in rural areas.

5.2.7 The right to abortion

The research was conducted during the period when the abortion Bill was being debated. This had an influence on the findings as respondents were not willing to give information as already indicated in page 75.

The results show that 48,4 percent of the women who found themselves pregnant unexpectedly thought of abortion. The main reasons were that they were not ready to have a child, there were socio-economic problems, it would disturb their schooling, or the older sibling was too young to have a sister or brother. Despite considering abortion, it was found that fear of death due to backstreet abortions and lack of money to go to proper institutions prevented many women from procuring one. Though many of the women were hearing about the Abortion Bill for the first time, 48 percent of them welcomed the idea as they felt it was going to reduce maternal death and it would also provide women with wider choices in reproductive health. Similarly, 52 percent who opposed the Bill felt strongly that it would deny the foetus the right to life and also indicated that it was against their religious beliefs.

5.3 DISCUSSION OF FINDINGS ACCORDING TO LITERATURE

The literature revealed that the norms of the society, customary marriages, lobola and cultural expectations in rural areas play a role in denying women their reproductive health rights. This is in line with the findings of this study as it was found that women are not expected to make decisions in matters affecting reproductive health, nor to use contraceptives without their husbands' consent. It is a prerequisite that husbands must come to the reproductive health clinic to sign consent to allow their wives to use contraceptives. The findings also revealed that in some families mothers-in-law still decide on the number of the children their sons may have. It was also indicated that the society does not approve of women using contraceptives (see table 4.23 on page 74).

The literature also indicated that the educational status and socio-economic status of a woman plays a major role in reproductive health. These women are assertive and are able to read all information pamphlets on reproductive health and are therefore equipped with tools which enable them to enjoy their reproductive health rights (Ngwenya 1994:26). The findings indicate that literacy level influences the method used to get information on contraceptive methods, awareness of different methods and full information on the use of contraceptives (see tables 4.27, 4.28 and 4.29 from pages 81 to 83).

A lack of full information on the action, side effects and instructions on how to use a contraceptive was found to be a problem as it denies women the right to make a wider choice. This is aggravated by the negative attitude of the health care providers and shortage of manpower in health services which makes it difficult for health care providers to get enough time to attend, explain and examine clients. Women do not enjoy their right to privacy, right to confidentiality and the right to dignity (Coliver 1995:132). This was confirmed by the findings of this study as indicated in figure 4.6 on page 65 and in table 4.17 on page 65.

It was also found that the Abortion and Sterilisation Act 2 of 1975 which has been replaced by the Choice on Termination of Pregnancy Act 92 of 1996 denied women their right to abort. This was reflected by the fact that 41,7 percent of the respondents who found themselves pregnant unexpectedly thought of abortion, but couldn't abort as the services of abortion were not accessible except in cases of rape, gross malformation of the foetus, incest and maternal ill-health.

5.4 CONCLUSIONS

Based on the data and findings as well as the literature review, the following conclusions were drawn:

All the respondents are aware of one or more methods of family planning. The

injection is the most popular method used, followed by the pill, which is also used more frequently although not the most reliable method.

The women are aware of their reproductive rights (see table 4.26, page 79, on awareness) though they do not enjoy those rights fully due to obstacles like cultural constraints, customary marriages and lobola, as indicated in the findings according to the instrument and literature.

Women with higher educational status enjoy their reproductive health rights more than those with a low educational status. This has been indicated by the statistical analysis as indicated from page 81 to 83. Educated women are able to comprehend information on contraceptives methods . They are therefore more aware of human rights as well as their reproductive health rights.

The higher the socio-economic status, the more assertive women become and the more they enjoy their reproductive health rights. Women who are not earning their own salaries or are earning below the breadline depend solely on their husbands for economical support. They are therefore unable to make their own decisions in matters affecting reproductive health. For example how can one decide on the number of children she may have, when she does not know how much money is needed to raise a child?

Generally, women are not given detailed information to enable them to make informed choices. The ethical principles of nursing are not upheld as there is no privacy, confidentiality or respect for individual worth and dignity.

