THE UNDERUTILISATION OF TERMINATION OF PREGNANCY (TOP) SERVICES BY WOMEN WITH UNINTENDED PREGNANCIES: A DESCRIPTIVE CASE STUDY IN COMMUNITY HEALTH CENTRES WITHIN THE CAPE METROPOLE, SOUTH AFRICA

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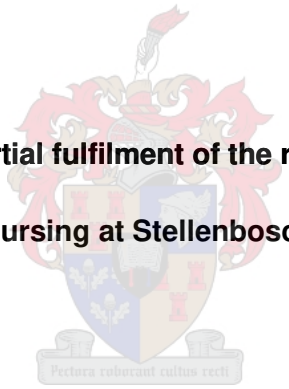

Thesis presented in the partial fulfilment of the requirements for the degree

Master of Nursing at Stellenbosch University

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March 2020

DECLARATION

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ABSTRACT

Background

Legislation in South Africa permits termination of pregnancies (TOPs) up to a gestational age of twelve weeks on request of a woman and furthermore to a gestational age of twenty weeks if the pregnancies pose significant risks to women's wellbeing or if the foetus suffers severe abnormalities, if the pregnancy resulted from rape or if the continuation of the pregnancy would affect the social or economic circumstances of the woman. After the twentieth week of pregnancy, termination is permitted when the woman's life is in danger or when severe malformation of the foetus is detected and injury to the foetus is evident. The public healthcare system provides free TOP services in settings easily accessible to the community. It has been found that despite available and accessible TOP services, women with unintended pregnancies still complied with unsafe TOP practices. The aim of this study was to describe the underutilisation of TOP services amongst women with unintended pregnancies in Community Health Centres (CHCs) within the Cape Metropole.

Methods

A qualitative approach with a single-descriptive case study design was used to explore the underutilisation of TOP services amongst women with unintended pregnancies that presented in the CHCs and who were seeking care after unsafe abortion attempts. The study applied purposive sampling to select participants from the Khayelitsha and Mitchells Plain CHCs. Permission to conduct the study was granted by The Health Research Ethics Committee of Stellenbosch University and the Western Cape Department of Health. Ten in-depth individual semi-structured interviews were conducted, transcribed and analysed, using the analytic technique as described by Robert Yin.

Results

The themes that emerged from both units of analysis were lack of access to information and services regarding TOP services, the stigma surrounding unintended pregnancies and the circumstances forcing unsafe TOP decisions. Some participants displayed awareness of TOP legislation, but still sought unsafe TOP methods. Healthcare providers were adequate in their provision of information regarding TOP services, but enquiries regarding these unsafe TOP services were based on information on the internet and advertisements on lampposts and the walls of buildings. Stigma due to the perceived opinion of the community and healthcare providers, the occurrence of rape and unintended pregnancy, in conjunction with personal circumstances such as maternal age and efforts to hide the pregnancy, forced these women to make unsafe TOP decisions. Feelings of regret were displayed only after an

unsafe TOP decision had been made. In addition to the above themes, another theme emerged from the second unit of analysis and this was related to healthcare providers' perceptions of unsafe TOPs. Healthcare providers were sensitive towards the women's circumstances, but some felt obliged to report the cases. Lack of feedback from law enforcement and the absence of management guidelines resulted in increased frustration.

Conclusion

The findings demonstrated that despite access to, and information regarding TOP services, women with unintended pregnancies still underutilised these services. In most cases, the stigma related to unwanted pregnancies, rape, maternal age and financial difficulties put pressure on these women in their effort to hide the pregnancy and they failed to access these services.

Keywords

Underutilisation, termination of pregnancy, unintended pregnancy

OPSOMMING

Agtergrond

In Suid-Afrika bepaal wetgewing dat aborsies op die versoek van ‘n vrou uitgevoer mag word tot op die gestasie van twaalf weke en verder tot ’n gestasie van twintig weke indien die swangerskap lewensbereigend is, abnormaliteite by die foetus voorkom, die swangerskap die gevolg van verkragting was of wanneer die swangerskap sosiale en ekonomiese welvaart beïnvloed. Na twintig weke van swangerskap word aborsie toegelaat wanneer dit lewensbedreigend is of wanvorming of besering van die foetus bespeur word. Die publieke gesondheidsisteem verskaf gratis aborsiedienste in toeganklike omgewings vir die gemeenskap. Ten spyte van beskikbare, toeganklike aborsiedienste gaan vroue met onbeplande swangerskappe voort om onveilige aborsiepraktyke te volg. Die doel van hierdie studie is om die onderbenutting van aborsiedienste by vroue met onbeplande swangerskap in gemeenskapsgesondheidsentrums binne die Kaapse Metropool te beskryf.

Metode

’n Kwalitatiewe benadering met ’n enkel-beskrywende gevalstudie-ontwerp is benut om die onderbenutting van aborsiedienste onder vroue met onbeplande swangerskap wat gepresenteer het in die Gemeenskapsgesondheidsentrums binne die Kaapse Metropool te verken. Doelgerigte steekproefneming is toegepas om deelnemers te selekteer by Khayelitsha- en Mitchells Plain-Gemeenskapsgesondheidsentrums. Toestemming om die studie uit te voer is toegestaan deur die Navorsings- Etiese Komitee van die Universiteit van Stellenbosch en ook van die Departement van Gesondheid van die Wes-Kaap. Na die voltooiing van tien in-diepte- individuele, semigestruktureerde onderhoude het transkripsie plaasgevind en daarna is dit analiseer met die hulp van Robert Yin se analitiese tegnieke.

Resultate

Die temas wat na vore gekom het vir beide eenhede van analise was die gebrek aan toegang tot aborsie-inligting en -dienste, die stigma rondom onbeplande swangerskappe en aborsies en omstandighede wat onveilige aborsiebesluite forseer het. Sommige deelnemers was bewus van aborsiewetgewing, maar het steeds onveilige aborsiemetodes gevolg. Gesondheidsdiensverskaffers het die nodige inligting rakende aborsiedienste verskaf, maar navraag by wyse van internettoegang en plakkate op lamppale en geboue was steeds teenwoordig. Die stigma van die waargeneemde mening van die gemeenskap en gesondheidsdiensverskaffer, verkragting en onbeplande swangerskappe tesame met persoonlike omstandighede soos moederlike ouderdom en pogings om die swangerskap geheim te hou, het hierdie vroue forseer om steeds onveilige aborsiebesluite te neem.

Gevoelens van spyt is getoon nadat onveilige aborsiebesluite geneem is. Buiten die bogenoemde temas het nog ’n tema uit die tweede eenheid van analise na vore gekom en dit behels gesondheidsdiensverskaffers se waarnemings oor onveilige aborsies. Gesondheidsdiensverskaffers was sensitief teenoor die vroue se omstandighede, maar sommige het verplig gevoel om die gevalle te rapporteer. Gebrek aan terugvoer van wetstoepassers en die afwesigheid van hanteringsriglyne het frustrasies laat ophoop.

Slotsom

Die bevindinge demonstreer dat ondanks toegang tot, en inligting oor aborsiedienste, vroue met onbeplande swangerskappe steeds hierdie dienste onderbenut. Stigma verwant aan onbeplande swangerskappe, verkragting, moederlike ouderdom en finansiële probleme forseer hierdie vroue in ’n poging om die swangerskappe geheim te hou en die toegang tot hierdie dienste het gefaal.

Sleutelwoorde

Onderbenutting, beëindiging van swangerskap, onbeplande swangerskap

ACKNOWLEDGEMENTS

The late Bruce lee said: *"Notice that the stiffest tree is most easily cracked, while the bamboo or willow survives by bending with the wind."*

This leads me to express the immense appreciation and thankfulness I feel in my heart towards the following greater beings and individuals who ultimately reduced the tornados in my life to refreshingly light breezes.

I wish to convey my deepest thanks as follows:

Above all to my Heavenly Father who despite the existence of many tornados, gave me the ability, courage, strength and determination to continue and under whom I was able to bend the knee to find my equilibrium again.

All my gratitude towards the Department of Health that granted me the opportunity and the facilities to conduct this research study.

The Community Healthcare Centres and their staff members that were involved in the study. They accepted me wholeheartedly and without them, this study would definitely have headed nowhere.

A special word of gratitude towards the participants, who have willingly opened up an emotional and sensitive time in their lives. Without them, this study would have not been possible.

To my supervisor, Dr. Doreen Kainyu Kaura, for her expertise, continuous support and her ability to recognise those times when I needed some persuasion and forceful motivation and also those times that she just had to hold back and give me my space.

I dedicate this study to:

My parents, Johan and Soez Benadé, for their investment in my education and my future and for the person they have brought me up to be. I am at a loss of words to express my gratitude towards these two humble and wonderful individuals.

To my husband Daniël Kotze, for his continuous support and motivation and for our personal time that he sacrificed to allow me to work uninterruptedly when I needed to. Thank you for believing in me when I didn't.

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ABBREVIATIONS

ANC	Ante-natal Care
CHC	Community Health Centre
ED	Emergency Department
GA	Gestational Age
LAP	Lower Abdominal Pain
MDG	Millennium Development Goals
MOU	Midwife Obstetric Unit
PV	Per Vagina
SDG	Sustainable Development Goals
TOP	Termination of Pregnancy
UN	United Nations

CHAPTER ONE

FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Women with unintended pregnancies and the behavioural actions resulting from their circumstances have led to the delivery of ethical phenomena in the women's health community at large. In 2008 it was globally estimated that approximately 86 million pregnancies were unintended, where the majority (74 million) occurred in the less developed countries (Haffejee, O'Connor, Govender, Reddy, Sibiya, Ghuman, Ngwongo & Borg, 2017). Pregnancies identified as unintended in 2005, resulted in 46 million of these women across the globe to deliberately resort to actions that would terminate these pregnancies. Of these terminations, 27 million were legal, with an astonishing 19 million that were believed to have occurred outside the legal framework (Jacobs, Hornsby & Marais, 2014: 864).

Since the amendment of the Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996 in South Africa, women were allowed to opt for a legal termination of pregnancy (TOP) under various circumstances. Two such scenarios included a TOP up to 20 weeks gestational age and another allowed a TOP after 20 weeks gestational age if the continuation of the pregnancy posed a significant risk to the woman's physical, psychological, social or economic health as stipulated by the CTOP Act No. 92 of 1996 (Republic of South Africa, 1996). Physical, psychological, social and economic well-being were viewed as open to different interpretations by diverse individuals or healthcare providers and if women were denied legal TOP services due to such interpretations, these women might have sought other options, such as unsafe TOPs. Legislation was not the only contributory factor that might have resulted in women seeking unsafe abortion services. According to Gerdts, DePiñeres, Hajri, Harries, Hossain, Puri, Vohra, Foster and Green (2014:1) poor socio-economic circumstances, stigma, geographical distance from a provider and lack of knowledge about the legal status of abortion on the part of women and potential providers, prevented many women from accessing safe abortion services, even in countries where abortion was legalised.

In this chapter the research question, goal and objectives are stipulated in line with the title of the research. In order to link the researcher's conceptual ideas to the research phenomenon of this study, a theoretical framework is discussed in relation to relevant literature. The research methodology was briefly summarised and the ethical principles

applied during the research process are discussed in depth. The purpose of the study was to explore the underutilisation of termination of pregnancy services of women with unintended pregnancies.

1.2 SIGNIFICANCE OF THE PROBLEM

A study showed that 213 million pregnancies occurred globally in 2012 and that 40 percent (%) of these pregnancies were unintended (Sedgh, Singh & Hosain, 2015:301). This study conducted by Sedgh et al. (2015:301) concluded that the 40 % was represented by three categories, namely: unplanned births, induced abortions and miscarriages. A clearer and more individual description of spontaneous or induced abortions was needed to examine the incidence of this phenomenon, as the 40 % mentioned above did not explicitly indicate the extent of the categories of these unintended pregnancies. In addition, Cohen (2009:2) found that factors such as the lack of qualified medical providers, the stigma associated with illegal abortions, poor health systems and grinding poverty contributed to high health risk and the social and financial burden of unsafe abortions.

In public healthcare facilities of South Africa, less than seven percent of the country's 3 880 facilities offer abortion services. The government failed the community on two accounts: the refusal of healthcare professionals to deliver abortion services was not addressed and information on the location of legal abortion services was not provided (Amnesty International, 2018). The research study served to explore the magnitude of underutilisation of termination of pregnancy services by women with unintended pregnancies in a Southern African context.

1.3 RATIONALE

Globally, five million women were annually admitted and treated for abortion-related consequences (Haddad & Nour, 2009:123). Health consequences for unsafe TOPs revealed three major concerns which included: the cause of mortality, nonfatal long-term complications and financial implications to the public health sector. The major causes of mortality were indicated as haemorrhage, infection, sepsis, genital trauma and necrotic bowel. Long-term complications included: poor wound healing, consequences of internal organ injury (urinary and stool incontinence) and bowel resections. Lastly, emergency post-abortion care in some cases required blood products and medical or surgical interventions, which caused additional costs to the public health sector (Haddad & Nour, 2009:123).

In addition to the above, the rationale for this research was twofold; firstly the researcher who practised her profession in a Community Health Centre (CHC) in the Western Cape, South Africa, observed that women were admitted for post- and intra-abortion care after inducing unsafe abortion practices. Secondly, the researcher further noticed that these

women's pregnancies were unintended and factors such as failed plans to procure legal abortions, concealment of pregnancies, rape and teenage pregnancies were gathered from their conversation. These factors might have led to the incidence of unsafe abortion practices.

The researcher also acknowledged that due to her religious and personal beliefs she was not in favour of termination of pregnancy services, but would have appreciated women who had felt the need for such practices to have utilised safe and professional abortion services. Regardless of this predisposition of the researcher regarding TOPs, she acknowledged that the underutilisation of legal TOP services might have contributed to the incidence of unsafe abortion practices and that numerous factors played a role in the case of each individual, which might have forced them to take such measures. This phenomenon was therefore in need of further exploration.

1.4 PROBLEM STATEMENT

According to Haddad and Nour (2009:122), unsafe abortions were the cause of 68 000 maternal deaths per year in the developing world. The United Nations (UN) established the millennium development goals (MDG) in the year 2000. The aim was to prevent 33 million unwanted pregnancies between 2011 and 2015 and to save the lives of women who were at risk of dying of complications during pregnancy and childbirth, including unsafe abortions (World Health Organization, 2015).

Owing to strict legislation in 11 out of 54 African countries, abortions had not been permitted for any reason since 2015 (Guttmacher Institute, 2016). With the amendment of the Choice of Termination of Pregnancy Act No. 92 of 1996, legislation was promulgated in South Africa, which allowed women to make choices regarding their reproductive health. Regardless of this legislation, unsafe TOPs still occurred. However, in 2010 in the Western Cape, 17% of women opted for self-induced TOPs before entering the legal healthcare system (Constant, Grossman, Lince & Harries, 2014:305). In addition, the Saving Mothers report of 2017 indicated 24 % of maternal mortalities in South Africa were related to unsafe TOP's. Amongst all avoidable factors, unsafe TOP's ranked the third most significant causes of maternal deaths (Republic of South Africa, 2018:30).

The above mentioned scenarios indicated the research problem: that the inadequate and/or the lack of utilisation of TOP services by women with unintended pregnancies might have resulted in unsafe TOPs and caused an increase in maternal mortality and morbidity.

1.5 RESEARCH QUESTION

Why do women with unintended pregnancies underutilise TOP services and how can the utilisation of TOP services be improved within CHCs in order to reduce morbidity and mortality associated with unsafe TOPs within the Cape Metropole in the Western Cape, South Africa?

1.6 RESEARCH AIM

The aim of this study was to explore factors that influenced the underutilisation of TOP services for women with unintended pregnancies within the CHCs in order to reduce morbidity and mortality associated with unsafe TOPs in the Western Cape, South Africa.

1.6.1 RESEARCH OBJECTIVES (RO)

The objectives of this study were to:

RO 1: Describe the perspectives of women with unintended pregnancies regarding the TOP services offered in two CHCs of the Cape Metropole within the Western Cape, South Africa.

RO 2: Determine the barriers to the utilisation of TOP services by women with unintended pregnancies in two CHCs of the Cape Metropole within the Western Cape, South Africa.

RO 3: Identify strategies in line with Sustainable Developmental Goals (SDGs) that could be put in to place to improve the utilisation of safe TOP services for women with unintended pregnancies provided in two CHCs of the Cape Metropole within the Western Cape, South Africa.

RO 4: To describe the perceptions of healthcare professionals who had dealt with women with unintended pregnancies who had underutilised TOP services in the two CHCs of the Cape Metropole within the Western Cape, South Africa.

1.7 THEORETICAL FRAMEWORK

According to Burns and Grove (2011:238) a theoretical framework is a conceptual idea that logically formulates notations to portions of a theory in order to guide the development of the study. Added to this, it allows the researcher to connect the findings of the study with the body of knowledge of nursing. In order to achieve the above, the researcher included a theoretical framework, discussed as follows.

1.8.1 The theory of planned behaviour

In 1985, Icek Ajzen proposed a behavioural theory that guided human planned behaviour in three major considerations. These three considerations were identified as behavioural beliefs, normative beliefs and control beliefs. Behavioural beliefs portray the individual's beliefs on the likely outcome of the behaviour. These beliefs are directly influenced by the individual's attitude towards certain behaviour, whereas normative beliefs are viewed as the beliefs regarding the normative expectations of other individuals and would mean subjective behaviour as to what the individual thinks other individuals want them to perform and which may ultimately result in perceived social pressure. Lastly, those beliefs regarding factors that contribute or hinder the planned behaviour are known as control beliefs. These beliefs give rise to perceived behavioural control (Ajzen, 1985). Behavioural intentions are formed when the attitude towards behaviour, the subjective norm and the perception of behavioural control are combined (Ajzen, 1985). According to Ajzen (1985), as a general rule, when an individual perceives a high tendency towards a positive attitude for the behaviour, when their norms are favourable to others' perceptions and they have a greater perceived behavioural control, it may result in a strong intention to perform the planned behaviour. This implied general rule allows the individual a sense of actual behavioural control as the individual who plans the behaviour is in control of their attitude towards the behaviour, their subjective norm and perceived behavioural control. With this level of control over the planned behaviour, the preceptor will rise to the occasion and execute their intentions when the opportunity arises. The essence of this theory can be summarised by stating that the intention is the generator for the planned behaviour (Ajzen, 1985).

The figure to follow illustrates the theory of planned behaviour of Icek Ajzen (1985).

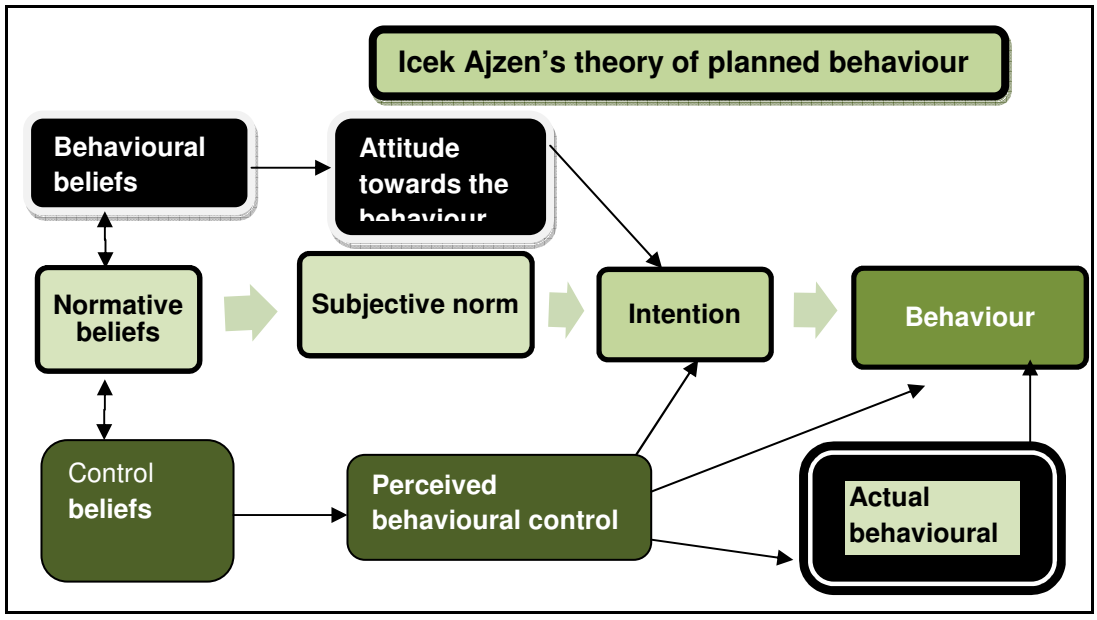

Figure 1.1 Theory of planned behaviour of Icek Ajzen

1.8.2 Application of the theory of planned behaviour

In order to understand a certain human behaviour, greater insight needs to be obtained in the thought processes that precede such planned behaviour. As illustrated in the theory of planned behaviour above, planned behaviour is preceded by intent. There were three beliefs that led to intent: behavioural beliefs (attitude towards the behaviour), normative beliefs (subjective norm) and control beliefs (factors that may facilitate or impede performance of the behaviour). In addition to this, control beliefs were influenced by perceived and actual behavioural control (Ajzen, 1985). The phenomenon of unsafe TOPs was under examination in this study and the thought processes as laid out above were explained with the support of the literature as set out in the following section.

1.8.2.1 Behavioural beliefs

According to Ajzen (1985) behavioural beliefs are perceived as the attitude towards the behaviour, which means that if the behaviour was perceived as positive there would be a greater intent and if the behaviour was perceived as negative there would be a lesser intent. According to the UN, in 2015 more than 41 % of the nearly 208 million pregnancies that occurred globally per year were unintended or unplanned and almost half of these pregnancies ended in termination. In relation to the theory of planned behaviour the pregnancy was unintended or unplanned and with an initial negative connection towards the pregnancy, the possible termination of this pregnancy turned the initial perception into a perception of positive behaviour. This seemingly positive attitude led to a greater intent to terminate the pregnancy.

1.8.2.2 Normative beliefs

Normative beliefs are the beliefs of the individual regarding the opinion of others and such beliefs led to the motivation of the individual to live up to that expectation. This resulted in perceived social pressure to adhere to certain behaviour (Ajzen, 1985). In Sri Lanka a study was conducted on the decision making of women with unintended pregnancies who had committed to unsafe TOP practices. The study concluded that decisions in favour of unsafe TOPs were predominantly based on economic instability and poor support from partners (Arambepola & Rajapaksa, 2014:91). In Kwazulu-Natal, South Africa, a descriptive cross-sectional survey examined the prevalence of unintended pregnancies. The study concluded that women with unintended pregnancies were more likely to have a single relationship status (Haffejee, O'Connor, Govender, Reddy, Sibiya, Ghuman, Ngxongo & Borg, 2017). In relation to the theory of planned behaviour their single relationship status (which implied poor support from partners) might be perceived as their subjective norm and might result in a higher intent to terminate the pregnancy.

According to Cockrill & Hessini (2014:593) TOP services were widely available globally, but were not socially accepted, which led to secrecy and selective disclosure in women's experience regarding TOPs. In the United States of America there was a close link between termination of pregnancy and religion. The general public of this country was gripped in a tug of war between religious affiliation and religiosity, which had a negative outcome for women seeking termination of pregnancy services (Frohwirth, Coleman & Moore, 2018). In a study regarding the management of religion and morality within the TOP experience, qualitative interviews were conducted and the findings portrayed that nearly all the respondents verbalised the influence of religion, religious communities and God, as related to their experiences to obtain an abortion. The respondents also unanimously expressed the notion that they perceived the opinions of the religious community as strongly opposed to abortion and that they had become aware of the stigma from religious families and community members (Frohwirth, Coleman & Moore, 2018).

Despite the existence of TOP legislation and safe abortion policies in Ghana, women with unintended pregnancies perceived that the society of Ghana, medical officers and midwifes were not in favour of pregnancy before marriage and this perception led them to seek unsafe abortion services in an effort to avoid the stigma (Atakro, Addo, Aboagye, Menlah, Garti, Amoa-Gyarteng, Sarpong, Adatara, Kumah, Asare, Mensah, Lutterodt & Boni, 2019:60). As stated in the literature above, factors such as religion and stigma influenced women's normative beliefs in processing the planned behaviour. In other words, stigma and religion (motivation to comply with expectations of others) led to the subjective norm of hiding or terminating the pregnancy (as a result of perceived social pressure) which then resulted in unsafe TOPs.

It emerged from a study conducted in Ghana that amongst women with unintended pregnancies who were at various levels of education, 87 % of the women had the need to pursue their education (Atakro, et al., 2019:60). Unintended pregnancies amongst college or tertiary female students in South Africa indicated 74.6 % occurrence amongst such students (Mbelle, Mabaso, Setswe & Sifunda, 2018). According to Haffejee, O'Connor, Govender, Reddy, Sibiya, Guman, Ngxongo and Borg (2017) South African women with low educational levels and a low income showed a higher prevalence of unintended pregnancies. The previous information might indicate that employment as well as social and economic status may have contributed towards the normative belief that these factors may have resulted in a greater intent to terminate pregnancies and ultimately led to a possible behaviour of unsafe TOPs.

In the United States of America a study was conducted in Chicago to examine the factors that influenced parental involvement in minors that sought an abortion. Close and supportive relationships, no further need to avoid disclosure, financial and logistical needs and circumstances of the minor which forced disclosure were amongst the factors that increased parental involvement. In contrast, factors that decreased parental involvement were found to be the following: to keep the parent-daughter relationship intact, fear or detachment and preservation of autonomy (Hasselbacher, Dekleva, Tristan & Gilliam, 2010). In addition to the above, a study conducted in Ghana found that unsafe TOPs were practiced to avoid the resentment and disappointment of parents or guardians (Atakro, et al., 2019:60). In that instance the theory of planned behaviour implied that the normative beliefs were the perceived opinions of parents, guardians or peers. This perception (possibly fear of disapproval) led them to a greater intent, which was to hide or terminate the pregnancy. Such greater intent ultimately led to the planned behaviour, namely unsafe TOPs.

Another factor that might contribute in the formation of normative beliefs is rape. This phenomenon is not very well researched due to the sensitivity of its nature. Some literature suggests that for approximately seven % of Brazilian women who were raped, it had resulted in a pregnancy. In general, these women were not aware that pregnancies may be terminated when it was the result of a rape. This misbelief resulted in the fact that these women did not seek a safe termination and opted for the unsafe termination of pregnancies (Blake, Drezett, Machi, Pereira, Raimundo, Oliveira, Tavares, Fiqueiredo, Paiva, Junior, Adami & Abreu, 2015).

1.8.2.3 Control beliefs

The last form of beliefs that led to intention was control beliefs. These beliefs were influenced by factors that might have haltered or contributed towards the intended behaviour and ultimately these beliefs gave rise to perceived behavioural control (Ajzen, 1985). In South Africa, TOPs were legalised in 1996 by the Choice on Termination of Pregnancy Act No. 92 of 1996 (Republic of South Africa, 1996) which gave all women the right to have a free TOP under certain circumstances named in the above act. An information brochure was posted on the Western Cape Government website regarding TOP services. To increase public awareness, this brochure addressed the availability of TOP services, methods to access these services and named the facilities which were providing these services (Western Cape Government, 2019). However, due to the stigma related to abortions, the attitude of healthcare professionals, their competencies in providing abortion services and the lack of facilities in rural areas that are certified to performed these services, abortion services still remained limited for many women and as a result unsafe TOPs were still occurring (Morroni, Myer & Tibazarwa, 2006). It should further be noted that a staggering

one-third of women involved in a study in 2004/2005 were not aware that TOPs were legal in South Africa and 61 % of the last pregnancies of the women in this sample were unintended (Morroni et. al., 2006). Frederico, Michielsen, Arnaldo and Decat (2018:329) declared that if women were better informed regarding TOP legislation, recommended locations and available services, these women with unintended pregnancies might have made safe and legal choices regarding their termination of pregnancy. This illustrated that the possible perceived behavioural beliefs indicated that TOPs were not legal, accessible or available and allowed for a stronger intention to omit to the behaviour of unsafe TOPs.

In addition to perceived behavioural control beliefs, actual control occurred when intentions were carried out when the opportunity arose (Ajzen, 1985). According to Trueman and Magwethshu (2013:398) there was an increase in lamppost advertisements for safe and pain-free TOPs up to the gestational age of 40 weeks, which suggested that the perceived behavioural control was that TOP services were illegal and not allowed. The individual pertained a sense of actual control by carrying out the intent (to terminate the pregnancy) when the opportunity arose. Evidentially the literature illustrates that intention is a result of the perceived behavioural, normative and control beliefs and the greater the intention, the greater the chance of performing the planned behaviour (Ajzen, 1985).

Behavioural beliefs form the attitude towards the behaviour; the pregnancy is unwanted and therefore perceived as negative. To terminate the pregnancy would change this perception of the unintended pregnancy to a positive attitude, because of no longer being pregnant. Normative beliefs, on the other hand, are the perceived opinions of others (Ajzen, 1985) and such beliefs are subject to numerous norms. A study conducted in Ghana in which the contributing factors to unsafe TOPs were examined, concluded that lack of knowledge of safe TOP services, poor socio-economic circumstances, cultural and parental/guardian disappointment or resentment and a desire to pursue education were amongst these factors (Atakro, et al., 2019:60). To obtain insight in how these factors influenced behaviour, Ajzen (1985) stated that where control beliefs played a role, the individual was under the impression that factors were in existence that impede or facilitate the performance of the behaviour. In relation to the literature above, such factors might include access to TOP services, lawfulness of these services and attitudes of the healthcare professional regarding TOP services. In essence, all of these beliefs contributed toward and individual perception of intent and if these factors created a high intent, there was a great possibility that the planned behaviour of unsafe TOP would occur.

The figure below provides a schematic illustration of the thought process of planned behaviour as proposed by numerous studies.

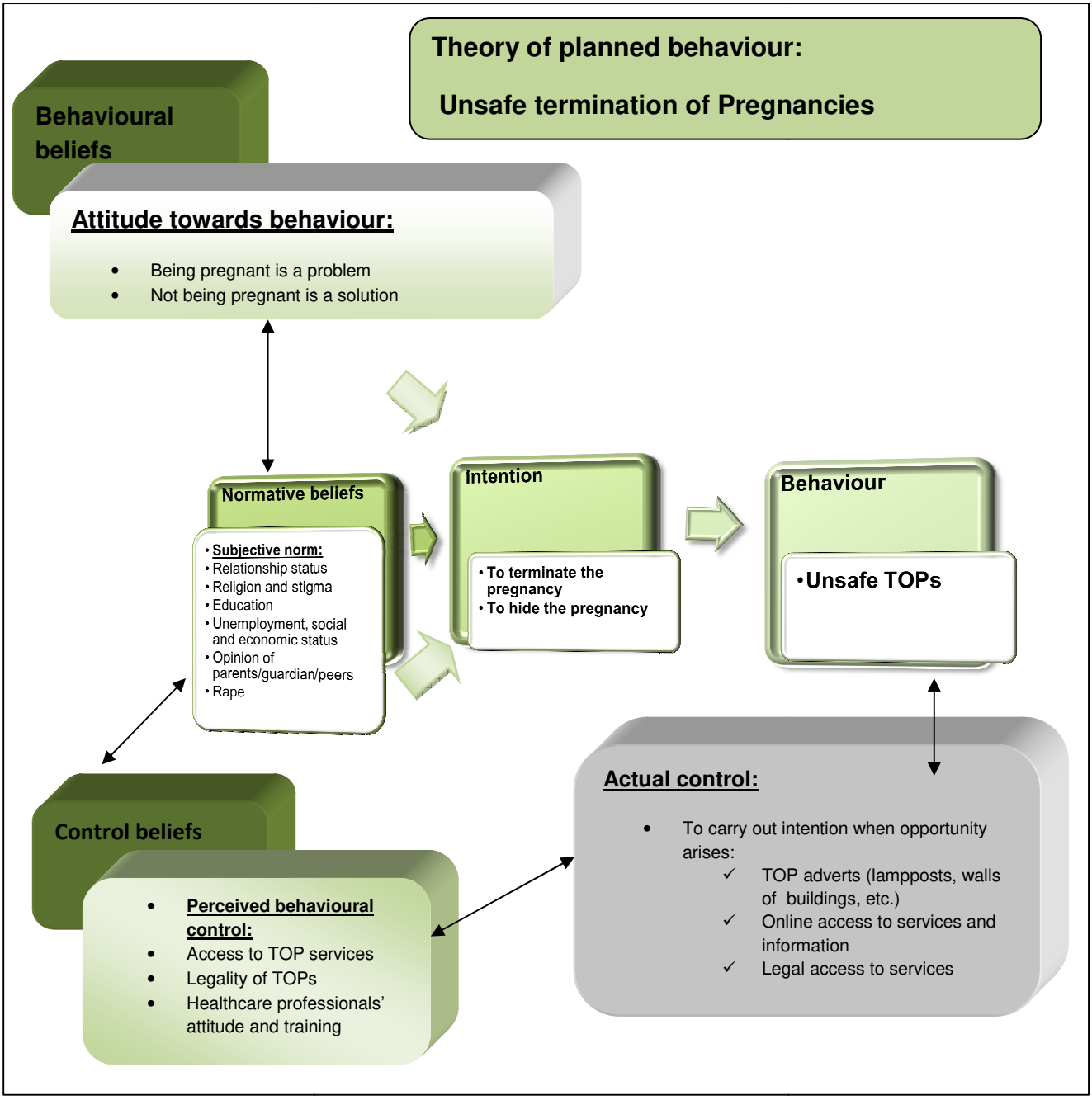

Figure 1.2 Theory of planned behaviour: unsafe TOPs

1.8 RESEARCH METHODOLOGY

In this qualitative study a single holistic case study design with multiple units of analysis was utilised. The study was conducted in Community Health Centres (CHCs) within the Cape Metropole district of the Western Cape, South Africa. These CHCs were identified as CHC One in the Khayelitsha sub-district and CHC Two in the Mitchells Plain sub-district. The population of the study included all women who resorted to unsafe abortion practices as a

result of the underutilisation of TOP services and who were identified upon admission in the CHCs for intra- and post-abortion care. The researcher deliberately selected women who had been admitted in CHC One and Two for post-termination of pregnancy care, following unsafe TOP practices. The sample size was determined at the stage where data saturation was met. Data collection tools included in-depth individual interviews with the use of semi-structured interview guides, field notes and document analysis. One interview was conducted in the presence of the supervisor, which made it possible to assess the researcher's interview skills and this interview also served to review the trustworthiness of the data collection tool. No alterations were needed to the interview process and therefore the data of the pilot interview were included in the analysis of data.

Trustworthiness was established by applying the elements as described by Lincoln and Guba in De Vos, Strydom, Fouché and Delport (2012:419) by the means of credibility, transferability, dependability and conformability, which were applied throughout the research process. Data were collected by the researcher on the premises of CHC One and CHC Two in a timeframe that was convenient to the participant. It took place over a period of fourteen months from June 2019 September 2019. The researcher obtained written consent from the participants to conduct and audio-tape the interview. Anonymity was assured by the use of a colour-coding system. Data analysis took place in that the researcher manually transcribed the data. Data triangulation was achieved by utilising in-depth interviews, field notes and document analysis as a multi-method approach.

The above serves as a summary of the research methodology that was utilised in this study. An in-depth discussion of this methodology will follow in Chapter Three.

1.9 ETHICAL CONSIDERATIONS

The research proposal was reviewed by the Health Research Ethics Committee (HREC) of Stellenbosch University and approval was obtained. The ethics reference number was S17/10/221 and the project number was indicated as 1675.

Health research ethics provided clear boundaries to which the researcher had to adhere and these boundaries set the ground rules in the ethical manner in which the study was conducted. Throughout the research process the ethical principles of respect for participant autonomy, beneficence, non-maleficence and respect for justice were incorporated (Moodley(ed.), 2015:41). The following section describes how the above-mentioned principles were applied. It will be categorised under the right to self-determination, the right to confidentiality and anonymity and the right to protection from discomfort and harm. In addition to the ethical principles that were applied, the researcher consulted the Singapore

Statement on Research Integrity (World Conference on Research Integrity, 2010) as well as the benchmarks of ethical research (Emanuel, Wendler, Kilen & Grady, 2004:189-930).

1.9.1 Right to self-determination

The right to self-determination was mainly focused on the ethical principle of autonomy which allowed the participant to be in ownership of their own health, treatment thereof and the decision to participate in the study. The participants were found competent and in full knowledge of the relevant information necessary to have made such a decision, which implied an autonomous decision. Aspects of autonomy included informed consent, truth telling and effective communication (Moodley(ed.), 2015:42). In view of informed consent, the aim, goal, purpose and data collection methods of the study were provided in English and in Afrikaans in understandable language which allowed the participant to make an informed decision regarding participation or the forfeit thereof. Truth telling was displayed by the researcher as no participants were deceived regarding the reason why they were being selected to participate in the study. Effective channels of communication were maintained as the researcher notified the participants regarding the findings and recommendations of the study. It was respected that participation in the research was voluntary, as the researcher did not coerce any participant to be included, nor was any participant financially rewarded to participate or remain in the study. All participants were allowed to withdraw from the study at any given stage and this was facilitated without any demand for an explanation from a participant.

1.9.2 Right to confidentiality and anonymity

The right to privacy of information as part of the ethical principle of respect for autonomy was applied to achieve the right to confidentiality and anonymity. The researcher guaranteed confidentiality, which gave participants the courage to divulge highly private and sensitive information (Moodley(ed.), 2015:48). The participants' right to privacy and confidentiality was respected by the use of colour-coding techniques. Face sheets which contained the participants' identities were removed. Data were captured by the researcher on the researcher's password-protected computer and access was allowed only to the researcher. This measure served to protect the participants' information. Owing to the sensitivity of the research topic the researcher included a waiver of parental consent which maintained privacy and in addition, kept information confidential in respect of those participants who fell within the age interval that required parental consent. While the study was in process, data documents were kept in a secure location. After the completion of the study, paper trail data documents were destroyed and electronic data documents were deleted from the storage

system. The researcher archived one set of data documents in a secure location and intends to destroy these documents five years after completion on the study.

Anonymity was ensured through the means that no identifiable information in the form of names, residential addresses or e-mail addresses were collected. During data collection the interviews were audio-taped and the researcher utilised the colour-coding system to assign identification. The study did not link any response with the participant's real identity.

1.9.3 Right to protection from discomfort and harm

The researcher aimed to live up to the participant's right to protection from discomfort and harm with the aid of the ethical principles of beneficence, non-maleficence and justice. Beneficence reverts to doing well to others and to cause no harm. These rights were applied trough the assurance of clinical competence of the researcher and the risk and benefit analysis for the participants (Moodley(ed.), 2015:57). As regards clinical competence, the researcher acquainted herself with the necessary interview skills which enabled her to conduct a professional in-depth interview. The researcher was trained as a professional nurse which allowed her to identify emotional exhaustion during the research interview. This implied that if the participant felt the need to withdraw from the interview at any given stage, the interview was discontinued and the participant received a debriefing counselling session. This counselling was provided at the data collection setting and, where available, this took place immediately.

