Published in final edited form as:

Health Care Women Int. 2018 November ; 39(11): 1163–1176. doi:10.1080/07399332.2017.1400034.

Women's Reproductive Decision Making and Abortion Experiences in Cape Town, South Africa: A Qualitative Study

Marie E. Sullivan, MPH¹, Abigail Harrison, PhD, MPH¹, Jane Harries, PhD, MPH², Namhla Sicwebu, Rochelle K. Rosen, PhD^{1,3}, and Omar Galárraga, PhD¹

¹Department of Behavioral and Social Science, Brown University School of Public Health, Providence, RI, USA

²Women's Health Research Unit School of Public Health & Family Medicine, University of Cape Town, Cape Town, South Africa

³Centers for Behavioral and Preventive Medicine, The Miriam Hospital, Providence, RI, USA

Abstract

Unintended pregnancy is a significant public health issue in South Africa. Despite free services including contraception, women face structural and institutional barriers to accessing care. This qualitative study comprised interviews with 16 women aged 18 to 40 years and receiving post-abortion services at a public clinic in Cape Town. Data analysis revealed three main themes: personal journeys in seeking abortion, contraceptive experiences, and contrasting feelings of empowerment (in reproductive decision making) and disempowerment (in the health care system). Women perceived themselves as solely responsible for their reproductive health, but found it difficult to obtain adequate information or services.

Keywords

Reproductive decision-making; Abortion services; Long acting reversible contraception (LARC); Health Care Access; Empowerment; South Africa

In the Western Cape of South Africa, 62.5% of sexually active women use a modern contraception method. (South Africa Demographic and Health Survey 2016) Despite free access to contraception in public health services, unintended pregnancy remains high, reflecting service delivery problems, inequitable access, and gaps in correct, consistent and continuous use. (N Lince-Deroche et al., 2016) In South Africa 18% of women report an unmet need for family planning. (South Africa Demographic and Health Survey 2016) Through in depth interviews, the authors explored women's reproductive decision-making, and the pathways of influence to those decisions, in the context of unintended pregnancy and abortion in Cape Town, South Africa. The reasoning behind why women are choosing long acting reversible contraception and discussions regarding ways to improve women's

reproductive health care experiences can provide insight to an international audience beyond the Western Cape of South Africa.

Hormonal injectable contraceptive methods (DMPA (Depo) and Net-EN) are the most widely used forms of birth control in both the Western Cape as well as South Africa as a whole. (South Africa Demographic and Health Survey 2016) This method requires regular follow-ups at either two or three month intervals, which can mean long waiting times, transportation costs and lost work time. Historically, South Africa has relied on intensive use of injectable contraceptives. (N Lince-Deroche et al., 2016) Contraceptive options have expanded through introduction of long-acting reversible contraception (LARC) methods, namely the implant (Implanon NXT) and intrauterine devices (the copper IUD, also known as the loop or the coil). LARCs are convenient as they do not require monthly follow-up, and are also highly effective, but not all methods are popular. (Patel, 2014) In the Western Cape, 2.3% of sexually active women use the IUD and 6.6% use the implant. Overall this is higher than South Africa as a whole, where 1.2% have an IUD and 3.9% have an implant. (South Africa Demographic and Health Survey 2016) These percentages are still very low despite the long-term effectiveness and easy removal of LARC methods.

Since 1996, abortion has been legal without restriction up to 12 weeks' gestation in South Africa, and is free in public sector facilities (CTOP) ("Facts on Abortion in Africa," 2015; R. Jewkes, Brown, Dickson-Tetteh, Levin, & Rees, 2002) Despite this, a high rate of unsafe abortion continues, reflecting ongoing social, economic and health service barriers. (Trueman & Magwentshu, 2013) Women face stigma when seeking abortion, and health care providers may refuse training or to perform abortions, causing service shortages. (Harries, Cooper, Strebel, & Colvin, 2014a; A. Harrison, Montgomery, Lurie, & Wilkinson, 2000) Thus, women may travel long distances for abortion services, often incurring high personal costs from childcare, transportation, and missed work. (Trueman & Magwentshu, 2013; Naomi Lince-Deroche et al., 2015) Private and non-governmental abortion services are unaffordable for many. (Trueman & Magwentshu, 2013) These factors - stigma, gestational age restrictions, lack of providers and cost - can push women into unsafe abortions. (Constant, Grossman, Lince, & Harries, 2014; Harries, Cooper, Strebel, & Colvin, 2014b; Harries, Gerdt, Momberg, & Foster, 2015; R. Jewkes et al., 2002; Trueman & Magwentshu, 2013) Women who receive clandestine abortion services face health risks from unqualified providers and also miss other benefits like post-abortion counseling and contraception advice. (Macha, Muyuni, Nkonde, & Faúndes, 2014; Mayi-Tsonga et al., 2014)