Traditional and cultural influence has resulted in husbands being given superiority over women by allowing them to sign consent for their wives. This is the problem of gender inequality, which is unfair as women are adults capable of making their own decisions.

The Choice of Termination of Pregnancy Act 92 of 1996 seems to be the only

answer to women 's problems in abortion issues. It will go a long way in securing reproductive autonomy for women.

5.5 RECOMMENDATIONS

Health care providers must get more training on matters affecting reproductive health care so that they have enough information, which will enable them to give detailed and full information to clients.

Only nurses with an interest in reproductive health should be allocated to reproductive health clinics as this can help in improving the attitude of nurses to clients, thereby helping clients to enjoy their rights to dignity, confidentiality and autonomy.

Reproductive health matters must be taught at high school level, to limit teenage pregnancy and to enable students to become mature future adults with responsibility equipped with knowledge.

Information on reproductive health must be taught equally to males and females. Both adults must be responsible for their sexual acts and decision making. This will also promote the issue of gender equality.

Nurses, like care group motivators and those based in the community, must be empowered with more information as they have close contact with the community. They will be able to spread the information faster in simpler terms and make it easier for everybody to understand.

Human rights lawyers, legal aid clinics, the Department of Justice and health care providers must take joint responsibility of informing people about their human rights and reproductive health rights, using the radio, which was found to be a very powerful means of communication in rural communities.

The Department of Health must make clients and patients aware of the patient's charter, which is a document containing the rights of patients, and it must be published in all eleven languages so that people are able to understand it better. This can be done through the use of the media or through awareness campaigns.

Providing vocational training and employment opportunities for women may help women to make independent choices regarding reproductive health rights as they will be economically self-sufficient.

Parents must be taught to realize that male and female children have equal worth and must be educated equally in order to get better jobs and to be more assertive.

Women and health care providers must challenge patriarchy by abolishing the standing order which gives men the status to sign consent forms for their wives to allow them to use contraceptives.

Health personnel must be encouraged to work in rural clinics by improving their conditions of services, giving them incentives like training opportunities, promotions and clinic allowances.

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The following areas require further investigation:

The rights of men in reproductive health

Establishing the problems that health care providers encounter in reproductive health

Determining ways of introducing reproductive health in high schools

The impact the Choice of Termination of Pregnancy Act of 1997 may have on the use

of contraceptive methods.

The same research may be repeated in other areas as this study covers a small area.

5.7 IMPLICATIONS FOR NURSING PRACTICE

Nursing practice has ethical principles to uphold. According to the Constitution, respect of human rights is also very important. The study findings yielded many implications that are applicable to nursing.

- Nurses should respect women and their self-worth as indicated in one of the fourteen precepts of nursing which state that :

  " the nurse must provide nursing care in accordance with human need and with respect for the dignity of man, irrespective of race, creed, nationality, social standing or political persuasion".

- Privacy must be maintained at all times to preserve patients' dignity and self worth. Health care professionals have an obligation to protect the patient's privacy. Pera & Van Tonder (1996:27) maintain that in reproductive health care a client voluntarily gives up a part of his privacy to a health care professional, but this does not imply that the patient gives up all right to privacy, nor does the whole world have the right of access to a patient's private affairs.

- Training must be provided to equip nurses with more information and knowledge that they can impart to clients.

- The philosophy of nursing is about caring. Nurses must uphold this by respecting clients' human rights. Basic human rights like the right to life, right to privacy, right to human dignity and the right to equality must be respected

as they are entrenched in the Constitution of South Africa as well as in ethical principles of nursing.

5.8 LIMITATIONS OF THE STUDY

The research has been limited to a small area of the population, based on the argument that each area or population group is different from any other area so the result may not be representative enough. The area of research covered only a part of the Northern Province so it is difficult to generalise the findings as being representative to all rural communities in South Africa. The questions on abortion were asked during the period when the Bill was under discussion, so it was very difficult for respondent to answer the questions. This could have had an influence on the findings.