The study did not pose any immediate physical risk to the participant as no medical or pharmacological intervention was included. The researcher guarded the participants from suffering any psychological risk as they were allowed to opt out of the interview and receive debriefing. These psychological risks would have been provoked by emotional discomfort, the development of a sense of shame or a negative perception of themselves that was formed during the interview. Social risks were implied by the nature of the research topic as it would expose the participants to social stigmatisation (Kruger, Ndebele & Horn, 2014: 63). The researcher assured anonymity and confidentiality to eliminate such risk. The participants would not directly benefit from the study, but were informed that the outcome of the study might assist women with similar experiences in the future. The risk-benefit was analysed and the researcher found that it complied with the principle of beneficence. Gratitude towards the participants was expressed by the offering refreshment after the interviews were completed.

The principle of non-maleficence placed an obligation upon the researcher to do no harm and in addition this, in the healthcare environment, the principle of justice was concerned with access to and allocation of resources (Watson, Mckenna, Cowman & Keady, 2008:

132). The participants' freedom of religion and belief was respected by omitting biased, religious perspectives and the influence of the personal views of the researcher. No immediate access to healthcare was promised as part of participation in the study. The participants were selected because their personal experience and perceptions were expected to provide great insight into the phenomenon at hand.

1.9.4 The Singapore Statement on Research Integrity

The Singapore Statement on Research Integrity was developed as part of the second World Conference on Research Integrity (WCRI) as a global guide to the responsible conduct of research. In this statement, four principles were stipulated. The researcher treated participants with honesty throughout the research process and accepted accountability in the conduct of the research. The researcher showed professional courtesy and fairness while working with healthcare professionals and participants at the selected study setting. Good stewardship of research was demonstrated by the researcher in respect of others (World Conference on Research Integrity, 2010).

As guided by the Singapore Statement on Research Integrity of 2010 the researcher held the following responsibilities throughout the research process:

1.10.4.1 Integrity

Integrity was demonstrated as the researcher had taken responsibility for the trustworthiness of the study by assuring credibility, transferability, dependability and conformability. Strategies on how these elements were applied will be discussed in Chapter Three.

1.10.4.2 Adherence to regulations

The researcher obtained ethical approval from both the Ethics Committee of Stellenbosch University and the National Department of Health to conduct the study.

1.10.4.3 Research methods

An appropriate research methodology that best suited the research question and which was in line with the title, goal, aims and objectives of the study was selected. Conclusions were not based on fixated data, but on analysis of evidence.

1.10.4.4 Research records

In consideration of the participants' confidentiality and anonymity the research records were kept accurately and clearly, which would allow other researchers to access these records for verification and replication purposes.

1.10.4.5 Research findings

After the researcher had established priority and claimed the ownership of the study, data and findings were shared openly and promptly on the databases of Stellenbosch University.

1.10.4.6 Authorship and publication acknowledgement

The researcher's supervisor was thoroughly appraised for her contribution in the research project and the names and roles of those who made significant contributions were acknowledged.

1.10.4.7 Peer review

Fair, prompt and rigorous evaluations were utilised in reviewing the literature on the work of other researchers. Confidentiality was respected throughout this reviewing process.

1.10.4.8 Conflict of interest

Religious views regarding termination of pregnancy services were held by the researcher. This view did not interfere with the trustworthiness of the study as the research findings were interpreted objectively.

1.10.4.9 Public communication

Professional comments in public discussion regarding the application and relevance of the research findings were limited to the researcher's recognised expertise. Professional comments were visibly distinguished from the researcher's opinions based on personal views.

1.10.4.10 Societal considerations

As indicated in the significance of the study, the researcher had illustrated the need for the study. The benefits to the community at large were weighed against the possible risks that the research may have posed (World Conference on Research Integrity, 2010). In conjunction with the ethical principle and the responsibilities of the Singapore Statement on Research Integrity, the researcher incorporated the benchmarks for multinational clinical research. Five of these principles were already portrayed during the discussion of the application of the ethical principle, namely collaborative partnership, fair selection of participants, favourable risk-benefit ratio, informed consent and respect for participants. Social value and scientific validity were illustrated as the aim of the research was to reduce maternal mortality and morbidity and the research design was selected to realise the social value for the primary beneficiaries of the research (Emanuel et. al. 2004:189-930).

1.10 DEFINITIONS

Community Health Centre – was defined as a 24-hour comprehensive unit operated by midwives. Occasionally these units stand alone as a maternity service and in such instance might be referred to as a midwife obstetric unit (MOU). This maternity service will run alongside other services such as emergency care, minor ailments, chronic diseases and health promotion services (Republic of South Africa, 2015c:20). In this study the term was applied for women admitted in either the MOU or the emergency department.

Health care professional – Also referred to as healthcare provider. These individuals study, advise on or provide preventative, curative, rehabilitative and promotional health services based on an extensive body of theoretical and factual knowledge in diagnoses and treatment of disease and other health problems (World Health Organization, 2010). For the purpose of this study they were the individuals who were involved in admitting, diagnosing or attending to women's care in the MOU or emergency department when these women sought help for intra- or post-abortion care.

Termination of pregnancy – can be classified as either medical or surgical methods of abortion. Medical abortions use pharmacological drugs to terminate the pregnancy and surgical abortions make use of trans-cervical procedures for termination the pregnancy which includes vacuum aspiration, dilatation and evacuation. Osmotic dilators are placement of thin rods made of seaweed or synthetic material which gradually dilates the cervix after placement (World Health Organization, 2014). In this study termination of pregnancy was referred to as the provision of services by trained healthcare professionals.

Unbooked pregnancy – refers to those situations where women had not initiated antenatal care services with a trained healthcare provider prior to the onset of labour (Iklaki, Inaku, Ekanem & Udo, 2011).

Underutilisation of termination of pregnancy services – refers to the state of not being used enough or not used to the fullest potential (Your Dictionary, N.d.). For the purpose of this study this term reverted to women not utilising termination of pregnancy services.

Unintended pregnancies – were defined as pregnancies that at the time of conception were either mistimed or unwanted. Mistimed pregnancies implicated that the women wanted the pregnancy to occur at a later stage and unwanted pregnancies referred to the women not wanting the pregnancy to occur at that time or any time in the future (Logan, Holcombe, Manlove & Ryan, 2007:1). In this study the phrase 'unintended pregnancies' was used as a general term which included unwanted, unplanned and untimely pregnancies.

Unsafe termination of pregnancy – was defined as those situations where the individuals involved in terminating an unintended pregnancy were not competent to perform the procedure, the environment was not conformed to minimal medical standards, or both of the above (Haddad & Nour, 2009:122).

1.11 DURATION OF THE STUDY

Ethical approval was obtained on 17 January 2018 for the duration of one calendar year. Additional extension was obtained to continue with the study up to January 2020. The proposal was submitted to the National Health Research Database (NHRD) on 26 January 2018. Data were collected from April 2018 up to June/September 2019 and analysed from July 2018 up to September 2019. The thesis was finally submitted for examination in December 2019.

1.12 CHAPTER OUTLINE

The chapters of the thesis could be outlined as follows:

Chapter One: An introduction and summary of the study is provided which allows the reader insight into the research topic at hand. The introduction is followed by a background which stipulated where the idea of the study has arisen.

Chapter Two: Provides an objective, critical summary of published literature relevant to the topic under consideration. This review of literature indicated the need for future research on the topic at hand.

Chapter Three: Provides a clear and detailed description of the research methodology. This chapter clarifies the choice of the research methodology and whether it was an appropriate approach relating to the title, goal, aim and objectives.

Chapter Four: Data were critically analysed on the basis of evidence. Interpretation of the results took place objectively; where after findings were interpreted and noted in a scientific manner.

Chapter Five: Conclusions were drawn from the results and findings of the study. Recommendations for healthcare practice and future research were made by the researcher at her recognised level of expertise.

1.13 SIGNIFICANCE OF THE STUDY

Knowledge was added to the body of the nursing and midwifery profession in the sense that greater insight was obtained on the essence and perceptions of women with unintended

pregnancies that had underutilised the available termination of pregnancy service. Policies and protocols were examined which revealed rich and insightful information on the standards of care, provision and the availability of termination of pregnancy services. This information enabled the researcher to make recommendations at her recognised level of expertise, which were based on the evidence derived from the data. The recommendations were portrayed in Chapter Five of this writing. In general, this study contributed towards the advancement of women's health as the outcome of this study might aid in the reduction of maternal mortality and morbidity. This can be achieved by providing information that has convinced the community at large to adhere to safe abortion practices.

1.14 SUMMARY

The background to the phenomenon of unplanned pregnancies and women's behaviour regarding the termination of these pregnancies was briefly outlined. The researcher was prompted to investigate the factors contributing to the underutilisation of termination of pregnancy services by women with unintended pregnancies. Literature suggested that such factors that may have contributed to the phenomenon under discussion can be summarised as poor socio-economic circumstances, lack of information on the location of services, lack of trained health care professionals, refusal of abortion services by healthcare providers and lack of knowledge regarding legislation regarding TOP services for women with unwanted pregnancies and those healthcare providers who may have contributed to the phenomenon. The researcher chose a qualitative approach with a case study design and collected data by the means of in-depth interviews, field notes and document analysis. This data collection process was selected as it provided the researcher with deeper insight regarding the perceptions and meaning of women who did not utilise TOP services.

1.15 CONCLUSION

The incidence of unintended pregnancies is taking place on a global scale. Although legislation in the majority of African counties inhibits abortion practices, South African legislation in the form of the CTOP does exist and allows women with unintended pregnancies to seek professional care. The theory of planned behaviour of Icek Ajzen (1985) explained how behavioural, normative and control beliefs contributed towards intent, which ultimately led to planned behaviour. Owing to the nature of the research topic, great consideration was applied regarding the ethical dimension of the research process. This chapter illustrated the means by which the rights of the participants were respected in view of self-determination, confidentiality and anonymity as well as protection form discomfort and harm. The researcher also illustrated how research integrity was applied with the guidance of the Singapore Statement of Research Integrity.

The following chapter provides an overview of literature regarding the prevalence of unintended pregnancies, TOP legislation, perceptions of healthcare providers and women with unintended pregnancies regarding TOP services, the utilisation of TOP services, TOP methods and the healthcare providers' code of conduct.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review served to bring a clearer understanding of the nature and meaning of the phenomenon that was examined. The researcher's efforts were placed in perspective, situating the topic in a larger knowledge pool. Broad functions of the literature review were to serve as a source for selecting the topic and to aid in refining the research question. These two functions reduced the chances of irrelevant topics to occur and prevented the duplication of research (De Vos, Strydom, Fouché & Delport, 2012:134).

The purpose of the literature review was to review the incidence of unintended pregnancies and the experience of women with unwanted pregnancies. The availability of legislation regarding TOP services from a global, African and South African viewpoint was explored. The researcher also reviewed the availability of legal termination of pregnancy services in the Cape Metropole, South Africa. Lastly, the underutilisation of TOP services by women with unintended pregnancies was reviewed.

2.2 REVIEWING AND PRESENTING THE LITERATURE

The literature review was performed prior to the onset of the research proposal. In the search strategy the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System online (MEDLINE), General Organism Optimized for Gratification and Logical Exploration (Google) and Google Scholar were utilised as search engines to obtain academic literature. Legislation and guidelines developed by the Constitution of South Africa were included in this review. Limitations were set on publications in English only. Literatures were obtained from e-journals and books. To ensure recent literature, only publications within the last ten years were included.

The keywords that were used in this literature review were: perceptions of women, healthcare providers, unintended pregnancies and underutilisation of TOP services.

2.3 FINDINGS FROM THE LITERATURE

The literature review was organised in accordance with the following themes as illustrated in the figure below.

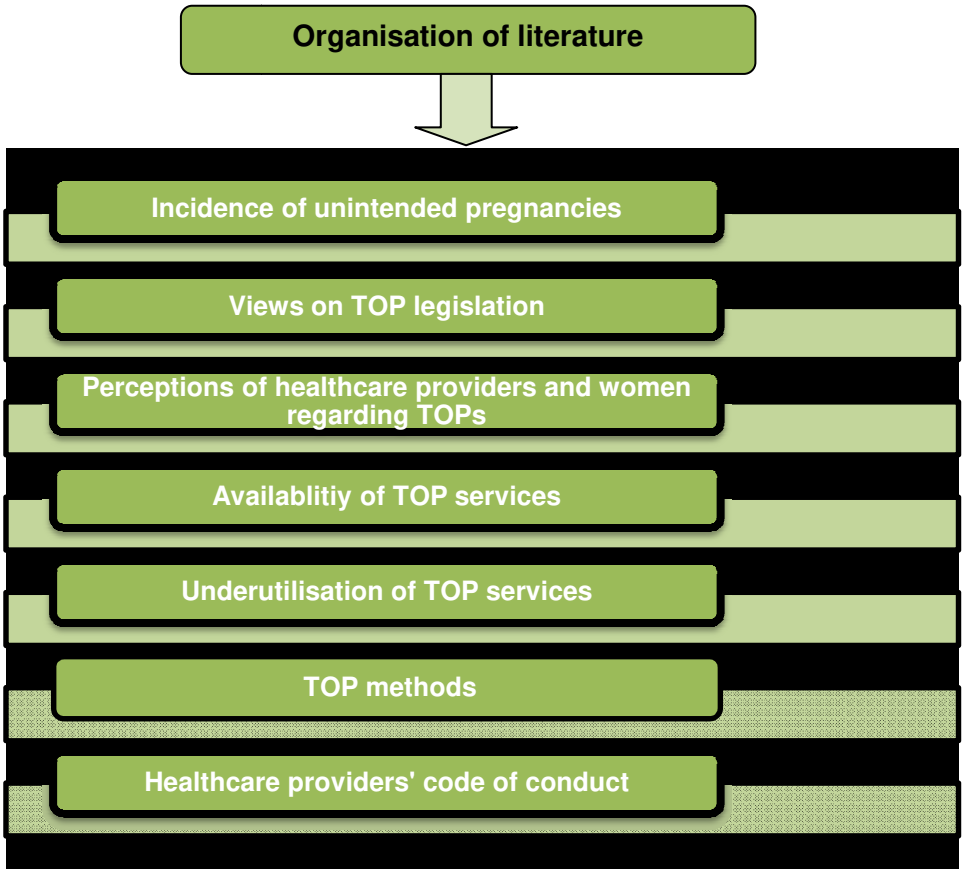

Figure 2.1 Organisation of literature review themes

2.3.1 THE INCIDENCE OF UNINTENDED PREGNANCIES

Unwanted pregnancies appear to be a phenomenon that not only existed in developing countries, but healthcare providers of developed countries were also faced with this tendency. Global perspective and tendencies as well as the care for women with unintended pregnancies were reviewed.

2.3.1.1 Global perspectives and tendencies

In a study conducted by a senior research associate and a research associate of the Guttmacher Institute of New York, the global incidence of unplanned pregnancies was explored. In this study Singh, Sedgh and Hussain (2010:241-242) classified unintended pregnancies as unplanned births, induced abortions and miscarriages. Globally, the incidence of unplanned pregnancies was estimated at 86 million. Amongst these estimates 33 million resulted in unplanned births, 41 million ultimately led to abortions and the remaining 11 million resulted in miscarriages (Singh, Sedgh & Hussain, 2010:243). The authors stated that one of the immediate outcomes of some of the unplanned pregnancies was induced abortions and in the light of restrictive abortion laws in many countries, this outcome appears to be unsafe. The goal as set by the United Nations (UN), the Millennium Development Goal (MDG) five (5) of reducing child mortality and improving maternal health

(United Nations, 2006), may be achieved by reducing the incidence and consequences of unplanned pregnancies (Singh, et al., 2010:241).

2.3.1.2 Care for women with unintended pregnancy

Healthcare professionals and midwives are often faced with women whose pregnancy was not intended. This phenomenon is much more common in the healthcare user community than may possibly be expected by healthcare providers and midwives. The responsibility and task rests on the shoulders of healthcare providers to avoid the premature conclusion of assumptions regarding women's feelings about their pregnancy (Frazer & Cooper (eds.), 2009:993).

Healthcare workers undertake tremendous responsibility in the provision of care to women with unwanted pregnancies. According to Simmonds and Likis (2011:794) these services should include appropriate assessment, counselling regarding options, provision of or referral for desired services, care conditions and prevention efforts aimed at decreasing future unintended pregnancies. The authors of this article explored the possibility that insufficient resources might have been available to provide adequate care, such as referral for adoption for women with unintended pregnancies. Healthcare workers might have been enabled by providing them with the knowledge to render the utmost service delivery in this regard.

This study was conducted by Registered Nurses in the United States of America. Another study was conducted in the United States of America by a psychiatrist, paediatrician and an obstetrician, who reviewed records to obtain greater perspective on relating factors that led women to postpone attendance of antenatal care. Denial and concealment of pregnancy were some of the characteristics explored in the study. The results indicated that of the 211 women that were interviewed, 29 % denied their pregnancy and 9 % kept their pregnancy a secret. Some of the women who participated in the study displayed feelings of ambivalence, had plans for adoption, had failed to procure TOPs or were rape victims (Friendman, Heneghan & Rosenthal, 2009: 178).

In Tanzania a cross-sectional survey study explored how unintended pregnancies provoked the delay in women initiating antenatal care (ANC) at a certain gestational age (Exavery, Kanté, Hingora, Mbaruka, Pemba & Phillips, 2013:35). At large, the responsibility of managing unintended pregnancies is shared by the women seeking ANC and the healthcare profession providing these care options in an unbiased manner. According to Exavery et al. (2013:35) it has been established that women who experience an unintended pregnancy were less likely to seek care than women with intended pregnancies.

In conclusion, the global perspectives of unintended pregnancies indicated that the majority of the outcomes of unintended pregnancies ends in either and TOP or miscarriage. The care of women with unintended pregnancies involved appropriate assessment, option counselling, provision of or referral for desired services and prevention efforts to avoid future unintended pregnancies. The literature above suggested a lack of referral options such as for adoption. In the instance of unintended pregnancies, a greater possibility existed that these women would not seek ANC, if compared to women with intended pregnancies. This may be the result of concealment and denial of the pregnancies or delay in seeking ANC.

2.3.2 TERMINATION OF PREGNANCY LEGISLATION

Legislation provides a framework and gives clear guidance to healthcare providers and healthcare users on this extremely ethical phenomenon of unwanted pregnancies and unsafe TOPs. The phenomenon was reviewed on the basis of the World Health Organization (WHO), the UN, TOP legislation in Africa and the Constitution of the Republic of South Africa.

2.3.2.1 The World Health Organization (WHO)

The WHO implemented a global strategic approach to strengthen the sexual and reproductive health policies and programmes. Ultimately, one of the strategies was to reduce the recourse to TOPs and improve the quality of existing TOP services. A total of 25 countries have used the WHO-sponsored strategic approach which involved a three-stage process, including strategies to assist countries to assess reproductive health needs and priorities. Secondly, strategies that had tested policies and programme adaptations to address these needs were advised and lastly this approach aimed to scale up successful interventions (World Health Organization, 2015).

The UN established the Millennium Development Goals (MDG) in the year 2000, a declaration that proclaimed that all 191 UN member states had agreed to try and achieve certain goals by the year 2015. Amongst the eight goals of the MDG, five were stipulated as aims to improve the maternal health of all (World Health Organization, 2000). In addition, the WHO implemented a global strategic approach to strengthen the sexual and reproductive health policies and programmes. Ultimately, one of the strategies was to reduce the recourse to TOPs and improve the quality of existing TOP services. A total of 25 countries have used the WHO-sponsored strategic approach and it involved a three-stage process for assisting countries to assess reproductive health needs and priorities, to test policies and programme adaptations to address these needs and to scale up successful interventions (World Health Organization, 2015). As part of this global strategy the aim was to prevent 33 million unwanted pregnancies between 2011 and 2015 and to save the lives of women who were at risk of dying of complications during pregnancy and childbirth, including unsafe

abortions (World Health Organization, 2015). To strengthen this global collaboration, the specific issue of prevention of unsafe abortions was applied in the strategic approach by countries such as Moldova, Mongolia, Romania and Viet Nam (World Health Organization, 2015).

Despite these strategies and specifically the Millennium Development Goal (MDG) five implemented by the WHO to improve maternal health, the incidence of unintended pregnancies still exists. The outcome of this strategy was portrayed by the global rate of unintended pregnancies that was estimated in 2012 at 53 per 1000 women aged 15-44 years. The highest regional rate was in Africa where 80 per 1000 pregnancies were unintended. In both Europe and Oceania the lowest unintended pregnancy rate was estimated at 43 per 1000 (Sedgh, Singh & Hussain, 2015: 306). As part of goal three (3) of the UN, the United Nations Development Programme (UNDP) aimed at achieving good health and well-being by 2030 and in order to reach these goals the MDGs were replaced by the Sustainable Development Goals (SDG). The focus has specifically been to ensure access to reproductive and sexual healthcare services (United Nations, 2016).

2.3.2.2 Africa

The revised abortion law in Ghana, enacted in 1985, is fairly broad, allowing for abortions in cases of rape, where continuation of the pregnancy would risk the life of the women or threaten her physical or mental health or if there is a substantial risk that the child would suffer from a serious physical abnormality or disease (African Union, 2013). In contrast with Ghana, the abortion laws in Ethiopia have not been available throughout the modern history of this country and the penal code allowed abortions only to save the life or preserve the health of the women (African Union, 2013). In addition to this, the abortions laws in Zambia are the most liberal in Africa. According to the African Union (2013:20) Zambia's abortion law of 1972 was modelled on the law of the United Kingdom (1967) and permits termination of pregnancy on health and socio-economic grounds.

The table to follow provides a summary of the laws and conditions under which TOP were permitted in different countries in Africa.

Table 1.1 Comparison of abortion legislation in Africa in 2016

Countries in Africa can be classified into six categories, according to the reason for which abortion is legally permitted		
Reason		**Country**
1	Prohibited altogether, or no explicit legal exception to save the life of a women	Angola, Central African Republic, Congo (Brazzaville), Democratic Republic of the Congo, Egypt, Gabon, Guinea-Bissau, Madagascar, Mauritania, São Tomé and Principe, Senegal

	Comparison of abortions legislation in Africa in 2016 (continued)	
	Reason	**Country**
2	To save the life of a woman	Côte d'Ivoire, Libya (e), Malawi, Mali (a, b), Nigeria, Somalia, South Sudan, Sudan (a), Tanzania, Uganda
3	To preserve physical health (and to save the woman's life)*	Benin (a, b, c), Burkina Faso (a, b, c), Burundi, Cameroon (a), Chad (c), Comoros, Djibouti, Equatorial Guinea (e, f), Eritrea (a, b), Ethiopia (a-d), Guinea (a-c), Kenya, Lesotho (a-c), Morocco (f), Niger (c), Rwanda (a, b, d), Togo (a-c), Zimbabwe (a, b, c)
4	To preserve mental health (and all of the above reasons)	Algeria, Botswana (a-c), The Gambia, Ghana (a-d), Liberia (a-c), Mauritius (a-c, e), Namibia (a-c), Seychelles (a-d), Sierra Leone, Swaziland (a-c)
5	Socio-economic reasons (and all of the above reasons)	Zambia (c)
6	Without restriction as to reason	Cape Verde, Mozambique, South Africa, Tunisia

Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health.

***Notes**: Some countries also allow abortion in cases of (a) rape, (b) incest, (c) fetal impairment or (d) other grounds. Some restrict abortion by requiring (e) parental or (f) spousal authorisation.*

Countries that allow abortion on socio-economic grounds or without restriction as to reason have gestational age limits (generally the first trimester); abortions may be permissible after the specified gestational age, but only on prescribed grounds.

Table adapted from the Guttmacher Institute, 2016 as in Centre for Reproductive Rights, 2016

2.3.2.3 The Constitution of the Republic of South Africa

The Constitution of the Republic of South Africa does not explicitly mention abortion, but two sections of the Bill of Rights mention reproductive rights. The Bill of Rights in Section 12(2)(a) of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), states that "Everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction". On the other hand Section 27(1)(a) states that "Everyone has the right to have access to healthcare services, including reproductive health care".

Deriving from this Bill of Rights of the Republic of South Africa the Choice on Termination of Pregnancy Act had its origin in 1996. In general, this Act provides the legal framework for healthcare providers and healthcare users. Section 2(1)(a) states that a pregnancy may be terminated upon request of a woman during the first 12 weeks of her pregnancy. In section 2(b) it is mentioned that a pregnancy may be terminated from the 12th week of gestational period up to the 20th week of gestational period if a medical practitioner (after a thorough consultation with the client) is of the opinion that (i) the continued pregnancy would pose a

risk or injury to the physical or mental health of the woman, (ii) there is a substantial risk that the foetus would suffer from a severe physical or mental abnormality, (iii) the pregnancy resulted from rape or incest and (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman (Republic of South Africa, 1996).

Section 2(c) of the Choice on Termination of Pregnancy Act (1996) makes provision for the termination of pregnancy after the 20th week of the gestational period if a medical practitioner, after consultation with another medical practitioner or registered midwife, is of the opinion that the continued pregnancy (i) would endanger the woman's life, (ii) would result in a severe malformation of the foetus or (iii) would pose a risk of injury to the foetus (Republic of South Africa, 1996).

The World Health Organization (2014:155) defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both. The Choice on Termination of pregnancy Act (1996) states in Section (2) that "the termination of a pregnancy may only be carried out by medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course".

According to Statistics South Africa (2015:80) the 1996 Choice on Termination of Pregnancy Act made medical and surgical TOPs free for all women of any age at public healthcare facilities. This has seen an increase in the uptake of legal TOPs. The year 2012 saw roughly twice the number of abortions (82 920) than there had been in 2005 (45 409) (Massyn, Day, Barron, Haynes, English & Padarath, 2013). Healthcare providers should be informed regarding the laws on abortion in their country or state of practice before they offer abortion counselling or nursing care to a woman choosing an abortion (Lowdermilk, Perry, Cashion & Alden, 2012:189).

In summary, the WHO aimed to strengthen sexual and reproductive health programmes and policies. The UN established the MDG to reduce recourse to TOP and to improve the quality of existing TOP services by the year 2015. This goal was replaced by the SDG to ensure access to reproductive and sexual healthcare services. In Africa, TOPs were permitted due to various reasons, including to save the woman's life, to preserve physical and mental health, due to socio-economic reasons and without any restrictions as to reason. South African legislation was the most liberal, and allowed TOP under numerous circumstances.

2.3.3 PERCEPTIONS OF HEALTHCARE PROVIDERS AND WOMEN REGARDING TERMINATION OF PREGNANCY

The healthcare providers' perceptions regarding TOPs, as well as perceptions of women with unintended pregnancies regarding TOPs, were reviewed.

2.3.3.1 Termination of pregnancies: Healthcare providers' perceptions

A qualitative study was conducted in Australia and New Zealand which explored the abortion laws relevant to that country and the efficacy with which healthcare providers applied their knowledge in the practical setting. The findings of this study concluded that medical practitioners were well aware of the applicable abortion laws (de Costa, Douglas & Black, 2013:184-189). The participants in this study were medical practitioners and did not include other healthcare providers of the multi-disciplinary team.

In Nepal, qualitative structured interviews were conducted amongst medical practitioners and nurses to explore their perception of the provision of abortion services (Möller, Őfverstedt & Siwe, 2012:135-140). The authors identified the following categories resulting from the analysis of the interviews: beneficial legal framework, a will to reach out to all, frustration about misuse and the dilemma of sex-selective TOPs. The general findings of the study concluded that legislation provided limited influence in the availability of TOP services. The healthcare providers felt the need to make a difference in assisting in TOP services as far as possible and sex-selective TOPs seemed to be the ethical dilemma that hampered the provision of TOP services (Möller et al., 2012: 135-140). The participants in this study were widely represented by different levels of experience and by gender and qualification frameworks. Interviews were conducted in English and only included respondents from the private sector.

The law of Burkina Faso prohibits abortion, except when the mother's life or health is endangered, in cases of severe fetal malformation or when the pregnancy results from rape or incest (Storeng & Ouattara, 2014:946-959). The authors of this study also explored the perceptions of healthcare workers on the provision of safe TOP services that might be contrary to their religious values and beliefs. Related to the aim to decrease women's complications due to inadequate professional TOP services, the need may persist to provide access and availability of the necessary services. Generally it seems that healthcare providers and policy writers were able to admit that there might be a gap in the provision of professional TOP services that might enhance maternal health in this country, because due to religious constraints and controversy regarding provision of abortion services, these role players appeared to be reluctant to announce their involvement in such changes (Storeng & Ouattara, 2014:946-959).

In South Africa, qualitative in-depth interviews were conducted amongst healthcare providers who were working in facilities that provide abortions services. These facilities included the public, private and non-governmental (NGO) sectors (Harries, Stinson & Orner, 2009). The results of this study concluded that providers of abortion services were knowledgeable and informed regarding the Choice on Termination of Pregnancy legislation and the healthcare workers that opposed abortions were unclear regarding the conditions under which a termination of pregnancy may be performed (Stinson & Orner, 2009). In addition to legislation, the barriers to service provision were also explored in this study. In relation to conscientious objection, both providers and non-providers seemed to lack insight in this phenomenon. According to Harries, Stinson and Orner (2009) influencing factors such as personal reasons often involved natural career trajectory or involvement was linked to previous encounters with unsafe TOPs. Other influencing factors such as moral reasons and religious beliefs were also examined by the authors. In general, some healthcare providers critically opposed abortion due to religious belief and some justified their actions based on what they perceived as morally acceptable (Harries et al., 2009).

2.3.3.2 Perception of women with unintended pregnancies

In Haiti a qualitative descriptive study was conducted to examine the experience of women in relation to the provision of abortion services (Albuja, Cianelli, Anglade, Owusu, Joseph, Sailsman & Ferrer, 2017:170-176). To ensure validity of the study the interviews were conducted in the participant's native tongue. The findings of the study concluded that cultural beliefs contributed to women not omitting to TOPs. Social and economic status appeared to be the major factor that allowed special circumstances where TOPs were justified. TOPs were mainly performed under unsafe conditions and knowledge that TOP in Haiti was viewed as illegal and appeared to be culturally unacceptable hindered safe TOP practices (Albuja et al., 2017:170-176).

In a study conducted in the public healthcare sector of Kenya, perceptions of women regarding TOPs were explored. The findings of the study concluded that women were stigmatised as murderers and sexual workers in the eyes of the general public. There was uncertainty regarding legality of TOP services which led to women secretly seeking alternative TOP methods. Women perceived abortions to be safer at a higher gestational age and women were not aware of any safe TOP methods (Marlow, Wamugi, Yegon, Fetters, Wanaswa & Msipa-Ndebele, 2014:149-158).

In conclusion the review revealed that healthcare providers were aware of TOP legislation and that TOP legislation did not influence service delivery of TOP. It was rather factors such as requests for sex selective TOPs, religious controversy and career trajectory that influenced these services. On the other hand, women with unintended pregnancies

expressed the notion that cultural beliefs and stigma that surrounded TOP were the main factors that led to these women underutilising safe TOP services.

2.3.4 AVAILABILITY OF TOP SERVICES

To enable women with unintended pregnancies to access TOP services, these services need to be available and easily accessible to all. The following section contains the literature review that relates to provision of TOP services in the Western Cape public healthcare systems.

According to Section 15(1) of The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996) “everyone has the right to freedom of conscience, religion, thought, belief and opinion”. The client’s rights to information and access to health care services, including termination of pregnancy, must however also be respected (Republic of South Africa, 2000). In reference to the Choice on Termination of Pregnancy Act (Act No. 92 of 1996) the Department of Health (Administration of the Western Cape) issued a policy on the management of termination of pregnancy services in the Western Cape. The aim of this policy was to provide equitable, accessible, cost-efficient and user-friendly services for women with unwanted pregnancies as part of the Reproductive Health Programme, integrated into the comprehensive health services (Republic of South Africa, 2000). In addition to the above-mentioned policy, the Western Cape Department of Health also issued an information brochure to the public regarding the availability of abortion services. Public hospitals, designated private medical practitioners and gynaecologists, non-profit providers such as the Marie Stopes centres in the Western Cape, offer safe and legal termination (Western Cape Department of Health, 2015).

The Constitution of the Republic of South Africa as well as the Department of Health was clear in their aim to provide accessible and free TOP services to all. Alternatives to public healthcare TOP services were provided in the form of non-profit organisations, private medical practitioners and gynaecologists who also rendered these services.

2.3.5 UNDERUTILISATION OF TOP SERVICES

The TOP debate was been dissected from various viewpoints in the past decade. There are legitimate and strongly expressed arguments both for and against TOPs. These viewpoints ranged from the extreme position of TOPs being viewed as equal to murder, to the liberal view that women are autonomous and have the right to exercise control over their bodies and their reproductive ability (Moodley (ed), 2015:253).

According to Azmat, Bilgrami, Shaikh, Mustafa and Hameed (2012:155-163) the knowledge regarding unsafe TOPs and the legal implications thereof in the light of the legal

representatives of Pakistan, were explored. The result of this study was conclusive that the general perception of the legal community of Pakistan was that TOPs were illegal. There was no clear knowledge of unsafe abortion practices as there were no records of unsafe abortions and therefore it was difficult to estimate. The participants made a general estimation which ranged from 100 to 1 000 TOPs per annum (Azmat et al., 2012:157). The hierarchy of the legal community was well represented, as the interviews in the study were conducted with participants ranging from law students to a judge. It was evident from this study that the general perception regarding a TOP was that it was a criminal offence and may lead to punishment under the recommendations of the country's court of law.

In Bangladesh, Romania and South Africa the relevant legislation in the light of policy reform and the influences thereof on the incidence of unsafe abortions were explored (Benson, Andersen & Samandari, 2011:1-12). From this study it appeared that even with adequate legislation on TOP and the accessibility and availability of TOP services, the incidence of unsafe TOP practices still continued. The study was conducted in the public sector of developing and underdeveloped countries.

In South Africa a study was conducted by registered nurses. The modernisation of legislation that safeguarded women in seeking TOP services was explored. In this study, Trueman and Magwentshu (2013:397-399) explored the increase in the practice of unsafe TOPs due to women resorting to services advertised in the form of posters on lampposts. The authors appeared to be concerned about the lack of interest of the Department of Health to eliminate this advertisement practice and thus safeguarding women from seeking non-professional assistance in TOP services. Another concern that was raised by the authors was the fact that in the fifth Saving Mothers Report, the term that was used was "miscarriage", and it seemed an impossible task to assess the numbers of TOP-related deaths (Trueman & Magwentshu, 2013:398). In addition to access information regarding TOP services on lampposts it is also evident that that information to healthcare services was obtained by the use of the internet. According to Baker, Wagner, Singer and Bundorf (2003:2405) the internet influences the provision of healthcare through numerous ways. It may either benefit by enhancing knowledge and information. Or in contrast, it may provide information that would have a negative effect on the welbeing on the indiviual that utilised these methods of information access.

In conclusion, a wide representation in the law community of Pakistan revealed that TOPs were viewed as a criminal offense and could be punished in the country's court of law. Despite the legislation to permit TOP in South Africa, unsafe TOPs were still occurring. Some were of the opinion that the Department of Health was turning a blind eye to the

existence of unsafe TOPs and due to inadequate statistics the mortality of unsafe TOPs was difficult to assess.

2.3.6 TERMINATION OF PREGNANCY METHODS

TOP methods were reviewed on the basis of two very opposing techniques which included safe TOP methods versus unsafe TOP methods.

2.3.6.1 Safe TOPs and the regulated use of Misoprostol

The WHO compiled a clinical practice handbook with the sole purpose to facilitate practical application of the clinical recommendations for safe TOP practices in healthcare settings. This handbook differentiates between medical and surgical TOPs and the treatment protocols differ according to the gestational age of the pregnancies. It does not serve as a training manual, but it aided healthcare providers in their proficiency in the providing holistic TOP services (World Health Organization, 2014:4). Misoprostol is a synthetic prostaglandin that is used to inhibit gastric acid secretion, but produces uterine contractions in pregnancy, and may cause uterine bleeding and miscarriage (Watkins, 2018:376). Misoprostol is the generic name, but this drug is also branded as Cytotec. Misoprostol can, in combination with the drug Mifepristone, be utilised to terminate pregnancies (WebMD, 2019). Following a recent enquiry from a pharmacy's stock chain manager in a community healthcare (CHC) setting in the Western Cape, it appeared that the cost of Misoprostol 200 micrograms (µg) tablets to the public healthcare system was five (5) rand and eight (8) cents per unit. The cost of Mifepristone 200 milligram (mg) was twenty (20) rand and sixty-nine (69) cents per unit (Turner, 2019).

In medical TOPs at a gestational age of more than twelve weeks the administration of Misoprostol and Mifepristone should occur in a healthcare facility until the expulsion of the pregnancy is complete. Healthcare providers should be aware that a woman's uterus is more sensitive to the effects of the above drugs as the gestational age of the pregnancy increases. At a gestational age of more than twenty weeks, some TOP services providers would consider to demise the foetus prior to the procedure (World Health Organization, 2014:34). There were two methods of drug administration in the execution of a medical TOP, which included either simultaneous administration of Misoprostol and Mifepristone or just the administration of Misoprostol alone. The first method of administration indicated the oral intake of a single dose of Mifepristone 200 mg in conjunction with a choice of two methods of Misoprostol administration. Misoprostol 800 µg should be taken vaginally and then followed with a 400 µg dosage taken vaginally or sublingually. The other means of administration included an oral intake of 400 µg of Misoprostol, followed by the vaginal or sublingual intake of 400 µg of Misoprostol, which should occur every three (3) hours up to a maximum of five

(5) dosages. Misoprostol should only be taken thirty-six to forty-eight hours after the intake of Mifepristone. If Misoprostol alone is administered, a dosage of 400 ųg, taken vaginally or sublingually every three (3) hours up to a maximum of five (5) dosages was indicated (World Health Organization, 2014:34).

From the above it was evident that the WHO aimed to improve reproductive and sexual health by the means of providing practical guidelines in the management of safe TOP services amongst healthcare providers in healthcare settings.

2.3.6.2 Unsafe TOP

Globally, approximately twenty-five million TOPs occurred on an annual basis and in the majority of these pregnancies, these were performed in developing countries. Among these eight (8) million were carried out in the least safe or dangerous conditions (Ganatra, Gerdts, Rossier, Johnson Jr., Tuncalp, Assifi, Sedgh, Singh, Bankole, Popinchalk, Bearak, Kang & Alkema, 2017). As stipulated by the WHO's standards required for safe TOP, they were classified into less safe and dangerous/least safe. Less safe TOPs were identified when outdated methods such as sharp curettage were utilised to perform the procedure, regarding whether the procedure was performed by a trained healthcare provider. Dangerous or least safe TOPs involved the ingestion of caustic sodas or traditional concoctions or the insertion of foreign bodies (Ganatra, et al., 2017).