Factors Affecting Women's Reproductive Health Care Seeking Behaviors

For many women, family planning and antenatal care during pregnancy provide their most frequent health care contact. While South Africa's public health care system is generally well-resourced, poor quality of care is common. Common barriers reflect inadequate care, including long wait times and lack of guidance from health care providers (Solarin & Black, 2013), like appropriate self-care and follow-up while using contraception. Beyond quality, misuse of power in the health care system is well-documented, ranging from clinical neglect to verbal and physical abuse, clearly affecting women's care-seeking decisions. (R. Jewkes, Abrahams, & Mvo, 1998; Kruger & Schoombee, 2010)

Gender inequality is an important structural factor underlying women's status and health outcomes in South Africa. Women may lack decision-making power in sexual relationships and thus experience violence when negotiating condom or contraceptive use, as well as restricted access to services and treatments. (Andersson, Cockcroft, & Shea, 2008; Gupta, 2000; Hoffman, 2006; Luke, 2003; Stirling, Rees, Kasedde, & Hankins, 2008) (Dunkle et al., 2004; Gupta, 2000; A. Harrison, Cleland, & Frohlich, 2008; A. Harrison, Colvin, C., Kuo, C., Swartz, A., Lurie, M., 2015; Stirling et al., 2008) Research also highlights the centrality of HIV/AIDS to women's reproductive health in South Africa. Women face an added burden in achieving optimal reproductive and sexual health while also managing HIV-related concerns. (Cooper et al., 2004).

Women's empowerment and reproductive health are central concerns in global development. The Millennium Development Goals and Sustainable Development Goals focus on gender equality and women's empowerment as strategies to reduce poverty, hunger, and disease. (Chopra et al., 2009; Sachs, 2012; UN, 2000) In South Africa, a similar emphasis on gender equality is prominent in policy discourses. Research has disclosed the country's severe epidemic of gender-based violence – among the highest levels in the world – highlighting intersections between violence and women's health outcomes. (Abrahams, Mathews, Martin, Lombard, & Jewkes, 2013; Dunkle et al., 2004; R. Jewkes, Flood, & Lang, 2015; R. K. Jewkes, Levin, & Penn-Kekana, 2003)

The authors' main areas of inquiry included how self-perceptions of personal empowerment affect women's reproductive health decisions, women's experiences accessing reproductive health care including abortion, and negotiation of reproductive decision-making within women's lives and relationships. Building on an established definition of "empowerment" - the ability to make choices that were previously denied - we sought to understand women's agency and sense of individual empowerment in making reproductive health decisions. (Kabeer, 1999)

Methods

Geographical Setting

Cape Town, the largest city in Western Cape Province, South Africa, has a multiethnic population comprised of: mixed race (referred to as Coloured), Black, White, plus recent immigrants. Three main languages are spoken: Afrikaans, isiXhosa, and English. (South Africa Demographic and Health Survey 2016) Interviews were conducted at a public community health center with a dedicated reproductive health service near Cape Town in June–July 2015.

The Study

This qualitative study was a sub-study of a small randomized controlled trial (N=100) to evaluate the effectiveness of a lottery-based economic incentive in increasing effective modern contraceptive use with condoms (dual protection) among reproductive age women at risk for unintended pregnancy and HIV/STIs (sexually transmitted infections). Study participants were 18–40 years, and were seeking abortion services (both surgical and

medical). Medical abortions were performed with Mifepristone at the clinic followed by Misoprostol at home. Surgical abortions, using manual vacuum aspiration (MVA), were performed at the clinic. Women in the RCT selected a post-abortion modern contraceptive method (injectable hormonal contraception, implant, or IUD), and agreed to return for 3 and 6-month follow-up.