5.9 FINAL CONCLUSION

To this end, the research may contribute positively to issues pertaining to reproductive health. If women could be equipped with education, vocational training in order to be self-reliant, as well as detailed information about contraceptives, they may be inspired to take responsibility for their own health, which is one of the major goals of primary health care.

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QUESTIONNAIRE

Thank you for your willingness to complete this questionnaire. The questionnaire consists of eight sections, and it would be appreciated if you would complete the entire questionnaire.

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Card number	
☐☐☐	1-3

SECTION A

INTERVIEWEE'S DEMOGRAPHY

Please write the number of the answer that you have chosen in the square to the right of the question, except where otherwise indicated. The numbers to the right of these squares are **for office use** only.

1 Age in years

0-20	=	1
21-30	=	2
31-40	=	3
41-50	=	4
51-60	=	5
Don't know	=	6

☐ 4

2 Present occupation

Unemployed	=	01
Self-employed	=	02
Scholar	=	03
Student	=	04
Childminder	=	05
Domestic worker	=	06
Housewife	=	07
Cashier	=	08
Sales person	=	09
Clerk	=	10
Nurse	=	11
Teacher	=	12
Selling vegetables	=	13
Hawker	=	14
Police	=	15
Other (specify)	=	16

_____

☐☐ 5-6

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3 How much money do you earn per month?

0-100	=	1
101-300	=	2
301-500	=	3
Other (specify)	=	4

_____ ☐ 7

4 Church affiliation

Lutheran	=	1
A.M.E.	=	2
Apostolic church	=	3
Presbyterian	=	4
Born again church	=	5
Roman Catholic	=	6
Dutch Reformed	=	7
Z.C.C.	=	8
Other (specify)	=	9

_____ ☐ 8

5 Highest standard passed

Non	=	1
Sub A-Std 2	=	2
Std 3-5	=	3
Std 6-9	=	4
Std 10	=	5
Post-secondary qualification	=	6
Other (specify)	=	7

_____ ☐ 9

6 Marital status

Single	=	1
Married	=	2
Widowed	=	3
Divorcee	=	4
Separated	=	5

☐ 10

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7 If married, in terms of which law are you married?

Customary law	=	1
In community of property	=	2
Accrual system	=	3
Out of community of property	=	4
Other (specify)	=	5

_____ ☐ 11

8 Has your husband paid lobola for you?

Yes	=	1
No	=	2

☐ 12

9 If your husband has given lobola for you, do you think that gives him the right to have sex with you whenever he wants?

Yes	=	1
No	=	2

☐ 13

10 Do you think paying lobola for you gives your husband the right to decide on the number of children you must have?

Yes	=	1
No	=	2

☐ 14

SECTION B

CONTRACEPTIVE METHOD AND INFORMATION

1 How many children do you have?

One	=	1
Two	=	2
Three	=	3
Other (specify)	=	4

_____ ☐ 15

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2 How old do you think a woman's youngest child should be before the next child is born?

1 year	=	1
2 years	=	2
3 years	=	3
Other (specify)	=	4

_____ ☐ 16

3 Have you ever heard of the following methods of family planning? (Indicate with an "X" in the square next to the appropriate method.)

Breastfeeding ☐ 17

Village medicine ☐ 18

Abstinence ☐ 19

Pill ☐ 20

Injection ☐ 21

Loop ☐ 22

Condom ☐ 23

Calendar or safe period ☐ 24

Withdrawal method ☐ 25

Cervical caps ☐ 26

Diaphragm ☐ 27

Spermicides/jelly ☐ 28

Sterilisation ☐ 29

Other (specify) ☐ 30

_____

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4 **Where did you learn of these methods? (Indicate with an "X" in the square next to the appropriate method).**

Radio	☐	31
Newspaper	☐	32
Church	☐	33
Friends	☐	34
Clinic, hospital or health centre	☐	35
Relatives	☐	36
Initiation school	☐	37
Older women	☐	38
Other (specify)	☐	39