According to the World Health Organization (2019) teenagers with unintended pregnancies were more likely to adhere to unsafe TOP practices. Barriers identified in accessing safe TOP services involved countries with restrictive TOP legislation, inadequate availability of services, high demanding cost of these services, stigma and conscience-objection of healthcare providers. Other barriers identified by the WHO involved numerous aspects such as mandatory waiting periods and counselling, misleading information, third-party outhirisation and unnecessary medical tests that delayed further care (World Health Organization, 2019).

Traditional medicine known amongst Xhosa women in South Africa is called *Umchamo wemfene* and converts to 'baboon urine' in the English language. It is in fact not baboon urine as the word implies, but consists of silicified Cape hyrax dassie and faeces scientifically known as hyraceum. This traditional remedy was utilised to ease menstrual discomfort; it acted as a diuretic; induced and eased labour (Dold & Cocks, 2012:29). A study was conducted in the Eastern Cape of South Africa that explored factors associated with mothers giving birth outside healthcare facilities. In this study one participant admitted adding traditional medicine in the form of *Umchamo wemfene* to induce labour (Alabi, O'Mahony, Wright & Ntsaba, 2015). According to Shah and Zao (2009:1471) induced

termination of pregnancy was suggested as a precursor for the birth outcome of a low-birthweight neonate, preterm or small-for-gestational-age neonate.

It was evident from the above literature that unsafe TOPs still occurred on an annual global scale. Recommended guidelines were established by the WHO to promote safe TOP practices and the availibitity of these services. Despite all of this, women with unintended pregnancies still resorted to unsafe TOP methods in the form of traditional medicines.

2.3.7 HEALTH CARE PROVIDERS' CODE OF CONDUCT

As previously portrayed in the literature review under the heading of availability of TOP services, everyone has rights according to the Constitution of South Africa. These rights included freedom of conscience, religion, thought, belief and opinions (Republic of South Africa, 1996). In order the value community rights when rendering care, the healthcare provider should adhere to the suggestions made by the Constitution. In addition to the Constitution of South Africa, the South African Nursing Council (SANC) established a code of ethics for nursing practitioners in South Africa in 2013 in terms of the provisions of the Nursing Act of 2005. Individuals in need of healthcare, treatment, advice, information or other health-related services should receive care from the nursing practitioners that uphold the ethical values of the profession. In addition to the above the SANC acknowledged that nursing practitioners were faced with a non-exhaustive list of examples of ethical dilemmas. One such example is TOPs and it may be advisable that in dealing with such instances, the aid of an ethical committee should be consulted in order to consider diverse values, views and perceptions (Republic of South Arica, 2013).

2.4 SUMMARY

In Chapter Two a review of literature regarding the experience of women with unwanted pregnancies that might have led to the tendency of unsafe abortions was presented. Legislation deriving from the Constitution of the Republic of South Africa regarding the Choice on Termination of Pregnancy Act No. 92 of 1996 as well as policies and guidelines of the Department of Health and their administrative counterparts were explored. In addition, unintended pregnancies, the perceptions of women and healthcare providers relating to abortion and trends in unsafe termination of pregnancy methods were explored.

2.5 CONCLUSION

It was evident from this review that the legislation regarding a woman's choice regarding the termination of pregnancy in the Republic of South Africa is amongst some of the most liberal on the continent. This country's legislation takes into consideration various factors such as the freedom of choice as a human right, social and economic circumstances as well as

health considerations which pose a risk to the woman in the continuation of the pregnancy. Although healthcare providers' perspectives in relation to termination of pregnancy services may vary, these services are predominantly available in the Western Cape in public, private as well as non-governmental organisations. As seen in this chapter, women with unintended pregnancies endure many challenges and thus the phenomenon of unsafe termination of pregnancies still exists.

The next chapter provides a description of the research methodology used to explore perceptions that lead to the underutilisation of TOP services amongst women with unintended pregnancies. The perception of healthcare providers who attended to the care of women with unintended pregnancies will also be explored.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The goal of the researcher was to explore the meaning of an identified phenomonon and the ultimate aim was to decribe and provide in-depth insight in human perceptions in this regard (Brink, Van der Walt & Van Rensburg, 2012:120). In this qualitative study the researcher explored the significance of people's lives as it occured in the real world. The views and perspectives of participants were well represented; contextual conditions as they occurred in real life were explicitly attended to; this research process also obtained insights from existing or new concepts to explain social behaviour and thinking and, lastly, multiple sources were acknowleged for evidence occurrence (Yin, 2015:9). Based on the above-mentioned features the researcher utilised a qualitative methodology for the proposed study, as this research described the life experience from the perspective of the individuals involved (Grove, Burns & Gray, 2013:57).

In Chapter one (1), the foundations of the phenomenon being studied were outlined in the form of a theoretical framework which provided the basis for the research at hand. The ethical principles that were applied throughout the research process were clearly discussed in the above-mentioned chapter. In Chapter two (2) the researcher examined literature regarding the incidence of unplanned pregnancies, TOP legislation, perceptions of healthcare providers as well as of women with unintended pregnancies as related to TOPs, and the underutilisation of TOP services. This chapter provides an in-depth discussion of the research methodology that was utilised to examine the real-life perceptions of women with unintended pregnancies who had underutilised TOP services, as well as the perceptions of healthcare providers who had attended to the care of women who had underutilised TOP services.

3.2 AIM AND OBJECTIVES

The aim of this study was to explore factors that influenced the underutilisation of TOP services for women with unintended pregnancies within the CHCs in order to reduce morbidity and mortality associated with unsafe abortions in the Western Cape, South Africa.

The objectives of this study were to:

RO 1: Describe the perspectives of women with unintended pregnancies regarding the TOP services offered in two CHCs of the Cape Metropole within the Western Cape, South Africa.

RO 2: Determine the barriers to the utilisation of TOP services by women with unintended pregnancies in two CHCs of the Cape Metropole within the Western Cape, South Africa.

RO 3: Identify strategies in line with SDGs that could be put in to place to improve the utilisation of safe TOP services by women with unintended pregnancies provided in two CHCs of the Cape Metropole within the Western Cape, South Africa.

RO 4: To describe the perceptions of healthcare professionals who had dealt with women with unintended pregnancies who had underutilised TOP services in the two CHCs of the Cape Metropole within the Western Cape, South Africa.

3.3 STUDY SETTING

There are nine provinces in the Republic of South Africa, namely: Western Cape, Eastern Cape, Northern Cape, Free State, KwaZulu-Natal, North West, Gauteng, Mpumalanga and Limpopo (Republic of South Africa, 2014a). The map below was adapted from Ngaka and Zwane (2018).

Figure 3.1 Map of the provinces of South Africa

The Western Cape Department of Health divided the province into the following health regions: Cape Town Metropole, Boland, Overberg, South Cape, Karoo and West Coast Winelands. The Cape Town Metropole was further divided into the following sub-districts: Northern, Central, Southern, Klipfontein, Mitchells Plain, Tygerberg, Khayelitsha and Helderberg (Republic of South Africa, 2014a). The eight health sub-districts are displayed on

the following map as adapted from Mumm, Diaz-Monsalve, Hänselmann and Kroeger (2017).

Figure 3.2 Map of the eight sub-districts of the Cape Metropole, South Africa

In the Western Cape Province there were 48 CHCs (Republic of South Africa, 2014a). A CHC was defined as a 24-hour comprehensive unit run by midwives. Occasionally these units stood alone as a maternity service and in such instance might be referred to as a midwife obstetric unit (MOU). These maternity services ran alongside other services such as emergency care, minor ailments, chronic diseases and health promotion services (Republic of South Africa, 2015c:20).

The list of designated facilities for termination of pregnancy in the Western Cape only indicated one CHC in the Kayelitsha sub-district and one CHC in the Mitchells Plain sub-district (Republic of South Africa, 2010). For this reason the proposed study was conducted in the Cape Metropole district within CHCs and the researcher purposively selected two CHCs: one in the Khayelitsha and another in the Mitchells Plain sub-district as the research setting. These two CHCs were indicated as CHC One and CHC Two.

CHC One is the only 24-hour facility in the Khayelitsha sub-district which serves the community of the Site B drainage area. The overflow of clients after the two surrounding eight-hour facilities in the community have completed their services for the day is managed by this facility. The Khayelitsha population is estimated at over 500 000 and the individuals that seek healthcare at this facility average 21 000 to 27 000 per calendar month (Western Cape Department of Health, 2009).

CHC Two was located near a bus terminus and in the centre of town to make it accessible to the community at large. This facility serves an estimated population of 1.2 million people. Healthcare is provided to this community by 170 staff members and on average 46 000 individuals seek assistance from their healthcare facility on a monthly basis. The individuals in this community are often burdened with difficult circumstances; there is a shortfall in education and accessibility to basic services. The community consists of 24.20% unemployed members and for those who receive an income, 17.87% of households fall below the poverty line. To portray the difficult living circumstances: 4.83% of this population have no access to electricity; 4.58% have no piped water in their dwelling or on the property and 6.42% are living in an informal dwelling. A total of 15.93% of this population have not completed grade seven (7) and 80.48% are not members of any medical aid and rely on the public service for their healthcare needs (Western Cape Department of Health, 2018).

3.4 RESEARCH DESIGN

To examine a phenomenon in the real-life environment, a case study design is best suited to answering the research question, as it examines various units of analysis (Burns & Grove, 2011:262). Yin (2014:91) describes four types of designs for case studies, namely: single-case holistic, single-case embedded, multiple-case holistic and multiple-case embedded designs. A single-case study is akin to a solitary enquiry and allows the same justification towards a solitary enquiry as that towards a single-case study (Yin, 2014:89). Descriptive case studies offered rich and revealing insights into the social world of a particular case (Yin, 2012:49).

The rationale for selecting a single-case study design was fourfold. Firstly, the testing of a significant theory can be represented by this type of design and, secondly, it forms the

platform in cases of an unusual nature that do not occur regularly. The third rationale for choosing a single-case study derived from the intention to provide meanings to social processes in relation to a proposed theory. Lastly, the single-case study allows valuable revelation regarding a specific phenomenon that was previously difficult to observe for the purpose of discerning social perception (Yin, 2014:89-91).

This study utilised a single-descriptive case study with two units of analysis. The subject of the case study was identified as the Community Health Centres within the Cape Metropole. The first unit of analysis included the perceptions of women with unintended pregnancies and the second unit of analysis included the perceptions of healthcare professionals regarding the prevalence of underutilisation amongst women with unintended pregnancies. The phenomenon of interest was the underutilisation of TOP services by women with unintended pregnancies, as well as the perceptions of the healthcare professionals who attended to the post-termination pregnancy care of women with unintended pregnancies.

3.5 POPULATION AND SAMPLING

The population was defined as the totality of persons, events, organisation units, case records or other sampling units with which the research problem was concerned (De Vos et. al.,2012:223). The researcher sought information on reported cases of unsafe abortion practices (in two CHCs) of women seeking post-abortion care. The researcher made contact via telephone with the Director of Women's Health in the Western Cape Department of Health (Director of Women's Health, 2017). No documentation or statistics were available regarding the incidence of unsafe abortion practices in the relevant CHCs. The previous facts implied that no actual data existed regarding the population of unsafe abortions in the relevant CHCs.

In the Saving Babies report of 2012-2013 the primary obstetric cause of perinatal deaths was categorised under ante-partum haemorrhage, fetal abnormalities, infections, intra-partum asphyxia, unexplained stillbirth, intrauterine growth restriction, no obstetric cause, spontaneous preterm labour and trauma (Republic of South Africa, 2014b). No actual recording of unsafe TOPs was documented in this category. In addition, client and family-associated factors were noted as an avoidable factor in the incidence of stillbirths and early neonatal deaths (Republic of South Africa, 2014b). In this report it was not clear whether unsafe TOP practices were amongst the patient and family-associated avoidable factors. Taking into account the above, the population was determined as all women who did not utilise TOP services and where this underutilisation resulted in making use of unsafe TOP practices.

Sampling referred to the researcher's process of selecting the sample from a population, which allowed her to obtain information regarding a phenomenon in a way that represented the population of interest at large (Brink, van der Walt & van Rensburg, 2012:132). Purposive sampling referred to the conscious selection of participants with a focus on the purpose of the study (Grove et al., 2013:356). The researcher purposively selected women who were admitted in the two relevant CHCs for post-abortion care following unsafe abortion practices as well as healthcare professionals who had dealt with the post-abortion care of women with unintended pregnancies.

The researcher conducted five individual interviews with purposively sampled women who were admitted to two CHCs within the Cape Metropole seeking assistance for post-abortion care after unsafe abortion practices. Two participants were recruited from CHC One and three from CHC Two. Five more individual interviews were conducted with healthcare professionals who cared for the women who had undergone unsafe TOP. CHC One delivered three participants and the other two were recruited from CHC Two. In addition to this, the researcher conducted a document analysis of documents pertaining to information regarding available TOP services in the facility, referral protocols to another facility, standard operation procedures and all the applicable documents relating to the study subject. The researcher purposively selected documents that brought insight and meaning to the research phenomenon.

Saturation of data occurred when additional sampling did not provide any new information; it rather reconfirmed information from previous sampling (Burns & Grove, 2011:317). The quality of the data was at a superior level and rich in content, which allowed the researcher to achieve optimal saturation of information with few participants (Burns & Grove, 2011:319). The sample size of the study comprised ten participants from two CHCs within the Cape Metropole and this was established at the level of data saturation. Saturation of data occurred when additional sampling did not provide new information; it only reconfirmed information from previous sampling (Burns & Grove, 2011:317). The sample was also determined at the point where the researcher had achieved understanding and insight regarding why women with unintended pregnancies had underutilised safe abortion services. Data saturation was met after the forth participant were interviewed in both of the units of analysis. In the forth interviews the data were reconfirming previous data and insight was obtained on the phenomenon examined.

3.5.1 Inclusion criteria

- All women who were identified by the healthcare professionals attending to their care, who did not utilise TOP services and presented at the CHC for post-abortion care.
- All healthcare professionals who attended to the care of women who did not utilise safe TOP services and then presented at the CHC seeking post-abortion care.

3.5.2 Exclusion criteria

There were no specific exclusion criteria

3.6 DATA COLLECTION TOOLS

The data collection strategy included in-depth interviews. The interviews were utilised as a method of data collection in which an interviewer obtained responses from a participant in a face-to-face encounter (Brink et al., 2012:157). Interviews focused on actions and were considered as verbal reports, as interviewee's responses were subjected to common problems of bias, poor recall or inaccurate articulation, therefore a reasonable approach was to confirm interview data with information from other sources (Yin, 2014:162-163).

The researcher conducted individual interviews and utilised a semi-structured interview guide. The researcher asked specific questions derived from the research objectives, followed by additional probes. Revert to appendix one for questions and probing words.

The researcher used multiple data collection methods and obtained data through in-depth interviews, field notes and document analysis. According to Yin (2014:170) the use of multiple sources in case study data collection created an advantage in this method and improved the quality of the study.

3.6.1 In-depth interviews

Interviews were interactions between the participant and the qualitative researcher, which produced data as words (Grove et al., 2013:271). In-depth interviews were flexible and free-flowing interactions where the interviewer allowed the interviewee a good deal of freedom, while considering the topic at hand and with discrete direction by the interviewer to obtain rich and insightful information in the allocated time (Morris, 2015:7).

In order to obtain in-depth and meaningful data, the researcher conducted interviews in person with the participant. The collection of data occurred through individual in-depth interviews, by using a semi-structured interview guides. The researcher introduced herself and thanked the participants for willingness to share their views. The interviews took place in a setting that was free of external disturbances. A note was placed on the door to notify the

staff that an interview was in progress. Good rapport with the participant was ensured, as the researcher allowed the participants to open up to this sensitive topic. Initiation of the in-depth interviews was conducted by open-ended questions derived from the research objectives and were followed by probing questions. The researcher is fluent in Afrikaans and in English, which allowed the interview to be conducted in any of these two languages. All the participants were comfortable to be interviewed in English, which implicated that there was no need for an interpreter. The participants were at any stage of the interview allowed to withdraw from, or to discontinue the interview. None of the participant's portrayed emotional distress, or had the need for debriefing counselling.

According to Yin (2014:160) prolonged case study interviews may take place over a period of two or more hours, where the researcher allows the participants to express their opinions freely and verbalise their interpretations regarding others. Shorter case study interviews are more focused and take about one hour in time duration. Although the interviews remain open-ended and assume a conversational manner, the researcher was then likely to adhere to the study protocol. The interviews lasted on average between thirty to sixty minutes, which implied that the researcher made use of shorter case study interviews. The researcher provided refreshments to the participants during and after the interviews. The researcher ensured that participants were aware of the confidentiality of the matter and that the participants were aware that all information was to be used for research purposes only. Grand tour questions were used to focus the attention on the specific objectives of the session. Grand tour questions establish a broad topic or sense but do not bias the conversation by presenting with a specific item of interest (Yin, 2015:145). To close the interview, the researcher thanked the participants for their willingness to participate.

3.6.2 Field notes

According to Yin (2014:181) the only characteristics of field notes are that they should be organised, categorised, completed and available for later access. The researcher obtained field notes from the interview by the means of documenting non-verbal behaviours from the participants. These notes were initially handwritten, after which they were typed and electronically stored on a password-protected computer. The researcher organised these notes according to major topics derived from the interview. Aside from this, the researcher made field notes regarding the organisation of the CHCs in terms of how TOP was in effect promoted at the two study settings.

3.6.3 Document analysis

According to Ritchie and Lewis (2004) in De Vos, Strydom, Fouché and Delport (2012:377) the analysis of documents involves the study of documents that already existed, either to

obtain insight in their content or to illuminate deeper meanings which may be revealed by their style and coverage. The strengths of document analysis include stability, as they were reviewed repeatedly; they were not created as a result of the case study, but obtained specific details of an event and were broad in terms of time span, setting and events. On the other hand, the weaknesses of documents included difficulty of access and retrieval; biased selectivity if collection was incomplete and reported bias of the author of any document (Yin, 2014:155).

The facility managers of both the institutions selected for the study were approached to gain access to the relevant documents. The researcher aimed to review documents such as protocols regarding TOP services and referral thereof, and availability of service methods in which unwanted pregnancies were identified. No documents as mentioned in the above regard were found by the researcher at neither of the data collection settings. Participant notes were analysed after the in-depth interviews had been conducted, in order to eliminate bias. The researcher displayed the documents analysed in collaboration with the interview analysis.

3.7 PILOT INTERVIEW

The pilot interview allowed the researcher to identify problems that occurred in the design of questions, in the sequencing of questions or in the procedure for recording responses (Grove et al., 2013:424). The researcher conducted one interview in the presence of the supervisor to make it possible to assess the researcher's interview skills and to evaluate the trustworthiness of the data collection tool. No alterations to the interview process were necessary and the pilot interview was included in the analysis of data. This ensured that the voice of the pilot participant was heard. According to Flick (2014:307) any interview, whether poorly conducted or involving a reluctant participant, would provide data about something.

3.8 TRUSTWORTHINESS

According to Lincoln and Guba in De Vos et al. (2012:419) credibility, transferability, dependability and conformability reflect the assumptions of the qualitative paradigm more accurately.

3.8.1 Credibility

In view of credibility, the goal was to demonstrate that the research was conducted in such a manner that it allowed accurate identification and description of the study subject (De Vos et al., 2012:420). According to Brink et. al. (2012:172) confidence in the truth can be established through prolonged engagement, persistent observation, triangulation, peer debriefing, member checks, negative case analysis and referral adequacy. In this study,

after initial recruitment of the participant was done by the attending healthcare provider, the researcher personally engaged with the participants in the field in order to build a trustworthy relationship. The researcher committed to stay in the field until data saturation had been met. This improved the quality of the study through assurance of adequate content. Persistent observations were met by identification of various attributes that impacted the study and those influences were obtained by continuous analysis (Brink et al. 2012:172).

According to Watson et.al. (2008:270) source triangulation can be achieved by utilising multiple sources in the data collection process. Source triangulation was achieved by the use of individual in-depth interviews, field notes and document analysis as data collection methods. The researcher also consulted with her peers in order to gain greater insight relating to the methodology and the phenomenon that were being studied. These peers were not part of the study, which allowed them to add objective contributions towards the research study. In order to achieve member checking, a second contact session with the participant should be planned to give the participant the opportunity to identify any incorrect reflections (Brink et al., 2012:172). The absence of member checking will be discussed in Chapter five (5) under the heading: limitations of the study. Negative case analysis as suggested by Brink et al. (2012:172) was excluded as part of the technique to establish confidence in the truth. The last effort to confirm credibility of the study was the referral adequacy. This was achieved by the researcher's manual and accurate transcriptions of the interviews.

3.8.2 Transferability

In view of transferability the researcher posed the question whether the findings of the research could be transferred from one specific situation or case to another (De Vos, et al., 2012:420). According to Polit and Beck (2010:493) the responsibility of the researcher was to provide adequate and in-depth detail in the research report in order to allow readers to evaluate the applicability of the data in other contexts.

3.8.3 Dependability

Dependability refers to the scenario where the evidence provided by similar participants and in a similar context, resulted in similar findings (Brink, et al., 2012:172). The researcher ensured that the research process was logical, well documented and auditable through following the same interview guide and by verifying the transcripts with the supervisor.

3.8.4 Confirmability

Confirmability is concerned with establishing whether the data represents the information provided by the participants and that the interpretation of the data was not the preliminary perceptions and ideas of the researcher's mind (Brink et al., 2012:173). The researcher ensured confirmability by verification of all transcripts by the researcher and the supervisor.

According to Shenton (2004:72) a key criteria of confirmability is that the researcher admits personal predispositions. Bracketing refers to the process where the researcher eliminates any preconceived ideas regarding the phenomenon under study (Brink et al., 2012:122). The researcher assured accuracy of the research findings and conducted the research free of bias and preconceived ideas regarding the phenomenon. The researcher had previously declared her position regarding TOPs and she deliberately set her views and beliefs aside to obtain greater meaning and insight. Continuous discussion took place between the researcher and the supervisor regarding the study at hand. Through discussion, the viewpoint of the investigator was placed in a broader perspective as others contributed their perceptions in respect of the investigation (Shenton, 2004:67).

3.9 DATA COLLECTION PROCESS

Permission to conduct the study was obtained from the HREC of Stellenbosch University and the DOH. After permission was granted, the researcher approached the facility managers of the two CHCs as well as the operational managers of the relevant departments and explained the purpose of the study. This information that was provided, contributed towards the permission granted to utilise the relevant facilities and units for research purposes.

The researcher involved the healthcare providers of the Midwife Obstetric Units (MOUs) and Emergency Departments as voluntary recruiters of participants prior to the onset of the data collections. The participants had already established a good rapport with the healthcare providers who were involved in their treatment and care and willingness to participate in this sensitive phenomenon was discussed by the healthcare provider. After verbal willingness was established, the healthcare provider made contact with the researcher via telephone, and only then the researcher privately approached the participant in person. The researcher obtained written consent to conduct the interview and to audio-tape the process. The inclusion criterion for this study did not explicitly indicate an age interval for the participants. It is possible that the participants fell within the age group where parental consent was needed. In order to protect the participants, the researcher applied to the Institutional Review Board (IRB) for a waiver of consent. A location and time convenient to the participants were arranged to conduct the interviews. The researcher collected data over a period of fourteen calendar months.

The researcher is fully employed at another institution, thus the time to recruit participants was limited to days when the researcher did not have obligations towards the researcher's employer. In this study the researcher was the primary investigator and did not utilise the services of any other fieldworker. Strategies to recruit participants included presentation of the research study at both the research institutions, informing healthcare workers regarding their role in the recruitment process; visibility and familiarity of the researcher towards the healthcare workers at the research institutions were reinforced. In addition to this, notes that contained the inclusion criteria of the study, steps to take when participants were identified and methods to contact the researcher were posted on the walls of the research sites. Despite all of the above efforts, none of the participants were identified by the researcher. All the participants were recruited by the healthcare workers once they were consulted or admitted in the separate departments of the research sites.

3.10 DATA ANALYSIS

After data collection, the interviews were manually transcribed by the researcher. A general analytic strategy was utilised to analyse the data, which involved four general strategies as outlined by Yin (2014:190-196) and included:

- Relying on theoretical propositions
- Working the data from the ground upwards
- Developing a case description, and
- Examining plausible rival explanations.

In addition to the above general analytic strategy, the analytic technique of explanation building was utilised to analyse data. According to Yin (2014:203) explanation building occurs in a narrative form and the elements of explanation is to provide insight regarding a certain occurrence by means of determining connections with concepts about the reasons why and the means of how situations had occurred.

3.10.1 Relying on theoretical propositions

Yin (2014:190) stipulated that theoretical propositions formed the objectives and design of the study and, ultimately, due to these concepts, portrayed the research question and literature review of the study. The researcher conceptualised a framework in Chapter One (1), which is indicative of the above.

3.10.2 Working the date from the ground up

Without any predisposed thoughts, data were evaluated by the means of reading through the transcripts, which led to the discovery of some additional concepts which had not been previously conceptualised (Yin, 2014:190). This strategy involved organising the case study report into sections by reading through the transcripts and making marginal notes, creating a theme for each section, followed by sequencing the themes which dictated the analytic technique.

3.10.3 Developing a case description

According to Yin (2014:194) a descriptive approach may aid the researcher to identify appropriate explanation to be analysed and may also allow the identification of complex patterns that indicate reasons for a certain occurrence. This strategy resulted in the identification of concepts that were not previously laid out in the conceptual framework and resulted in additional data to emerge, which allowed recommendations to be made.

3.10.4 Examining plausible rival explanations

Rival explanations are viewed as perceptions formed, other than those that were stipulated by theoretical propositions, working the data from the ground up and developing a case

description (Yin, 2014:195). The researcher incorporated the existence of rival explanation as an addition to the predisposed concepts, rather than to reject the data that emerged.

Data triangulation was achieved by incorporating in-depth interviews, field notes and document analysis as a multi-method approach in data collection. Data triangulation involved the collection of data from multiple sources for the purpose of analysis. This should be in the same study and each source should focus on the phenomenon of interest (Watson et. al., 2008: 270). To summarise the data analysis process, the researcher utilised the sequencing of qualitative analysis related to the five Cs, including: codes, concepts, categories, connections and conclusions (Watson et al., 2008:345).

3.11 SUMMARY

This chapter provided a detailed discussion of the research methodology that was followed by the researcher in this study. Some of the aims and objectives of this study were to describe the perspective of unsafe TOPs, those of women who had unintended pregnancies and also those of healthcare professionals who had attended to these women's care. In addition, the study also aimed to identify barriers to the utilisation of safe TOP services and to identify strategies that may improve the utilisation of TOP services in CHCs in the Western Cape, South Africa. The research design of this study was a single-descriptive case study with two units of analysis. The first unit of analysis comprised women with unintended pregnancies who had underutilised TOP services and the second unit of analysis comprised healthcare professionals who had attended to the care of women who had underutilised TOP services and sought post-termination care. The researcher utilised in-depth individual interviews and in addition to that, the use of field notes and document analysis were included in data collection strategies in order to obtain rich and insightful meanings. The data from the pilot interview were found adequate and the pilot interview was taken into account in the findings. Throughout the whole research process, the researcher maintained trustworthiness by adhering to the principles of credibility, transferability, dependability and confirmability.

The next chapter will contain a discussion of the findings of the study.

CHAPTER FOUR

STUDY FINDINGS

4.1 INTRODUCTION

Chapter Three (3) provided a detailed discussion regarding the research methodology that was utilised in this study. In this chapter the results are displayed after data collection in the two CHCs, where women and healthcare professionals were interviewed. The perspectives of both women with unintended pregnancies who underutilised termination of pregnancy services, as well as the perspectives of healthcare professionals who cared for the women who attended the health facility after termination of pregnancy, were portrayed.

The aim of this study was to explore the factors that influenced the underutilisation of TOP services for women with unintended pregnancies within the CHCs in order to reduce morbidity and mortality associated with unsafe TOPs in the Western Cape, South Africa. The findings for this single-descriptive case study of community health centres (CHCs) were analysed in two units of analysis which included the women with unintended pregnancies who had terminated their pregnancies as well as the healthcare professionals who had attended to the women after the termination of pregnancies. Data interpretation was accomplished by the use of a general analytic strategy as outlined by Robert Yin (2014). This analytic strategy was laid out in the data analysis section of Chapter Three (3) of this thesis. The data in the following pages was categorised under three sections: analysis of the transcribed interviews and field notes of women with unintended pregnancies who terminated pregnancies away from the health care services; analysis of interviews of healthcare professionals who had cared for women after termination of pregnancies; and lastly a document analysis. The document analysis includes analysis of protocols, policies and Standard Operating Procedures (SOPs) in the two CHCs.

4.2 DEMOGRAPHIC INFORMATION

The demographic information will be presented in a summative table form with the inclusion of data derived from both the units of analysis. The first unit of analysis comprised women with unintended pregnancies who had underutilised TOP services. The second unit of analysis involved healthcare professionals who attended to the care of women who had underutilised TOP services. The demographic information will be followed by the presentation of the researcher's field notes and, lastly, the themes, subthemes and categories that emerged from the interviews will be presented in a narrative form.

Table 4.1 Demographic information of participants

Demographic information					
First unit of analysis: Interviews with women who underutilised TOP services					
Participant	**One**	**Two**	**Three**	**Four**	**Five**
Age	Twenty-two	Sixteen	Twenty-four	Seventeen	Twenty-one
Race	Black	Black	Coloured	Black	Black
Gravidity	Two	One	One	One	One
Parity	One	Nought	Nought	Nought	Nought
Marital status	Single	Single: Terminated the relationship when pregnancy occurred	Single: Terminated the relationship when pregnancy occurred	Single: In a relationship	Single: Terminated the relationship when pregnancy occurred
Employment	Employed	Student	Unemployed	Student	Student
Level of education	Tertiary	Attending Grade Ten	Secondary	Attending Grade 10	Attending tertiary level
Language preferences	isiXhosa and English	isiXhosa and English	English and Afrikaans	isiXhosa and English	isiXhosa and English
Second unit of analysis: Interviews with healthcare professionals					
Healthcare Professional	**One**	**Two**	**Three**	**Four**	**Five**
Race	Black	Black	Black	Coloured	Black
Level of education	All completed their training in Advanced Midwifery and Neonatology				
Experiences in years	Sixteen	Seven	Seven	Fourteen	Nineteen
Language preferences	isiXhosa and English	isiXhosa and English	isiXhosa and English	Afrikaans and English	isiXhosa and English

4.3 FIELD NOTES

These field notes originated from the handwritten notes of the researcher and are presented starting with Participant One and following a numerical order up to Participant Five.

Participant One: At the time of the interview the participant had given birth one week before and she came to the MOU for her post-natal check-up visit. On first contact the participant seemed calm and relaxed. She had her baby with her and the interview was conducted with

her baby in arms and at some stage of the interview she even breastfed the baby. She seemed extroverted, outgoing and maintained and open body posture throughout the interview. She seemed content with her baby now and demonstrated affection towards her baby numerous times during the interview.

Participant Two: On first contact with the participant she seemed very shy and introverted, with a soft-spoken tone of voice. She maintained a closed body posture right through the interview. It also appeared that the participant had a cold and the researcher gave the option to do the interview at a later stage, but the participant wanted to continue.

Participant Three: The medical practitioner in attendance at the emergency department identified and recruited the participant for the study. Although the participant had given consent, she was reluctant to meet the interviewer in person. She was willing to communicate with the researcher via electronic media only and after the interview process and her anonymity had been explained, she consented to meeting the interviewer in person. During the interview the participant displayed an open body posture and was very well-spoken in English. She brought a female friend to accompany her, who waited in the waiting area while the interview was in progress. She appeared knowledgeable and smart and seemed quite extroverted. She repeatedly showed remorse regarding her action and bowed her head towards the floor when she revealed what she had done, but appeared to be well in control of her emotions.

Participant Four: The participant was identified by the attending Healthcare Professionals at the MOU of the research site and the Healthcare Professionals on duty made contact with the researcher when the participant was just admitted. Upon arrival of the researcher at the research site, the baby was still manually ventilated and eventually the baby passed away while the researcher was still on site. The researcher approached the participant approximately two hours after the baby was deceased in order obtain consent to make contact with the participant at a later stage. The participant agreed to do the interview right then. She was offered the opportunity to be interviewed at a later stage, which she declined and the interview was conducted that day. She appeared well in control of her emotions and some sort of relief and did not seem distraught. She spoke in a soft tone and displayed an open body posture throughout the interview. More than once during the interview a sense of humour was displayed. On admission to the MOU and at the time of the delivery and interview none of her relatives were present. Only round about the time the interview was concluded, relatives arrived in the unit to render their support to her. She confided to the healthcare workers to attend to her relatives and reveal the necessary information.

Participant Five: The participant was identified by the professional nurse on duty at the emergency department and verbal consent was obtained in order for the researcher to contact her. The participant was interviewed only two weeks after her admission as that was a convenient time to her. On first contact with the participant, she seemed nervous, shy and introverted. She arrived alone and approximately one and a half hours late for the scheduled meeting, as she was utilising public transport and was awaiting a taxi to get to the research site. Initially, during the first five minutes of the interview, the participant displayed a closed body posture and she tried to rush through the interview. After the first five minutes the participant took her shoes off and started to relax and provided the researcher with valuable information.

4.4 THEMES AND SUBTHEMES EMERGING FROM THE FIRST UNIT OF ANALYSIS: WOMEN WITH UNINTENDED PREGNANCIES AND UNSAFE TOP

The first objective of this study was to describe the perspectives of women regarding the TOP services offered for women with unintended pregnancies and after the completion of the coding process the principal theme of the underutilisation of TOP services amongst women with unintended pregnancies was inferred to this objective of this study. The three themes that emerged from the data forming this principle theme included: access to information and services regarding TOPs, surrounding stigma of unintended pregnancies and TOPs, circumstances forcing the unsafe TOP decisions, financial circumstances and, lastly, feelings regarding self-inflicted actions taken. The table below illustrates the themes, subthemes and categories that emerged from the data of the first unit of analysis.

Table 4.2 Themes, subthemes and categories emerging from the first unit of analysis

Themes	Subthemes	Categories
Access to information and services regarding TOP services	▪ Access to information regarding TOP services	▪ Information regarding TOP legislation ▪ Online access to information on TOP services ▪ TOP adverts on lampposts, walls of buildings
	▪ Access to TOP services	▪ Failure/delay to initiate contact with healthcare provider ▪ Betrayal by alleged healthcare provider
Surrounding stigma of unintended pregnancies and TOPs	▪ Social stigma	▪ Religious beliefs ▪ Perceived opinion of the community ▪ Rape ▪ Unwanted pregnancies
	▪ Healthcare professionals institutional failure	▪ Attitude of healthcare professionals

Table 4.2 Themes, subthemes and categories emerging from the first unit of analysis (continued)

Themes	Subthemes	Categories
Circumstances forcing the unsafe TOP decisions	▪ Social circumstances	▪ Relationship status ▪ Opinion of and respect for parents/guardians ▪ Perception that partner/relative will not render support ▪ Poor support by partner
	▪ Personal circumstances	▪ Maternal age ▪ Unwanted pregnancies ▪ Efforts to hide the pregnancy ▪ Feelings of disbelief ▪ Feelings of hopelessness
	▪ Health care professional's attitudes	▪ Failure to respond to healthcare provider's referral ▪ Healthcare provider failed to provide options
	▪ Financial circumstances	▪ Unemployment and financial difficulties ▪ Pursuit of education and training ▪ Financial exploitation
	▪ Psychological status	▪ Feelings of regret ▪ Feelings of guilt

4.4.1 Theme One: Access to information and services regarding TOP

After data were analysed, two subthemes emerged from this theme, which included access to information regarding TOP services and access to TOP services. For participants to make informed decisions, they required accurate and appropriate information. The knowledge levels were based on access to the required decision and appropriate support necessary to understand the information.

4.4.1.1 Subtheme: Access to information regarding TOP services

Several categories emerged to from the subtheme information regarding TOP services. Information regarding TOP legislation, online access to information on TOP services and TOP adverts on lampposts and the walls of buildings were amongst these.

Information regarding TOP legislation

The participants were unaware of the TOP services provided and of the legislation that allows access to TOP services. The participants who indicated that they were unaware of information regarding safe TOP services made decisions to access the available TOP practices which turned out to be very unsafe, therefore ending up in the healthcare facility with complications.

> "*I don't know where to access termination of pregnancy services." [Participant Five]*

However, although they did not know where to access the services, three of the participants were aware that the method and the gestational age at which they were attempting to terminate the pregnancy were illegal in terms of the South African constitution. One of the participants was, however, informed regarding the risk of terminating an advanced pregnancy, but due to fear, chose to use unsafe methods.

> *"That was on a Thursday when I took the pills, already knowing I was twenty weeks pregnant. But there was no other option for me. Like I said, I did not want the child." [Participant Three]*

> *"So we went to the doctor and we did a scan, we discovered it was six months and it was too late to terminate the pregnancy. So that's where I panicked." [Participant Four]*

Even with the knowledge that their actions were illegal, the participants seemed desperate enough to go ahead and terminate the pregnancy, using methods they could access. The consequences of the termination of pregnancy by these women were not seen as a priority; they rather viewed being able to get rid of the problem as the only important aspect.

> *"And because also like…is like it's believed that according to the Constitution rights, it's illegal to abort over twenty week period. So I had no choice." [Participant Three]*

The desperation to terminate pregnancy was not based on access to information, but rather on the fact that the participants were willing to risk their lives and break the law in order to be free of the pregnancy. They were aware that it was a risky choice and the access to the services in the healthcare facilities was restricted to the time limits.

> *"I know very well that it's not the safest option for me, but I was like come what may, death or whatever, but then, I'm taking it. That's my option at that time, and I'd like you to know that this is my option at this time. I knew from the start that is was like dodgy, that it was dingy, it was completely illegal. It is illegal, I know that. And I was just like, okay, they will ask me anyway and that's my best bet. That's why I chose that route." [Participant One]*

Peer consultation was also seen as a source of information where friends gave advice that was welcome at the time. Other participants made contact with healthcare professionals including private healthcare professionals. The participants received the appropriate information to access TOP services. However, participants unfortunately only received appropriate access to information regarding TOP when they were advanced in their pregnancy. The health care services could not offer the TOP service and the women sought other services in desperation.

> *"I could start off where I, like discovered I was pregnant. Too little too late, how can I say? I came to the MOU, I had certain symptoms of pregnancy, but I first went off to a private doctor. He couldn't tell me how far I was in my pregnancy and from there I got a referral because I wanted to do a TOP. But like I say, I did not know how far I was because I only took a urine test. And then I came to the MOU with a referral letter to say that I'm wanting to do a TOP. I went to the nurse and then she helped me, she assisted me, took a blood test and did a scan. And unfortunately she told me that I was too far in my pregnancy, I was eighteen weeks, no I was twenty weeks, sorry, too far apparently to have the abortion." [Participant Three]*

> *"So I only found out when I was actually six months far and really pregnant. So I first told a friend of mine and she went on that there is a way where I could terminate the pregnancy." [Participant Four]*

Information on referral systems was offered to the participants only after they attempted a termination of the pregnancy based on their own means and knowledge.