Qualitative Data Collection and Procedures

Women were approached to participate in the qualitative study after completing the RCT baseline questionnaire. Research methods included in-depth interviews (IDIs), participant observations (POs), and one expert interview. This small sample (N=16) was deemed sufficient given the detailed socio-demographic and reproductive health data collected through the RCT, plus the participant observations and expert interview, permitting triangulation of data across methods and participants. Sample size was based on anticipated data saturation in key areas of inquiry, and available resources. To deepen and enrich the understanding of women's reproductive decision-making, we opted for a smaller, in-depth investigation rather than a larger sample with broad coverage.

Sixteen women were purposively recruited for IDIs and provided informed consent. Interviews were conducted in English unless women preferred to speak isiXhosa. Two local interviewers assisted at all interviews, including those in English, to clarify questions and translate when necessary. One interview was completed in isiXhosa and then translated to English. A transcript was prepared for each interview from digital recordings and reviewed for translation quality, accuracy, and anonymized.

In-Depth Interviews—The in-depth interviews followed a semi-structured question guide addressing: participants' abortion experience, access to reproductive health services, reproductive decision-making, feelings of empowerment, and resources for reproductive health decisions. Questions were open-ended to elicit women's perspectives more fully. Interviews lasted approximately one half hour conducted in a private space with snacks; there was no other incentive although a transportation fee was provided to RCT participants.

Challenges arose during data collection, as many women did not understand the questions about empowerment. The original questions, drawn from standard health survey items, were intended to assess women's perceived control over decisions and actions. The question guide was adjusted following the initial interviews using an iterative process with local interviewers. Words like "power," "independent," and "strong" were substituted for "empowerment" in two of the questions, reflecting the difficulties of translating "empowerment" into isiXhosa. These changes were effective, leading to more robust dialogue with the participants, and an iterative research process that emphasized triangulation of multiple data sources.

In addition to the 16 IDIs, one key informant interview with the clinic's chief reproductive health provider was conducted, addressing professional responsibilities, women's contraceptive use, and access to abortion and reproductive health services.

Additional Data Collection Methods—Participant observations (PO) were conducted in the study clinic two days a week for seven weeks, and included talking with women in the waiting room and observing daily clinic procedures. Field notes from these observations informed a deeper understanding of research findings. Finally, baseline quantitative survey data from the parent RCT was extracted to compile a detailed socio-demographic profile, contraceptive and reproductive histories, and general health status for each participant.

Data analysis

Transcripts were first read to identify major themes and inform development of a structured coding scheme. Four research team members discussed the interpretation of women's responses, with cross-cultural input from the two interviewers. This process revealed several broad thematic areas: abortion experience, empowerment/disempowerment, reproductive decision-making, and autonomy in reproductive health decisions. Analytical codes were developed within each thematic area by two study team members using a structured, consensus-driven process. The final coding scheme included both *a priori* and emergent themes. (Ulin, Robinson, & Tolley, 2005)

Data were organized and analyzed using NVivo qualitative data analysis software (QSR International Pty Ltd. Version 10, 2012.), with data reduction rules constructed to elicit the most pertinent data, and with triangulation of data from the key informant interview, quantitative baseline survey, and the IDIs.

Ethics Approval

Research approvals were obtained from two IRBs (international and local) and also from the provincial Department of Health in South Africa.

Results

The 16 study participants ranged from 19 to 38 years old (mean age = 28.5), with diverse backgrounds: black South African, Coloured, and non-South African (from Malawi) (Table 1). Eight women planned to use injectable hormonal contraception after their abortion while 4 selected the implant and 4 the IUD. (Table 1 shows income, employment, relationship status and other details).

Three major, interconnected themes emerged: personal journeys in seeking abortion, and the reasons; contraceptive experiences and reproductive decision making; and sense of empowerment related to reproductive health. First, women described their journeys personally and through the health care system in seeking abortion, including navigating an unclear pathway often filled with shame, judgment, and confusion. Second, women described their non-use or inconsistent use of contraception, and the circumstances surrounding their unintended pregnancy. Third, women discussed their perceived control of decisions about contraception, abortion and reproductive health care, reflected in a sense of personal responsibility and not depending on men. However, a contrasting sense of disempowerment emerged, related to the structural context of treatment by health service providers, and women's lack of access to adequate health information.