_____

5 **Which of the following methods have you used in the past? (Indicate with an "X" in the square next to the appropriate method.)**

Breastfeeding	☐	40
Village medicine	☐	41
Abstinence	☐	42
Pill	☐	43
Injection	☐	44
Loop	☐	45
Condom	☐	46

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Calendar or safe period	☐	47
Withdrawal method	☐	48
Cervical caps	☐	49
Diaphragm	☐	50
Spermicides/jelly	☐	51
Sterilisation	☐	52
Other (specify)	☐	53

_____

6 Give the reasons why you stopped using the above-mentioned methods.

_____

_____ 54

7 Which method are you currently using?

_____

_____ 55

8 Do you have full information on how this method works?

Yes = 1
No = 2

☐ 56

9 Were you made aware of the side effects of this method?

Yes = 1
No = 2

☐ 57

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10 If yes, what are the side effects?

_____

_____

_____ 58

11 Are you using the method of your choice?

Yes = 1
No = 2

☐ 59

12 If no, who chose the method for you?

Husband = 1
The health care provider = 2
Mother-in-law = 3
Myself = 4
Other (specify) = 5

_____ ☐ 60

13 Do you think it is right for anyone to choose a contraceptive method for you except yourself?

Yes = 1
No = 2

☐ 61

14 Are you allowed to change a method?

Yes = 1
No = 2

☐ 62

15 Are you aware of a pap smear test?

Yes = 1
No = 2

☐ 63

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16 How often are contraceptives obtainable in your clinic?

Daily	=	1
Twice weekly	=	2
Weekly	=	3
Other (specify)	=	4

_____ ☐ 64

17 What do providers do before issuing contraceptives?

Taking of blood pressure	=	1	☐ 65
Weighing	=	2	☐ 66
Breast examination	=	3	☐ 67
Issuing the method only	=	4	☐ 68
Ask if there are any complaints about the method	=	5	☐ 69

18 Have you ever become pregnant while you were using a contraception?

Yes	=	1
No	=	2

☐ 70

19 If yes, what method of contraception were you using?

Pill	=	1	☐ 71
Injection	=	2	☐ 72
Intra-uterine device	=	3	☐ 73
Other (specify)	=	4	☐ 74

_____

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SECTION C

PRIVACY

1 Do you enter the screening room alone?

Yes = 1
No = 2

☐ 75

2 If no, who accompanies you?

Nurse = 1 ☐ 76

Family = 2 ☐ 77

Husband = 3 ☐ 78

Other patients = 4 ☐ 79

Other (specify) = 5 ☐ 80

_____

3 When do you feel free to verbalise your fears and problems about the method to the provider of services?

When alone = 1 ☐ 1

When with family = 2 ☐ 2

When with husband = 3 ☐ 3

In front of other clients = 4 ☐ 4

4 Do you feel comfortable attending the clinic with the people of your own age group?

Yes = 1
No = 2

☐ 5

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5 How can you describe the services at the clinic?

Embarrassing	=	1	☐ 6
Friendly	=	2	☐ 7
Professional	=	3	☐ 8
Other (specify)	=	4	☐ 9

_____

6 What do you think must be done to improve the services?

_____

_____ 10

SECTION D

1 Does your employer grant you time to attend the reproductive health clinic if you need contraception?

Yes	=	1
No	=	2

☐ 11

2 Does the employer make provision for a family planning clinic at the workplace?

Yes	=	1
No	=	2

☐ 12

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3 **If you have to go to the clinic under what type of leave is the day classified?**

Vacation leave with full pay	=	1
Sick leave with full pay	=	2
Special day	=	3
Hours which do not affect leave days	=	4
Other (specify)	=	5

_____ ☐ 13

4 **Are there any other policies set by your employer pertaining to your reproductive health clinic attendance?**

Yes	=	1
No	=	2
If yes, indicate	=	3

_____ ☐ 14

SECTION E

1 **Do you discuss family planning with your husband?**

Yes	=	1
No	=	2

☐ 15

2 **If no, why not?**

_____ 16

3 **Is your husband aware that you are using contraceptives?**

Yes	=	1
No	=	2

☐ 17

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4 If yes, how did he find out?