> *"We came into the hospital and then they, the doctor asked me if, or the doctor told me about the theatre…there is a theatre in doing abortions. I suppose to come here at first because it is a safe and clean environment, not…because both pills should have damaged me. So then the doctor writes a folder for me and then she said I must go to the theatre." [Participant Two]*

> *"I'm going to a process of an abortion at (name of institution withheld), they can make pills they say I must drink it. Then on Monday I must go back there." [Participant Two]*

Appropriate referral systems were offered by the healthcare providers only after fetal demise has been discovered. No prior contact with healthcare providers implicated and the participant was referred to a next level of care facility due to the intrauterine death (IUD).

> *"Admission of this participant occurred in the emergency department after the intake of Misoprostol approximately three days ago. She was admitted with complaints of lower abdominal pain (LAP) and did not initiate ante-natal care (ANC). In the emergency department an ultrasound revealed and gestational age (GA) of eighteen weeks and four days with no foetal heart rate present. She was transferred to a tertiary level hospital for induction of labour for a confirmed intrauterine death (IUD)." [Document analysis, Participant Three]*

One participant had information regarding access to TOP medications as they worked in a pharmaceutical company.

> *"I work at a pharmaceutical company. We make pills for big companies. We don't deal with one-on-one patient; we deal with big companies and make pills for them." [Participant One]*

The unsafe termination of pregnancies did not occur merely due to lack of access to information and services regarding TOPs. Awareness regarding the gestational age limits which inhibit access to TOP services, decisions to consult peers regarding other TOP services and knowledge regarding TOP medication resulted in efforts to terminate pregnancy. When healthcare providers were given the opportunity to refer to safe TOP services, the instances had already occurred.

Online access to TOP services and information

Most of the women had accessed the internet and utilised the search engine Google to obtain information and access TOP information. Access to information was easily obtained and after failure of peers to provide the necessary information, on enquiry the internet did not disappoint. Access was obtained to contact information of various healthcare providers.

> *"I started searching online and all of that. And I was like, okay buying these pills and oh my gosh. You can Google anyone, you can Google anything. Because I didn't even Google the pills, the pills I only found them when I…because I only said…abortions. The store was just there." [Participant One]*

> *"I met this guy in town. He goes by the name of Doctor (name of practitioner withheld). I got his number from Google." [Participant Three]*

> *"First I did a search on Google, there were various doctors there. Then I asked my friend since she has done it before. But her...she was different, because she was only three months. So it was quite earlier. Then I didn't know the address so I took the doctor's number from the internet and I went there. He is Doctor (name of practitioner withheld)." [Participant Four]*

> *"I research a doctor, you know, who got pills! And then I find that guy's number and then I contacted him. And then he gave me some direction to his building. Then I got there." [Participant Five]*

Even though internet services were utilised in browsing information regarding unsafe TOP services, these methods were not applied to seek information regarding access to TOP services in CHCs. The ability to obtain knowledge from the internet exists, but was not utilised by these women and it can therefore be viewed that the efforts to terminate the pregnancy outside the parameters of the CHC was intended.

TOP adverts on lampposts and walls of buildings

The source of access to information to TOP services by means of adverts on lampposts and walls of buildings was evident from one participant. Despite having access to internet services on her cellular phone, she did not utilise the internet source and acted upon the information she obtained from an advert that was posted on a church wall near the area where she lived.

> *"I see it near a location where I live on some building. It was "plak" on the church wall. It says Abortion. Then it gives the number." [Participant Two]*

Little effort was needed to obtain information regarding TOP services as this information was readily available by the means of visual advertisements on locations near the area of residence. Minimal effort was needed to obtain information regarding access to unsafe TOP services.

4.4.1.2 Subtheme: Access to TOP services

The subtheme of access to TOP services emerged from access to information and services regarding TOP services. Failure/delay to initiate contact with healthcare providers and betrayal by alleged healthcare provided were the categories that derived from this subtheme.

Failure/delay to initiate contact with healthcare provider

The women at first had no indication, or at least were in denial, that possible pregnancies existed and self-reasoning led them to buy home pregnancy tests to confirm the pregnancies. Although it was considered by one of the women to seek assistance from a private medical institution, in these cases both women failed to seek access to healthcare providers and confirmed the pregnancy themselves.

> *"It's my first visit. All those months I wasn't sure, because there were no sign of me being pregnant. And my Granny thought like, no you are just getting fat. That's what usually happens to me. I have season this year that I'm fat, the other year I was thin and that's what confuses me. So, I was hoping to get (name of private institution withheld) and then I decided to do a home pregnancy test. Then I found out that I was pregnant." [Participant Four]*

The admission of the following participant occurred in the MOU of the research institution and she had no relative or acquaintance with her. She had no prior contact with health care professionals and therefore had not initiated antenatal care. [Document Analysis Participant Four]

> *"Until I was like, It's no use denying, lemme just check for it. I went and got the pregnancy test, it came up positive and agh, what now?" [Participant One]*

After confirmation of pregnancy, in the following case the immediate decision was to opt for termination of the pregnancy. It seemed there was no intent of initiation of contact with a healthcare provider; it was only after concerns arose that the termination did not have the intended outcome that contact was made with healthcare providers.

> *"I found out that I am pregnant and then I decided to do an abortion. I went to Cape Town and bought some pills by a private doctor. And then I took that, but then it didn't bleed. That's what I was worried about. And then I came to the hospital and then they found out, no there are some products left in my womb." [Participant Five]*

Some women turned to faith to resolve the matter of the unintended pregnancies, therefore did not even attempt to initiate contact with healthcare providers, either for confirmation of the pregnancy, or the initiation of antenatal care services.

> *"I didn't, funny enough, I didn't. Because I was like, uhuh, it's not going to come to the point of me having the baby as far as I know, it's not gonna come to that, if I prayed hard enough about it." [Participant One]*

At this tertiary level of care facility, ANC was initiated for the participant; she consulted a social worker and was given the option to give the baby up for adoption. She was referred back to continue ANC at the CHC level. [Document Analysis Participant One]

An attempt was made to obtain access to information and services by contacting the individual who provided the abortion services in the first place. Enquiries were made by means of cellular phone texting and adherence to the advice from the health care provider occurred initially, but after some time, there were doubts regarding the efficacy of the given advice, which led the women to seek help at the CHC.

> *"I texted him, I told him that nothing happened, so what I'm going to do and then he said: "No, you must wait; maybe the process is taking too long". And then I waited Sunday, the whole day. Nothing! And then I was like, no let me just stop talking to this guy, because he is not giving me the proper thing to do. And then I decided to come to the clinic." [Participant Five]*

Denial of the need of medical assistance was evident in the case of this woman. Only when the intensity of the labour contractions became unbearable to her, she sought assistance from a relative to accompany her to the CHC, where she received the adequate care.

> *"This morning I started feeling like I was really in pain. But I tell myself maybe it's just a minor pain and it will pass. But as the day went through, I couldn't help it anymore. So that's when I asked my cousin to accompany me to come to the clinic. That's where I got help." [Participant Four]*

> *"She was fully dilated on admission to the MOU and admitted to taking Misoprostol in an attempt to terminate the pregnancy. On clinical palpation she had a GA of twenty-seven weeks and shortly thereafter she delivered a male baby with a weight of eight hundred and eighty (880) grams. The baby was intubated and manually ventilated by the attending medical practitioner on site. After consultation with a tertiary-level hospital it was recommended that all resuscitation efforts should be stopped and the baby passed away approximately one hour after the delivery." [Document Analysis Participant Four]*

Some of the participants ascribed their bodily changes to seasonal weight gain and did not even consider the possibility of a pregnancy. After many self-reasoning processes, the choice was made to perform a home pregnancy test instead of having the pregnancy confirmed by the CHC. The participants failed to make contact with healthcare workers to initiate antenatal care or to obtain assistance with TOP advice. One of the participants revealed that immediately after she found out she was pregnant, she opted for the TOP and never considered to utilise the TOP services provided at the CHC. Another participant turned to faith to resolve the matter of the unintended pregnancy and therefore never initiated antenatal care and only when her religion did not come through, she turned to an unsafe TOP for help. Some participants only sought help after they had already attempted the unsafe TOP and experienced signs of labour. Healthcare providers provided them with the necessary assistance and referrals, but in some instances it was too late and the birth ended in neonatal demise.

Betrayed by alleged healthcare provider

It appears that information and access regarding TOP services was obtained by means of electronic media and that assistance was sought from healthcare providers who appeared to be professional and organised. Financial payment was made in order to receive a certain service and in so doing, these women entrusted their lives and care into the alleged healthcare provider's hands. They felt betrayed, disappointed and depressed because the services they have paid for did not render the expected care.

> *"I would say he made me feel like he was very convincing, like he told me, "No nothing would happen. You will have a normal period". Not knowing that I was actually carrying a baby. I was totally clueless of how this procedure was going to be done, because it's medical at the end of the day. I thought it would just be a normal period, like he made me believe. But how can I say, where he were situated it wasn't in a dirty place, it was in a building and facility. It looked organized. And it made me belief, okay this is going to work out for me and then nothing else would happen. Without knowing what could actually happen." [Participant Three]*

> *"And ya, of course they charge huge amount of money. I felt down, and I regretted even more the money that you spent." [Participant Four]*

> *"I could have died if I didn't come here to the clinic and waited that guy to give me another pills…another pills…another pills! It's just; I'm just disappointed in that guy. I thought that guy was a private registered doctor you know, but then I*

saw that no this guy man is not that. He is just a doctor; he doesn't know what he is doing. That's why I paid money, because I thought he's a professionalist and I wouldn't get hurt." [Participant Five]

The participants were disappointed in the service that was rendered to them by the alleged healthcare providers. They had high expectancies that these healthcare providers would resolve the matter of their unintended pregnancy, which apparently did not happen. All of these women had to seek healthcare at the CHC after their unsafe TOP attempt.

4.4.2 Theme Two: Surrounding stigma of unplanned pregnancies and TOPs

After the process of data analysis the subtheme of social stigma and the institutional failure of healthcare professionals emerged from the data. The women were in need of service in a caring, non-judgmental environment, as they were already carrying the burden of the unintended pregnancy.

4.4.2.1 Subtheme: Social Stigma

Social stigma reverts to these women due to the perceptions of their own religious beliefs and this ultimately prevented the disclosure of the unintended pregnancies to relatives or peers. Perceptions of the women regarding the possible opinion of the community led them to desperately seek termination of pregnancy services outside the CHCs.

Religious beliefs

Despite religious beliefs that are in conflict against termination of pregnancy, these women, in a desperate effort, knowingly went against what is perceived in their own religion as unacceptable and continued to terminated the pregnancy.

"Because I was thinking to myself…what do I do now? Because it was something bad. And I'm thinking in my mind that, one; I don't believe in abortion, I don't. But I was like, in that situation it was like, no, there is no way in my heart I kept. I'm glad that in my depressed state I was still like finding prayer and all of that. And I'd just sit and pray at home and pray for hours on end and pray, cry, pray, cry, pray. And I was like, Lord, come on. And I go through things in the world; this is just what you had to bring to my door this time. Then one day of the week I'd be like, no help me with this baby and I'd pray and then the other six days of the week, no, let it die. Stillborn, whatever let it die! And no man, let me just take this in both hands." [Participant One]

"However, I'm Muslim. So what I did was totally against…" [Participant Three]

The above participant did not finish her sentence in the interview, but her non-verbal communication indicated that this was not accepted in her household. The participant continuously shook her head from side to side and then stared down at the floor. [Field notes Participant Three]

"Yeah, I'm a church person I can say. I'm a church person." [Participant Five]

Some of these women indicated that termination of a pregnancy was not well accepted either in the personal views or the opinions of the religious community. Another woman admitted that she attended church, but did not express her opinions regarding TOP clearly. Even though these women were aware of the opinion of their religious community, they still continued to pursue unsafe TOP choices.

Perceived opinion of the community

The fear of these women that they would suffer possible social judgement from the community and their perception that they might be burdened by mocking comments as a result of their pregnancy or the manner in which the baby was conceived, withheld these women from confiding in a peer or relative regarding the matter of their pregnancy. They did not disclose the event that had occurred in their lives prior to the unintended pregnancy; they rather chose to take the matter into their own hands in their efforts to avoid stigma.

> *"The way people would be talking, like in the streets and all of that. Ha, church girl…! It be those comments. Hey, church girl, what happened?" [Participant One]*

> *"But the main thing of it all is, like trying to terminate the child. I was scared. I was scared of what people might say. You know people say all those nasty things and I'm a very sensitive person. I can't take insults just like that!" [Participant Four]*

Previous experience of the doctor-patient confidentiality that had been breached, led this woman to seek health care assistance in an area that fell outside the area where she lived. The fear that her mother would obtain information regarding her whereabouts resulted in her not seeking assistance in the CHCs where she lived.

> *"I chose to come here. It was a decision that I took. Ya, like, mom, I'm taking that decision, because one, there's a lot of people that know my mom. We can say doctor-patient confidentiality and all of that, but fact of the matter, when I started*

> *going to the clinic for like uhm…the prevention, my mom knew about it. She was like ah, you are preventing now, you know. And you won't really be like in case it goes to a friend, because I know who her friends are. I know that it's still gonna get to her in that sense." [Participant One]*

The fear of mockery from the community regarding the situation a person of religion finds herself in and the perception that the community may bestow unkind comments regarding the unintended pregnancy, forced these women to conceal the pregnancy and opt for unsafe TOP choices. Previous experience of personal information that was revealed to her mother as a result of the breach of doctor-patient confidentiality, led this women to seek healthcare in an area outside her area of residence.

Rape

Inability to recall what happened at a certain timeframe of a person's life leads to numerous unanswered questions. In this case, the only sure knowledge was that this woman had been naked and she knew that she had been raped.

> *"Since I'm not drinking anything, can I have a glass of water? And he poured me a glass of water and I drink the glass of water. And that's all I know, really. Because I woke up four days later having found out from like the neighbour that the date was now December, because it was the thirtieth of November when we went to the party. And when I woke up it was the fourth now. And I was like; okay I was naked so something had happened sexually. I couldn't remember anything of the night. Because I knew that I'd been raped. Apart from what, apart from what had happened other than that, I don't know." [Participant One]*

The surrounding stigma of an unintended pregnancy that was conceived by means of rape and the inability to provide exact details regarding the night the rape occurred, forced this participant to hide the pregnancy. Because of the manner in which conception took place, the pregnancy was therefore unintended and the woman turned to faith to resolve the matter, which was not successful. This ultimately led to unsafe TOP choices.

Unwanted pregnancies

Despite the changes in her body through self-observation and feeling the baby kick, the participant did not identify the existence of the current pregnancy and did not conclude that she was pregnant. The pregnancy had occurred due to rape; this woman did not want the pregnancy and was in denial of the pregnancy to herself and her relatives.

> *"Because naturally I pressed my stomach. It was only in June, was it? May, June, May, when my mom was like, are you pregnant? Why are you looking pregnant? And I'd be like, nah, I'm not pregnant. I don't look, come on, does a pregnant person look like me? And she'd be like, come now? Have you not been telling me about a boyfriend? Let me just feel your belly. And I'm like, ma, I'm not pregnant, I'm just denying. And I was like, no, it can't be. What am I gonna do with a baby of somebody I don't even know? And (laugh) I remember when it was just…I was just trying to deny and deny and look at myself and no, my figure is still there. Surely there's no baby, surely the baby would be kicking or something?" [Participant One]*

In this case the knowledge that a pregnancy can occur after coitus did exist, but the lack of changes in her body and the lack of signs and symptoms of pregnancy made her believe that the pregnancy did not exist.

> *"No, I was shocked. I didn't believe I became pregnant. Me? Because I last had sex in May! So I didn't notice anything that time…all this months. So that's why I was shocked." [Participant Five]*

In an effort to eliminate the event on the night of the rape, the participant initially tried to convince herself that she was not pregnant and ultimately to deny the pregnancy as well. Although conception could occur on a consensual basis, unlike the above, pregnancy could come as an utter shock. Both women sought unsafe abortion services.

4.4.2.2 Subtheme: Healthcare professional institutional failure

Emerging from the theme of the stigma surrounding unintended pregnancy and TOPs the category of the attitude of health care professionals derived from the subtheme of healthcare professionals' institutional failure.

Attitude of healthcare professionals

In this instance the attempt to terminate the pregnancy had already occurred and referral was permitted to the next level of care facility. The action or attempt to terminate the pregnancy was known to the healthcare providers; there is evidence of coldness and lack of empathy that persists amongst healthcare workers. The need for health care providers to report rather than to care came across strongly and a great sense of judgment and scrutiny was felt by this participant.

> *"That's why I say I had regrets, because at the hospital they made me also…I felt judged by the staff, but knowing it was their job and not knowing why I did it. But like I said, at the hospital the staff wasn't…they like totally told me like this is a police matter. You could go and sit at the police and it's basically murder what you did and that is how I felt. They made me feel like I was the murderer." [Participant Three]*

The feelings reflected above were not indicative of the attitudes of the healthcare providers at the research site, as the management of the care of this participant was handed over to another level of care facility. It appears as if in some instances healthcare providers do judge women who have attempted an unsafe TOP.

4.4.3 Theme Three: Circumstances forcing the unsafe TOP decisions

The conclusion drawn from the data analysis process was that five subthemes emerged from this theme, including: social circumstances, personal circumstances, healthcare professionals' attitude, financial circumstances and psychological status. In order for the participants to utilise termination of pregnancy services, the effect of outliers should not influence their choice on termination of pregnancy services.

4.4.3.1 Subtheme: Social circumstances

Circumstances that forced participants to utilise unsafe TOP services were viewed on the basis of relationship status, the opinion of and respect for parents/guardians, the participants' perception that their partner or relative would not render support, the evidence of poor support by a partner and the absence of support by the family and the partner.

Relationship status

Although two of the participants were in a stable relationship, both of them were still attending secondary level education facilities and acceptance of the unintended pregnancy was difficult, which led to the underutilisation of safe termination of pregnancy services.

> *"I have a boyfriend, uhm, he is eighteen years. He live here in (area withheld) where I live. We've been dating since 2017." [Participant Two]*

> *"He is my first boyfriend till now, since Grade eight. Yeah, he cares. I could say he is involved in anything that is happening in my life. His family knows about me. Yes, that kind of a relationship." [Participant Four]*

It was also indicated that a long-term relationship had ended due to the occurrence of an unintended pregnancy. One of the participants perceived her partner as emotionally absent.

> "*I had a partner, he was a foreigner, he is a foreigner, basically! And the moment I told him I'm pregnant, he actually left me and we were together in relationship for three years. And how can I say? Emotionally he was never there for me." [Participant Three]*

Even in the absence of a stable intimate partner, unintended pregnancies occurred and forced these two women to take unsafe TOP decisions.

> *"I mean like, there's no boyfriend like all this time, because I've been single for like two years, two and something years." [Participant One]*

> "*Now, I'm not in a relationship, no!" [Participant Five]*

The influence of the relationship status on the choice on the unsafe termination of pregnancy varied. Some of these women revealed that they were not in a relationship at all; the conception occurred due to rape and in another instance it was consensual coitus. A long-term relationship of three years ended as a result of the unintended pregnancy. The involvement of partners was evident, but in both instances the pregnancy occurred in the teenage life phase, which haltered the acceptance of these pregnancies.

Opinion of and respect for parents/guardians

In an effort to maintain a high level of approval and respect for and from parents/guardians, these women opted to confide only a fair amount of what was actually happening in their lives. They opted not to disclose unintended pregnancies and choices to perform unsafe TOPs were withheld.

> *"We are close, but sometimes I'm too, I'm scared to share things with my mother. I ask her to told her that I was pregnant. I thought maybe she was going to be upset with me, or not. She's going to be disappointed in me." [Participant Two]*

> *I have...I didn't tell my parents the complete story. I told them I gave birth to a stillborn, just to make matters not seem…you understand?" [Participant Three]*

The concern for the health of relatives and the perception that their relatives were disappointed, withheld these women from revealing additional information regarding their unintended pregnancy. The fear for their relative's mortality due to ill-health forced them to undertake unsafe TOP decisions in order to protect their relatives from the knowledge of an unintended pregnancy.

> *"I'm like Gogo, I'm sorry and all of that. And I was just like I can't tell her because of the state she was in, she was just…she was not fine then. I couldn't tell her. We talk about everything, boyfriends, whatever, church. But I just couldn't tell her that one thing and it's like no way am I telling her, because she's just die from a heart attack and she'd just uhm, the year before she had left work because of health reasons, so I was like I'm just gonna die with it. I'm just gonna keep quiet and deal. That's all fine." [Participant One]*

> *"So I thought of my grandfather how…so he's a person with a heart attack. So this could maybe shock him, but anyway! And ya, my family was so disappointed because they expect this much from me. At school I do my best so, like even now my uncles and my grandmother is disappointed, but she told me that she will accept the situation. And no matter what happens, I'd still go to school." [Participant Four]*

In some instances good communication between mother and daughter was evident, but in an effort to maintain the respect for her mother, the woman decided to withhold knowledge of the pregnancy from her mother. Similar to the above case, another participant did not disclose her attempt to terminate the pregnancy, but rather chose to deviate from the truth in an attempt to maintain her parents' opinion of and respect for her. The perception of the possible health risk that the revelation of the pregnancy might impose, forced women with unintended pregnancy to opt for unsafe TOP decisions.

Perception that partner/relative would not render support

Perceptions of women with unintended pregnancies regarding the support of their partner or relative forced them to make unsafe TOP decisions. One of the participants was of the opinion that her mother would not support her, but after she was requested by her mother to trust and confide in her, she received plenty of support and with the aid of her mother she was taken to seek healthcare assistance in the CHC. Another participant was also forced to make unsafe TOP decisions and felt that support was given by her relatives at a stage where there was little to be done about it.

> *"She said I must tell her the truth so that she can help me, because maybe those pills are kind of dangerous. So I tell her that I am pregnant. Then she asked me if I drink the pills. I said yes I drink the first one. Then she said that we must come to the hospital." [Participant Two]*

> *"Ya! But that was too late. They all say those things just after I took the pills." [Participant Four]*

Failure to admit the pregnancy to the partner and to involve the partner in the pregnancy was precipitated by the participant's perception that her partner would deny the paternity of the unborn baby. In this case, this perception compelled the woman in a desperate attempt to eliminate the unintended pregnancy by taking unsafe TOP decisions.

> *"I think, okay, I knew my last boyfriend and then I knew that he was going to deny it because he is not here in Cape Town. He is in the Eastern Cape. So he won't belief that he's the father of the child." [Participant Five]*

The perception that relatives would not render support forced the unsafe TOP decision. In the end, the pregnancies were revealed to the relatives and support was rendered despite the opinion of the women with the unintended pregnancies that this would not happen. Some felt that it was just a means of saying, as it was already too late. Relationships were terminated on the perceived opinion that the partner would not render support and would deny his involvement in the pregnancy. The opportunity was not given to the father to be involved in the pregnancy; the decision was made for him on the assumption of his partner that he would deny the pregnancy.

Poor support from, or absence of partner

Denial of paternity and absence of the partner after ending a long-term relationship, left the participant feeling abandoned and having to make a decision on their own, which resulted in a sense of hopelessness to carry the emotional burden of the unplanned pregnancy alone. This participant was desperately forced towards an unsafe TOP decision.

> *"And then like I say, he left me basically. And I was on my own, which is why I chose to have the abortion, not knowing how far I was in my pregnancy, because I even bleed throughout the pregnancy. He became distant and being then there was a moment that he even told me, or asked me: Whose child is it? Like I was in a relationship with him for three years! What are you actually telling me? What do you label me at?" [Participant three]*

Even with the history of a long-term relationship, the partner denied his involvement in the conception of the baby, which left the woman with feelings of utter disbelief. In addition to this, she felt alone and without support and therefore opted to terminate the pregnancy.

4.4.3.2 Subtheme: Personal circumstances

The subtheme of personal circumstances was derived from the theme of circumstances forcing the decision to undergo unsafe TOP by women with unintended pregnancies. The categories of maternal age, unintended pregnancy, efforts to hide the pregnancy and feelings of disbelief and regret emerged from this subtheme.

Maternal age

Being pregnant as a teenager implies not being prepared to carry a pregnancy or to be a mother. Such participants were not ready to have a child at their tender age. At this young age the pregnancy was unintended and forced the woman to adhere to unsafe TOP decisions.

> *"I'm sixteen years old. Then I found out that I am pregnant. So I decided to terminate the child. I am not ready to have a child." [Participant Two]*

> *"I'm seventeen years old. I've never been ready for a baby or being a mother. So I never thought at this age I would have a child. So I could say I was quit careless." [Participant Four]*

Unintended pregnancies

Efforts to terminate pregnancy by seeking advice online instead of first initiating contact with healthcare professionals at the CHC were symptomatic of the forced decision that was taken in an effort to terminate the unintended pregnancy. In this case, the amount of tablets to be taken as well as the timeframe was questioned by the woman, but in a desperate attempt to terminate the pregnancy she continued with the consumption of the tablets as she was instructed.

> *"And I sat there and, ya, I ordered these pills online. They came. Then I got this pills that came with the instructions of how I use them, this guy told me you use them like this. Take four each hour. 'Each hour…?' It was like, I took those four." [Participant One]*

This participant was admitted to the MOU on a clinical measurement GA of twenty-eight weeks with complaints of LAP. She never initiated ANC. The participant revealed that she had been raped, which had resulted in an unintended pregnancy. She admitted that prior to her admission to the MOU she had taken four Misoprostol tablets sublingually in an attempt to terminate the pregnancy. [Document analysis Participant One]

Forced action to adhere to an unsafe TOP decision illustrates the measures this woman undertook in order terminate the unintended pregnancy. Further measures were taken to hide the efforts of the forced decision by denying the intake of the tablets. Her actions were only revealed once confronted and she was left no option but to come forth with the truth.

> *"Then I bought some pills to some guys that I take the number of the post that was posted on the wall…and call the guy, then he said he gonna come to my (area of residence withheld) and gave me the pills. They said I must first eat and drink the tablets. I didn't feel anything. And then they said I must take the second one after two hours. So after two hours I go and I hide those pills under my pillow. And I go to my pillow to take them and I didn't found them and I keep quiet. I didn't ask anyone at home. On Tuesday when I came back to school my mother called me and asked me about "what is this" and I said or act like I don't know the pills. She said I must tell her the truth." [Participant Two]*

On admission she had no medical symptoms and came to the unit in fear of side-effects after she had taken Misoprostol. An ultrasound was done which revealed a GA of eighteen weeks and also confirmed an IUD. She was referred to a tertiary level institution for further management. The attending medical practitioner on duty in the unit identified and recruited this participant. [Document analysis Participant Two]

Despite the emotional turmoil that unknowingly awaited this woman, she continued to consume the Cytotec and Mifepristone. Her ability to exactly name the medications she consumed, displayed she was knowledgeable in some way. Although the exact consequences and the processes of the termination were unknown, the unintended pregnancy forced her towards these actions.

> *"And then he gave me a set of pills called Cytotec and Mifepristone. And then he told me how to take it eventually. And I took the pills. It was the Mifepristone. He told me to take it at home. Because I asked him if there were any other option, like does he do surgical abortions? But he told me no, that's medical only, like medicine only. And then okay, I chose to do it. Yet not knowing that I would have to…what comes afterwards. You understand? I wasn't aware. And then I took it the Thursday and then I started getting contractions, because he told me to insert the Cytotec vaginally. Not telling me that I would actually bleed out and having to go through what I did." [Participant Three]*

The following participant involved a peer in her quest to terminate the unintended pregnancy and if not for the interruptions provoked by her aunt, the consumption of all ten tablets would have occurred.

> *"So I still went to my friend, then we went to this doctor in Cape Town. I thought that maybe it would be a hospital or…but it (when we got there) everything was just weird. It was just a room and then he started to take out some pills. It was like ten pills and he gave me the other two and said that after the baby has come out the other two will clean. So when I got home, ya, I took two of them. So I couldn't take the third one, my aunt came and then she spoke to me. But at that time I had already taken the pills." [Participant Four]*

Soon after the discovery of the pregnancy, the next participant was forced to adhere to an unsafe TOP decision in her efforts to terminate the unintended pregnancy.

> *"I found out that I am pregnant and then I decided to do an abortion. I went to Cape Town and bought some pills to a private doctor and then he gave me some instructions on how to take those meds. And then I took that, but I didn't bleed. I don't remember the name! But its Cyto…what, what! That guy told me to take two and put them under my tongue and then takes three and put them in my vagina. Ya, there were five pills." [Participant Five]*

The various techniques portrayed in an attempt to terminate the pregnancy, either by means of oral or vaginal intake of Misoprostol/Cytotec, indicate that the pregnancies were unintended. The measures that these women applied to terminate their pregnancies were risky because of the amounts of Misoprostol that was consumed and this is an indication of their desperacy to terminate the pregnancy.

Efforts to hide the pregnancy

Decisions to delay contact with healthcare providers or to transfer to a facility where help could be rendered was influenced by the following participant's attempt to hide her pregnancy. Because she concealed the pregnancy, this participant chose to attend healthcare services without any companion.

> *"You know, if the ambulance comes at my home, then she's gonna be like for who, where? No, nobody's sick here, you know. Nothing! She doesn't know*

> *anything at that time. I'm like, okay, I need to go to the hospital myself." [Participant One]*

Both a partner and a friend were kept in the dark as related to the next participant's pregnancy status, due to fear of revealing the unintended pregnancy to her relatives. She was forced to end the relationship with her partner, rather than to reveal the pregnancy and then she concealed her effort to terminate the pregnancy from her mother and sister.

> *"I didn't want to…I didn't want everybody to find out that I'm pregnant and I wanted to get rid of it before everyone could notice that I'm pregnant. I didn't told him that I am pregnant and I didn't told him that I'm going to do this abortion. I break up with him. I didn't want him to find out that I'm pregnant." [Participant Two]*
>
> *"I was not sure if she was going to tell my mother or my sister. So I didn't trust anyone. Just keep it inside." [Participant Two].*

At first, the pregnancy of the following participant was concealed by the absence of physiological appearances of the pregnancy and because she was introverted and not very talkative at home, the participant was able to hide the pregnancy.

> *"Because at home I'm a quiet child so nobody have guessed that I'm pregnant or that. And I didn't have all the hormones or anything that would make them suspicious." [Participant Four]*

Ultimately, the pregnancies were unintended and numerous efforts were made to hide these pregnancies. After the intake of Misoprostol, the labour pains and the situation provoked a certain need for medical care. When during the course of the night the situation became intense, decisions were made not to contact emergency medical services as an aid to access services at the CHC. The arrival of the emergency service personnel would have revealed the pregnancy and the participant chose to wait for sunrise in order to utilise public transport services to get access to healthcare. In other instances the relationship with the partners was ended in their attempts to terminate pregnancy. Some other of these women withheld information regarding their pregnancy status from everyone else in an effort to avoid the pregnancy being disclosed to their relatives. The introverted personality traits and the lack of signs of the pregnancy aided the participants to hide the pregnancy from their relatives.

Feelings of disbelief

To find oneself in a situation with very few problem-solving solutions, left the women with feelings of utter disbelief. Despite the initial overwhelming feelings regarding the situation, the following participant was left with no other option than to make unsafe TOP decisions.

> *"I was devastated; overwhelmed. I didn't know how to deal with the situation." [Participant Three]*

Feelings of hopelessness

The discovery of her gestational age and the information she received that a legal TOP would not be permitted at that stage, forced the following participant towards the only means she thought were possible to terminate the pregnancy: an unsafe TOP.

> *"But like I say, the nurses here, they made me aware off I was too far in my pregnancy to have an abortion, whether it be surgically or medically. And I just didn't actually know what to do at that point. That's why I chose to go the back road, and choose to do it illegally. I didn't know what to do. Then I chose that, the only route that I thought was available for me." [Participant Three]*

Healthcare providers determined that due to gestational age restrictions a TOP was not permitted. The woman was denied access to terminate the pregnancy, but was referred to initiate antenatal care. This was not the option the participant had sought and she was forced to make an unsafe TOP decision.

4.4.3.3 Subtheme: Healthcare professionals' attitudes

The attitudes of healthcare professionals contributed towards the circumstances that forced women with unintended pregnancies to commit to unsafe TOP decisions. Failure to respond to healthcare providers' referrals and the failure of healthcare providers to provide options were categorised under this theme.

Failure to respond to Healthcare providers' referrals

Two participants had previous contact with healthcare providers and were told to come back the following day in order to facilitate antenatal care or to determine the exact gestational age to allow further management. Both of the women in these cases failed to return on the healthcare provider's request and ended up taking unsafe TOP decisions.

> *"She had contact with healthcare worker three days prior to her consultation in the emergency department. On the initial contact she enquired regarding a TOP and she was declined due to GA constrictions. She was referred for initiation of*

antenatal care but unfortunately did not adhere to the referral. On admission in the emergency department she presented with complaints of vaginal bleeding after she had taken Misoprostol and an ultrasound confirmed a IUD at a GA of approximately twenty weeks. She was referred to a district level hospital." [Document Analysis Participant Three]

"And then she gave me a letter to come book myself in the MOU. I didn't go, like I said, I got cold feet. And I had a friend with me and then I told her that I can't have this child and did not want the child. And then I chose a back road abortion clinic." [Participant Three]

"I went to the clinic actually, I was there to prevent, then they checked me and say I cannot prevent because you are already pregnant. They told me that I need to come again so that they can do all those things and scan and see. Then they asked me how many months? And I was like I really don't know. And then they were like, since you don't know, come back tomorrow so that you can meet up with the doctor. I didn't go there." [Participant Five]

The healthcare providers were not provided an opportunity to appropriately initiate antenatal care or to refer these women for further management as their desperation to terminate the unintended pregnancy forced them to take unsafe TOP decisions outside the CHCs.

"This participant was admitted in the emergency department of the research site and had no previous contact with a healthcare worker, and therefore did not initiate antenatal care." [Document analysis Participant Two]

"Admission of this woman occurred in the emergency department after the intake of Misoprostol approximately three days ago. She was admitted with complaints of lower abdominal pain (LAP) and did not initiate antenatal care (ANC)." [Document Analysis Participant Five]

Healthcare provider failed to provide options

Access to healthcare was gained in order to be assisted in a safe and legal TOP, but due to gestational age constrictions the participant was denied access to the termination services. Unfortunately the healthcare professionals failed to provide alternatives to the TOP in the form of a possible adoption. This dead end led the participant to choose an unsafe method of the termination of the pregnancy.

> *"They only told me that unfortunately, I was too late in my pregnancy to have a TOP. That's why…and then I chose to what I did and go for the medical abortion which was illegal, but they never gave me other options or actually asked me why I want to do it. So we can say it wasn't helpful. All they told me was I had to be referred here; they didn't actually giving me options on what I could have done or maybe given the baby up for adoption" [Participant Three]*

Contact with healthcare professionals was established by this participant; she was denied healthcare on the initial contact and requested to return the following day. As she was desperate, she failed to return and rather chose to terminate the pregnancy in an unsafe manner.

> *"They told me that I need to come again so that they can do all those things and scan and see. Because they asked me how many months? And I was like, I really don't know. And then they were like, since you don't know, come back tomorrow so that you can meet up with the doctor." [Participant Five]*

None of these women who attempted unsafe TOPs had initiated antenatal care. Although two women had prior contact with healthcare providers they failed to return to these services. The rest of the women never initiated contact with healthcare workers at any stage but accessed healthcare only when the problem arose.

4.4.3.4 Subtheme: Financial circumstances

Financial circumstances form part of the situation that forced the participants to make unsafe TOP decisions. Unemployment and financial difficulties, pursuit of education and training as well as financial exploitation were identified through data analysis and in their desperation, these women had underutilised safe termination of pregnancy services.

Unemployment and financial difficulties

Some of the women were still attended school and were at the mercy of money that they had saved up. Funds were also obtained with the aid of a boyfriend and by the exchange of a gift card in return for cash. Instead of spending this money for what it was intended for, the women were forced to spend it on an unsafe TOP.

> "*We were saving some money, both of us." [Participant Two]*

> *"Well, my boyfriend...We...I have a gift card which my aunty always gives me just to spoil myself. So we went to Edgars, the sport section, and we change the gift*

> *card in exchange for money. So I managed to get six hundred rand, then he came with another six hundred rand. He asked his father, he told some sort of story, so that is how we managed to get the money." [Participant Four]*

Parents provide the opportunity to their children to enhance their circumstances and their education and this participant did not want to disappoint her parents in their efforts to support her educational career by divulging the pregnancy to them. Instead, some women chose to make unsafe TOP decisions in order to relieve the financial burden that a pregnancy might induce on their parents.

> *"Actually we are not affording. My parents are working so hard for me to get started, so they will be disappointed if I told them that I am pregnant." [Participant Five]*

Assistance of her partner in his business allowed the following woman a source of income. When the partner discovered that she was pregnant, the relationship ended and she lost her means of income. She made other efforts to terminate the pregnancy, but was not able to come forth with the funds. Owing to her unemployment and the lack of funds to terminate the pregnancy by alternative means, the participant was forced to make an unsafe TOP decision.

> *"I was with him in, and he's got couple of shops. And I was helping him out, and business wise it is, was small tips." [Participant Three]*

> *"I also contacted Mary Stopes. But the cost was also way over my limit and I'm financially not stable to do so. And the cost was, like they give you an option of having to do it while you are sedated, when you are asleep. And even that also cost money, it costed one thousand two-hundred rand, and for the procedure I would say, the whole procedure would have been seven thousand rand plus minus." [Participant Three]*

Teenage pregnancies forced some of these women to utilise funds from savings and gift cards that were exchanged for cash in order to access unsafe TOP services. The loss of income resulting from the termination of a relationship due the unintended pregnancy, forced the unsafe TOP decision. Efforts were made to find alternatives by means of contacting Mary Stopes, but this was of no avail, as the funds were just not available.

Pursuit in education and training

Some women were either attending secondary level education or they were pursuing future studies at a tertiary level institution. Owing to lack of income and reliance on parents/ guardians for financial support, the circumstances that forced them to make unsafe TOP decisions were based on their pursuit of education and training.

> *"I'm sixteen years old. I'm doing my Grade Ten." [Participant Two]*

> *"I'm seventeen years old and I attend (name of school withheld) high." [Participant Four]*

> *"Currently I'm busy studying, trying to study electrical engineering. I'm going to do intro." [Participant Five]*

It is evident that due to the fact that these women were still pursuing a secondary level career, the pregnancies came as a big surprise and were not planned. The financial pressure to raise a child under these circumstances led them to make unsafe TOP choices.

Financial exploitation

Services for TOPs rendered in a public healthcare setting were not related to financial expenditure. These women had the perception that the impending pregnancy would probably cause greater financial difficulties and despite unemployment and financial difficulties, funds were obtained in various ways in their attempts to terminate the unintended pregnancy. This resulted in financial expenditure and placed a further burden on an already financially constrained individual.