Abortion Experiences

Personal Journeys Seeking Abortion Services—Many women experienced passive discouragement in seeking abortion, resulting from disorganization, poor quality service, and too few providers. Some women were actively discouraged from abortion by a health care provider, peers or family members, yet the overarching barriers were structural and system-related.

Many women did not know what to expect regarding their abortion. Up to 9 weeks' gestation, women may be referred for either a medical or surgical abortion, but only surgical abortions are performed thereafter. Women received little support as they sought to understand these details, including misinformation, poor directions and uncertainty over clinic locations. Many women received incomplete information from referring clinics, not infrequently bouncing between clinics and hospitals with long lines and few personnel to answer questions. Generally, women confirm pregnancy at a primary care clinic, then receive an ultrasound in another facility, before proceeding to the abortion clinic, often walking these distances. As one woman described: *It's completely disorganized. Especially when we are in the state that we are in The TOP [termination of pregnancy] provider was not here ... The waiting rooms... the hard chairs. It's cold and inhospitable for everyone who is sitting there getting cold and you're in pain... I just feel things could be a little ... more comfortable for us. (35-year-old mother of one; secondary school graduate)*

Similarly, another woman said:

“[After] 3 hours ... someone finally tells me, you shouldn't be here. You should be downstairs and now you're late so I don't know if they [will help you]. ” (31-year-old mother of one; secondary school graduate)

Such experiences reflect the reality of personnel shortages and intermittent quality of care in public health facilities.

Often, health care providers did not provide complete information about how to access a safe abortion. This may have reflected their own mixed feelings about abortion, and also a lack of transparency and timely information for health care procedures more generally. Regardless, some women felt they had to advocate for their right to abortion:

I was counseled 4–5 times... The first thing I was told was “I don't judge” ... Also, “have you changed your mind” ...? How am I going to know if I'm going to change my mind if I don't even know what's going to happen next? ... I think there is a big part of the procedure that's missing and that's telling me “this is what is going to happen to you.” (35-year-old mother of one; secondary school graduate)

Many women told us “*It's scary when you don't know what to expect*” (31-year-old mother of one; secondary school graduate). Other women were misinformed that having multiple abortions means “*a very high risk that you won't be able to have children one day*” (19-year-old without children; university student). Others used the internet to seek information not provided at other clinics. Although abortion is provided free in the public sector, many women were concerned about insufficient resources. As one woman stated, “*not everybody can afford to travel this much... people have to work*” (35-year-old mother of one; secondary

school graduate). From long lines to unpleasant experiences like nurses *shouting about having sex and then coming back here having STDs ...*, women recounted frequent harsh treatment and frustration with the convoluted health care system (*38-year-old mother of two; technical college graduate*).

Reasons for Abortion—Women offered multiple reasons for abortion, including financial concerns, already having multiple children, and the need to finish school. One was reluctant to have another child without being married, but didn't tell her partner about the abortion, fearing he would not be supportive. Others cited relationship concerns, including lack of trust, like a cheating partner who did not want anything to do with her pregnancy or an alcoholic partner who would not be a trusted father, as well as recent divorce or not being ready to raise a child with a new partner. Two HIV positive women discussed the need to focus first on their own health and starting antiretroviral therapy so as to prevent HIV transmission to their child.

Contraception and Reproductive decision-making

Each woman received pre-abortion contraception counseling and education, focused mainly on choosing a contraceptive method for after the abortion. For some women, this provided their first knowledge of long acting contraceptive methods, as one said:

She explain everything to us, [the nurse]. She explain a lot. I'm very happy. Because I know something that I didn't know ... about the loop [IUD] and implant ... I only knew about injection and pills. (28-year-old mother of two; completed grade 11)

Women experienced a lack of consistency between health providers at different facilities. One woman described a nurse who insisted that she had given her a pamphlet about contraceptive choices, stating "*they give everyone one*" although in fact she was informed only about the contraceptive implant (*31-year-old mother of one; secondary school graduate*). Many women found it difficult to start a dialogue about family planning. One woman described how it felt "*...like the doors are not open*" and when she sought information about the best family planning for her the health care provider responded: "*you can choose yourself because I already gave you the papers*" (*24-year-old mother of one; secondary school graduate*). Another woman said:

We don't get someone to talk about these things openly. We don't always get people that encourage us women. There are a lot of people in abusive relationships. Women that you don't even know and she walks up and down with a smile ... So for women to get power to have control over her own body (31 year-old mother of two; secondary school graduate).