Had a discussion with him	=	1
Found out by chance	=	2
Told by his mother	=	3
Found out by other means (specify)	=	4

_____ ☐ 18

5 If no, what will happen if your husband discovers that you are using contraceptives without his knowledge?

Will let me continue	=	1	☐ 19
Will send me to my parents	=	2	☐ 20
Will hit me	=	3	☐ 21
Will ask me to stop	=	4	☐ 22
Will confront the providers	=	5	☐ 23

6 Is there any other person other than your husband who can decide how many children you may have?

My mother	=	1	☐ 24
Mother-in-law	=	2	☐ 25
Husband's first wife	=	3	☐ 26
Sister-in-law	=	4	☐ 27
Nobody	=	5	☐ 28

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7 **If a husband and wife are going to learn about contraception, who must go and get information?**

Wife	=	1
Husband	=	2
Both	=	3
Don't know	=	4

☐ 29

8 **Does society approve of women using contraceptives?**

Yes	=	1
No	=	2
Not sure	=	3

☐ 30

9 **If yes, under which circumstances do they approve?**

Spacing children	=	1	☐ 31
Limiting the sizes of the family	=	2	☐ 32
When wife has a small baby	=	3	☐ 33
Other (specify)	=	4	☐ 34

_____

10 **If no, what do you think is the reason?**

Makes women weak and sick	=	1	☐ 35
Induces sterility	=	2	☐ 36
Destroys libido in men	=	3	☐ 37
Black genocide	=	4	☐ 38
Other (specify)	=	5	☐ 39

_____

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SECTION G

1 Have you ever found yourself pregnant unexpectedly?

Yes = 1
No = 2

☐ 40

2 Have you ever thought of having an abortion?

Yes = 1
No = 2

☐ 41

3 If yes, what was the reason?

I was not ready to have a child = 1 ☐ 42

My older child was still too young to have a sister or brother = 2 ☐ 43

I did not have enough money to support a child = 3 ☐ 44

It would have disturbed my school years or career = 4 ☐ 45

Other (specify) = 5 ☐ 46

_____

4 Have you managed to abort?

Yes = 1
No = 2

☐ 47

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5 If no, why?

I was afraid of death due to backstreet abortion	=	1	☐	48
I did not have enough money to pay for the abortion	=	2	☐	49
I felt I have to accept my responsibilities	=	3	☐	50
It would have been against my religious beliefs	=	4	☐	51
Other (specify)	=	5	☐	52

_____

6 Do you think the termination of pregnancy bill is good?

Yes	=	1		
No	=	2	☐	53

7 If yes, why?

It gives the woman the right to choose	=	1	☐	54
It gives women who have made mistakes a second chance	=	2	☐	55
It will reduce the mortality rate of women who died due to back street abortion	=	3	☐	56
It will improve women's health	=	4	☐	57
Other (specify)	=	5	☐	58

_____

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8 If no, why?

It denies the foetus the right to life	=	1	☐	59
It is against my religious belief	=	2	☐	60
I think it is morally wrong	=	3	☐	61
It will lead to contraceptive irresponsibility	=	4	☐	62
Other (specify)	=	5	☐	63

_____

SECTION H

1 Are you aware that as an adult you have the freedom to choose the method of contraception that you like?

Yes = 1
No = 2

☐ 64

2 Are you aware that your husband is not allowed to decide on your behalf on matters affecting your reproductive health?

Yes = 1
No = 2

☐ 65

3 Are you aware that providers are supposed to give you full information on all methods of contraception before you choose?