> *"She said the pills was one fifty, so I pay her the one fifty." [Participant Two]*

Only after the financial expenditure had been made, the participant realised that she had been exploited. Her suspicions were confirmed by a healthcare professional who attended to her care after she had already made the unsafe TOP choice.

> *"And then I paid him a thousand rand or so for the pills. And then that just told me is money making scheme at the end of the day. Because when I spoke to the doctor when I was rushed here, and then I explained so what happened and then she told me: 'No, these people are "skelm" and that's how they get to young girls'. Because how many women haven't like lost their lives or their children because of how they chose to go for this procedure." [Participant Three]*

Feelings of regret and a depressed state of mind occurred as a result of the financial exploitation. In the opinion of the participant it was a great amount of money that had been spent.

> *"And ya, of course they charge huge amount of money…one thousand two-hundred rand. I felt down, and regretted even more the money that I have spent." [Participant Four]*

Funds awarded by the parents of one of the participants to be utilised for education, were used to contribute financially contribute towards the decision of an unsafe TOP. In the opinion of this women money had been spend unnecessarily and if better choices had been made to seek healthcare prior to the unsafe TOP, the financial outcome would have been different.

> *"The medication cost nine hundred and fifty rand and then I use the taxi to go there, the taxi was eighteen rand. My parents gave me money to go to school and then I took that money. Maybe if for the first time I came here to the clinic and see them, maybe things would have been easier. Because I wasted my money because of that guy. He doesn't know what he is doing. He's just after the money." [Participant Five]*

The amounts that these women were willing to contribute towards the unsafe TOP choice probably varied from the asking price. As stated above, a teenager used the money in her savings account to pay hundred and fifty rand to access these services. Another participant utilised nine hundred and fifty rand which was provided by her parents towards her education to pursue the unsafe TOP. For one participant, only after contact with a healthcare provider at the CHC was made, she realised that the services she has paid for was financial exploitation.

4.4.3.4 Subtheme: Psychological status

Despite the deliberate choice of these women to adhere to the unsafe TOPs, all of them suffered the consequences of feelings of regret and guilt after they had already made the attempt to terminate the pregnancy.

Feelings of regret

Efforts to initiate unsafe TOP were made, but in the process the women suffered great feelings of regret and opted to discontinue the process. In an effort to alleviate the feelings of regret, the participants discarded the remainder of the tablets that had not been consumed.

> *"But I was regretting, a world was happening within me was like, no, don't, spit them out, spit them out, now! Then after those four pills I was just like, no, I took them, flushed them down the drain. And I was just like, okay, I don't want to do it anymore. I flushed the rest down." [Participant One]*

> *"Immediately I took them I regretted it." [Participant Two]*

Although the decision to choose an unsafe TOP was forced, the emotionally troubling consequences of such a decision proved to be relentless.

> *"I really regret it because at the end of the day, it's a child I was killing. I felt like a murderer. Not fair, I know! All of the consequences of what I did, without even knowing that. Because of what I went through and what I chose. It's traumatic, a traumatic experience. And now that I'm home (and it's been a week now) and I'm not coping the way I should. Because like I say, I regret my decision, and it's traumatising. At the end of the day, I feel like I killed my baby. And I can't…I can't put it in words." [Participant Three]*

Feelings of regret were evident only after the attempt had been made to terminate the pregnancy. The hope that no harm would be done to the baby and the notion that there might be a possible way to cope with a pregnancy at a certain age, contributed towards the feelings of regret.

> *"So that's when there was a moment of regret because I have already taken two pills. But I thought it wasn't going to do harm because I didn't eat all the rest. Honestly I hope that maybe the baby will be fine, because it's what…first I didn't want him, but then maybe it's just feelings and help. Maybe things will be better because I'm not the first one to fall pregnant at an early age." [Participant Four]*

Circumstances had led to the choice on unsafe a TOP. Although no regret was portrayed, some remorse regarding the manner in which the pregnancy was terminated allowed some level of unhappiness.

> *"I wouldn't lie, I'm not regretting anything, ya. But I'm not happy with this in time about what I've done. But then I'm trying to live with my decision, ya, because for*

me it was my best option." [Participant Five]

Immediately after the attempt to terminate the pregnancy had been made, the majority of these women felt feelings of regret. Some thought that maybe there was a change that they could take care of the baby after all and others experienced the feelings of regret due to the labour process they had initiated. Only one participant revealed that she did not experience any feelings of regret, but that she could have chosen other options or rather sought care at the CHC first.

Feelings of guilt

Due to the circumstances that forced the termination of the pregnancy in an unsafe manner, consequences of feelings of self-hatred and guilt were suffered.

> *"And now what I did was…it makes me, like make hate myself even more. I'm trying to cope, just trying to cope." [Participant Three]*

Even though the decision to commit to unsafe TOP was forced, the feeling of hope arises that there could have been another solution if the pregnancy had rather been confided to a relative. The participant experienced feelings that the current situation was her own decision and fault.

> *"Ya, because I feel like I didn't give him a chance to live. Taken things…I didn't think that much. Like how would I put it? I could say it's just all my fault, because maybe my Granny would have spoken to my grandfather and things would be okay. But I just panicked and did my own thing. But to me I'll feel guilty because I could say I had already accepted the situation and at night when nothing happened, I just thought that nothing was going to happen. The baby was going to grow; now I was going to give birth in March because that was the date that I was given. So in the morning I was quit frightened. I was thinking maybe the baby could die. At first I had those intentions of the dying baby. At that time all I could think of is how cruel I could be just…well I'm not that type of person. So that's what I thought off. I was really selfish." [Participant Four]*

There might have been the slightest possibility of remaining hope that maybe the baby could have been cared for after all. The participant started to anticipate being a mother and felt feelings of guilt towards her own actions at a stage after the termination of pregnancy had been concluded. Another participant was struggling to come to terms with the decision she had made to unlawfully terminate the pregnancy.

4.5 THEMSE AND SUBTHEMES EMERGING FROM THE SECOND UNITS OF ANALYISIS: WOMEN WITH UNINTENDED PREGNANCIES AND UNSAFE TOP

The principal theme of the underutilisation of TOP services amongst women with unintended pregnancies is related to the second objective of this study: the perceptions of healthcare professionals regarding the prevalence of underutilisation of TOP services amongst women with unintended pregnancies. The four themes that emerged from the data forming this principle theme included: access to information and services regarding TOP services, the stigma surrounding unintended pregnancies and TOPs, circumstances forcing the unsafe TOP decisions and healthcare providers' perceptions regarding unsafe TOPs. The table to follow illustrates the themes and subthemes emerging from the interviews.

The table below illustrates the themes, subthemes and categories that emerged from the data analysis.

Table 4.3 Themes, subthemes and categories emerging from the second unit of analysis

Themes	Subthemes	Categories
Access to information and services regarding TOP services	▪ Access to information regarding TOP services	▪ Healthcare provider's perception on available TOP services ▪ Healthcare provider's provision of information regarding TOP services ▪ Healthcare provider's perception on access to TOP information ▪ Information regarding TOP legislation ▪ TOP adverts on lamppost
	▪ Access to TOP services	▪ Failure/delay to initiate contact with healthcare provider ▪ Betrayal by alleged Healthcare provider
The surrounding stigma of unintended pregnancies and TOPs	▪ Social stigma	▪ Perceived opinion of healthcare providers ▪ Rape ▪ Unwanted pregnancies
Circumstances forcing the unsafe TOP decisions	▪ Social circumstances	▪ Opinion of and respect for parents/guardians ▪ Poor support from partner
	▪ Personal circumstances	▪ Maternal age ▪ Unintended pregnancies ▪ Efforts to hide the pregnancy
	▪ Financial circumstances	▪ Unemployment and financial difficulties ▪ Pursuit in education and training ▪ Financial exploitation ▪

Table 4.3 Themes, subthemes and categories emerging from the second unit of analysis (continued)

Themes	Subthemes	Categories
Healthcare providers' perceptions regarding unsafe TOPs	▪ Healthcare providers' code of conduct and provision of services	▪ Attitude of healthcare providers ▪ Appropriate referral systems ▪ Available family planning services
	▪ Ethical dilemmas	▪ Perceptions on the use of Misoprostol ▪ Legal obligations to report Misoprostol intake ▪ Healthcare provider's frustration with law enforcement system
	▪ Management guidelines on unsafe use of Misoprostol	▪ Lack of management guidelines on the excessive use of Misoprostol

4.5.1 Theme One: Access to information and services regarding TOP services

The two subthemes that emerged from this theme after data analysis was completed included: access to information regarding TOP services and access to TOP services. For participants to make informed decisions they required accurate, appropriate information regarding available TOP services in order to make informed decisions. The knowledge levels were based on the Healthcare Professional's's perception on the available TOP services and information regarding TOP services.

4.5.1.1 Subtheme: Access to information regarding TOP services

Accesses to information regarding TOP services was displayed in the data by means of the following categories: healthcare provider's perception on available TOP services, healthcare provider's provision of information regarding TOP services, healthcare provider's perception on access to TOP information, information regarding TOP legislation and, lastly, TOP adverts on lampposts and walls of buildings.

Healthcare provider's perception on available TOP services

Despite available TOP services within the CHC, women with unintended pregnancies chose not to utilise these services. Services were only utilised by women with unintended pregnancies after their own attempts to terminate the pregnancy and they found themselves in a situation where the matter could not be resolved on their own and help was therefore sought at the CHC.

> *"Yes, there is a TOP service available in Day Hospital. Instead of them going there to the doctor to do this backstreet abortion, and then they…when they can't handle it anymore, they come to us." [Healthcare Professional One]*

> *"And I told her: 'Why didn't you come to the clinic, because we do…they do it here next to by the day hospital, they do the TOPs'." [Healthcare Professional Four]*

Although knowledge existed to terminate the pregnancy by other means, it was at least opted to seek advice from healthcare providers in order to access TOP services the proper way.

> *"And now she decided today to do the TOP, and I sit down and talk to her about it. And she said: 'Sister, if you don't take this thing out of me, I got the people outside (African guys), I'm gonna buy the tablet.' Then I ask her: 'what tablets are you using?' and she said 'I don't know but people are buying these tablets there.' Then I write a letter, I booked her full." [Healthcare Professional Five]*

In addition to TOP services that could be accessed in the CHC, the Healthcare Professional had the perception that when accesses to TOP services within CHC were not obtained, services were available in other organisations that permit lawful termination of pregnancy services.

> "*There are a lot of places that you can also go for help. If you don't want to go to the day hospital there's other places that you can also go to that also admits, what is that other one…? Mary Stopes! Yes, they can 'mos' also do it there also 'mos'. That's 'mos' a legal…a legal place, neh?" [Healthcare Professional Four]*

Healthcare providers were of the opinion that there are TOP services and referral systems to TOP services available. They expressed a great deal of frustration when these services were not utilised. Even if TOP services at CHCs were not utilised, the healthcare providers felt that there were other options available to access TOP services than to do an unsafe TOP. At least some women with an unintended pregnancy, despite knowledge of other TOP methods, did make enquiries regarding services and were referred appropriately.

Healthcare provider's provision of information regarding TOP services

Accesses to information regarding TOP services were available to women with unintended pregnancies. This information was provided by the healthcare providers at the CHC who had dealt with the enquiry process.

> *"Some patients if they want to do TOP they will come and ask: 'Sister, how about this now? What can I do to have the abortion?' They will 'somma' go straight to trauma; speak to one of the sisters. They will guide, they will direct you which way you must go. So they do 'mos' the ultrasound to find out how far. If they are far, then they'll give a letter to come to MOU and book." [Healthcare Professional One]*

Efforts were made by the healthcare professional to confirm the pregnancy and in order for women with unintended pregnancies to utilise TOP services, information regarding access to TOP services was provided.

> *"And then I took her to the clinic, then they did a pregnancy test and the pregnancy test was positive. And I ask her: 'You are the person that wanted that information?' and she said 'Yes, Sister'. Then I find twenty centimetre symphysis fundus (SF) and I said please on Monday, go to (name of institution withheld) because they do the teenagers there." [Healthcare Professional Three]*

> *"And then I told her, 'No don't go there, I will first find out of what all this, and all this'. And I said: 'No, no, no, you're not gonna go that way. Rather bring her into me, there by the MOU so that I can sort that out and I can rather go the legal way there by us, by the day hospital." [Healthcare Professional Four]*

The mother of a teenager attempted to utilise self-medication methods to terminate the pregnancy and was fortunately unsuccessful. After the mother's failed attempt, she accessed the CHC for advice on how to access proper TOP services.

> *"A seventeen-year-old brought by her mother, her mother telling her that I want this baby out. She tried to mix this 'umchamo wemfene' and one mix it with castor oil. She only had to go to the bathroom over and over again, but the baby is still fine. So I said let me just book you so that you can go with her for a TOP. Don't go anywhere, don't give anything, otherwise you gonna kill your child." [Healthcare Professional Five]*

When healthcare providers were given the opportunity, they acted on the enquiry of the women seeking healthcare and provided the necessary information. In the instance when health care needs could not be met at the CHC, healthcare providers aided in the appropriate referral to a next level of care facility.

Healthcare provider's perception on access to information

As to the perception of the healthcare provider, in this specific instance the woman with the unintended pregnancy seemingly gave the impression that she was well-informed regarding TOP services. This observation was made by the healthcare provider on the basis of evaluating the linguistic ability and terminology utilised, which would only be evident in an individual with knowledge of TOP services and information

> *"But this is someone who is well-informed, cause from…you know! It's not like judging a person, but from her own vocabulary, you can say this is someone who knows medical terms. Her English is quite polished, you know. It's someone who you can say she's smart enough to make a safe decision. So I'm not sure how she ended up, you know, taking that route, you know, waiting that long to take such a drastic action." [Healthcare Professional Two]*

The observation of the level of knowledge was based on the healthcare provider's assumptions; on her one-on-one consultation with the woman whom had underutilised TOP services and indicated that there was access to information regarding TOPs and the related services.

Information regarding TOP legislation

The healthcare provider was aware that termination of pregnancies that occurred in instances not permitted by the order of trained healthcare providers, was not safe or was not viewed as appropriate in terms of the legal framework of the TOP legislation.

> *"I know that if someone terminates illegally, I mean, especially at that gas station then is like a criminal…a criminal act, because it's not a legal termination." [Healthcare Professional Two]*

In addition to this, another healthcare provider indicated that she was knowledgeable regarding the legality of TOPs permitted outside the framework of trained healthcare providers, but was not aware of the fact the women who had underutilised TOP services might possibly be charged with n criminal offense.

> *"I didn't think before the doctor explained to me that that was a…I know that it was illegal to do abortion on the street. But I didn't know it can…the patient can end up to jail because of that." [Healthcare Professional Three]*

Access to information regarding TOP services and information was obtained by means of enquiries from members of the community where they lived. Unfortunately the women with the unintended pregnancies merely listened to the advice of community members and did not attempt to further access TOP information and services.

> *"So the patient she told me that she knew she was pregnant and they...she asked to the…like to the neighbours and they say because the stomach is too big, so they won't help her, like at (name of institution withheld), so because they do there, like legal abortion." [Healthcare Professional Three]*

In her observation, the healthcare provider was of the opinion that these women had access to legislation regarding safe TOPs

> *"So she knew that it was way past I mean a safe period to terminate a pregnancy, according to me." [Healthcare Professional Two]*

No specific reference was made by healthcare providers to the legislation that permits TOPs in South Africa, even though the healthcare providers were aware of the legality of TOP information and access that was sought outside the environment of the healthcare systems. One healthcare provider was unaware of the fact that if a woman had attempted an unsafe abortion and the outcome was neonatal demise; the action could be charged as a criminal offense. Some of the healthcare providers were of the opinion that the women who had sought post-abortion care were aware of TOP legislation.

TOP adverts on lampposts

Access to and information regarding TOP services was obtained by the means of information that was available on lampposts. The specific locations of the advertisements were not indicated, but contact was initiated telephonically to obtain access to these TOP services.

> *"There are those…like those pamphlet that they 'plak' on the…on the street, man. So she found the information there. Then she called the number that was there and the person on the phone said she must meet her at the town." [Healthcare Professional Three]*

> *"They saw this poster on the poles outside about these illegal abortions. And she contacted this people on this number, phone number, and she went to I think Bellville, and she met this gentleman there." [Healthcare Professional Four]*

Relatives also made enquiries to healthcare providers in order to obtain information regarding TOP services and access thereto. These enquiries were the result of information obtained regarding TOPs that was advertised on a lamppost.

> *"And the other incident I remember now is like, it's not, I won't say it's a private incident, but it's somebody I know that also contacted me once when I was at home, saying that her cousin is pregnant, but she don't want this baby. Is there something they can do? Because she says she wants to go also…because she sends pictures of this advert. 'Sister, my friend, my cousin is seeing this posters and she wants to go to this people for the abortion because she don't want this baby'." [Healthcare Professional Four]*

All cases of women who had attempted an unsafe TOP and who was cared for by the healthcare professionals interviewed, had revealed that the access to TOP information was obtained by means of advertisements on lampposts.

4.5.1.2 Subtheme: Access to TOP services

To enable women with unintended pregnancies to utilise TOP services, access to these services were vital. Deriving from the principal theme of access to information and services regarding TOP services, the subthemes of failure/delay to initiate contact with healthcare providers and betrayal by alleged healthcare providers hampered these women's access to safe TOP services and information.

Failure/delay to initiate contact with healthcare provider

Access to TOP services was not evident, as the data derived from the interviews with healthcare professionals repeatedly revealed that the contact with the healthcare workers was the first, as they did not initiate antenatal care to confirm the pregnancy or to be referred for safe TOPs.

> *"So the patient came, she was unbooked." [Healthcare Professional Two]*

> *"When I attend a patient, an unbooked patient, she was thirty-two years (gravida three, para two) by sympysis fundus (SF) that day." [Healthcare Professional Three]*

The women with the unintended pregnancies established contact with healthcare providers only once the effect of uterine contractions became unbearable and forced the access to the CHC.

> *"And we had a lady coming in with severe abdominal pain, uhm, not booked with us. Came from the hospital complaining of abdominal pain and she was pregnant, the day hospital send her over to us." [Healthcare Professional Four]*

Access to TOP services and prior contact with the healthcare providers to attend to pregnancy care were not utilised as this woman had not initiated antenatal care services and failed to seek assistance when she was in labour. Access to services was sought only after the mother discovered that the baby was stillborn and she was forced to initiate contact with healthcare providers.

> *"And then I also had another incident were, uhm, I was working on the Sunday and this lady…the ambulance brought this lady in as she gave birth at home. She was also unbooked. She gave birth at home and the foetus was, the baby wasn't alive. It was a big baby. I think the baby weighed more than two thousand grams." [Healthcare Professional Four]*

In an effort to hide the circumstance regarding the conception of the baby, failure to initiate antenatal care occurred. An attempt was made to seek assistance from another healthcare provider outside the setting of the CHC and only when that assistance failed to deliver results, she opted to seek help at the CHC.

> *"But because she was unbooked….because it was not her intention to do…to do the antenatal visit due to rape case. She didn't want the baby. That is why she decided to go to the doctor alone and do this…and not knowing that it's going to take some time to come out the foetus. Then because of the pain now was unbearable, she decided to come to us" [Healthcare Professional One]*

No initiation of antenatal care of any sort was established by any of the women with unintended pregnancy. Contact with healthcare providers was sought only after labour-related problems had occurred or even after they had given birth at home. The opportunity for healthcare providers to render proper antenatal care and to discover unintended

pregnancy were not available as aid from healthcare providers was sought only once the problems had occurred.

Betrayal by alleged healthcare provider

In a desperate attempt to access TOP services outside the setting of the CHC, in this case the woman was the victim of misconduct by an alleged healthcare provider. Fortunately the woman kept her presence of mind and declined the controversial services provided. Although she did not adhere to the healthcare provider's aid in utilising the proposed method of TOP services, she did purchase the medication and continued with her own quest to terminate the pregnancy. Access to healthcare services within the CHC was sought only when she presented with uterine contractions.

> *"And so she said she went to Cape Town and meet with someone on the street and they give her these pills. Because they say he offered that he will insert them and he will push by his penis inside so that it would work quicker. And the patient she refused. So she said: 'Okay, I'll take the instructions' and the guys that gave the pills told the patient that when she feels any pain she must go to the nearest MOU. That is why when she feels the pain she came to us." [Healthcare Professional Three]*

The alleged healthcare provider failed to provide information on the process and aftermath of the attempted termination of pregnancy. The provision of adequate information regarding the TOP process would have allowed the participant to make informed decisions.

> *"And the person didn't want to do the business in the mall and the person called her outside in the parking area and he explained to her. And she's told him that she don't want this baby, whatever. Then he gave her this tablets, she gave the money and not knowing that…I'm not much but I don't think you can use that tablets when you are so far pregnant, because she was really far pregnant. But that people don't know it and they don't explain to the people all these things, but anyway, she took the tablets and they explained to her how to take the tablets but "Sister I didn't know that I was gonna have a baby like this that is dead*." [Healthcare Professional Four]

The alleged healthcare providers distantiate themselves from any problems that might arise due to the service they have provided, by advising women who had sought help from them to seek help at the MOUs if labour contractions started. The only intention of the alleged healthcare provider is to provide the medication, to get paid for the transaction and then

there is no further care rendered to the woman who has sought help from them. They leave the woman in the dark regarding the labour process, risks and possible outcomes.

4.5.2 Theme Two: Stigma surrounding unintended pregnancies and TOPs

The data analysis process revealed that the underutilisation of TOP services amongst women with unintended pregnancies was subjected to the surrounding stigma of unintended pregnancy and TOP. Social stigma emerges as a subtheme from this principle theme.

4.5.2.1 Subtheme: Social stigma

The perceived opinions of healthcare providers, conception due to rape and the incidence of unwanted pregnancies were the factors that hampered women's intent to access TOP services. These factors contributed towards the underutilisation of TOP services amongst women with unintended pregnancies.

Perceived opinion of healthcare providers

The fear of the healthcare providers' moral judgment, and in protection of negative opinions from other individuals, led to attempts to terminate pregnancy outside the setting of the CHC. The attempts continued without the knowledge of gestational age limits and the possible consequences that might occur due to the termination attempt.

> *"She says she was scared, she was thinking what is the people gonna think. What is the staff, maybe the nursing staff, gonna think. She didn't know what to think. She just thought I'm just gonna do it illegally, she didn't know the consequences, didn't know she was too far pregnant to get rid of this baby." [Healthcare Professional Four]*

Rape

An emotional effort to conceal the circumstances that led to the existence of the pregnancy and the fear of judgement resulted in the attempt to seek other TOP services than those that is offered in the CHCs.

> *"And when asked, she started crying and says she don't want the baby because she has been raped. She said she didn't want people to judge her if she was raped." [Healthcare Professional One]*

Rape, combined with the perceived opinion of the healthcare providers and the fact that the pregnancy was unwanted, were the social circumstances associated unsafe TOP. Such circumstances had forced the women's decision to adhere to unsafe TOP practices.

Unwanted pregnancies

Strong feelings opposing the current pregnancy were displayed and the intake of certain medications to terminate the pregnancy suggested the actions taken to terminate the pregnancy. It is clear that the pregnancy was definitely not wanted.

> *"She was forthcoming with the information and she did say that she absolutely doesn't want the baby. Yeah, she was actually in labour because she drank something. So she did describe the tablets that she took." [Healthcare Professional Two]*

Although the reasons why they had become pregnant remained unknown, the women indicated that their pregnancies were unwanted.

> *"She didn't tell the reason; she just said she didn't want the pregnancy." [Healthcare Professional Three]*
> *"And eventually she said she don't want the baby." [Healthcare Professional Four]*

Apart from the perceived opinion of healthcare providers and the fact that the pregnancy was the result of rape, unwanted pregnancy in almost all instances contributed towards the perception of social stigma that resulted in the forced action to undertake unsafe termination of pregnancy.

4.5.3 Theme Three: Circumstances forcing the unsafe TOP decisions

The data revealed the circumstances that forced the unsafe TOP decisions and resulted in underutilisation of TOP services. Social, personal and financial circumstances as well as psychological status were some of the reasons that forced women with unintended pregnancies decide on TOP.

4.5.3.2 Subtheme: Social circumstances

In an effort to maintain the high level of opinions of and respect for their parents parents/guardians, the pregnancies were concealed. In desperation to terminate the pregnancy and to prevent the revelation of the pregnancy to parents/guardians, TOP services were underutilised.

Opinion of and respect for parents/guardians

The perceived opinions of healthcare providers explained the fear to disclose unintended pregnancies in teenagers, and these fears forced the participants rather to choose not to reveal the pregnancy. They rather opted to underutilisation of TOP services.

> *"So I don't know where is this gonna stop. I don't know. I think the reason may be why people is doing it also, because if you go looking at the teenagers, because they may be all very scared of their parents." [Healthcare Professional Four]*

The magnitude of the problems of unsafe TOPs caused frustration for healthcare providers. . Teenage pregnancy and the effects of unsafe TOP decisions need to be addressed by these healthcare providers.

Poor support from partner

Pride towards a partner that had left during a very needy period of a women's life is a clear reaction related to the occurrence of unintended pregnancy. Strong feelings that oppose the existence of the unborn baby, led the mothers to make unsafe TOP decisions.

> *"Another thing is, the reasons of the boyfriend, maybe somebody got pregnant with someone and he ran away, because he doesn't want to stay, she's go that inner pride inside, so she doesn't want to stay with this child with that runaway boyfriend. So they decided to do the TOP." [Healthcare Professional five]*

Without the proper support of a partner, the women does not see the way forward to raise her unborn child; the only option was to terminate the pregnancy. These circumstances in which she felt inadequate to raise the unborn child alone, forced her to seek help outside the parameters of the CHC.

4.5.3.3 Subtheme: Personal circumstances

The underutilisation of TOP services was influenced by personal circumstances, as was revealed by this emerging subtheme. Under this subtheme the categories of maternal age, unintended pregnancies and efforts to hide the pregnancy were identified as personal circumstances that contributed towards forced unsafe TOP decisions.

Maternal age

The teenager took drastic measures, in the form of leaving the safety of her parent's house, in order to hide her pregnancy in an effort to avoid scrutiny of her parents' strict upbringing.

> *"Apparently she ran away from home, scared of the mother! Because number one, she's still a teenager, didn't plan this pregnancy, scared of the mother because they are very strict parents."[Healthcare Professional Four]*

Decisions of teenagers on the spur of the moment had led to poor sexual behaviour which resulted in the occurrence of unintended pregnancies. Furthermore, the lack of support from parents/guardians forced the unsafe TOP decisions.

> *"And another thing what I notice is this, these teenagers they go and have the boyfriends. One-night stands or whatever and then they fall pregnant. And you find out that she does not want a baby sometimes because of the parents, one of them or both of the parents or whatever." [Healthcare Professional Five]*

The personal circumstances surrounding a pregnancy that occurred at a young maternal age ultimately resulted in the pregnancy being unwanted. Owing to strict upbringing, teenagers chose not to confide in their parents regarding the pregnancy and some of them rather chose the run away from home. In other instances the parents were not supportive of the pregnancy and this created to forced decision to terminate the pregnancy.

Unintended pregnancies

Access to healthcare services was sought outside the parameters of the CHC in an effort to terminate the pregnancy. On contact with the healthcare providers at the CHC the effort to terminate the pregnancy was not disclosed, but clinical examinations revealed otherwise. The unintended pregnancy therefore forced the action of unsafe TOP decisions.

> *"So she went to the doctor in town centre because she wants to do…to abort the baby. But apparently that doctor inserted Misoprostol to her. But when she came to us, she never told us that she's coming from the doctor until we did the vaginal examination, only to find out there were tablets coming out there." [Healthcare Professional One]*

In this case the effort to terminate the pregnancy persisted over a period of two days. The participant kept on consuming tablets in her pursuit to terminate the pregnancy. Her unsafe TOP decision evolved around her unintended pregnancy.

> *"When she arrived she was about thirty-two weeks. And she said she took four Misoprostols. In total it was twelve. But like at first she took two, then she took another two, or another four, but she was giving herself like four to six hours or so, and nothing happened. Then the following day, like, she drank another six or so. But in total, in twenty-four hours, she had taken twelve Misoprostols then she finally went into labour." [Healthcare Professional Two]*

The unwillingness to admit the current pregnancy status and the deception that she was not aware of her pregnancy status, had led this woman to underutilise TOP service. Her desperate attempts led her to deny the pregnancy altogether and her efforts to terminate the pregnancy were revealed on clinical examination when the Misoprostol tablets were discovered.

> *"According to her she didn't know that she was pregnant then. She didn't feel anything. She was…her periods were normal, so then I did my observations and I did the palpations. Then when I did my PV I noticed that there were something rough inside, vaginally. Then when I scoop and I come out it was four tablets. One was slightly dissolved and the other three were like full. And when I checked, they were Misoprostol tablets and my colleague confirmed also that those are Misoprostol." [Healthcare Professional Three]*

The unintended pregnancy forced the unsafe TOP decisions and therefore forced the intake of Misoprostol in a desperate attempt to terminate the pregnancy without utilising TOP services at the CHC.

> *"And then I was also working night now the other day. Me and my colleague was working night shift at about a few months back, and I was on lunch and she also had the same incident on the patient that came, but also found Misoprostols in the patient's vagina." [Healthcare Professional Four]*

A substantial amount of Misoprostol was utilised in an effort to terminate this pregnancy. Not only did the choice of unsafe TOP decisions pose serious risks to the mother, but it proved to be fatal and ended in both maternal and fetal demise.

> *"She bought twelve tablets from this African guy. Now she's contracting like anything. Do the blood pressure, the blood pressure was shooting. Everything was abnormal. While we were calling the ambulance, we lose the mother and the baby, because of this abortion thing. She couldn't tell us why she wanted to do the abortion at that stage." [Healthcare Professional Five]*

Self-medication concoctions were utilised to alleviate to problem of the unintended pregnancy. In desperation to terminate the pregnancy, the lack of consideration regarding the possible effects of the concoctions resulted in a baby being born severely distressed in

the following case. Despite substantial efforts from healthcare providers to revive the baby, it was to no avail.

> *"The lady came from home with a mixture, the mixture of the spirits, brandy, miso and castor oil. And this drink I just call the 'baboon urine' in English but in our language it is 'Umchamo wemfene'. And we had to transfer the person because the uterus can rupture at any given time. So when we try to transfer, call the ambulance and whatever, the baby just got out green like a grass, meconium and flat. Trying to resuscitate that, unfortunately we lose the baby." [Healthcare Professional Five]*

The women either self-inserted Misoprostol tablets vaginally, or inserted by the provider of the Misoprostol tablets. The amounts of Misoprostol intake varied from two to twelve tablets and the two methods of intake were concluded to be either orally or vaginally. The evidence of the choices of unsafe TOP were revealed by the healthcare providers at the CHCs by means of clinical diagnoses and finding the Misoprostol still undissolved in some patients' vaginas. Sadly, in one incident, despite the efforts of the healthcare providers, the intake of the twelve Misoprostols had proved to be one too many and resulted in ending the lives of both the mother and her unborn baby. In other cases of the intake of self-medicated concoctions, there were no effects to the mother apart from the process of labour, but the intensity of the contractions were too distressful to the foetus and despite resuscitation efforts of healthcare providers, the birth ended in an early neonatal death.

Efforts to hide the pregnancy

The fear of judgment regarding the manner of conception evoked lack of disclosure to relatives and peers. The effort to hide the pregnancy resulted in the choice of unsafe TOP.

> *"She came alone. She didn't have nobody with her. She just came alone because she was 'mos' hiding this. Because she said she was scared people will judge her that she abort, not knowing that she has been raped." [Healthcare Professional One]*

Unsafe TOP decisions were forced amongst these teenagers in efforts to hide the pregnancy from their relatives.

> *"Because number one the mother didn't know she was pregnant." [Healthcare Professional Four]*

> *"Then the patients doesn't want the parent to know, whether she's pregnant or not." [Healthcare Professional Five]*

Choices were made to attend healthcare services alone in an effort to hide the pregnancy and not revealing the circumstances on the conception of the baby, either to the community or to acquaintances. Unsafe TOP decisions were forced onto these teenagers due to efforts to hide the pregnancies from their parents.

4.5.3.4 Subtheme: Financial circumstances

The underutilisation of TOP services was emerged due to pressure of financial difficulties in conjunction with unemployment. In addition to the above, the pursuit of education also led to underutilisation in TOP choices. The amounts that were spent in efforts to terminate pregnancy, revealed the financial exploitation of these women.

Unemployment and financial difficulties

The partner was involved in the life and decision-making processes of one of the participants but despite this, the unsafe TOP decision was forced by their financial circumstances. In another instance the involvement of the partner was not mentioned, but in both these instances they were unable to raise another child as they recently had a baby and this led them rather to attempt unsafe abortion practices than to utilise TOP services.

> *"She admitted to me crying that she didn't want the baby. She and the boyfriend decided that they cannot afford this baby as she had a baby the previous year." [Healthcare Professional Four]*

> *"But some of them they do TOP because the baby is still small. They can't handle financially." [Healthcare Professional One]*

The financial responsibility of raising her other children without proper financial aid and a place of residence led to hopeless financial circumstances that enforced the unsafe TOP choice. The lack of available support systems for the mother to turn to, further exacerbated the poor financial situation.

> *"Then after that she said: "No sister, this thing is as I don't have parents, I've got three babies at home, I'm not working and I don't have a place to stay. So I don't know what am I gonna do with this baby'." [Healthcare Professional Five]*

The financial circumstances that forced the unsafe TOP decisions were related to unemployment, lack of parental support and lack of a stable place of living. Even in the presence of a supporting partner the burden of raising another child seemed impossible.

Pursuit of education and training

In their efforts to complete their education, women were forced to make unsafe TOP decisions due to their financial circumstances and therefore underutilised TOP services

> *"But some of them they do TOP because they are studying." [Healthcare Professional One]*

Women who were pursuing secondary or tertiary level studies were assumed to have financial constraints and were possibly dependent on their parents/guardians. In view of the obligations of studying and financial dependency, the pregnancies were unintended. These circumstances led the women to make unsafe TOP decisions.

Financial exploitation

The funds needed to seek assistance with termination of pregnancy services outside the CHC varied in the amounts. Despite the fact that TOP services rendered at a public health setting were free of charge, efforts to terminate the pregnancy resulted in financial exploitation.

> *"She bought the tablets on the street, I think it was ten hundred rand, she told me." [Healthcare Professional Four]*

Even though one of the partners in the relationship was unemployed, the funds were obtained from the other partner who was employed. An already burdened household was financially further exploited by the forced unsafe TOP decision.

> *"And she said she's not working. Her boyfriend is working. She collected the money; the boyfriend gave her the money. I think it was also eight hundred, seven hundred rand, somewhere there." [Healthcare Professional Four]*

The knowledge of accessing medications to aid an unsafe attempt to terminate the pregnancy was prevalent within the community. The healthcare provider revealed the location and description of the area where these medications were found, which implied that these medications were readily available, although at a great financial cost.

> *"They say that they took it from Site C from one of the containers; they say the yellow container in Site C. And each tablet was five hundred and sixty rand." [Healthcare Professional Five]*

The setting of the CHCs to a certain extent indicates the general level of income of the community at large. Public health services strive to provide free and accessible services to all. However, the financial pressures and possible resolutions to resolve unintended pregnancies forced these women to access unsafe TOP services and to deplete their available funds even more. Despite unemployment, desperate attempts were still made to access the medications.

4.5.4 Theme Four: Healthcare provider's perceptions on unsafe TOPs

In the process of data analysis three subthemes emerged from this theme which included: healthcare provider's code of conduct and provision of services, ethical dilemmas and management guidelines on unsafe use of Misoprostol. Healthcare professionals were to be able to adhere to fair and just delivery of service; the phenomenon of unintended pregnancies and taking care of it, were understood.

4.5.4.1 Subtheme: Healthcare provider's code of conduct and provision of services

The data suggested that healthcare providers' code of conduct and provision of service were based on the attitude of the healthcare providers, appropriate referral systems and available family planning services.

Attitude of Healthcare providers

Healthcare professionals adhered to the basic principle that human life should be treated with respect and dignity. Harsh judgements were not made and opinions of the participants did not impede on the healthcare providers' code of conduct and provision of service.

> *"You can't judge them because you don't know their circumstances. You just do your work, respect their feelings and whatever their decision. Don't ask them why you do this, why, or what is the reason you are killing or whatever. Don't ask those funny questions." [Healthcare Professional One]*

Some form of resistance towards a participant's choice was revealed and an effort was made by healthcare provider to instantiate her own personal belief from that of the participant. Despite the healthcare provider's personal convictions, they acted in a professional manner and delivered the required service.

> *"Oh for me it felt, you know, and you're not supposed to be, you know, so subjective and, you know expected to be so objective and be able to separate yourself from the patient. But I felt very upset. I felt very…I don't know! I actually didn't want to interact with that patient. But unfortunately, it's our job you know." [Healthcare Professional Two]*

The healthcare professionals adhere to their code of conduct and displayed a fair attitude towards the treatment of women with unintended pregnancies. Their own personal feelings did not interfere with the holistic treatment of the women with unintended pregnancies. Although in some instances it was difficult for healthcare providers to distantiate themselves from the given scenario, they managed to do so and continued providing the necessary care.

Appropriate referral systems

In some cases the need for additional care was identified by the healthcare provider in order to provide complete emotional and physical wellbeing. The feelings and fears that the participant portrayed were respected and she was treated according to her emotional needs.

> *"She was fully dilated already, and bearing down. The foetus came out with those tablets also, and she didn't even wanted to look what sex it is. She was screaming and hiding herself and said that she didn't want to see it. She was very traumatised. But we just asked if she wants to see the social worker regarding that. So we did refer her to the social worker so that she can verbalise more." [Healthcare Professional One]*

The healthcare providers utilised the referral guidelines available in writing in their units in order to render the appropriate care. Even though the participants were admitted after their attempts to terminate the pregnancy, the healthcare providers used their clinical skills to identify premature labour.

> *"That is why when she feels the pain she came to us. Then I phoned (name of institution withheld) because it was a (name of institution withheld) case because she was below thirty-five weeks. Because from thirty five weeks and above we refer to one, and from thirty-four and lower we refer to level two." [Healthcare Professional Three]*

> *"She was in her twenties, twenty weeks pregnant. And I had to rebook her and I had to refer her to (name of institution withheld) and (name of institution withheld) had to refer her to (name of institution withheld) hospital due to gestational age." [Healthcare Professional Four]*

The guidelines of maternity care in South Africa of 2007 assisted the healthcare professional to manage and refer these participants appropriately. These women presented with premature labour due to Misoprostol intake as an attempt to terminate the pregnancy. [Document analysis]

In some instances the termination of the pregnancies were prohibited due to gestational age limits. The healthcare providers provided antenatal care services when such occasions occurred and even provided options to be aided in the process of giving the baby up for adoption if the women wished not to continue the care of the baby.