Compounding this, many women did not know what questions to ask health care providers, despite understanding that better knowledge would give them greater agency regarding their reproductive health.

Women also talked about the importance of financial stability in planning reproductive decisions: "*if you have money, you can plan all your things... you have power*" (*38-year-old*

mother of two; technical college graduate). Many women agreed on the importance of not having more children without being able to provide financially. They perceived family planning as a financial decision, and a key component of controlling their own autonomy. After an unintended pregnancy, one woman explained this as an important future goal:

[Without] family planning you just have children every year, you can't ... survive and you can't be able to take care of children (27-year-old mother of two; secondary school graduate).

For many women, the choice of abortion signified control over one aspect of their lives. Some women did not tell their partners for fear of a negative reaction. One woman discussed women's sense of responsibility for reproductive health as being more important than men's *"because it's her body and if pregnancy or STDs she's going to have to deal with it"* (19-year-old without children; university student). This influenced some women's favorable attitudes toward the LARC methods, which allowed them greater control over family planning. As one said:

With the loop [IUD] it's not something that he's going to pick up on because he's not going to know it's there ... this is a lot of men's thinking, if you're using contraceptives that means you're sleeping around ... something like an IUD or the implant the woman would be able to do it without the male's input ... the same with the injection, but the male does have a lot of persuasion with regards to the condom only ... [and] the pills are something he can take away." (31-year-old mother of one; secondary school graduate).

Women's Empowerment and Reproductive Health

Despite the prevailing gender and power dynamics of relationships, many women described a sense of equal control regarding reproductive health. Many explained they were responsible for their abortion decision, and most had traveled to the clinic without their partners. Similarly, these women controlled decisions about contraception. Most women said their partner supported contraceptive use, although some women's current partners wanted to have children. Thus, while most women viewed family planning negotiation as an important way for women to advocate for their reproductive health, most also said that if their partner did not support contraception they would not discuss it. When asked how they would advise a woman who didn't have much negotiating power, many women suggested *"go behind his back [to] do the family planning"* (27-year-old mother of two; secondary school graduate).

Women discussed their negotiating strategies, and how to confidently assert power in reproductive decisions:

Your husband is going to say, "why do we have to use condoms?" and just give a reason ... if you talk to him and explain why maybe he'll understand. Because a man is stubborn. They are stubborn, until we convince them (28-year-old mother of three; completed grade 11).

Women were especially concerned about controlling decisions about family size, often for practical reasons like focusing on educating and feeding the children they already have.

Discussion

These findings highlight how women's complex and sometimes contradictory reproductive decisions influence health outcomes. In this study, many women discussed how they assert power in reproductive decision-making to control contraceptive use and their abortion decision. They perceived themselves as empowered and strong, a feeling grounded in a sense of personal responsibility for both reproductive and broader life decisions. This sense of agency, however, contrasted with certain realities of women's lives. Some were clearly not in equal or supportive relationships, achieving desired outcomes by hiding contraceptive use and even their abortion from male partners. Further, all women in the study had experienced an unintended or unwanted pregnancy, signifying failure in their pregnancy prevention strategy. Equally, however, accessing abortion reflected a desired outcome, grounded in women's agency and right to choose. Most notably, these findings captured the stark contrasts between women's sense of personal agency, and the relative disempowerment they experienced within the health system. Most women described stigma, confusion and lack of support *en route* to their abortion. Beyond abortion itself, many women lacked essential knowledge about contraception and reproductive health. They sought engagement with health providers to enable better and more appropriate choices, particularly regarding contraceptive methods. Yet many women were disappointed by their limited access to such services. Most women viewed control over reproductive decision making as essential in planning for future pregnancies, and they viewed high quality reproductive health care as a means to achieve this.