Yes = 1
No = 2

☐ 66

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4 **Are you aware that nobody is allowed to force you to choose the method of contraception that you don't like?**

Yes = 1
No = 2

☐ 67

5 **Are you aware that you are allowed to go to the clinic at anytime during emergencies (eg if you run short of pills before the return date)?**

Yes = 1
No = 2

☐ 68

6 **Do you know what a pap smear is?**

Yes = 1
No = 2

☐ 69

7 **Are you aware that you must go for a pap smear test every year?**

Yes = 1
No = 2

☐ 70

8 **Are you aware that you must undergo a routine check up every time you come to the reproductive health clinic?**

Yes = 1
No = 2

☐ 71

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9 **Are you aware that you have the right to refuse treatment if you don't like it?**

Yes = 1
No = 2

☐ 72

10 **Are you aware that you have the right to adequate information concerning your treatment?**

Yes = 1
No = 2

☐ 73

11 **Are you aware that you have a right to confidentiality of information?**

Yes = 1
No = 2

☐ 74

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

➢ PLEASE TURN OVER

APPENDIX B

1 CHEMAY
683 PRETORIUS STREET
ARCADIA 0083
06-08-1996

The Director General
Department of health
Northern Province
Private bag x9302
Pietersburg
0700

Dear Sir

PERMISSION TO CONDUCT RESEARCH

I hereby request permission to conduct research in region 4 at .... Hospital and .... Clinic.

I'm a student at UNISA doing masters (cur) in nursing science. Attached please find my proposal for your information.

Hoping my request will meet your immediate attention.

With thanks

F.M RALIPHADA

APPENDIX C

Northern Province

DEPARTMENT OF HEALTH & WELFARE

POLICY & PLANNING
ENQUIRIES: N.S. MAHLANGU
REFERENCE: RESEARCH

2 September 1996

Ms Mavis Raliphada
Ichemay
683 Pretorius Street
ARCADIA
0083

Dear Ms. Raliphada

RE: PERMISSION TO CONDUCT RESEARCH ON REPRODUCTIVE HEALTH RIGHTS OF WOMEN IN RURAL COMMUNITIES.

1. Permission is hereby granted to conduct research on reproductive rights in .
2. The Department needs a copy of the Research study findings for its resource centre.
3. The researcher should be prepared to assist us in interpretation and implementation of the recommendations where possible.
4. Implications: Permission should be requested from hospital Management.

Sincerely,

Nicholas Cuss

SUPERINTENDENT- GENERAL.
DEPARTMENT OF HEALTH AND WELFARE,
NORTHERN PROVINCE

TEL: 0152 - 291-2010/7
291-2637
295-2851/2

FAX: 0152 - 291-1156
291-5146

34 HANS VAN RENSBURG
STREET, PIETERSBURG
0700

DR JAN MOOLMAN BUILDIN
PRIVATE BAG X9302

APPENDIX D

COVER LETTER

Reproductive health is very important as it shapes up the woman's whole life. Currently there are a lot of obstacles which denies women the right to reproductive health.

In view of this I am conducting research to find out the obstacles which denies women freedom to enjoy reproductive health, to establish a contribution which can be used by the Department of health to improve the services.

Your help is earnestly required because without your assistance I will not be able to reflect the true picture.

Anonymity and confidentiality will be guaranteed.

Thanking you in anticipation.

I..... hereby agree to take part in the research. Hoping that my name will remain confidential as promised by the researcher.

APPENDIX E

Northern Transvaal Province
HEALTH AND SOCIAL WELFARE

Ref. No. : 7/3/2

Enq. : Superintendent

Tel. No. :

Fax No. :

Ms Mavis Raliphada
Ichemay
683 Pretorious Street
ARCADIA
0083

Dear Ms Raliphada

RE : PERMISSION TO CONDUCT RESEARCH ON REPRODUCTIVE HEALTH RIGHTS OF WOMEN IN RURAL COMMUNITIES. : YOURSELF.

1. This item has reference.

2. Permission has been granted by Management to the researcher to conduct her research with consent of the respondants.

Yours Faithfully

.....
MEDICAL SUPERINTENDENT.
/aan-30.09.1996/