> *"Sometimes when it is too late for them for a TOP, the sisters will send them around to come and book. I mean, obviously the sister gave them counselling saying it is too far along to do the TOP. But at the end of the day I think they get solutions of giving up the baby for adoption." [Healthcare Professional Four]*

Healthcare providers in a labour ward found themselves in the position where they had to think on their feet and provide emotional and physical care as the situation at that moment required. A woman delivered a stillborn baby as a result of her unsafe TOP attempt and she immediately required emotional supportive care. Without hesitation the healthcare provider referred this woman to the appropriate services. Another healthcare provider who was of the opinion that in instances where TOP access was denied due to gestational age limits, provided other options in the form of possible adoption of the baby.

Available family planning services

The healthcare providers were trained to provide various methods of family planning services. The healthcare providers who were interviewed were all working in an MOU setting at the CHC; even though family planning services were evident, these services were provided only once a delivery or miscarriage had occurred.

> *"And myself and my other colleague, we are implant…implanon trained and you know post-placental intrauterine contraception device (PPIUCD) trained. So we could have been able to give her a long-acting contraceptive (LAC) method." [Healthcare Professional Two]*

> *"Really we offer everything, like we start to the long acting like Post-placental intrauterine device (PPIUCD), then it's Implanon, then Petogen (but they say Petogen is going to be stopped). But we do explain. You explain everything, then you tell them their benefit to those, but we like to promote the long-acting family planning, because it helps, man." [Healthcare Professional Three]*

Another healthcare provider indicated that there were family planning services available at the CHC and sympathised with the fact that women had to follow such drastic measures to terminate the pregnancy.

> *"And it is sad to think that there is family planning available. But the people go that way." [Healthcare Professional Four]*

In the view of the healthcare provider there was knowledge regarding family planning services. All sorts of poor reasons for self-justification resulted in them not accessing these family planning services.

> *"They know about family planning. One said: 'No I don't want to be fat, no I don't want to menstruate all the time. If I'm using the Petogen it is making me fat. If I use the pills it is making me…!' They've got those sorts of reasons of not picking the family planning; otherwise it's not that they don't know." [Healthcare Professional Five]*

Healthcare providers in the labour wards were trained to provide various methods of family planning, including the long-term methods. Efforts were made to give proper information regarding these family planning methods. Other healthcare providers were of the opinion that family panning was available and due to various reasons such as weight gain and continuous menstrual cycles, women opted not to utilise these services.

4.5.4.2 Subtheme: Ethical dilemmas

From the principal theme of healthcare providers' perceptions on unsafe TOP, the subtheme of ethical dilemmas emerged. Perceptions on the use of Misoprostol, legal obligations to report Misoprostol intake and healthcare providers' frustration with the law enforcement system were revealed by this subtheme.

Perceptions on the use of Misoprostol

Healthcare providers was knowledgeable regarding the medical use of Misoprostol, and were in agreement that this drug should not be utilised to unsafely terminate pregnancies, but rather to be utilised in the management of medical emergencies that developed after the birth of a baby.

> *"Misoprostol 'mos' is a drug. Nobody can just take it, we must control it if we are gonna insert it, but apparently we are using it for postpartum haemorrhage patients. Not to abort." [Healthcare Professional One]*

> *"You know the thing is, those people first of all, we don't know where they get the medication from. The Misoprostol is not given like that. We use the Misoprostol to the patients that is coming from theatre, too the patient that is bleeding too*

> *much. You see what I mean? And it's supposed to be prescribed, it's a scheduled drug that one." [Healthcare Professional Five]*

It appeared that it was the opinion of healthcare providers that Misoprostol was not supposed to be easily accessed in the form of self-prescription drugs, but in spite of that they were still accessed by unknown means.

> *"I'm not really sure if anyone can just access, because from the pharmacies I haven't really seen Miso being stocked, like on the shelves, those self-accessible shelves. But somehow people get hold of Miso. It seems like it's easy to get hold of it. I'm not really sure how." [Healthcare Professional Two]*

One healthcare provider even reflected her personal views on the use of Misoprostal as obtained through her own real life experiences with intake of Misoprostal. She wholeheartedly expressed her dismay regarding the deliberate choice to utilise Misoprostol in an attempt to terminate a pregnancy.

> *"And you know, personally, Misoprostol…I used Misoprostol. You use it in a medical sense that, uhm, when you have a miscarriage, the doctors will normally give it so to contract the uterus and to stop the bleeding. And it's a terrible, terrible tablet to drink. I mean, it is like, it feels like your whole intestine has been turned around and you have so much pain. And I just can't believe that the mothers will put themselves through that." [Healthcare Professional Four]*

The agreements were that Misoprostol is a scheduled drug that should be prescribed and administered in an obstetric emergency such as postpartum haemorrhage and not as a method to terminate pregnancy without the assistance of healthcare providers. Personal experiences on the use of Misoprostol as a means of contracting the uterus after a miscarriage were shared and empathy was portrayed as to the intensity of the uterine contractions. It was difficult for this healthcare provider to understand the deliberate choices to take Misoprostol to bring on the uterine contractions themselves.

Legal obligations to report Misoprostol intake

Even though the healthcare provider was aware that the action the client took in an unsafe attempt to terminate the pregnancy was unlawful, she expressed conflicting personal feelings and felt empathy towards the client.

> *"I felt sorry for the patient. Truly speaking! I don't know if it is because…I don't now! But I felt sorry and I didn't want the patient to go to jail, because I didn't know the story behind of why she wanted to do the backstreet abortion." [Healthcare Professional Three]*

Another healthcare provider even utilised the fear of the law enforcement system to obtain information regarding unsafe TOP actions.

> *"And I told her: "But if you're not gonna tell me, we can have to get the police in, because I know what this tablets is using for and I know what they do on the streets, where they are selling this tablets on the street for abortion'." [Healthcare Professional Four]*

The same healthcare provider revealed another instance where she was involved in the management of the client who had attempted the unsafe TOP and ultimately gave birth to a stillborn baby at home. The healthcare provider felt obligated to notify this case to law enforcement services. The baby was admitted as dead on arrival and the circumstances related to the stillbirth needed to be investigated.

> *"The baby came here dead on arrival according to us. We had to get the police involved." [Healthcare Professional Four]*

Even though some healthcare providers felt that the Misoprostol obtained outside the means of a registered healthcare facility was an act to be reported to the law enforcement system. Some healthcare providers expressed some empathy with the desperate deeds of women with unintended pregnancies. For other healthcare providers it was easier to involve the law enforcement services, as in one instance the birth of a baby was not attended to by a healthcare professional and the circumstances foregoing the baby's birth or death were unknown.

Healthcare provider's frustration with the law enforcement system

Healthcare providers mentioned on numerous occasions that they were of the opinion that there was a legal obligation for the law enforcement system to work in conjunction with the healthcare providers to get to the bottom of the matter of access to unsafe termination of pregnancy services. A healthcare provider also expressed her frustration that a case had been reported but no feedback had been obtained regarding the outcome and wanted to

know whether there were any strategies developed to prevent this from happening again in future.

> *"Maybe I think it can be…uhm, I think in the criminal sense of the way. I think it can…something must be…something must be done. Because I mean, if the patient goes away here and you give information to the police, and you give all your whatever, you never get feedback. Did they follow up on this case? Is it just a case that is just been thrown away? It's just the file is there, finish and 'klaar'. Nobody worries about that, you know what I'm saying? They don't give feedback. Nobody tells us what is happening to this…to this case." [Healthcare Professional Four]*

> *"You know, when the patient is out of here they are out of here, you don't get any feedback from the person. That is…that is for me, it's a little bit…it's not a nice feeling. I want to know what is being done outside in the community. Is the police following up on these cases? Is there any arrest that has been made?" [Healthcare Professional Four]*

Healthcare providers sought assistance from the South African police services to aid them in exposing the unlawful provision of Misoprostol to the women with unintended pregnancies. A healthcare professional expressed her disappointment that it was of no avail to seek help.

> *"The first time that I saw that, we call the police and said: 'Listen, can you go to Site C for us to a yellow container, to those African guys? Then don't go yourselves there, send somebody and go and buy these and pretend if one police lady, that is not wearing a uniform, pretending as if she wants the tablets.' This is the thing that I wanted to know. But you know 'mos' the police, the South African police. They never came back and when I'm looking for them, nobody knows about what we ask for." [Healthcare Professional Five]*

The intention of healthcare providers to report unsafe termination of pregnancy attempts was not to expose or judge women with unintended pregnancy, but rather to ensure that the spread of scheduled prescription drugs should be exposed. These efforts of healthcare providers were merely to safeguard women with unintended pregnancies rather to seek termination of pregnancy services inside the CHCs.

4.5.4.3 Subtheme: Management guidelines on unsafe use of Misoprostol

Emerging from the principal theme of healthcare providers' perceptions regarding unsafe TOPs the subtheme of management guidelines on unsafe use of Misoprostol was revealed.

Lack of management guidelines on the excessive use of Misoprostol

All five healthcare providers indicated that there were no clear management and referral guidelines regarding clients who had been admitted after excessive use of Misoprostol.

> *"We didn't have any guidelines on the management of patients who insert Misoprostol." [Healthcare Professional One]*

> *"But then there's no set protocol on how to actually go about with a matter within our facility that if something like this happens, then I'm expected to do one, two, three. So that is not stipulated down in writing. There's no set protocol, then it becomes my dilemma of me on the spot when I'm dealing with that case, on how to go about this. Do I use ethics, morals, humanity?" [Healthcare Professional Two]*

In two instances the clients were referred by the healthcare providers on the basis of clinical diagnoses and referral guidelines for premature labour.

> *"A protocol that we use that if the patient is complaining of lower abdominal pain and she have contractions, and she's less than thirty-four weeks, she's a (name of institution withheld) patient. So if she's above thirty-four weeks it's a (name of institution withheld) patient. But there is nothing that is specific about the threatening abortion, or whatever. There's nothing specifically to guide us about that." [Healthcare Professional Three]*

> *"We manage them…most of the patients that, like the two incidents that I had the patients wasn't booked. So we found the Misoprostols still inside the vagina. So what we normally do is we take it out and we refer and we put it like, I put it in a specimen jar, we send it with to the doctor, to the hospital. So at the end of the day it causes 'mos' preterm labour, because maybe they are twenty something weeks. So most definitely we have to book the patient, and refer the patient as…as if it is a preterm labour." [Healthcare Professional Four]*

Some healthcare providers felt that they were dealing with labour and birth care of women with unintended pregnancies the best they could, but perceived that even that was not adequate in the eyes of their superiors. There were no clear guidelines and healthcare providers were left to manage these situations as the moment required.

> *"Otherwise there is no guideline telling us what if the patient coming with this and this and this, what you must do. Instead sometimes we are to be blamed, you*

know? They come in fully dilated, there's nothing you can do. You just deal with the situation at that given moment. So it's where our problem lies, but some way we deal with the situation and we are dealing with these situations. They are making us feel so painful inside. There are cases whereby you feel like there is a demised baby there, but there is no counselling, no nothing." [Healthcare Professional Five]

"The maternity care guidelines of South Africa of 2007 were available in the units and clearly indicate the management of premature labour. In those guidelines there were no management instructions on the excessive use of Misoprostol." [Document Analysis]

There was unanimous agreement that although there were guidelines to aid the healthcare providers in managing patients with premature labour, the lack of guidelines to manage excessive Misoprostol intake created some dilemmas. The majority of the healthcare providers felt they had to deal with the situation when it occurred. Even though the healthcare providers experienced secondary grief regarding the demise of a mother's baby, the lack of debriefing sessions that were offered resulted in emotional trauma to some healthcare providers. The aim of all healthcare providers in a labour ward was to deliver healthy babies to healthy mothers. If for some reason this statement is not true either for the mother or for the baby, it leaves the healthcare provider with a great deal of blame.

4.6 SUMMARY

In this chapter the demographic data as well as the findings of the underutilisation of termination of pregnancy services by women with unintended pregnancies were discussed. The perceptions of five women whom had attempted unsafe termination of pregnancy, as well as their differences in ethnicity, age group, gravidity and parity, marital status, employment level, educational level and language preferences were discussed as part of the fist unit of analysis. The perceptions of five healthcare professionals who had attended to the care of women, who had underutilised TOP services in the past, were discussed as part of the second unit of analysis. In conjunction with the above, the healthcare provider's ethnicity, highest level of education, experience in years and language preferences were also portrayed. After the process of data analysis, four themes and twelve subthemes emerged from the data.

Access to TOP information regarding TOP services was discussed on the basis of healthcare providers' perceptions regarding available TOP services, the healthcare providers' provision of information regarding TOP services, the healthcare providers'

perception regarding access to TOP services, information regarding TOP legislation and access to TOP information on lampposts and walls of buildings. In addition, it was found that TOP services were underutilised due to failure or delay to initiate contact with healthcare providers and betrayal by alleged healthcare providers. It was proved that the social stigma surrounding unintended pregnancies led these women to seek services outside the parameters of the CHC. The choices of unsafe TOP decisions were forced by social, personal and financial circumstances and some feelings of regret were evident in these women only after they had made the unsafe TOP decisions. The healthcare providers' perceptions regarding unsafe TOPs revealed the existing code of conduct and provision of services that healthcare providers adhere to, as well as the ethical dilemmas and lack of guidelines that hampered the care for these women with unintended pregnancies.

The figure to follow will essentially portray the findings and discussions of this chapter regarding the underutilisation of TOP services amongst women with unintended pregnancies.

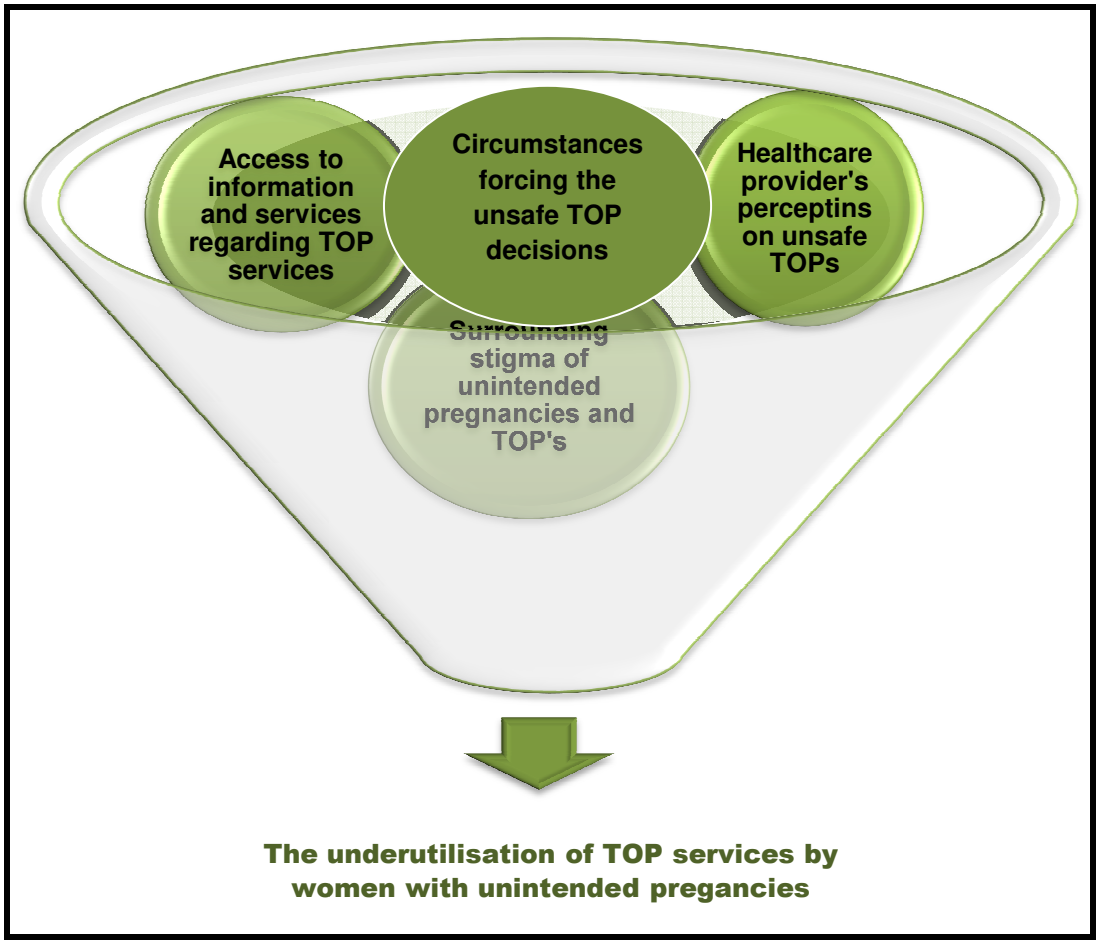

Figure 4.1 The essence of underutilisation of TOP services

4.7 CONCLUSION

The findings of the underutilisation of TOP services amongst women with unintended pregnancies were discussed as revealed by the women themselves and on the basis of the perceptions of the healthcare professionals who had previously dealt with the care of women with unintended pregnancies. An unplanned pregnancy made it difficult for the women to seek assistance within the services of the CHCs. Efforts to hide the pregnancies due to maternal age, pursuit in education, the stigma surrounding rape and respect for and the opinion of their parents were some of the reasons that led these women to make unsafe TOP decisions.

In Chapter Five (5) the discussions, conclusions and recommendations of the research study will be presented.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The background and foundation of the study were presented in the introductory chapter, including the theory that Icek Ajzen established in 1985 regarding planned behaviour and which the researcher utilised to guide the development of this study. The introductory chapter was followed by a literature review that revealed the incidence of unintended pregnancies, views on TOP legislation, perceptions of healthcare providers and women with unintended pregnancies regarding TOPs, the availability of TOP services, TOP methods as well as the code of conduct of healthcare providers.

A qualitative single descriptive case study approach was utilised with the use of individual semi-structured interviews, field notes and document analysis as aids to meet the objectives and aim of this study. The principles of Lincoln and Guba in the form of credibility, transferability, dependability and conformability were applied throughout the research. The research methodology and trustworthiness were described in Chapter Three. In Chapter Four the data was analysed, using Robert Yin's general analytic technique. The data revealed four main themes, which were: access to information and services regarding TOP services, the stigma surrounding unintended pregnancy and TOPs, circumstances forcing the unsafe TOP decisions and healthcare providers' perceptions on unsafe TOPs.

This chapter portrays the discussion of conclusions drawn from the findings revealed in the data analysis. In addition, the researcher notes the limitations of the study, makes recommendations to improve service delivery and gives suggestions for future research.

5.2 DISCUSSION

The data revealed four main themes related to the underutilisation of TOP services for women with unintended pregnancies. The following discussion portrays the findings of the study in relation to the aim and objectives of this research.

5.2.1 Unintended pregnancies and TOP services: Control beliefs

Access to information and services regarding TOP are of cardinal importance in the utilisation of safe TOP services in CHCs in the public health sector. It should be noted that maternity care and reproductive health form an integral component of primary healthcare

and free service delivery to all pregnant women. In South Africa, one of the aims was to focus on fulfilling the basic needs of rural and urban communities. As part of this strategy, in July of 1994 the Minister of Health specifically announced free healthcare services for all pregnant women (Republic of South Africa, 2015b).

The conceptual framework of this study as applied by means of Ajzen's Theory of Planned behaviour (1985) is consistent with the study findings. According to Ajzjen (1985) control beliefs are those attributes that influence the intent to certain behaviour. Despite the provision of these free healthcare services to all, women with unintended pregnancies were still accessing information regarding TOP and TOP services outside the parameters of the public healthcare settings as indicated in the findings of this study.

In one instance, access to information regarding TOP medication was obtained from the workplace, as the woman with the unintended pregnancy was employed at a pharmaceutical company. The literature review did not reveal any study that was consistent with these findings. Some women were unaware of the services that provide information and access to TOP services. A study conducted in Ghana was consistent with this finding. The study demonstrated that the greater part of the respondents showed a lack of knowledge of safe TOP services (Atakro, et al., 2019:60).

Other women revealed that enquiries were made regarding TOP, but due to unknown gestational age and gestational age restrictions, access was denied and they were requested to return the following day, which unfortunately did not occur. Some women were aware that according to the Constitution of South Africa it was unlawful to terminate pregnancy after the gestational age of twenty weeks had been reached. This finding reverts to another study conducted in Cape Town, South Africa, in which it was revealed that knowledge of TOP legislation in South Africa was evident amongst women with unintended pregnancies and that women were denied access to safe TOP services due to gestational age restrictions. This resulted in women accessing illegal TOP services (Harries, Gerdts, Momberg & Foster, 2015: 25). In this study the methods of choice of TOP that they pursued were unsafe and illegal, but in their desperation they still proceeded with the decision to terminate the pregnancy. These women also sought peer consultation as a means to access TOP services.

Access to safe TOP services was only obtained after an unsafe TOP had been attempted. The women presented in the CHCs with complications and were then referred appropriately. Healthcare providers were of the opinion that TOP services were not only available in the

CHCs, but also at non-profit organisations and that women with unintended pregnancies should rather opt to access these services. Efforts were made by healthcare providers to inform and educate women regarding TOP services provided at the CHCs.

Accessing information and services obtained from the internet possibly decreased the health status of individuals who followed this route (Baker, Wagner, Singer & Bundorf, 2003: 2405). In this study, information and access to unsafe TOP services was obtained by the use of electronic media in the form of Google search engines. In the opinion of some or the women who were interviewed, the information was easily obtained and the internet provided a wide variety of information. Both the women with unintended pregnancies and the healthcare providers revealed that other methods to obtain information and access to TOP information included advertisements on lampposts and building walls. The access of health care information on the internet as well as by the means of advertisements on lampposts and walls of building, led to underutilisation of safe TOP services by these women.

Amnesty International reported that only 505 of South Africa's 3 880 designated public healthcare facilities performed TOP services (Amnesty International, 2018). These statistics were not exclusively indicative of public healthcare facilities in the Western Cape. It was indicated that one CHC in Mitchells Plain sub-district and one in Khayelitsha sub-district were designated to render TOPs in the Western Cape (Republic of South Africa, 2010). Contrary to the above, healthcare providers revealed that TOP services were rendered on the premises at only one of these research facilities. It was a further problem that women with unintended pregnancies who sought TOP services had to be referred to another facility. Poor access to TOP services was also related to the failure or delay to initiate contact with healthcare providers. The unintended pregnancies were confirmed by the women themselves and some even sought a TOP immediately after the pregnancy had been confirmed and/or turned towards their faith to resolve the matter of the unintended pregnancy.

In an effort to hide the pregnancy or the attempt to terminate the pregnancy, women delayed seeking medical assistance. All the healthcare providers who were interviewed revealed that no prior attempt had been made by the women with unintended pregnancy to initiate contact with healthcare providers. The first contact was initiated when the women incurred problems due to the unsafe TOP attempt. Instead of accessing TOP services at public healthcare facilities, women with unintended pregnancies rather opted to seek assistance by other means, with the result that these women accessed healthcare from individuals that portrayed themselves as trained healthcare providers.

5.2.2 Barriers to the utilisation of TOP services: Normative beliefs

The theoretical framework proposed in Chapter One suggested that the theory of planned behaviour guided individuals' planned behaviour as based on behavioural beliefs, normative beliefs and control beliefs. Strong intentions to perform planned behaviour occurred when individuals perceived a positive outcome towards a planned behaviour, their norms were favourable to others' perceptions and the planned behaviour created a strong sense of the individual's control (Ajzen, 1985).

The above may be related to the underutilisation of TOP services, as the perceived positive attitude to conceal or hide the pregnancy resulted in the individual's sense of control by resorting to an unsafe TOP choice and ultimately obtaining the desired outcome of terminating the pregnancy. The barriers to the utilisation of TOP services were found to be circumstances that forced the unsafe TOP decisions. Ajzen (1985) suggested that behaviour was subject to the normative expectations of other individuals. These barriers, in relation to the subjective norm, are discussed as related to social circumstances, personal circumstances, financial circumstances, the attitude of healthcare professionals and the psychological status of the women with an unintended pregnancy.

5.2.2.1 Social circumstances

The social circumstance of marital status is one of the possible factors in either the occurrence of induced abortions, or the lack thereof, in the incidence of an unintended pregnancy (Fusco, de Souza e Silva & Andreani, 2012:716). In this study, none of the women with unintended pregnancies who were interviewed indicated that they were married. Two of the women were in relationships, but were still undergoing secondary education and both of the individuals in the relationship were under the financial care of their parents/guardians. One woman revealed that a long-term relationshiop had ended due to the occurrence of the unintended pregnancy. The other two women indicated that they were not in a relationship at all; in one instance the pregnacy occurred due to rape and in the other instance the pregnancy occurred due to cosensual sexual activity.
Another social circumstance that forced the TOP decisions was the opinions of and respect for parents/guardians.

According to Atakro, et al. (2019:17) unsafe TOPs were practiced in an attempt to avoid parental disapointment and resentment. One of the healthcare providers in this study was of the opinion that teenagers in fear of their parents' reactions, did not disclose the pregnancy to their relatives or peers and rather underutilised the safe TOP services. The women with unintended pregnancies that were interviewed, revealed that they wanted to maintain the respect of their parents and this led them to seek unsafe TOP choices. In addition to the fear

of dissapointing their parents/guardians, the fear that the knowledge of the unintended pregnancy might pose serious health risks due to emotional distress to their parent/ guardian, also forced the unsafe TOP decisions.

The perception that partners or relatives would not render support or that they would receive poor support from partners resulted in the underutilisatin of TOP services. The answer to safe TOP choices lies in the inclusion of partners who share responsibility in reproductive choices and practices as well as the inclusion of prevention and intervention initiatives for women as regards effectiveness and accessibility (Jacobs & Hornsby, 2014). One healhtcare provider mentioned that women were forced into unsafe TOP decisions due to the absecence of a partner. Women felt that relatives rendered support at a stage that unsafe TOP descision could not be undone. The preconceived idea that the partner would deny involvement in the existence of the pregnancy, and the actual denial of involvement, resulted in two of the women interviewed to pursue unsafe TOP choices.

5.2.2.2 Personal circumstances

The data of this study revealed that personal circumstances such as maternal age, unintended pregnancy, efforts to hide the pregnancy and feelings of disbelief and hopelessness were amongst the barriers in the utilisation of TOP services. In Africa, a fourth of women aged fifteen to nineteen were found to be particularly vulnerable to underutilise safe TOP services, as they had a high risk of unintended pregnancy (Shah & Ahman, 2005). Two women, at the age of sixteen and seventeen years, felt that they were not prepared to being a mother or to raise a child. Some healthcare providers in this study expressed the fact that teenagers had left the safety of their parents' home in an attempt to conceal the pregnancy in order to avoid scrutiny from their parents' convictions. Some teenagers accidentally fell pregnant due to irresponsible sexual behaviour which resulted in an unwanted pregnancy. Poor support from parents forced these women to turn to unsafe TOP choices.

As indicated by the inclusion criteria of this study, all participants were selected on the basis that their pregnancies were viewed as unintended and therefore resulted in the unsafe TOP events. They accessed TOP services online and from advertisements on the walls of buildings, including peer consultation, and made the unsafe TOP choices and continued in the pursuit on their TOP choices despite not being aware what the outcome of these choices would be. In addition to the above the healthcare providers who cared for the women who resorted to unsafe TOP methods, revealed that these women did not disclose their Misoprostol intake at first and the utilisation of this drug was only discovered by clinical

examination. In one instance the attempt to terminate the pregnancy was made at a relatively mature gestational age of 32 (thirty-two) weeks. According to the data of the healthcare provider interviews, not only was the drug Misoprostol used in the attempt to terminate the pregnancy, but self-administered concoctions in the form of “umchamo wemfene” was utilised as well. It is thus evident that these women with unintended pregnancies rather resorted to self-resolving methods to terminate the pregnancy as opposed to access of safe TOP services.

Efforts to hide the pregnancies were displayed by these women. Choices to delay in seeking emergency transport care during the night when the need for healthcare assistance occurred and rather to opt for using public transport services during the day, were some of the efforts revealed in an attempt to hide the pregnancy. Some women chose to terminate the pregnancy before bodily changes could reveal it and others decided just to conceal the pregnancy from relatives or peers. Feelings of disbelief were evident when the pregnancy was discovered by one of the participants and was left in a situation that seemed impossible for her to resolve. Some women experienced feelings of hopelessness when the access to TOP services were denied due to gestational age restrictions and therefore forced the action of an unsafe TOP choice.

5.2.2.3 Financial circumstances

The data revealed that unsafe TOP choices were required due to unemployment and financial difficulties or the pursuit of education and training. In addition to the above-mentioned financial circumstances, the women with unintended pregnancies were desperate to terminate the pregnancy and a degree of financial exploitation was revealed. Socio-economic conditions such as the financial difficulties, unemployment and lack of economic support resulted in women with unintended pregnancies to indulge in unsafe TOP practices (Atakro, et al., 2019:11). One participant in the study revealed that her parents were struggling to make a living and she feared their disappointment if the pregnancy was disclosed. Another woman mentioned that prior to her pregnancy she had been a business associate of her partner and once the pregnancy was disclosed, the romantic and business relationship was terminated. This resulted in a financial dilemma. Some of the women were supported financially by their parents or guardians and therefore unemployed. Funds for the unsafe TOP were obtained by means of exchanging gift cards for money and extracting money from personal savings.

In this instance access to TOP services was denied due to gestational age restrictions and in an attempt to resolve the situation, the consultation with non-profit TOP organisations did not

deliver results due to financial constraints. The views of the healthcare providers were that women with unintended pregnancies underutilised TOP services due to unemployment, short birth intervals and absence of parents' or financial support. The pursuit of education and training were viewed by the healthcare providers as another barrier to the underutilisation of TOP services. The interviews with the women revealed that some of them were still attending secondary and tertiary level education and could therefore not continue with the pregnancy, which then resulted in the unsafe TOP decision.

As previously stated, according to the Constitution of the Republic of South, all women should receive healthcare services free of charge (Republic of South Africa, 2015c). The availability of funds should therefore not have been a predisposing factor in the utilisation of TOP services. The women's desperate attempts to terminate the pregnancy caused the occurrence of financial exploitation. Amounts involved in the provision of these unsafe services varied from R150 up to R1 200. Funds for these unsafe TOP services were taken from personal savings, gift cards and money provided by parents for educational purposes. Only after these amounts had already spent and the outcome to terminate the pregnancy had not been obtained, these women realised that they had been financially exploited.

5.2.2.4 The attitude of healthcare professionals: normative influence

The failure of healthcare providers to provide other alternatives such as referral for adoption in instances where TOP was denied due to gestational age restrictions and failure to respond to healthcare providers' referrals, forced unsafe TOP decisions. Women with unintended pregnancies had predisposed ideas regarding judgemental and negative attitudes of healthcare providers when TOP services were sought in public healthcare facilities (Harries, Orner, Gabriel & Mitchell, 2007:7).

In this study, the attitudes of healthcare providers were not specifically portrayed, but some women who made enquiries regarding TOP and pregnancy prevention services were denied access due to TOP legislation. The healthcare providers requested these women to return the following day in order to initiate ANC services or to determine the exact gestational age; thus the referral to alternative services regarding TOP were not initiated on the first contact with the healthcare provider. Lack of the provision of alternative methods to TOP resulted in women making unsafe TOP choices.

5.2.2.5 Psychological status

Women with unintended pregnancies expressed strong feelings of guilt when they initially accessed TOP services. There was less correlation with their moral and religious beliefs

than with the practical considerations of pain, side-effects and efficacy (Fielding, Edmund & Schaff, 2002:39). In this study the women's psycological status prior to their unsafe TOP attempt was not portrayd. Feelings of guilt were displayed after the termination of the pregnancy had occurred and the women expressed hatred towards themselves. Feelings of regret varied according to the means and measure. Immediate feelings of regret occurred after the intake of Misoprostol and some women could not continue further intake of the drug to complete the TOP process. The sense of hope that the pregnancy could have turned out well, caused this feelings of regret. One woman expressed feelings of regret because of the traumatic consequences she had caused to herself and even confessed that she felt like a murderer. Contrary to the above, another woman was forthcoming that she did not experience any feelings of regret, but rather that she was dissatisfied with her choice of TOP. The link between psycological status and the barrier towards the utilisation of TOP services is not evident in this study, but the feelings of guilt and regret that followed the unsafe TOP choice were evident.

5.2.3 Strategies to improve utilisation of safe TOP services: Intention of behaviour

Goal three of the UNDP aims to establish good health and wellbeing for all by the year 2030. As part of this goal, universal access to sexual and reproductive healthcare services needed to be established (United Nations, 2016). The data of this study revealed that the stigma surrounding unintended pregnancy as well as healthcare professionals' institutional failure resulted in women with unintended pregnancies to underutilise TOP services. Some of these women with unintended pregnancies had the perception that their religious community and their own religious views prevented them from seeking safe TOP services. They pursued unsafe TOP methods in an effort to conceal the unintended pregnancy. Based on the findings above, the theory of planned behaviour of Ajzen (1985) indicated that greater behavioural, normative and control beliefs resulted in greater intent to perform the planned behaviour. The stigma surrounding unintended pregnancy (normative beliefs) and the attitudes of healthcare professionals (control beliefs leading to perceived behavioural control) regarding unwanted pregnancy (behavioural beliefs) led to intentions to terminate or hide the pregnancy.

One woman's pregnancy was the result of rape. She avoided possible scrutiny and the burden of social stigma from her religious community by pursuing unsafe TOP methods in an effort to conceal the unintended pregnancy. Similarly, a healthcare provider also revealed that one of the women had been raped and the fear of judgement due to the manner of conception compelled her to access unsafe TOP services. Rape can be linked to normative beliefs that influenced these women with unintended pregnancies to hide or terminate the

pregnancies. Previous experiences of doctor-patient confidentiality being breached, and which resulted in personal information being disclosed to relatives, forced a woman to seek healthcare services in a facility outside her area of residence. This may be explained by the theory of Ajzen (1985) that control beliefs (leading to perceived behavioural control) resulted in greater intent. In other words, the perceived attitude of healthcare providers by breaching doctor-patient confidentiality (control beliefs) resulted in these women accessing healthcare in a facility outside their area of residence (intention to hide the pregnancy).

The quality of health care for women seeking TOP services was influenced by the judgemental attitude of healthcare providers towards women of a younger age (Harries, Stinson & Orner, 2009: 303). The women with unintended pregnancies did not perceive indiscriminating or judgemental treatment form the research facility, but rather experienced these attitudes from healthcare providers in the healthcare facilities they were referred to. The interview with one healthcare professional revealed that the women with unintended pregnancies did not access TOP services due to their perception of possible resentment from the healthcare providers at the CHC. Data from the interviews with the healthcare professionals indicated that although reasons were not stipulated, the women explicitly mentioned that their pregnancies were unwanted. This resulted in the underutilisation of safe TOP services.

5.2.4 Healthcare professionals' perception of underutilisation of TOP services

Data from the interviews with the healthcare professionals revealed their perceptions in relation to the occurring phenomenon of underutilisation of TOP services. Issues regarding the healthcare provider's code of conduct and provision of services, ethical dilemmas in the workplace and the lack of management guidelines on unsafe use of Misoprostol were derived from these interviews.

The Western Cape Government is committed to service and promotes the values of care, competence, accountability, integrity, innovation and responsiveness. All departments of the public service have vowed to implement the fourth principle of Batho Pele by treating individuals with courtesy and consideration (Western Cape Government, 2019). One healthcare professional who dealt with the care of a women who had attempted an unsafe TOP, felt that the women were treated with respect and dignity and that no judgements were made.

Under the provision of the Nursing Act of 2005, the SANC established a Code of Ethics for Nursing Practitioners in South Africa, which declares that the building blocks of ethical

decision-making comprise of knowledge regarding the application of moral and ethical principles in relation to patient care (Republic of South Africa, 2013). One healthcare professional had trouble to distantiate herself from the circumstances and initially did not want to manage the presenting case, but made a deliberate choice to render services as she was obliged to by the code of conduct of the profession.

As women with unintended pregnancies presented in the CHCs in the need of assistance after an unsafe TOP attempt, healthcare providers found themselves in situations where immediate action was required. The appropriate referral systems on the basis of the management of premature labour were in place. The Department of Health of the Western Cape provides information regarding access to contraceptives and the various methods and means to initiate contact with these service providers (Department of Health, 2019). Healthcare providers felt that they were amazed regarding the unsafe TOP attempts as information on TOP services was provided whenever required. Even in instances where a TOP was restricted due to gestational age, alternative options in the form of adoption were provided. Healthcare providers were of the opinion that pregnancy preventative services were being provided at the CHC by trained healthcare providers, that various family planning options were available, but that healthcare users provided numerous reasons for underutilising these services. One healthcare provider found it sad that women still resorted to unsafe TOP choices despite the available family planning services.

Ethics is defined as the philosophical discipline that results from a process of reflection that is justifiable by rational and systematic reasoning. An individual's actions may be prohibited by law, but not from a viewpoint of ethical reasoning (Moodley(ed.), 2015:11). The healthcare professionals who were interviewed stated their view that the use of Misoprostol should be regulated and controlled and that it should not be accessible via self-prescription. Most of these healthcare professionals only experienced the use of Misoprostol in the utilisation in the control of postpartum haemorrhage or after the incidence of a spontaneous miscarriage. One healthcare professional expressed her sympathy towards women who had deliberately taken Misoprostol, as she had had a personal traumatic experience with the use of this drug.

The healthcare providers displayed varied perceptions of their legal obligation to report the unsafe use of Misoprostol. The Medicines and Related Substances Control Act, Act 101 of 1965, stipulates that no individual is allowed to manufacture or be in possession of a scheduled substance, unless it was prescribed by a healthcare provider (Republic of South Africa, 1965). Some expressed their remorse towards the women who had unsafely taken

Misoprostol, because of the possible lawful outcome of the women's actions by the unsafe intake of Misoprostol, which was only disclosed by another healthcare professional at a referral facility. In the instance when a new-born is admitted dead on arrival (DOA), law enforcement should be contacted and the new-born's body should be referred for a forensic post mortem (Republic of South Africa, 2015c:111). Another healthcare professional felt obliged to report the Misoprostol intake, as the circumstances of the women's admission were related to the baby being declared dead on arrival and there was a need to involved law enforcement. Assistance was sought from law enforcement to expose the uncontrolled providers of Misoprostol, but the healthcare providers were rather left with frustration due to the lack of feedback from law enforcement.

According to the Maternal Care Guidelines of South Africa (2007:100), preterm labour is defined as spontaneous labour that occurs before the gestational age of thirty-seven weeks. The management of premature labour takes place on the basis of the gestation according to various levels of care, as set out in this guideline. Two of the healthcare professionals mentioned that women who were admitted after unsafe TOP efforts had presented with premature labour and they were managed accordingly in terms of the available Maternal Care Guidelines in the unit. All of the healthcare professionals who were interviewed were of the opinion that there were no guidelines on the management of Misoprostol intake and that they had to act on their own initiative. One healthcare professional mentioned that in the instance of a neonatal demise, she felt she was blamed and there were no debriefing sessions available to her.

