Communities were largely driven to interact with universities by their proactive development strategies, rather than short-term needs. For example, the informal settlement community participated in a local government intermediary-led process that brought in the university academic as a neutral actor to find solutions acceptable to the community and environmental authorities, after prolonged service-delivery protests.

Initiation and maintenance of the interaction, however, relied strongly on community leadership who acted as intermediaries between academics and community members. All four cases included organisational innovations to facilitate new community structures, and educational interventions to support the active participation of some community members. For example, training community leaders in research to audit fish stocks or undertake household audits, or in new farming techniques to support indigenous breeds of cattle, or forming committees to represent the community's interests.

The level of participation and agency possible on the part of the individuals in the marginalised communities seemed limited, and the direct benefit to their livelihoods was not evident in the short term.

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Clearly, the boundaries of what can counts as innovation, defined as 'a new product, or process, or form of organisation for production', were stretched. The changes introduced were primarily new forms of organisation for production, or introducing existing technologies new to a 'community', in 'doing-using- and-interacting' modes, rather than science and technology-led modes of innovation.

If the distinctive role of the university is knowledge generation, and most of the activity with marginalised communities is local adoption and diffusion, should the university be involved in livelihood oriented projects? Is such work not the domain of organisations like development agencies and NGOs or local government?

Academics should not be expected to play the role of development agencies. The university's distinctive role lies in extending its scholarship to the benefit of marginalised communities.

The answer lies in the fact that the impact of interactions on livelihoods may have been limited in their direct scale and reach, but the involvement of the university in the network meant that it could have wider implications. For example, intensive work with the small fishing community succeeded in protecting the access of some two hundred people to livelihoods, over twenty years. However, the significant research published and the engagement with government around the network could have an impact on practices in many other fishing communities.

Marginalised women in the sewing micro-enterprise improved their skills, designs and access to informal markets, but were unsuccessful in accessing formal markets or value chains. There was no sustained income source for individual members, and the reach of the project was limited to a small number of women per year. However, many women proceeded to their own micro-enterprise, students were trained, and the technology station gained valuable expertise that could be implemented in working with other micro-enterprises.

A general conclusion therefore, is to avoid slippage in expectations. Academics should not be expected to play the role of development agencies. The university's distinctive role lies in extending its scholarship to the benefit of marginalised communities. ■

**The study agreement included a confidentiality clause that the names of the institutions involved would be withheld.*

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Gauging awareness of the right to terminate pregnancy

The Choice of Termination of Pregnancy Act was passed 18 years ago, yet a study conducted in the rural areas of the Vhembe district in Limpopo showed that less than 50% of its young participants knew about the act. This lack of knowledge could hinder young people who need to make use of termination of pregnancy (TOP) services, say *Thelmah Maluleke* and *Sylvia Vuledzani Hadzhi*.

The Choice of Termination of Pregnancy Act (CTOP) gives women of any age access to abortion services upon request during the first 12 weeks of pregnancy, and in some cases, up to 20 weeks of pregnancy. But even before its introduction, the CTOP evoked a lot of morally related debates and arguments, some of which had a negative impact on the implementation and dissemination of information related to the CTOP and abortion services.

These negative moral debates created several challenges for both the TOP service providers and the women needing these services. Firstly, they made it difficult for some abortion service providers to communicate their services, which affected the accessibility of those services.

Secondly, dissemination of information about the availability of abortion services in public health facilities was hindered by some healthcare workers and the public. In some instances, nurses and doctors providing TOP services were labelled murderers of unborn babies. Like their clients, they were often victimised, stigmatised and even ostracised by their colleagues and communities.

Thirdly, women needing abortion services were unable to access them because of fear of retribution from anti-abortion moralists. It is well documented that in some communities, women who have abortions keep them secret because they are afraid of victimisation or that they will be stigmatised or even ostracised by their relatives and community.

Some other studies show that women fail to access abortion services from government facilities due to the resistance and unwillingness of some health providers to perform the termination of pregnancy procedure. Some nurses and doctors are unwilling to assist in TOP and refuse to give any information as to where the CTOP clinics are located within health facilities.

The consequence of women's failure to access TOP services is that they end up carrying the unwanted pregnancy to term, which could lead to the abandonment or neglect of the child. Studies show that women also resort to unsafe abortion, which could result in serious complications and death, and that women who cannot access the designated TOP clinics tend to seek assistance from traditional healers with dire consequences, ranging from infection to fatalities.

This article addresses the knowledge of the CTOP among young people in the rural areas of the Vhembe district.

Methods

Four remote rural villages with at least 300 households and a fixed clinic or mobile clinic visiting point were selected. Self-administered questionnaires were used to collect information from a random sample of 544 young people (136 per village, females and males). The questionnaires were in English, Sepedi, Tshivenda and Xitsonga.

Results

Profile of participants

The majority (87.5%) of the participants were unmarried and almost two thirds (64.7%) had never had children, 20% had one child and 5% had two children. More females (68%) than males (32%) participated in the study.

Those who had three and more children were mainly males, constituting 7.4% of the participants, assuming that male participants could have children with more than one woman. The religious affiliations of the participants were as follows: Christian (65.9%); African religion (25.7%); Muslim (2.2%); and unaffiliated (5.6%).

Almost 60% of the participants had a secondary education, 35% a tertiary education, and only 4% had no education. Women and men were almost equal at all levels of educational attainment. However, almost 60% of those who had no education were women.