These findings offer some contrasts to the structural context of gender inequality and violence that pervades many South African women's lives and relationships. Indeed, these women represent a select group that has achieved – despite many challenges – an important reproductive health outcome, and may differ in important ways from other South African women. Also, this study was conducted in Cape Town, a relatively well-resourced part of the country, and most women had some secondary education. However, women described unequal relationships with men, leading some women to clandestine contraceptive use and other secretive behaviors. From the limited number of interviews, it is hard to say definitively that women prefer injectable contraception. There could be several reasons more women chose this method from it being more familiar to women in South Africa and LARCS being perceived more widely as newer methods. Overall, there does seem to be a desire for methods that can be used covertly without a male partner's knowledge. These means of controlling their reproductive lives offers an important reminder that women can and do have agency even within a context of inequality.

Women described difficulties in navigating the health care system, which affected their abortion care-seeking and attempts to learn and gain health information. Challenges in accessing abortion services are well known: in South Africa, the lack of abortion providers and ongoing stigma regarding abortion mean that women often face substantial costs and experience guilt and shame. (Harries et al., 2014a; A. Harrison et al., 2000; Naomi Lince-Deroche et al., 2015; Trueman & Magwentshu, 2013), feelings that are compounded by well-known quality of care issues (R. Jewkes et al., 1998; Kruger & Schoombee, 2010; Solarin & Black, 2013) These qualitative findings extend this understanding, however, to

focus on women's perceived loss of control and sense of disempowerment within the health care system, and their lack of reproductive health literacy.

Limitations

These findings derive from a small qualitative sample, although data from multiple sources were triangulated to provide deeper insights. These women are a select group who successfully sought abortion care, and may thus not represent all women. Further, women's different experiences within the clinic setting, including some medical and some surgical abortions, possibly influenced their responses. Although these findings are not generalizable beyond the immediate context, this is appropriate for a qualitative study, and describing the barriers women face in accessing reproductive health services has broad relevance.

Implications for Practice and Policy

These findings suggest ways to improve women's reproductive health care experiences. First, increasing women's reproductive health literacy is important, through improved counseling and access to clear, simple materials about contraceptive methods and choices. Health literacy requires empowering choices through knowledge and understanding, not only providing information. Second, although recent policy attention has increased both access to and demand for long acting reversible contraceptive methods (LARCs), more efforts are essential to reduce unintended pregnancies. Other evidence-based strategies like health systems navigators to guide women through complex reproductive health care processes could also be effective. Male partner engagement is additionally an important next step since men are not usually well informed about contraception and women's needs. A starting point is gender-focused health education that helps to engage and inform men, and to strengthen women through a better understanding from their male partners about contraceptive preferences. This would additionally focus on debunking some of the negative stereotypes about contraception.

Ultimately, increasing demand from women themselves will require attention to both health literacy and quality of care. Women's sense of disempowerment and disappointment with the health care system point to a fundamental lack of trust between patients and reproductive health care providers, signifying slow progress toward a "trust-based health system". (Gilson, 2003) With a currently favorable policy environment, this research is timely and well-positioned to contribute to changes and improvements in reproductive health care.

Acknowledgments

Funding Statement: This study was funded by Competitive Seed Funding from the Office of the Vice President for Research, Brown University and the Nora Kahn Piore Award, Brown University School of Public Health

References

Abrahams N, Mathews S, Martin LJ, Lombard C, Jewkes R. 2013; Intimate partner femicide in South Africa in 1999 and 2009. *PLoS Med.* 10(4):e1001412. [PubMed: 23565064]