5.3 LIMITATIONS TO THE STUDY

Observation as a data gathering instrument can be used in surveys, case studies and experiments, either in isolation, or in combination with questionnaires and interviews (Watson, et al., 2008:310). The researcher only utilised in-depth individual interviews, field notes and document analysis as part of the process of data gathering. During the time that the researcher spent in the field, numerous observations were made which could have contributed towards the study findings, but this method of data gathering was not included in the proposed research methodology for the present study.

The primary instrument for data collection and analysis was the researcher. Data was not mediated through interventions, questionnaires or machines, but rather via the human instrument who was the researcher (Atieno, 2009). The findings of this study were dependent on the researcher's knowledge of the research process and the researcher's

expertise to gather and interpret the data. As this was the first study conducted by the researcher, this could have influenced the study findings.

The WHO defines teenagers as individuals during the time period between the ages of ten and nineteen (in Kibel & Wagstaff, 2001:140). No limitations were set for inclusion criteria regarding the age and race of the study participants. The demographic data of this study revealed that 40 % of the women with unintended pregnancies who had underutilised TOP services were teenagers. In addition to age, 10 % of the participants were of coloured ethnicity and 90 % were of black ethnicity. The above was not representative of the South African and Western Cape diversity and could therefore not be generalised as to age or race.

In order to achieve reliability of the study, the technique of member checking could possibly be utilised as a measure of credibility (Brink, et al., 2012:172). The researcher had however already experienced difficulties with the women with unintended pregnancies who had underutilised TOP services to consent to one individual interview. A second interview was therefore not granted. In the second unit of analysis, healthcare professionals who had dealt with the care of women who had underutilised TOP services were interviewed. Owing to work scheduling, operational needs and service delivery demands, the researcher also experienced difficulty in finding a timeframe suitable to conduct the interviews with these participants. The researcher had requested to return and validate the data by means of a follow-up interview after the interview had been transcribed. All participants declined, however, and considered the initial interview to be adequate.

5.4 PERSONAL REFLECTION

The researcher is in fulltime employment as a healthcare professional at another public healthcare facility and prior to the onset of the research, periodic incidences of the underutilisation of TOP services was witnessed. As previously declared, the researcher strongly opposes TOPs due to personal and religious beliefs, but felt the need to explore this phenomenon in order to gain insight in the perceptions of others and to illuminate preconceived biases in the care of these women. As with the onset of any research study, the idea initially was to bring change in the research field, to improve utilisation of healthcare services and the access thereof as well as to influence the perceptions of the caretaker, including the researcher herself. It was soon realised that in order to achieve the above, collaboration with other academic studies, healthcare providers, healthcare institutions, policy reformers and many more would be needed.

The phenomenon that was being explored was of a highly ethical nature and numerous difficulties were encountered. The researcher spent elongated and continuous periods in the field in an effort to identify participants, which was of no avail. Only after multiple efforts to make the study known and to establish rapport with the healthcare providers attending to the care of the women with unintended pregnancy and who had underutilised TOP services, the researcher had success in recruiting participants. Although the participants had already given verbal consent to be contacted by the researcher, it was difficult to arrange a time schedule that was suitable for them to meet for the interview. In some instances their desperate efforts to terminate the pregnancy outside the parameters of a healthcare setting and the fact that they concealed their actions from peers and relatives, made them reluctant to return to the healthcare setting. Contact sessions with participants were initiated when they had already been obliged by the healthcare providers to seek routine follow-up care. Interviews were conducted after services had already been rendered to them. The ordeal of these women as revealed during the interviews rather troubled the researcher and debriefing sessions were sought from peers.

5.5 CONCLUSIONS

It was the perception of healthcare providers that women with unintended pregnancies were knowledgeable regarding the access of TOP services at public healthcare facilities. These healthcare providers also felt that adequate provision of access to TOP services and means of TOP referral were provided by them when the inquiry occurred. These findings were in contrast with another study in which it was found that termination of pregnancies outside designated facilities were the result of lack of information on abortion rights and poor accessibility to services (Jewkes, Gumede, Westaway, Dickson, Brown & Rees, 2005:1240).

Healthcare providers were informed regarding TOP legislation. The knowledge of women regarding TOP legislation was varied. Some were not aware of gestational age constrictions, while others were well aware and in their desperation to terminate their pregnancy, still pursued their unsafe TOP choices. These findings were consistent with a study that showed that one-third of the women surveyed in the particular study, were not aware that abortion was legal in South Africa (Morroni, et al., 2006). Information on TOP services was obtained from the internet as well as advertisements on the walls of buildings. Consistent with the above, one study came to the conclusion that there was an increase in advertisements posted on lampposts and the walls of buildings in South Africa (Trueman & Magwentshu, 2013:398).

Women with unintended pregnancies, on the other hand, made some enquiries regarding TOP services and were denied TOP services due to gestational age constrictions. This showed similarity to a study in which it was found that the denial of TOPs due to gestational age limits resulted in women with unintended pregnancies seeking illegal abortion services elsewhere (Gerdts, et al., 2014). Access to TOP services was influenced by the failure of women with unintended pregnancies to initiate contact with healthcare providers. In some instances access to healthcare services was delayed, as women resorted to unsafe TOP methods first, and only accessed healthcare when they were in the need of assistance due to labour-related queries. These findings were confirmed by another study that concluded that women with unintended pregnancies experienced longer delays in seeking care (Mutua, Maina, Achia & Izugbara, 2015:241).

The underutilisation of TOP services was related to the stigma surrounding unintended pregnancies and TOPs. Factors such as the perceived opinion of healthcare providers and the community, religious beliefs, conception due to rape and unwanted pregnancies, influenced the access to safe TOP services. A study in Brazil concluded that factors related to environmental, cultural and social circumstances, as well as the relationship with relatives, and their beliefs, had compelled women with unintended pregnancies to seek legal abortions after the incidence of sexual assault (Blake et al., 2015). The findings of this study however included the stigma of the perception of healthcare providers as a factor associated with women underutilising TOP services.

It was also evident that choices of unsafe TOP decisions were forced in view of various circumstances. Social circumstances such as relationship status, the opinion of and respect for parents/guardians, the women's perception that partners/relatives would not render support, as well as poor support from partners, resulted in unsafe TOPs. Other contributing factors towards forced TOP decisions were personal circumstances. Feelings of disbelief and hopelessness when the pregnancy was discovered, immature maternal age and efforts to hide the pregnancy were revealed as personal circumstances that hindered the utilisation of safe TOP services. In addition to social and personal circumstances, the existence of financial deficiency was also relevant to women with unintended pregnancies who sought unsafe TOP methods.

Financial circumstances included unemployment and financial difficulties, as well as pursuit of education and training. Although not directly related to financial circumstances, the choice of unsafe TOP access resulted in financial exploitation. The psychological status of women with unintended pregnancies, that preceded their unsafe TOP choice, was not evident in this study. Feelings of regret and guilt were, however, displayed by these women once the

unsafe TOP action had already occurred. These findings proved to be consistent with a study conducted in Ghana, which found the same factors contributing to unsafe TOPs (Atakro, et al., 2019). However, the desire to bear children only after marriage, as indicated by Atakro, et. al. (2019) did not emerge in this study.

Healthcare confirmed that positive attitudes were displayed to women seeking TOP services; appropriate referral systems to TOP and post-unsafe TOP services were provided. These healthcare providers also confirmed the availability of family prevention services and found it difficult to understand the underutilisation of these services. A study found that healthcare providers who were responsible for the care of women with unintended pregnancies, by optimising these care levels, could improve the service outcome for women with unintended pregnancies (Simmonds & Lakis, 2011:805).

Healthcare providers viewed the use of Misoprostol only in the management of gynaecological and obstetric emergencies and not as a means to terminate pregnancies. There was no evidence of a management protocol that would guide healthcare providers in the management of excessive intake of Misoprostol. The general feeling was that this drug should be controlled and prescribed. Some healthcare providers felt the need to report the unsafe TOP to law enforcement as an effort to prevent future abuse of this drug in an unsafe manner and in so doing to reduce maternal mortality. Healthcare providers expressed frustration toward law enforcement due to lack of feedback from cases that had been reported in the past. Similar to the perception of the healthcare providers in this study, another study likewise indicated that legal reform in itself did not prove to be sufficient to reduce the incidence of unsafe TOP practices, but could play a role in the decrease of maternal mortality rates (Belton, Whittaker, Fonseca, Wells-Brown & Pais, 2009:61).

5.6 RECOMMENDATIONS

The literature review conducted in Chapter Two of this study, in collaboration with the data analysis process and the findings derived therefrom, led the researcher to reach the following conclusions.

5.6.1 Reinforcement of ANC implementation on pregnancy confirmation

Reinforcement of the implementation of the initiation of ANC at first contact with healthcare providers and on confirmation of the pregnancy would allow the healthcare professionals to provide better support to the women. Maternity care serves to be an integral part of primary health care and a free health service for all pregnant women. When pregnancy is confirmed at primary health care level, the women should receive first antenatal care and be issued with an antenatal care booklet (Republic of South Africa, 2015c).

Although this study indicated that initiation of ANC was absent in the cases of all of the women, some efforts were made to initiate contact with healthcare providers by means of pregnancy prevention and TOP services enquiry. These enquiries led to the women either being declined TOP access due to legislation constrictions, or preventative services being declined as the result of a current pregnant status. Healthcare services were not initiated on first contact and these women were requested to return the following day. Both forfeited the request and ended up resorting to unsafe TOP choices. In combination with the recommendation to follow, the reinforcement of implementation of ANC at first contact with a healthcare provider, could aid in the identification of unintended pregnancies.

5.6.2 TOP assessment tool inclusion in Maternal Case Record (MCR)

The MCR is a standardised national booklet that serves as the principal record of a woman's pregnancy and should be issued to the woman on initiation of ANC. This record includes assessment tools such as the gravidogram, clinic checklist that identifies ANC visits, check list for pregnancy risk assessments as well as a mental health screening tool (Republic of South Africa, 2015c). After confirming the pregnancy on the first visit, the aim is to identify women who are in need of TOP services and to refer those women (Republic of South Africa, 2015c).

No assessment tool is available in the MCR that allows the identification and referral of women with unintended pregnancies. In some instances, women in this study initiated contact with healthcare providers. Immediate ANC and identification of unintended pregnancies were not initiated by healthcare providers. The inaction of healthcare providers ultimately led these women to access unsafe TOP services. If unintended pregnancy could be identified at an early stage, underutilisation of safe TOP services could be prevented. The inclusion of an assessment tool to identify women with unintended pregnancy on initial contact with healthcare providers is therefore recommended.

5.6.3 Utilisation of technology for TOP services in Public Healthcare

It is evident from this study that women with unintended pregnancies utilised internet search engines to become knowledgeable regarding information and access of various TOP services. A mechanism referred to as a SEO, or search engine optimisation, enables a website to appear in the top list of the search results after a search has been conducted by using specific keywords related to the researched topic (Yalçin & Köse, 2010:488).

Recruitment of online research can be facilitated by numerous tools of Google AdWords that were originally developed for advertising products and services. These tools include specific keywords that trigger the advertisement, targeting specific geographical areas, timing advertisements and conducting multiple options. AdWords also consists of tools to manage the cost of advertisements. By clicking on a displayed advertisement the costs are already incurred and to display these advertisement is not related to any additional charge (Gross, Liu, Contreras, Muños & Leykin, 2014:18). The Western Cape Department of Health's website can be optimised by the use of SEO and Google AdWords. This strategy would enable the Department of Health to be the first in providing information regarding TOP services and could possibly limit the utilisation of unsafe TOP providers.

5.6.4 Implementation of Misoprostol management protocol in CHCs

In this study the healthcare providers expressed the opinion that in the instance of excessive Misoprostol intake, the women normally presented with signs of premature labour. Clinical diagnosis of the attending healthcare provider confirmed the diagnosis of premature labour that made further management and referral necessary. The Guidelines for Maternity Care in South Africa (2015:101) assisted healthcare providers in their management of premature labour. The document analysis revealed that the guidelines on the management of premature labour were available in the involved units.

Apart from the availability of the guidelines of the management of premature labour, the healthcare providers in this study expressed their concern that there were no guidelines available to aid them in the management of excessive Misoprostol intake. The healthcare providers felt they were left to act on their own intuition and were troubled to observe these women battling severe uterine contractions. In one instance the excessive use of Misoprostol ended up in a maternal mortality. By implementing guidelines on the management of women who utilised high dosages of Misoprostol, maternal mortality could be decreased.

5.6.5 Development of incident reporting Standard Operating Procedures (SOPs)

Standard Operating Procedures (SOPs) is a process document that provides detailed descriptions of guidelines to perform a certain task. The purpose of the SOP is to standardise work procedures for staff to obtain the desired outcome of a fixed set of tasks (Akyar, 2012:368). In this study, healthcare providers who were taking care of women who attempted unsafe TOPs, felt frustrated due to the lack of feedback that received from law enforcement after reporting the incidents. Healthcare providers expressed that the intention of reporting the cases was not to expose the women they had cared for, but rather to prevent women with unintended pregnancies to utilise these services in the future.

The development of a SOP could decrease the utilisation of unsafe TOP services by means of collaboration between public services sectors. The health sector could obtain the information regarding the presenting case and the law enforcement sector could then follow up on the provided information. The anonymity of women who had adhered to unsafe TOP choices should be respected in the handling of the information. By these means, the providers of unsafe TOP services might be identified. The development of a SOP in the reporting of unsafe TOP incidents could lead to the decrease in underutilisation of TOP services.

The table 5.1 below summarises the recommendations.

Table 5.1 Recommendations

Recommendations as derived from the study findings	
Objectives	**Recommendations**
Identify unintended pregnancies	1. Reinforcement of implementation of initiation of ANC at first contact with healthcare provider and on confirmation of pregnancy
	2. The inclusion in the Maternal Case Record (MCR) of an assessment tool to identify and refer the women with unintended pregnancies, at the first ANC visit
Increase access to TOP services	3. Implement strategies to promote knowledge of the provision of TOP services in Public Healthcare facilities by the utilisation of technology.
Decrease maternal mortality	4. Implementation of a management protocol in CHCs on the management of excessive Misoprostol intake
	5. Development of Standard Operating Procedures (SOP) on the reporting of an unsafe TOP incidence.

5.7 FUTURE RESEARCH

The following areas of future research could be explored:

- The effects of the implementation of a health promotion programme for women with unintended pregnancies to access safe TOP services
- The experience of women with unintended pregnancies who were denied TOP access due to gestational age limits
- Exploring the existence of identification of an unintended pregnancy on first contact with a healthcare provider

- The role of immediate antenatal care initiation on confirmation of pregnancy and the influence of this on unsafe TOPs
- Exploring the collaboration between the Department of Health and the Department of Law enforcement as an influence on access of unsafe TOPs
- Examining strategies to prevent unintended pregnancies amongst women who are pursuing secondary and tertiary level education.

5.8 DISSEMINATION

The intention is to provide a copy of the report of the study findings to the CHCs involved in the study, as well as to other public service delivery sectors that may benefit from these findings. Recommendations to improve the utilisation of TOP services amongst women with unintended pregnancies were included in this report.

For the purposes of communicating knowledge, the researcher will publish the thesis electronically through the University of Stellenbosch via SUN Scholar and is planning to submit an article in an accredited peer-reviewed journal. A further aim of the researcher is to present the study, when the opportunity arises, at various platforms such as the Department of Health Research Day, Stellenbosch University Research Day, Midwifery Symposium and Midwifery Day.

5.9 CONCLUSION

This chapter laid out the findings of the study as guided by the research question. The perceptions of women and healthcare providers regarding the underutilisation of TOP services amongst women with unintended pregnancies were explored. Discussions and conclusions were based on the objectives of this study. This included the perspectives of women with unintended pregnancies regarding availability of TOP services, the barriers that inhibited the utilisation of these services, strategies to improve utilisation of services and the perceptions of healthcare professionals in relation to TOP services. The exclusion of observation as a data gathering method, the fact that the researcher was the primary instrument, the lack of evidence to generalise age or race and the restrictions as to member checking were identified as limitations of the study. Recommendations were made with the objective of identifying unintended pregnancies, increasing access to TOP services and decreasing maternal mortality. Suggestions for future research were based on data that derived from this study.

Despite the liberal South African legislation that allows TOP under various circumstances, the incidence of the underutilisation of TOP services amongst women with unintended

pregnancies still occurs. Although free access to public health care facilities regarding reproductive health for all women was declared in the Constitution of the Republic of South Africa, denial of TOP services resulted in women seeking unsafe TOP services outside the parameters of the public healthcare setting. Various circumstances led to the forced TOP choice and these women's desperate efforts to terminate the pregnancy led to financial exploitation by opportunists alleging to be healthcare providers. In order to campaign against the underutilisation of TOP services, public healthcare access to services and information regarding TOP services needs to be reviewed.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

Approved

New Application

Health Research Ethics Committee (HREC)

17/01/2018
Project Reference #: 1675
HREC Reference #: S17/10/221
Title: The underutilization of Termination of Pregnancy Services by women with unintended pregnancies: A descriptive case study in Community Health Centers within the Cape Metropole, South Africa

Dear Miss Elcalien Benade,

The **New Application** received on 26/10/2017 was reviewed by members of the **Health Research Ethics Committee 2 (HREC 2)** via **expedited** review procedures on 17/01/2018 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **This project has approval for 12 months from the date of this letter.**

Please remember to use your **project reference number (1675)** on any documents or correspondence with the HREC concerning your research protocol.

Please note that this decision will be ratified at the next HREC full committee meeting. HREC reserves the right to suspend the approval and torequest changes or clarifications from applicants. The coordinator will notify the applicant (and if applicable, the supervisor) of the changes or suspension within 1 day of receiving the notice of suspension from HREC. HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Please note you can submit your progress report through the online ethics application process, available at: https://apply.ethics.sun.ac.za and the application should be submitted to the Committee before the year has expired. Please see Forms and Instructions on our HREC website for guidance on how to submit a progress report.

The Committee wil then consider the continuation of the project for a further year (if necessary).Annually a number of projects may be selected racdomly for an external audit.

T

Translation of the consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (WesternCape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website (www.sun.ac.za/healthresearchethics)

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,
Mr. Francis Masiye,
HREC Coordinator,
Health Research Ethics Committee 2 (HREC 2).

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Department of Health).

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Progress Report Approval Letter

29/01/2019

Project ID: 1675

Ethics Reference #: S17/10/221

Title: The underutilization of Termination of Pregnancy Services by women with unintended pregnancies: A descriptive case study in Community Health Centres within the Cape Metropole, South Africa

Dear Miss Elcalien Benade,

Your request for extension/annual renewal of ethics approval dated 23/01/2019 16:04 refers.

The Health Research Ethics Committee reviewed and approved the annual progress report you submitted through an expedited review process. The approval of this project is extended for a further year.

Approval date: 29 January 2019

Expiry date: 28 January 2020

Kindly be reminded to submit progress reports two (2) months before expiry date.

Where to submit any documentation
Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your **Project ID [1675]** and Ethics Reference Number **[S17/10/221]** on any documents or correspondence with the HREC concerning your research protocol.

National Health Research Ethics Council (NHREC) Registration Numbers: REC-130408-012 for HREC1 and

REC-230208-010 for HREC2

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005240 for HREC1

Institutional Review Board (IRB) Number: IRB0005239 for HREC2

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Department of Health).

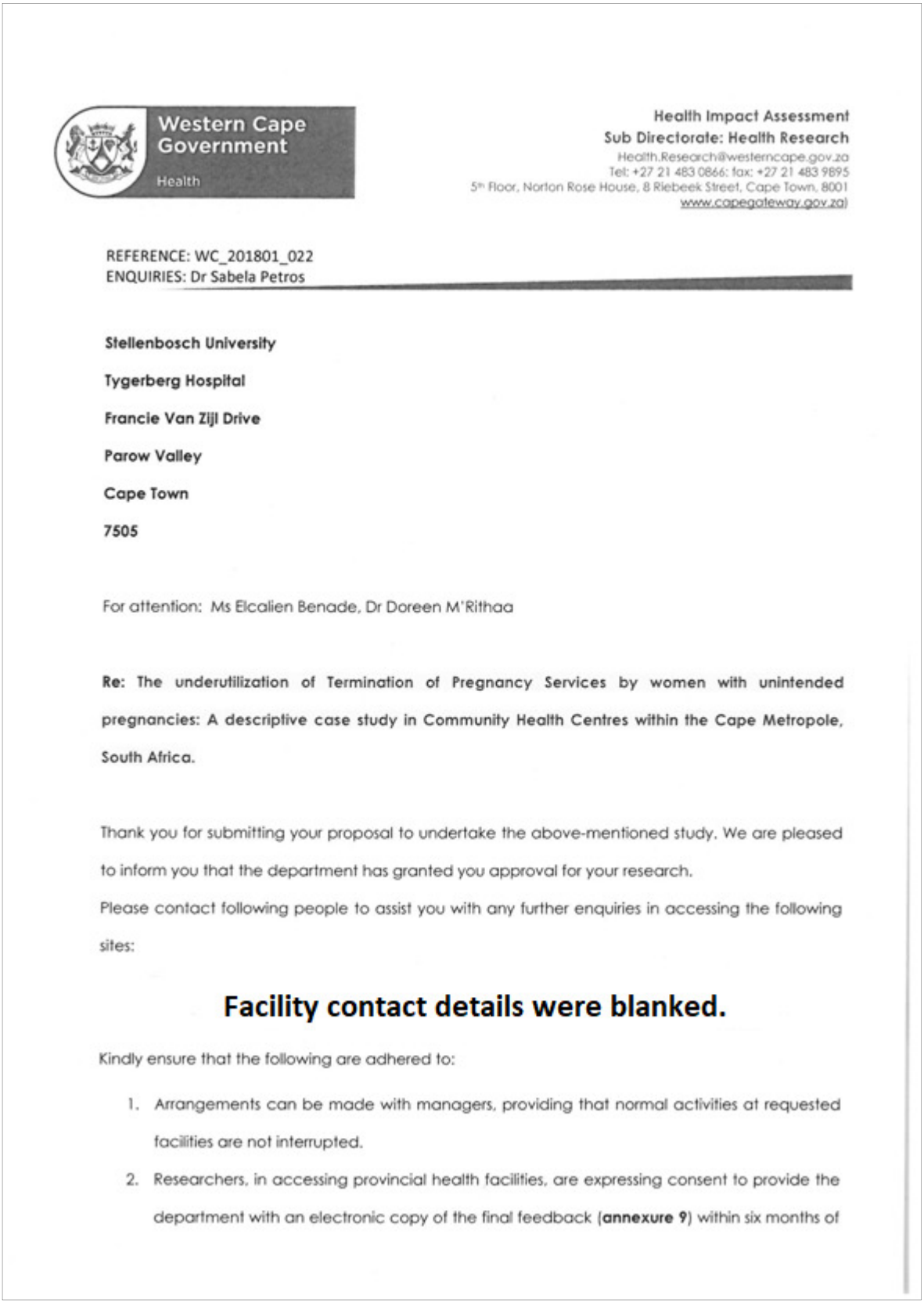
Yours Sincerely,

Mr. Francis Masiye

HREC Coordinator,

Health Research Ethics Committee 2 (HREC2).

Appendix 2: Permission obtained from institutions/department of health



Western Cape Government
Health

Health Impact Assessment
Sub Directorate: Health Research
Health.Research@westerncape.gov.za
Tel: +27 21 483 0866; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201801_022
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Tygerberg Hospital

Francie Van Zijl Drive

Parow Valley

Cape Town

7505

For attention: Ms Elcalien Benade, Dr Doreen M'Rithaa

Re: The underutilization of Termination of Pregnancy Services by women with unintended pregnancies: A descriptive case study in Community Health Centres within the Cape Metropole, South Africa.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

Facility contact details were blanked.

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of

completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DATE: 20/06/2018

CC: **Personal details of signatories were blanked**

Appendix 3: Participant information leaflet and declaration of consent by participants and investigators

In English:

Department of Nursing Science and Midwifery

Informed Consent Form (ICF): Information Sheet

This informed consent form is for women with unintended pregnancies who has underutilised the available TOP services in Community Health Centres One and Two in the Metropole who are invited to participate in the research of this phenomenon

Name of Principle Investigator: **Elcalien Kotze**

Name of Organization: **Stellenbosch University**

Introduction:
I am Elcalien Benadé, busy with my Master's degree at Stellenbosch University. I am doing research on the underutilisation of Termination Of Pregnancy (TOP) services by women with unintended pregnancies which attend to post- or intra-abortion care at Community Health Centres (CHC's). I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me.

Purpose of the research:
The underutilisation of TOP services still occurs despite the legalization in South Africa thereof. Many women suffer emotional, physical turmoil during the very lonely process and we want to find ways to stop this from happening. We believe you can help us by telling us what you know about unintended pregnancies and the underutilisation of TOP services. We want to learn more about the ways women with unintended pregnancies seek care because this knowledge might help us to learn how to better assist these women.

Type of Research Intervention:
This research will involve your participation in an individual in-depth interview conducted by the researcher that will take 60-90 minutes. Refreshments will also be provided.

Participant Selection:
After the healthcare provider has approached you and obtained permission to inform me, the Researcher, regarding your admission in the unit and the circumstances relating to your admission. I will approach you and invite you to take part in this research because we feel that your experience and perceptions can contribute much to our understanding and knowledge of women who underutilise TOP services.

Voluntary Participation:
Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate all services you receive at this Centre will continue and nothing will change.

Procedures:
We are asking you to help us learn more about underutilisation of TOP services by women with unintended pregnancies. We are inviting you to take part in this research project. If you accept, you will be asked to participate in an interview with myself. During the interview will sit down in a comfortable place at the Centre. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The information recorder is confidential, and no one else except Doreen Kainyu Kaura will access the information documented during your interview. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The tape will be electronically kept by the researcher on a password protected computer and no one else except Doreen Kainyu Kaura will have access to the tapes. The tapes will be destroyed after the transcriptions have been completed and verified.

Duration:
The research takes place over three months in total. During that time we will visit you once for an interview of 60-90 minutes and might conduct a follow-up interview of the same duration if further data is needed.

Risks:
We are asking you to share with us some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in any interview if you do not wish to do so. You do not have to give us any reason for not responding to a question or taking part in an interview.

Benefits:
There will be no direct benefits to you, but your participation is likely to help us find out more about how to prevent the underutilization of TOP services and to properly assist women with unintended pregnancies in your community.

Reimbursements:
We will not provide any incentive to take part in the research, but will offer refreshment to you.

Confidentiality
The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside the research team and the information that we will collect will be kept private. Any information about you will have a color code instead of your name on it. Only the researcher will know your color code and we will lock that information up with a lock and key.

Sharing the results:
Nothing that you tell us today will be shared outside the research team, and nothing will be attributed to your name. The knowledge that we get from this research will be shared with you and your community before it is made available to the public. Each participant will receive a summary of the results, where after the result will be published.

Right to Refuse of Withdraw:
You do not have to participate in this research if you do not wish to do so. You may stop participating in the interview at any time that you wish. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly

Who to contact
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me at 083 9786 775. This proposal has been reviewed and approved by Stellenbosch Ethical Review Board (ERB), which is a committee whose task is to make sure that the research participants are protected from harm

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Informed Consent Form (ICF): Certificate of Consent

I have been invited to participate in research about the underutilisation of Termination of Pregnancy (TOP) by women with unintended pregnancies.

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

Print name of Participant_____ **Date**_____

Day/month/year

Signature of Participant_____

If the participant is illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of participant**

Signature of witness_____

Date_____

Day/month/year

Statement by the researcher/person taking the consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1) **Interview regarding the underutilisation of TOP of women with unintended pregnancies**
2) **One to one interview (in the case of linguistic difficulties, an interpreter may be present)**
3) **Duration of the interview is 40-60 min at a place of convenience to the participant**
4) **The participant my at any stage of the interview withdraw from the study**

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntary

A copy of the ICF has been provided to the participant

Print name of Researcher/person taking the consent_____

Signature of Researcher/person taking the consent_____

Date_____

Day/month/year

Consent form adapted from the World Health Organization: Informed Consent Form Template for Qualitative studies (World Health Organization, N.d)

In Afrikaans:

Departement van Verpleegkunde en Verloskunde

Ingeligde Toestemmingsvorm (IT): Inligtingsblad

Hierdie ingeligde toestemmingsvorm is bedoel vir vroue met onbeplande swangerskappe wat die beskikbare Terminasie van Swangerskap dienste in Gemeenskapsdienssetrums Een en Twee in die Kaapse Metropool onderbenut het. Hierdie vroue is uitgenooi om deel te neem aan die navorsing van hierdie fenomoneem.

Naam van Primêre Ondersoeker: **Elcalien Kotze**

Naam van Organisasie: **Universiteit van Stellenbosch**

Inleiding:
Ek is Elcalien Benadé, en is tans besig met my Meestersgraad by die Universiteit van Stellenbosch. Ek doen navorsing oor die onderbenutting van Terminasie van Swangerskap dienste by vroue met onbeplande swangerskappe wat tydens- of na-aborsie sorg by Gemeenskapsdienssentrums bywoon. Ek gaan nou inligting aan u verskaf en u uitnooi om deel te wees van hierdie navorsing. U hoef nie vandag te besluit of u wel aan die studie wil deelneem nie. Voordat u besluit, kan u met enige persoon waarmee u gemaklik voel gesles oor die navorsing. Hierdie toestemmingsvorm mag woorde bevat wat u nie verstaan nie. U kan vroy voel om my te stop ten enige tyd soos wat ons deur die inligting gaan, en ek sal die tyd neem om dit aan u te verduidelik. As u enigsins later vrae het, is u welkom om dit te vra.

Doel van die navorsing:
Die onderbenutting van Terminasie van Swangerskapdienste vind steeds plaas ten spyte van wetgewing in Suid-Afrika wat hierdie dienste toelaat. Baie vroue ervaar emosionele en fisiese onrus gedurende hierdie eensame proses en ons wil maniere vind om dit te verhoed. Ons glo ons kan u help deurdat u ons vertel van wat u weet oor onbeplande swangerskappe en die onderbenutting van Terminasie van Swangerskap dienste. Ons wil graag meer weet oor die wyses waarop vroue met onbeplande swangerskappe hulp soek, want hierdie kennis kan ons help om in die toekoms beter dienste aan hierdie vroue te verskaf.

Tipe Navorsingsintervensie:
Hierdie navorsing sluit u deelname in deur ‘n individuele in-diepte onderhoud wat deur die navorser gelei word. Ververwings verskaf sal word. Hierdie onderhoud sal 60-90 minute duur.

Deelnemer Seleksie:
Ek sal u benader en uitnooi om deel te neem in hierdie navorsing want ons voel dat u ervarings en persepsies kan bydra tot ons insig en kennis van vrouens wat Terminasie van Swangerskap dienste onderbenut. Hierdie sal slegs plaasvind nadat die gesonheidsorg verskaffer u benader het oor moontlike deelname en nadat toestemming verskry is om my, die Navorser, in te lig oor u huidige

toelating in die betrokke eenheid en die omstadighede verwant aan u toelating.

Vrywillige deelname:
U deelname in hierdie navorsing is totaal en al vrywillig. Dit is u keuse of u wil deelneem of nie. U toekomstige behandeling en diens by hier Gesondheidsentrum sal nie beïnvloed word deur u belsuit om nie deel te neem aan die navorsing.

Prosedures:
Ons vra u om ons te help om meer te leer oor die onderbenutting van Terminasie van Swangerskappe by vroue met onbeplande swangerskappe. Ons nooi u dus uiit om deel te wees van hierdie navorsings projek. As u die uitnodiging aanvaar, sal u gevra word om deel te neem in ‘n onderhou gelei deur myself, of ‘n ander onderhoudvoerder. Gedurende die onderhoud sal ek of die ander onderhoudvoerder u laat plaasneem op ‘n gemaklike plek in die Gesondheidsdienssentrum. As dit beter is vir u, kan die onderhoud plaasvind in die gemak van u eie of ‘n vriend/vriendin se woning. Indien u nie enige van die vrae tydens die onderhoud wil beantwoord, kan u ons net inlig en dan sal ons aanbeweeg na die volgende vraag. Niemand anders behalwe die onderhoudvoerder sal teenwoordig wees, tensy u die ondersteuning van ‘n ander persoon van u keuse verlang. Die inligting wat opgeneem word is vertroulik en niemand anders behalwe Doreen Kainyu Kaura sal toegang verkry oor die ingligting gedokumenteer tydens die onderhoud. Die hele onderhoud sal op ‘n band opgeneem word, maar niemand sal geïdentifiseer word d.m.v. name op hierdie band. Die band sal elektronies gestoor word deur die navorser op ‘n wagwoord beskermde rekenaar en niemand anders behalwe Doreen Kainyu Kaura sal toegang hê tot die bande. Die bande sal vernietig word nadat die transkripsies voltooi en geverifieer is.

Duur:
Die navorsing neem plaas oor ‘n tydperk van drie maande in totaal. Gedurende hierdie tyd sal ons u een maal besoek vir ‘n onderhoud van 60-90 minute en mag ons dalk weer ‘n opvolg-onderhoud voer indien verdere data benodig word.

Risiko’s:
Ons vra van u om baie persoonlike en vertroulike inligting met ons te deel, en u mag ongemaklik voel om oor van hierdie onderwerpe te praat. U hoef nie enige vraag te beantwoord of deel te neem aan enige onderhoud indien dit nie u wens is om so te doen. U hoef nie aan ons enige rede te verskaf hoekom u nie op ‘n vraag reageer of aan die onderhoud wil deelneem.

Voordele:
Daar sal geen direkte voordele vir u wees, maar u deelname sal heel waarskynlik vir ons help om meer wyses te vind oor hoe om die onderbenutting van Terminasie van Swangerskap dienste te voorkom, en ook hoe om vroue met onbeplande swanerskappe in u gemeenskap te ondersteun.

Vergoedings:
Ons sal nie enige aansporing om aan die navorsing deel te neem verskaf, maar ons sal wel versnapperings aanbied aan u.

Vertroulikheid
Die navorsing wat in die gemeenskap gedoen word mag moontlik aandag trek, en as u deelneem mag daar vrae aan u gevra word oor die mense in die gemeenskap. Ons sal nie inligting deel oor u aan individue buite die navorsingspan nie. Die inligting wat ons insamel sal privaat gehou word.

Enige inligting oor u sal ‘n kleur kode in plaas van u naam bevat. Slegs die navorser sal u kleur kode ken, en daardie inligting sal gestoor word agter slot en grendel.

Bekendmaking van die uitslae:
Geen inligting van u vandag met ons deel sal versprei word buite die navorsingspan of enigsins gekoppel word aan u naam. Die kennis wat ons insamel vanaf hierdie navorsing sal bekend gemaak word aan u en u gemeenskap voordat dit beskikbaar gestel word aan die publiek. Elke deelnemer sal ‘n opsomming van die uitlsae ontvang en daarna sal die uitslae gepubliseer word

Die reg om deelname te weier of om te onttrek:
U hoef nie deel te neem aan hierdie navorsing as dit nie u wense is nie. U mag ter enige tyd deelname aan die onderhoud onttrek. Aan die einde van die onderhoud gaan ek aan u die geleentheid gee om u opmerkings te hersien, en u mag versoek dat gedeeltes van hierdie opmerkings verander of verwyder word as u nie saam stem met my notas, of as u voel dat u nie die vraag korrek verstaan het nie.

Wie om te kontak?
Indien u enige vrae het, kan u dit nou vir my vra of op ‘n latere stadium. Indien u graag later vrae wil vra, kan u my gerus kontak by 083 9786 775. Hierdie navorsing voorstelling is vooraf goedgekeur deur Stellenbosch Universiteit se Etiese herdieningsraad. Hulle bestaan uit ‘n komittee wat hulle daartoe ywer om te verseker dat deelnemers beskerm word van enige skade.

U kan nou vir my enige vrae vra oor enige gedeelte van die navorsing studie. Het u enige vrae?

Ingeligde Toestemmingsvorm (IT): Sertifikaat van Toestemming

Ek is uitgenooi om deel te neem in navorsing oor vroue met onbeplande swangerskappe wat dieTerminasie van Swangerskap dienste onderbenut.

Ek het die voorafgegaande inligtingsbald gelees, of dit is aan my gelees. Ek het die geleentheid gehad om vrae te vra, en enige vrae wat ek gevra het, is volgens my bevrediging beantwoord. Ek gee vrywillig toestemming om ‘n deelnemer te wees aan hierdie studie

Naam van deelnemer in drukskrif_____ **Datum**_____

Dag/maand/jaar

Handtekening van deelnemer_____

Indien die deelnemer ongeletterd is

Ek is 'n getuie van die akkurate voorlesing van die toestemmingsvorm aan die petensiële deelnemer, en die betrokke individu het die geleentheid gehad om vrae te vra. Ek bevestig dat hierdie individue vrywillige toestemming verleen het.

Naam van getuie in drukskrif_____ **Duimafdruk van deelnemer**

Handtekening van getuie _____

Datum_____

Dag/maand/jaar

Verklaring deur die navorser/persoon wat die toestemming verskry

Ek het die inligtingsblad akkuraat voorgelees aan die potensiële deelnemer. Ek het ook tot die beste van my vermoë verseker dat die deelnemer verstaan dat die volgende gedoen gaan word:

1) **'n Onderhoud aangaande vroue met onbeplande swangerskappe wat Terminasie van Swangerskap dienster onderbenut.**
2) **Een tot een onderhoud (in die geval van taal probleme, sal 'n vertaler teenwoordig wees).**
3) **Die onderhoud sal ongeveer 60-90 minute duur en dit sal plaasvind op 'n plek van gemak vir die deelnemer.**
4) **Die deelnemer mag op enige stadium van die onderhoud onttrek vanaf die studie.**

Ek bevestig dat die deelnemer die geleentheid gegun is om vrae te vra oor die studie, en dat al die vrae korrek en tot die beste van my vermoë beantwoord is. Ek bevestig dat die individu nie oorreed is om aan die studie deel te neem, maar dat deelname vrywillig verkry is.

'n Afskrif van die IT is verskaf aan die deelnemer.

Navorser/Persoon wat toestemming verkry in drukskrif_____

Handtekening van Navorser/Persoon wat toestemming verkry_____

Datum_____

Dag/maand/jaar

Ingeligde toestemmingsvorm aangepas vanaf die Wêreld Gesondheidsorg Organisasie: Informed Consent Form Template for Qualitative studies (World Health Organization, N.d).

Appendix 4: Interview guides

4.1 Interview guide for women with unintended pregnancies

Introduction

My name is …….. The aim of this study was to explore factors influencing the underutilisation of TOP services for women with unintended pregnancies within the CHC's in order to reduce maternal morbidity and mortality associated with unsafe abortions within the Cape Metropole in the Western Cape in South Africa.