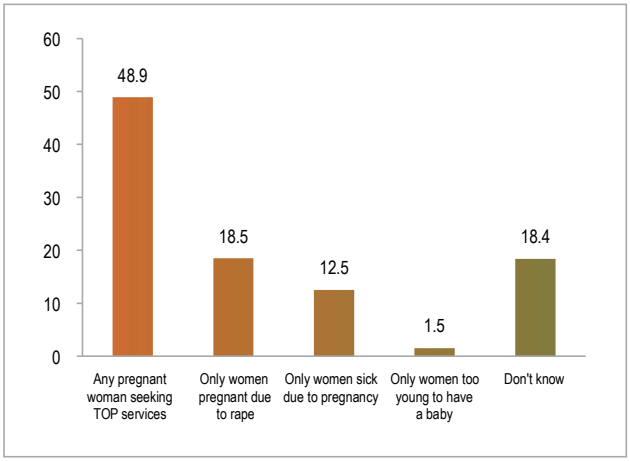
78.7% of participants had heard about termination of pregnancy.

Knowledge of the CTOP (n=544)

A total of 428 (78.7%) participants had heard about termination of pregnancy and among those, 248 (57.9%) knew someone who had had an abortion. The majority (93.6%) of those who knew someone who had TOP were adults aged between 20 and 25 years (80.24%), 13.31% were between 18 and 19 years, and 6.45% were between 15 and 17 years. Among those who had some knowledge of TOP, 295 (68.9%) had knowledge about the CTOP. Interestingly, there were more participants (73.5%) who were aware of the health facilities offering TOP in their district.

Participants who had some knowledge about the CTOP were asked to indicate what the act said about people who could access TOP (Figure 1). The results indicated that less than 50% of the participants who had some knowledge of the CTOP were aware that any pregnant woman seeking TOP could access the services.

Figure 1: Knowledge of who can access CTOP

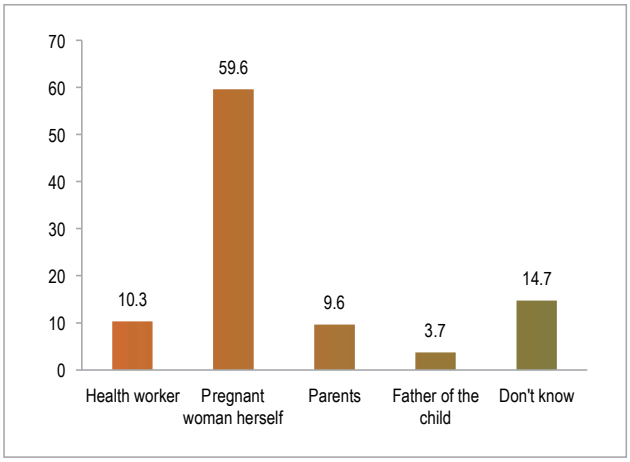


Source: Maluleke & Hadzhi

Knowledge about who is responsible for taking decisions related to TOP

Almost 60% of the participants were aware that the pregnant woman herself was the only person who could take a decision regarding termination of pregnancy, while more than 10% of those thought a health worker could make that decision and 9.6% and 3.7% were of the view that parents of the mother and the father of the child respectively were the ones that could make a decision about TOP. A little less than 50% of the participants who were aware of the CTOP knew that pregnant women did not need permission from the father of the child to terminate their pregnancy (Figure 2).

Figure 2: Knowledge about who is responsible for taking decisions related to TOP (n=295).

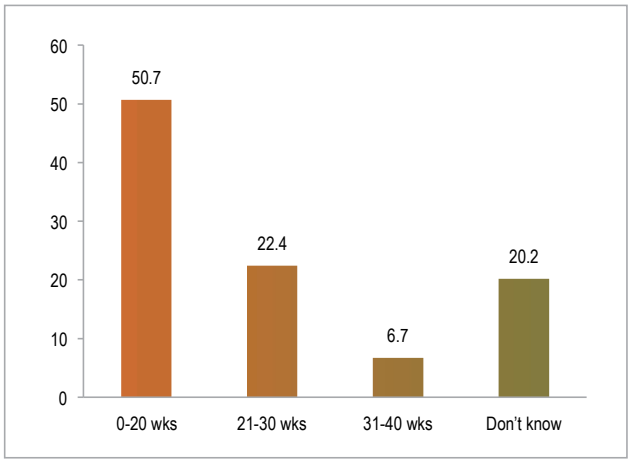


Source: Maluleke & Hadzhi

Weeks of pregnancy at which TOP can be performed

Participants were further asked to indicate the gestational age of pregnancy at which TOP could be performed. A little more than 50% were aware that a pregnancy could not be terminated after its 20th week (Figure 3). Lack of knowledge and information about the period women are legible to terminate pregnancy could be a contributory factor for delays among women in seeking TOP services.

Figure 3: Weeks of pregnancy at which TOP can be performed (n=292).



Source: Maluleke & Hadzhi

The major source of information on the CTOP was through the media (42%), in spite of the fact that these villages had a fixed clinic and community health workers. Other sources of information were the school (15%) and health services (17%). The majority (94%) had knowledge of the places where TOP could be performed, while 4% indicated the traditional healer and another 2% did not know where TOP services were offered.

Support for termination of pregnancy by choice was low (15%). However, the participants supported TOP in case of rape (68%) and for medical reasons.

Generally the participants were opposed to the existence of the CTOP. In their view pregnant women should never be allowed a choice to terminate their pregnancy. The decision to terminate pregnancy must be made by a doctor and only if the woman's life is threatened by the pregnancy or as a result of rape.

Discussion and recommendations

The age and education level of the participants were important factors associated with knowledge of the CTOP. Older participants had more knowledge about TOP in general and were more likely to know someone who had had an abortion than the younger participants.

More effort is needed to create awareness about TOP, the CTOP and the health facilities that offer TOP services to ensure young people needing these services access them, thus reducing the risk of unsafe abortions. ■

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