- Andersson N, Cockcroft A, Shea B. 2008; Gender-based violence and HIV: relevance for HIV prevention in hyperendemic countries of southern Africa. *Aids*. 22(Suppl 4):S73–S86. [PubMed: 19033757]
- Chopra M, Lawn JE, Sanders D, Barron P, Karim SSA, Bradshaw D, ... Mayosi BM. 2009; Achieving the health Millennium Development Goals for South Africa: challenges and priorities. *The Lancet*. 374(9694):1023–1031.
- Constant D, Grossman D, Lince N, Harries J. 2014; Self-induction of abortion among women accessing second-trimester abortion services in the public sector, Western Cape Province, South Africa: An exploratory study. *South African Medical Journal*. 104(4):302–304. [PubMed: 25118559]
- Cooper D, Morroni C, Orner P, Moodley J, Harries J, Cullingworth L, Hoffman M. 2004; Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status. *Reproductive Health Matters*. 12(24):70–85. [PubMed: 15626198]
- Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD. 2004; Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*. 363(9419):1415–1421.
- Facts on Abortion in Africa. Guttmacher Institute; 2015.
- Gilson L. 2003; Trust and the development of health care as a social institution. *Social Science & Medicine*. 56(7):1453–1468. [PubMed: 12614697]
- Gupta GR. 2000; Gender, sexuality, and HIV/AIDS: The what, the why, and the how. *HIV AIDS Policy Law Rev*. 5(4):86–93.
- Harries J, Cooper D, Strebel A, Colvin CJ. 2014; Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. *Reproductive Health*. 11(1):16. [PubMed: 24571633]
- Harries J, Gerdt C, Momberg M, Foster DG. 2015; An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. *Reproductive Health*. 12(1):1. [PubMed: 25561377]
- Harrison A, Cleland J, Frohlich J. 2008; Young people's sexual partnerships in KwaZulu-Natal, South Africa: patterns, contextual influences, and HIV risk. *Studies in family planning*. 39(4):295–308. [PubMed: 19248716]
- Harrison A, Colvin C, Kuo C, Swartz A, Lurie M. 2015; Sustained High HIV Incidence in Young Women in Southern Africa: Social, Behavioral, and Structural Factors and Emerging Intervention Approaches. *Current HIV/AIDS Reports*. 12(2):207–215. [PubMed: 25855338]
- Harrison A, Montgomery ET, Lurie M, Wilkinson D. 2000; Barriers to implementing South Africa's termination of pregnancy act in rural KwaZulu/Natal. *Health Policy and Planning*. 15(4):424–431. [PubMed: 11124246]
- Hoffman S, O'Sullivan L, Harrison A, Dolezal C, Monroe-Wise A. 2006; HIV risk behaviors and the context of sexual coercion in young adults' sexual interactions: Results from a diary study in rural South Africa. *Sexually transmitted diseases*. 33(1):52–58. [PubMed: 16385222]
- Jewkes R, Abrahams N, Mvo Z. 1998; Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*. 47(11):1781–1795. [PubMed: 9877348]
- Jewkes R, Brown H, Dickson-Tetteh K, Levin J, Rees H. 2002; Prevalence of morbidity associated with abortion before and after legalisation in South Africa. *BMJ*. 324(7348):1252–1253. [PubMed: 12028979]
- Jewkes R, Flood M, Lang J. 2015; From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *The Lancet*. 385(9977):1580–1589.
- Jewkes RK, Levin JB, Penn-Kekana LA. 2003; Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Social Science & Medicine*. 56(1):125–134. [PubMed: 12435556]
- Kabeer N. 1999; Resources, agency, achievements: Reflections on the measurement of women's empowerment. *Development and change*. 30(3):435–464.
- Kruger LM, Schoombee C. 2010; The other side of caring: abuse in a South African maternity ward. *Journal of reproductive and infant psychology*. 28(1):84–101.

- Lince-Deroche N, Constant D, Harries J, Blanchard K, Sinanovic E, Grossman D. 2015; The costs of accessing abortion in South Africa: women's costs associated with second-trimester abortion services in Western Cape Province. *Contraception*. 92(4):339–344. [PubMed: 26142621]
- Lince-Deroche N, Pleaner M, Harries J, Morroni C, Mullick S, Firnhaber C, ... Sinanovic E. 2016 Achieving universal access to sexual and reproductive health services: The potential and pitfalls for contraceptive services in South Africa. *South African Health Review*. :95–106.
- Luke N. 2003; Age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa. *Studies in family planning*. 34(2):67–86. [PubMed: 12889340]
- Macha S, Muyuni M, Nkonde S, Faúndes A. 2014; Increasing access to legal termination of pregnancy and postabortion contraception at the University Teaching Hospital, Lusaka, Zambia. *International Journal of Gynecology & Obstetrics*. 126:S49–S51. [PubMed: 24786142]
- Mayi-Tsonga S, Obiang PA, Minkobame U, Ngouafo D, Ambounda N, de Souza MH. 2014; Introduction of postabortion contraception, prioritizing long-acting reversible contraceptives, in the principal maternity hospital of Gabon. *International Journal of Gynecology & Obstetrics*. 126:S45–S48. [PubMed: 24745694]
- Patel M. 2014; Contraception: Everyone's responsibility. *South African Medical Journal*. 104(9)doi: 10.7196/SAMJ.8764
- Sachs JD. 2012; From millennium development goals to sustainable development goals. *The Lancet*. 379(9832):2206–2211.
- Solarin I, Black V. 2013; "They told me to come back": women's antenatal care booking experience in inner-city Johannesburg. *Maternal and child health journal*. 17(2):359–367. [PubMed: 22527767]
- South Africa Demographic and Health Survey 2016: Key Indicator Report, Statistics South Africa. Pretoria: 2017.
- Stirling M, Rees H, Kasedde S, Hankins C. 2008; Introduction: addressing the vulnerability of young women and girls to stop the HIV epidemic in southern Africa. *Aids*. 22:S1–S3.
- Trueman KA, Magwentshu M. 2013; Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa. *American journal of public health*. 103(3):397–399. [PubMed: 23327279]
- Ulin, P, Robinson, E, Tolley, E. *Qualitative Methods in Public Health: A Field Guide for Applied Research*. San Francisco, CA: Jossey-Bass; 2005.
- UN. United Nations Millennium Declaration [Press release]. 2000. Retrieved from <http://www.un.org/millennium/declaration/ares552e.pdf>

Biographies

Marie E. Sullivan, MPH is a current medical student at George Washington School of Medicine and Health Sciences. She earned her MPH at Brown University where she concentrated in global health studies. Her research interests include sexual and reproductive health.

Abigail Harrison, PhD, MPH is Assistant Professor, Department of Behavioral and Social Sciences at the Brown University School of Public Health. She is a social epidemiologist who conducts qualitative research on young women's reproductive health and HIV prevention interventions in sub-Saharan Africa.

Jane Harries, PhD, MPH is Director and Associate Professor, Women's Health Research Unit, School of Public Health and Family Medicine, University of Cape Town. She is a social scientist who conducts qualitative and quantitative research on women's reproductive health including contraceptive use, abortion and health service utilization.

Namhla Sicwebu is an MPH student at the University of Cape Town, School of Public Health and Family Medicine. She is interested in women's reproductive health and qualitative research, and is conducting a study on caregiver-led HIV disclosure among children in South Africa.

Rochelle K. Rosen, PhD is a research scientist at the Centers for Behavioral and Preventive Medicine, The Miriam Hospital, and assistant professor (research), Department of Behavioral and Social Sciences, Brown University School of Public Health. She is a medical anthropologist who conducts cross-cultural research on health promotion.

Omar Galárraga, PhD is Assistant Professor, Department of Health Services, Policy and Practice at the Brown University School of Public Health. He is a health economist with research interests in behavioral economics, conditional economic incentives, and implementation and evaluation of global HIV prevention interventions.

Table 1

Sociodemographic characteristics

Variable	Mean	Range
Age (years)	28.5	19–38
Variable	Percentage (%)	Absolute number (out of 16) N= 16
Ethnicity or Racial Category		
Coloured *	37.5	6
African	62.5	10 (3 from Malawi)
Type of contraception		
Injection	50	8
Implant	25	4
IUD	25	4
HIV status		
Positive	25	4
Negative	68.8	11
Refused to disclose	6.3	1
Education		
Completed primary	18.8	3
Completed grade 11	25	4
Secondary school graduate **	43.8	7
Post secondary education	12.5	2
Employment		
Currently employed full time	25	4
Currently employed part time ***	31.3	5
Currently unemployed	43.8	7
Marriage Status		
Married	18.8	3
Serious relationship	31.3	5
Has a boyfriend	25	4
Not in relationship	25	4
Partner Age		
Younger	18.8	3
Same age	6.3	1
1–2 years older	6.3	1
3–5 years older	12.5	2
5+ years older	31.3	5
Not in a relationship	25	4

Variable	Mean	Range
Children		
0	6.3	1
1	31.3	5
2	43.8	7
3	18.8	3
More than 3	0	0

* The “Coloured” label is an apartheid-era designated racial category still used for official purposes to describe South Africans of mixed ancestry; a majority of this population speaks Afrikaans as a first language. (“South Africa Demographic and Health Survey 2003,” 2007)

** This means they have passed the matriculation exam and completed what is commonly known in South Africa as “Matric year.”

*** Part time jobs including domestic worker, trade, and the informal sector.