Demographic data

1. **Tell me about yourself.**
   Probes:
   - ✓ Age:
   - ✓ Race:
   - ✓ Gravidity
   - ✓ Parity
   - ✓ Marital status: Married /Single/ Divorced /Traditional/Widowed/ Stable relationship
   - ✓ Employed:
   - ✓ Highest level of education:
   - ✓ Acceptability of pregnancy/abortion in your household/community?
   - ✓ Languages fluent: Afrikaans / English/ Xhosa

RO 1 *To describe the perspectives of women regarding the TOP services offered for unintended pregnancies in the Cape Metropole within the Western Cape in South Africa.*

2. **Let's talk about the current pregnancy**
   Probes:
   - ✓ termination of pregnancy
   - ✓ Knowledge services
   - ✓ Health information received (II)
   - ✓ Health professionals
   - ✓ Family planning services

RO 2 To determine the barriers to the utilisation of TOP services by women with

unintended pregnancies in two CHC's of the Cape Metropole within the Western Cape, South Africa.

Let's talk about how you accessed termination of the current pregnancy.

Probes:

- ✓ Knowledge of services
- ✓ Health Education offered
- ✓ Client services provided
- ✓ Code of conduct by providers

RO 3 To identify strategies in line with SDG's that could be put into place to improve the utilisation of safe TOP services for women with unintended pregnancies provided in two CHC's of the Cape Metropole within the Western Cape, South Africa.

3. **Tell me about information you would have liked before your pregnancy and after.**

Probes:

- ✓ Sources of information
- ✓ Types of information
- ✓ Information services
- ✓ Information channels
- ✓ Code of conduct

4. **Anything else you would like to tell me?**
5. **Thank you for your time**

(II)

4.2 Interview guide for healthcare professionals

Introduction

My name is …….. The aim of this study was to explore factors influencing the underutilisation of TOP services for women with unintended pregnancies within the CHC's in order to reduce maternal morbidity and mortality associated with unsafe abortions within the Cape Metropole in the Western Cape in South Africa.

Demographic data

6. **Tell me about yourself and your career as a healthcare professional**

   Probes:

   - ✓ Years' experience
   - ✓ Race:
   - ✓ Highest level of education:
   - ✓ Acceptability of pregnancy/abortion in your household/community?
   - ✓ Languages fluent: Afrikaans / English/ Xhosa

RO 1 *To describe the perspectives of women regarding the TOP services offered for unintended pregnancies in the Cape Metropole within the Western Cape in South Africa.*

7. **Let's talk about the cases of unsafe abortions of women with unintended pregnancies**

   Probes:

   - ✓ Protocols and policy's on termination of pregnancy
   - ✓ Family planning services
   - ✓ Management and referral protocols on managing cases of women who had unsafe abortions

RO 2 To determine the barriers to the utilisation of TOP services by women with unintended pregnancies in two CHC's of the Cape Metropole within the Western Cape, South Africa.

Let's talk about how termination of pregnancy services can be assessed.

Probes:

- ✓ Knowledge of services
- ✓ Health Education offered
- ✓ Client services provided (i)

- ✓ Code of conduct by providers

RO 3 To identify strategies in line with SDG's that could be put into place to improve the utilisation of safe TOP services for women with unintended pregnancies provided in two CHC's of the Cape Metropole within the Western Cape, South Africa.

8. Tell me about information you would have liked before managing a patient whom has undergone an unsafe abortion.

Probes:

- ✓ Sources of information
- ✓ Types of information
- ✓ Information services
- ✓ Information channels
- ✓ Code of conduct

9. What is your experience regarding the prevalence of unsafe abortions?

RO4: *The perceptions of healthcare professionals regarding the prevalence of underutilisation of termination of pregnancy services amongst women with unintended pregnancies.*

10. Anything else you would like to tell me?

11. Thank you for your time (II)

Appendix 5: Document analysis sheet

Document analysis sheet
Name of Community Health Centre: _____ **Date of review:** _____
Document (1) relevant to TOP services: Description:
Document (2) relevant to TOP services: Description:
Protocol on identification of unintended pregnancies Description:
Protocol on post-abortion care and counselling Description:
Promotion of TOP services available in the institution and if not, referral protocols: Description:
Information review by: **Signature:**

Appendix 6: Extract of transcribed interviews

PARTICIPANT PURPLE TRANSCRIBTION

Interviewer:	*I*
Participant:	P

I: Can you tell me little bit about yourself?

P: Okay, I'm 24 years old. I decide… should I say my address or…?

I: No, it doesn't matter, it is not necessary, Ja!

P: Okay, so I would start off where I, like… discovered I was pregnant.

I: Okay

P: Too little too late, how could I say? I came to the MOU, I had certain symptoms of pregnancy, but I first went off to a private doctor.

I: Yes

P: He couldn't tell me how far I was in my pregnancy and being… from there I got a referral because I wanted to do a TOP. But like I say, I did not know how far I was because I only took a urine test.

I: Okay

P: And then I came to the MOU with a referral letter to say that I'm wanting to do a TOP.

I: Yes

P: And then yeah, I came back and then I got cold feet, so to say.

I: Yeah

P: I went to the nurse and then she helped me, she assisted me: took a blood test and did a scan. And then unfortunately she told me that I was too far in my pregnancy. I was 18 weeks. No, I was 20 weeks, sorry, too far apparently to have the abortion.

(Participant taking deep breath)

P: Yes. I was devastated, overwhelmed. I didn't know how to deal with the situation. And then she gave me a letter to come and book myself in the MOU. I didn't go, like I said, I got cold feet. I had a friend with me and then I told her that I can't have this child and did not want the child. And then I chose a back road abortion clinic. And that's how it started. And then I met this guy in town. He goes by the name of Dr. Khai. Yeah, I met up with him (I got his number on Google). Yeah

(Big sigh from participant)

P: And then he gave me a set of pills called Cytotec and Mifepristone. And then he told me how to takes it eventually. That was on a Thursday when I took the pills, already knowing that I was twenty weeks pregnant. But there was no other option for me. Like I said, I did not want the child.

(Participant sniffing)

I: Okay

P: And then I took pills. It was the Mifepristone. He told me to take it at home. Because I asked him if there were any other option…like… do he… does he do surgical abortions. But he told me no, that's medical only, like medicine use only.

I: Yes

P: And then okay, I chose to do it. Yet not knowing that I would have to… what comes afterwards. You understand? I wasn't aware!

I: Ah huh!

P: And then I took it the Thursday and then I started getting contractions, because he told me to insert the Cytotec vaginally.

I: Okay

P: Not telling me that I would actually bleed out and having to go through what I did.

I: Yes

P: Okay, I was rushed to the MOU, I mean, the emergency section on Friday. And then, okay, then the nurse told me that what I did was… it was illegal. I was aware of what I did.

I: Yes

P: And I really regret it, because at the end of the day, it's a child I was killing. I felt like a murderer. Not... not fair. I know!

(Participant taking a deep breath)

P: And yeah! And then… I was… the doctors told me about your research also. And according to the law, what I did was illegal. I know because at (name of institution), they told me that I could only have an abortion from up to 18 weeks, not further. And yet I chose to get rid of the child. And yeah, then they helped me at the emergency section. And they did what they had to do- put me on a drip. And like I say, I was experiencing contractions, not knowing that I had to give birth, like normally and deliver it.

I: Mmmm!

P: From here I was transferred to the districts hospital, and that's when they told me that I could have like…. they could have removed my womb!

I: Mmmm!

P: All of the consequences of what I did, without even knowing that. Because of what I went through and what I chose.

I: Ya

P: Yeah, it was… it's traumatic, a traumatic experience. And now that I'm home (and it's been a week now) and I'm…I'm not coping the way I should. Because like I say, I regret my decision, and it's, it's traumatizing. At the end of the day, I feel like I killed my baby. And I can't, I can't put it in words.

(Participant sniffing)

P: But like I say, the nurses here, they made me aware off I was too far in my pregnancy to have an abortion, whether it be surgically or medically. And I just didn't actually… I didn't know what to do at that point. That's why I chose to go the back road… and choose to do it illegally, but…

I: Okay

P: It's not a good thing.

(Nervous laugh from participant)

P: It's not, Ya!

I: If we go back…uhm! Thank you for giving me a lot of information now. If we go back when you said you are 24 years old! Can you tell me a little bit about yourself…work or education, or…?

P: Okay! I passed matric. I had my matric. I had a partner, he was a foreigner... he is a foreigner, basically.

I: Yes

P: And the moment I told him I'm pregnant, he actually left me and we were together in relationship for three years. And how can I say… emotionally he was never there for me.

I: Mmm!

P: I was with him in...And he's got a couple of shops. And I was helping him out, and business wise it is was small tips.

I: Yes. We can take a break? Here's a tissue?

P: Won't be needing it, I'm keeping it in.

I: Okay

P: Yes. And then like I say, he left me basically. And I was on my own, which is why I chose to have the abortion, not knowing how far I was in my pregnancy, because I even bleed throughout the pregnancy. It just didn't…You understand?

I: Ya

P: And then that's why I'm going to the MOU to find out exactly what's going on so that I could take further steps, but they didn't give me the option of maybe having a surgical abortion, which I thought was legal. Not… it's not so! It didn't work out that way. Ya!

I: Ya. It's fine you can take a sip of water! We can take a break? Ya! Are you…are you okay?

P: I am okay! I'm taking it one day at a time.

I: Okay

P: It's all I can do!

I: Yes. You said you… you came to the MOU? You were referred from a private doctor…

P: …private doctor…

I: …and then you came to the MOU and they've given you the option to come book? Have they ever given you any other option or..

P: No

I: …counselling on?

P: No. None of that! They only told me that unfortunately, I was too late in my pregnancy to have a TOP. That's why… and then I chose to what I did and go for the medical abortion which was illegal, but they never gave me other options or actually asked me why I want to do it. So we can say it wasn't helpful.

I: Ya

P: You understand

I: Ya. It seems like you felt…you felt hopeless…

P: Yes

I*: … and you came for help and then what now?*

P: Exactly! I didn't know what to do. Then I chose that, the only route that I thought was available for me. I also contacted Mary Stopes. But the cost was also way over my limit and I'm financially not stable to do so.

I: Ya

P: And because also like… is like it's believed that according to the Constitution rights, it's illegal to abort over a 20 week period. So I had no choice.

I: If I may ask? What was the cost of the procedure at Mary Stopes?

P: It was from…wait…it depends on your first and your second trimester. They only do it from up until before 20 weeks and I was really on my 20 weeks going on for 21 weeks.

I: Uh!

P: And the cost was for… like… they give you an option of having to... what… like to do it while you are sedated, when you are asleep. And even that also cost money, it costed R1200, and for the procedure I would say, the whole procedure would have been R7000 plus minus. So…

I: Yoh!

P: Exactly!

I: Ya

(Sigh from participant)

P: I'm taking it one day at a time, that's all I can do.

I: Yes

P: But…so I spoke to the doctor at the district hospital, she asked me if I would want to see the psychiatrists? I said "no" but I would want to come for counselling! And that is why!

I: Ya, that's great that you are at least reaching out.

P: Yes

I: Yes! Okay, so after so… you said you got cold feet and you didn't want to come back and that is when you also mentioned that you googled and you found this doctor in town!

P: Yes

I: What was your experience there?

P: There! I would say he made me feel like… he was very convincing, like he told me no nothing would happen. You will have normal period. Not knowing that I was actually carrying a baby. I was totally clueless of how this procedure was going to be done, because its medical end of the day. I thought it would just be a normal period… like he made me believe. But how can I say, were he were situated it wasn't in a dirty place, it was in a building and facility. It looked organized.

I: It looked legit

P: Yes it did! And it made me believe, okay, this is going to work out for me and then nothing else would happen. Without knowing what could actually happen.

I: Yes

P: But yes… and then I paid him a thousand rand or so for the pills. And then that just told me is money making scheme at the end of the day. Because when I spoke to the doctor when I was rushed here, and then I explained so what happened and then she told me: no, these people are "skelm" and that's how they get to young girls. Because how many women haven't, like lost their lives or their children because of how they chose to go for this procedure. So…

I: Yes

P: Yes. It's traumatizing but I'm going through it and getting through it because I have to.

I*: If I reflect back on your feelings it seems like you're you were hopeful that person could help you?*

P: Exactly, I was.

I: And then also it might they might look idyllic like it's going to be just…

P: …a simple procedure!

I: …a simple procedure!

P: It wasn't…it wasn't!

I: How are you feeling about that?

P: That's why I say I had regrets, because at the hospital they made me also. I felt judged by the staff, but knowing it was their job. And not knowing why I did it…

I: Yes

P: You understand. But then I felt judged there like I was labelled a murderer. At the back of my mind I was feeling that way.

I: Mmm!

P: That's what I can say.

I: You were mentioning this staff. Is it the staff at the emergency unit when you were admitted here or which staff are you referring to?

P: No, at the hospital, the district hospital. Not the staff over here.

I: Oh, so after you were…?

P: They were helpful regardless of my situation that I chose; they were helpful. Because they had no choice, I could either loose the baby or I had already lost the baby. But I could have lost my life as well. So they chose to see me to the hospital but there the staff was totally…they were helpful to the extent and they did what they had to do but they weren't there to offer me counselling at the end of the day. And when I spoke to the doctor she asked me if I want to see a psychiatrist there and then I said: "no, I can come here for counselling". Because when I was here Friday… when they rushed me…before they rushed me…

I: Mmm

P: The nurses here, the sisters, they told me I can come anytime if I need to speak to someone at least, just to get through things. So…

I: Ya

P: But like I said, at the hospital the staff wasn't…they like totally told me like this is a police matter. You could go and sit at the police and it's basically murder what you did and that is how I felt. They made me feel like I was the murderer.

I: Yes

P: I know it's killing a baby at the end of the day. I's a child I was carrying… and I do regret what I did. Honestly I do.

I: What do you think you needed to have done things differently?

P: What do you mean now?

I: Like information before the time?

P: That's what I needed from this thing. They didn't give it to me. All they told me was I had to be referred here; they didn't actually giving me options on what I could have done or maybe given up the baby for adoption.

I: Okay

P: That's what I'm trying to say.

I: Yes

P: But they didn't do that. They just told me I had to come here and furthermore didn't explain anything else to me, which is why I just walked out. I didn't even booked myself in at the MOU.

I: Mmm

P: So you feels like you were here, you did make contact and you were shocked that you were pregnant or that they…

P: It was overwhelming

(Interviewer clean throat)

I: And they just give you a date to come back, they didn't give you an option?

P: No, there was no option. They just gave me a letter to come here and…like a normal procedure you're just gonna have the baby at the end of the day. You don't know if you want this baby. At the end of the day I could have killed the child, if I gave birth to the child…I'm just saying for example. T

I: Mmm

P: They didn't give me the option of like telling me this and that… they are like…you understand?

I: Yes

P: Giving me options, they didn't do that. Ja. That's why I say, I'm not coping with it the way I should. It's just like I'm trying to move on and move forward and that could never happen, but at the end it's still you here.

I: How are you feeling now, exactly?

P: Like I say….(big sigh)…like I'm trying to block things out, but it's there. It happened and I had to cope with it one way or the other. I have to speak to someone about it, because it's no joke. No joke at all. It's not.

I: So you say you have to speak to someone, how is your support? Is there…?

P: My family and I have friends, but for me it's not enough, like professional help - definitely! That is what I need.

I: Yes

P: That is what I need

I: Is your family aware of everything?

P: However…I'm Muslim… so what I did was totally against… I have…I didn't tell my parents the complete story. I told them I gave birth to stillborn, just to make matters not seem… you understand!

I: Yes

P: Like worse then what it already is! So, they don't know. That' why I'm coping on my own, basically. And my friends who know what I did and who I trust, are there for me, but professionally I need help. That's why I need to speak to somebody. Ja.

I: You also mentioned that (interviewer cleaning throat) sorry, that at the district hospital you were… you felt you felt judged? And how did it make you feel at that time? Do you want to be there or did you feel like…?

P: Like… okay, I know I was at a hospital. They were doing what they had to do and how could I say, I was alone. I was… no family came there. But the nurses they… you know nurses are strict on their own, but the doctors they never really spoke to me. They just told me what I did was… is illegal and basically they did not tell me like…or give me any other option, or asked me why… why did you do that? Nothing like that! But as for the nurses: there was one who helped me deliver the baby. I had to deliver the baby in the ward itself. They did not take me to a labour ward either.

(Participant sniffing)

P: There's doctors there who will come like from the morning to the night. Night check-up before they leave or…I'm sure there had to be a sister in charge there, but like I sadly delivered the baby in the ward itself. I never actually…they told me I'm one centimetre apart. That was like for, basically, from the Saturday, no from the Friday night till the Saturday. The Saturday afternoon I gave birth. But then there wasn't a doctor to actually tell me how far I was with my labour. You understand? So, yeah, but how can I say I felt alone and they will helpful to the extend. Not…they could have done more for me, basically. That's what I'm saying. But okay, I'm getting there. But I need help. That's what I really need.

I: So it seems like the experience of giving birth was more traumatic than actually what happened?

P: Yes. Because like…what… the doctor never even told me that I was going to deliver the baby. She just told me, like, she didn't tell me anything. She just came to check up and tell me how okay, or you are one centimetre open… you are bleeding. I told her and she asked me if I'm experiencing any pain or cramps and I explained my situation at that time.

I: Mmm

P: But, like, I can't say that they were there when I delivered. They didn't really care. Because when the nurse… it was like night time before ten I'd say. And then I was telling the nurse that I'm experiencing pain, can't she give me something for the pain. And then she went to the doctor and the doctor actually reckons for her: "no, this is like I'm only…I have another patient to see too. I don't know 20 hands. And I mean, this was serious case, whose was mine, and she wasn't there for me. So I can't say I had a great experience there, but yet here at the MOU they were helpful before like, like the first time I came. But wasn't…at that emergency, they there for me, the sisters. My experience at the district hospital wasn't the best. There could have been… there could have been more options and more help.

I: Mmm! Were you…when you were admitted either here in the Trauma unit or by the other hospital! Were you aware of the…how was…was the baby still alive or not?

P: No. At the emergency unit…!

I: Yes

P: They told me that there was no heartbeat then. I did not know what was going to happen next. One of the nurses here told me they were going to do a scrape, a womb scrape and I thought it was maybe a suction process. But when I went to the hospital, I was so unaware of what was going on. They didn't tell me what they were going to do. Until the last minute…I asked the doctor (she came to do a scan on me) and then I asked her: "what's going to happen now" and then she tell me you're gonna have to deliver the baby. And I mean, I've never had any kids before. So this was totally, so in such a short space of time, I had to take in a lot and it's no joke. It's really no joke. But because she never told me anything, she just told me that moment, like it was a couple of hours before I gave birth that she told me like you're gonna have to deliver this baby on your own.

I: So it seems like they were just expecting of you to just be okay and know what's gonna happen exactly next?

P: And I wasn't aware of it.

I: Ya

P: That's what. Ya. I'm working lately. I'm independent now. So…

I*: Okay*

P: That what…I'm there at least. Just coping with work. It's keeping me occupied.

I: Okay

P: But like I say, I have to speak to someone just to through it. That's what I need to do.

I: For sure. Sorry, I keep in reflecting. I'm going to go back to when you were at the other hospital. And when you when you delivered? What happened after the delivery? Were you given any health information or?

P: No, I was there, I delivered. And then the nurses were there to help me with the delivery. From there I basically took a shower and they said, I did not see a doctor. They never came to check up until the night. And then they did a scan to see my uterus was still intact and everything. I then the doctor, I don't know I can't remember her name exactly

I: Doesn't matter

P: And then she told me like she just gave me the consequences of what happened and what I did. She didn't actually tell me anything else, like, only asked me if I can speak to the psychiatrist and I said no, I chose counselling. So she didn't actually tell me anything until the night, but during the day the nurses just came to check up and then I was discharged the Sunday. I delivered the Saturday and the Sunday I went home. Because, the like I say the doctors, they come and go, but they not really there for their patients. Especially in my case, they weren't there to actually help me with what I was dealing with. Regardless of what I did was illegal, I understand that, but at the end of the day I felt judged. So that's what I can say.

I: Ya, so it seems like you've… I did something wrong. I know. I admit it!

P: Yes

I: But like, please help me now?

P: That's what I wanted. And they only did what they could on the... to their terms and how they want to do it for me. The nurses were more there for me than the doctors. Because when they read up my folder, like, that they saw what I did, and I took the medical route at my gestation -,were I was and how far I was in my pregnancy; they chose to judge me. I could see it man. It was… it wasn't nice. It wasn't. Ja. It was my experience at the district hospital! But like here, when I left here, the nurse…the sisters, they were helpful.

I: Yes

P: They were. I can say that, they made me feel more at home because it's elderly woman and they could see I was experiencing something that I didn't know what to expect next.

I: Mmmm

P: You understand

I: Yes

P: That's why I could say nothing bad of the MOU section here, but the district hospital it's not the way it should be. The way they dealt with things. No, they could have done more for me.

I: Yes

P: That's what I can say

I: Okay. And are you in any relationship now at the moment?

P: No, not for now, not any time soon.

I: Have you ever spoken to your previous boyfriend again?

P: Yes, we have spoken but we are not together anymore. I made him aware of that like…he made…like before… when I told him (I didn't tell him that I was pregnant), I told him round about a and he became distant and being then there was a moment that he even told me, or asked me: "whose child is it"? Like I was in a relationship with him for three years? What are you actually telling me? What do you label… what, like what do you label me at?

I: Mmm

P: You understand. So I have spoken to him and I have told him, like, I'm not upset with you. We can move on with our lives because I'm only going to be at peace if I forgive myself for what I did. And I forgive you, you can move on with your life but we are not together anymore. I don't hate men, because what I did was… it was my choice. I'm an adult! And of course I can't say that I won't be in relationship like tomorrow but in future maybe but not now. Like I'm uncomfortable around men, I just need my friends around me. That's how I feel right now.

I: It seems like you are the worst Judge of yourself.

P: Yeah…Yeah. And now…what I did… was… it makes me, like makes me hate myself even more. I'm trying to cope. Just trying to cope!

(Big sigh from participant)

P: Is there any other questions you want to ask me?

I: Is anything else you would like to tell me?

P: Well right now. I would like to see you again, honestly.

I: Okay

P: I'm…like I said; I'm taking it one day at a time.

I: Okay

P: And just to get your things I really need someone to be and help me cope through it.

I: Okay

P: That's all I need.

I: Thank you. Thank you so much for sharing this difficult time in your life with me. So we… just thank you very much. So I'm going to stop the recording now.

HEALTHCARE PROFESSIONAL TWO CHC TWO TRANSCRIPTION

Interviewer:	*I*
Participant:	P

I: Can you tell me a little bit about yourself and your career as a healthcare professional?

P: Okay, I am sister Jacobs. I'm a professional nurse, practicing in obstetrics and neonatology. Uhm, before I started here at MOU, I was working in Mowbray for a year and a half after my studies. Uhm, came to MOU in 2006 been working here ever since. I've…I did my advance in the year 2016 and from then now I'm and advanced midwife as well. So yes, this career is very unpredictable very fast, very uhm sometimes can be emotional, but I love what I'm doing. Sometimes you with a lot of challenges with the community with your work place, but at the end of the day, I'm here to provide a service and I love doing what I'm doing, everyday!

I: Thank you so much. So as we discussed earlier, the reason for us doing this interview is to determine factors why patients do unsafe abortions while there are legal abortion services available. Have you ever come across such cases?

P: Yes, I've personally, in my work place I… I think I dealt with I will say three cases.

I: Okay

P: And the one, the first case I think it was when I was working night shift. And we had a lady coming in with severe abdominal pain. Uhm, not booked with us, came from the hospital complaining of abdominal pain and she was pregnant, the day hospital sends her over to us. I examined and when I examined her, I found inside the vagina the Misoprostol tablets.

I: Uhmm

P: Three, I think it was three. And I asked her: "lady where did you get this tablets from", because I know Misoprostol so I could…I knew it was Misoprostols. And she couldn't answer, she don't want to answer me. It was I think she was scared number one

I: Yes

P: And began she's not booked and she didn't know what was happening. And I told her: "but if you're not gonna tell me, we can have to get the police in, because I know what this tablets is using for and I know what they do on the streets, where they selling this tablets on the street for abortion. So you're gonna have to tell me and I'm gonna have to refer you to hospital, because I think she was twenty-five, twenty-six weeks pregnant. She was in her twenties, twenty weeks pregnant. And I had to rebook her and I had referred her to Mowbray and Mobray had to refer her to Grootte Schuur hospital due to the gestational age. And eventually she said that she don't waned the baby. She bought the tablets on the street, I think it was ten hundred rand, she told me. And uhm...I'm not quite sure if the people explained to them how... what is the… how do you use the tablets

I: Yes

P: And what is the consequence of this tablet or whatever, I don't know! But anyway, she didn't wanted the baby. And I phoned Mowbray, I presented the patient to Mowbray, I put the tablets in a specimen jar and I send it with. And uhm, the only thing that I'm not so very happy about is that we never get feedback what happened to this patients and what happened to these babies. So we transfer the patients away from us or they be discharged, we never follow up, we don't get back to them. What is happening? How for the cases getting, sometimes that's a police case. And we never hear what is happening with that and that is the part that I would like to know

I: Yes

P: What is being done outside? Is there something being done to stop this illegal TOP's outside or whatever. I don't know.

I: Yes

P: But we never get feedback. As we like, I never heard from that lady again, you know what I'm saying!

(Pause)

P: And then I also had another incident were, uh, I was working on the Sunday and this lady… the ambulance brought this lady in as she gave birth at home. She was also unbooked. She gave birth at home and the foetus was, the baby wasn't alive. It was a big baby. I think the baby weighed more than two thousand grams.

(Participant thinking)

P: And the baby was more than two thousand grams and the baby wasn't alive. And the ambulance brought the baby in. And upon questioning all things: "what was happening, why all this and why that"? She admitted to me crying that she didn't want the baby. She and the boyfriend decided that they cannot afford this baby. She had a baby the previous year and they saw this posters on the poles outside…

I: Uhm

P: …about these illegal abortions. And she contacted this people on this number, phone number, and she went to I think it was Bellville, some shopping centre in Bellville. I can't remember the shopping centre, but it was a shopping centre in Bellville, and she met this gentleman there. And she says she's not working. Her boyfriend is working. She collected the money; the boyfriend gave her the money. I think it was also eight hundred, seven hundred rand, somewhere there. And the boyfriend gave the money, she went to this people, she met this person in the mall. And it was…I think it was…she said to me it was like a Nigerian type of person

I: Yes

P: And the person didn't want to do the business in the mall and the person called her outside in the parking area and he explained to her. And she's told him that she don't want this baby, whatever. Then he gave her this tablets, she gave the money and not knowing that…I'm not much but I don't think you can use that tablets when you are so far pregnant, because she was really far pregnant. But that people don't know it and they don't explain to the people all these things, but anyway, she took the tablets and they explained to her how to take the tablets but "sister I didn't know that I was gonna have a baby like this that is dead.

I: Ya

P: And uhm…she said that…and she went home, took the tablets as the people told her to. And then that specific day her mom, she said she and her brother was alone at home, her mom is working somewhere, and she got this pain. And she said she gave birth at home and the baby didn't cry, and the baby was like a stillborn. And uhm…and I told her: "why didn't you come to the clinic".

I: Yes

P: Because we do…they do it here next to by the day hospital, they do the TOP's and she say she was scared, she was thinking what is the people gonna think. What is the staff, maybe the nursing staff gonna think. She didn't know what to think. She just thought I'm gonna do it illegally, she didn't know the consequences, didn't know she was too far pregnant…

I: Yes

P: …to get rid of this baby. And she was crying and crying and crying, and eventually the brother got hold of the mother, and the mother came and the mother was very upset. It was a whole… the mother was very upset…upset. Because number one the mother didn't know she was pregnant, and now because she did the illegal abortion and now the baby…there's a body that must be buried.

I: Yes

P: And she said if she knew that, uhm, if she knew she was going to give birth to a dead baby, she wouldn't have done that thing. I mean, it's sad. And I mean because of the way they came here, is a "dead on arrival" according to us.

I: Yes

P: The baby came here dead on arrival according to us. We had to get the police involved.

I: Yes

P: And the police came. I had to phone the police and they took a statement from the mother, from the patient, took a statement from me, and took a statement from the brother who was there at home. And at the end of the day the patient was also discharge and we don't hear anything like I said, every time something like that happen you just don't know. It's just like a dead end.

I: Ya

P: You know, when the patient is out of here they are out of here; you don't get any feedback from the person. That is that is for me, it's a little bit…it's not a nice feeling. I want to know what is being done outside in the community. Is the police following up on these cases? Is there any arrest that has been made?

I: Yes

P: I want to know that. But I don't, I don't get any feedback from nobody, you see!

I: It seems like you feel we get the information.

P: Ya

I: And we provide it to the police.

P: But we don't know what's happening. You know what I'm saying? I mean, tomorrow it can be somebody else you know what I'm saying? And then I was also working night shift now the other day. Me and my colleague was working night shift at about few months back, and but I was on lunch and she also had the same incident on the patient that came, but also found Misoprostols in the patients vagina. And she was also transferred to Mowbray. Same scenario as the first one, didn't wanted the baby, went to the back street abortion people, gave them the tablets. And you know, it is… I don't know, but it is just the people don't know the consequence of those tablets. That tablets is there for certain purposes in the medical field. But outside it's got an illegal purpose.

I: Yes

P: You know what I'm saying? And the other incident I also remember now, is like, it's not, I won't say it's a private incident, but it's somebody I know that also contacted me once when I was at home. Saying that her cousin is pregnant, but she don't want… the cousin don't want this baby. Is there something that they can do? And I told them that, uhm, I don't want…because of this incident that knows, rather…because she says she wants to go also…because she sends pictures of this adverts. "Sister, my friend…my cousin is seeing this posters and she wants to go to this people for the abortion because she don't want this baby" and what else. And then I told her, "no don't go there, I will first find out of what all this, and all this" And I said: "no, no, no, you're not gonna go that way".

I: Yes

P: Rather bring her into me, there by the MOU so that I can sort that out and I can rather go the legal way there by us, by the day hospital

I: Yes

P: And because apparently she ran away from home, scared of the mother. Because she scared number one, she's still a teenager, didn't plan this pregnancy, scared of the mother because they are very strict parents as well.

I: Yes

P: And, uhm, scared…she ran away from home and that is how she got in contact with me now. And, uhm, and I said: "no, no, just get this child so that she to come to me and so we

can sort her out. And eventually I think…she never ended up with me. Because now a few weeks back when I saw this lady again that asked me all of this questions, and I asked her what happened to that girl that you tell me that was pregnant? And apparently she had a miscarriage or something, so I don't know if it is a miscarriage?

I: Or what happened?

P: Or is there something that went on there that she's not telling anybody or whatever, but according to her cousin she said she had a miscarriage. So I can also maybe belief she went somewhere

I: Ya, something sounds suspicion.

P: Yes. Because she also told this cousin that she wants to go because she saw this posters…

I: Yes

P: …on the poles outside. And I mean, this posters outside I don't know if the people… there's a lot, of lot of places where you can go for help. If you don't want to go to the day hospital there's other places that you can also go to that also admits, what is that other one…?

(Participant looked at researcher for an answer)

P*: Mary Stopes?* Yes, they can "mos" also do it there also "mos". That's "mos" also a legal…

I: Yes

P: …a legal place, neh? But, I don't know, for it's just a sad thing that…I mean it's a person's choice at the end of the day, but how they go about it, is not… is not the right way. And even if you go to the TOP, there's a sister that's doing the TOP next door, she also will explain to you that some people use this, uhm, TOP's here by the medical…uhm, by the legal one, the medical one that they do as a method of family planning, hey.

I: Ya

P: And it is sad to think that there is family planning available.

I: Yes

P: But the people go that way…

I: Yes

P: …of doing it, of using it as a family planning.

I: Yes

P: So I don't know where is this gonna stop. I don't know. I think the reason may be why people is doing it also, because if you go looking at the teenagers, because they may be all very scared of their parents

I: Uhuh

P: And maybe thinking I told my mother and my father. There was another young lady also now, she was sixteen. So she was also very emotional, man, when she came to book. And, uhm, I also send her to the social worker. And, uhm, I asked her why she sounding so emotional, is there something wrong? She said: "Sister I'm very scared, my mother…I'm not happy. My mother and my father are very strict people. And now I'm pregnant, I'm sixteen years old and I didn't plan this. And I'm scared because they're not very happy with me. We don't talk to each other in the house and explain to her: It is okay for a parent to find out a child is pregnant, it's a shock for the first few days, few weeks, whatever, how long they decide to be cross or whatever. I think at the end of the day they're gonna love that baby.

I: Uhm

P: They're gonna help and support you with that baby, whatever. It's only going to be for the beginning

I: Yes

P: Give them time to come to terms with it. As time goes on, explain to them how you feel, how you are sorry that you made this mistake, whatever. Instead of being scared and then you go that way?

I: Ya

P: You know, the illegal abortion way, instead of doing that. You see what I'm saying? So I said okay and then I also sent her to a social worker so that she can speak to them in case she wants to go the other way. You know what I'm saying? It's not nice to see patients, especially youngster…

I: Yes

P: Doing this. I mean, I've dealt with a lot of young patients already, but I mean, it's not nice for me to see it.

I: So it seems like if we look back at the cases that you've told me about, like you feel frustrated in in the way they've done abortions and that you feel that something needs to be done in the in the health system and in the criminal system?

P: Maybe I think it can be…uhm, I think in the criminal sense of the way. I think it can… something must be… something must be done. Because I mean, if the patient goes away here and give you information to the police, and you give all your whatever, you never get feedback. Did they follow up on this case? Is it just a case that is just been thrown away? I don't know. It's just the file is there, finish and "klaar". Nobody worries about that. You know what I'm saying?

I: Ya

P: They don't give feedback. Nobody tells us what is happening to this… to this case. Even… even, it's the same scenario as when patients give birth at home and the baby is not alive, like a stillborn at home. You…They bring the baby in. It's a police matter. The police is taking the body away to forensic investigation, whatever. But you never get feedback also,

you never know. Maybe their mother could have been some… could have done something to that baby. We don't know that, you know? She's just all innocent, whatever, I don't know. But we never get feedback. And it's frustrating for us to… to do all this, to get the police involved and not knowing.

I: Yes

P: What is happening at the end of the day? What is happening to that mother?

I: Yes

P: You know what I'm saying? So it's frustrating, it's the same with medical TOP…with the illegal TOP's. And you know, personally, Misoprostol…I used Misoprostol. You use it in a medical sense that, uhm, when you have a miscarriage, the doctors will normally give it so to contract the uterus and to stop the bleeding.

I: Yes

P: And it's a terrible, terrible tablet to drink. I mean, it is like, it feels like your whole intestine has been turned around and you have so much pain. And I just can't believe that the mothers will put themselves through that.

I: Ya

P: And having to endure all that pain to have that baby.

I: Ya

P: You know what I'm saying? Yoh, it is terrible. I can't believe. But because I know, I took that tablet and I had to drink that tablet. Before I took that tablet I was crying already, because I know here the pain is gonna come again because I must take this tablet. I mean, it's not… that is not a nice tablet.

I: Yes

P: So to take that tablet and to…I don't know how they can…how they can do that. I mean, maybe because they don't tell them all this things, maybe they don't know, they don't know what is happening.

I: Yes.

P: I don't know.

I: And the management of the patients, if I can call it, who had Misoprostol intake! Is there any protocols that guide you with the management of those patients? Or how do you manage and refer those patients?

P: Is that the illegal…the abortion patient?

I: Yes

(Researcher cleaning her throat)

P: We manage them…most of the patients that, like the two incidents that I had the patients wasn't booked. So we found the Misoprostols still inside the vagina.

I: Yes

P: So what we normally do is we take it out and we refer and we put it like, I put it in a specimen jar, we send it whith to the dotor, to the hospital. So the end of the day it causes "mos" preterm labour, because maybe they are twenty something weeks.

I: Okay

P: So it can put you in preterm labour, so they must be referred.

I: Okay

P: So, uhm, it won't cause you any bleeding or whatever, because Misoprostol is suppose to stop the bleeding, but it's supposed to contract the uterus

I: Yes

P: So it will put you into labour. So whenever the patient use Misoprostol, they will have pain and they will come in here and they will have preterm labour, if it's more than 20 something weeks. You know?

I: Yes

P: So most definitely we have to book the patient, and refer the patient as…as if it is a preterm labour.

I: Okay. So thank you! So you refer the patient…

P: Yes

I: …according to the preterm labour protocol

P: Yes.

I: Okay

P: So whatever happened there? I don't know, if the babies been born alive or not alive, if whatever, because most of the patients is twenty-something weeks, twenty-three, twenty-four, twenty-five, whatever. Will the baby be alive right now? Will they stopped it, will they whatever. I don't know. That's why I say we don't know the management further. But we manage the patient as if the patient is in preterm labour.

I: Yes. So as you said, so they were referred both these instances where they took the Misoprostol because both of them were premature labour.

P: Yes

I: And it seems like you feel there was an obligation towards the attending physician on the other hospital to report this case to the police.

P: Yes, that's right. If it is being reported the police I don't know.

I: Okay

P: We don't know, that's why I said we don't get feedback. We don't know what's happening so patient on the other side. Do they refer to they refer the patient to the police, that's what I don't know. That's what we don't get feedback.

I: Okay

P: So that is a…that is a part of the frustration that I have personally.

I: Yes

P: Because I wanted to know what happened to this patient. You see!

I: Yes

P: I mean it is like, how do you call it? Get rid of your baby. Like a murder as the people will call it outside. I mean, it is their choice at the end of the day, but what is happening to them?

I: So it seems like you feel if those… if the cases are reported to the police then it might be a cry out to the community: "stop doing this, because this is illegal or giving knowledge out to the community.

P: Yes, definitely.

I: But if we just keep on turning, turning our…

P: Turning a blind eye, it will just continue, because nothing happened to you.

I: Yes

P: You see what I'm saying, because in two, three year's time I can do it again.

I: Yes

P: You see, because nothing happened to me the first time I did it. What's stopping you from doing it again?

(Background noise)

P: Nothing, you know.

I: For sure, I agree

P: Ya, nothing will happen to you, because at the end nothing happened to me the first time, so why can't I do it the second time?

I: Yes

P: And why can't I tell my neighbour, or my friend or my whatever?

I: Okay

P: You know what I'm saying?

I: Yes

P: You can do this, you can do that, you can do that, and nothing is gonna happen.

I: Ya, because the community, they speak to each other.

P: They speak to each other, of course.

I: Okay

P: So when is it going to end, I don't know. We cannot say!

I: Hopefully we will find some good information in all of the study's interviews and then we can see what we can do with that.

P: Is the patients all clued up about the legal way? Do we know that? Do they know… do we know that the patients outside know that they can come to the hospital for TOP's? Sometimes the patient's phone us in the labour ward or where ever: "Sister, uhm, do you people do abortions there?" You know, things like that!

I: Mmm

P: But does everybody know it? You know what I'm saying?

I: Okay, so you said you worked labour ward! Do you sometimes…do you rotate and work in the other unit sometimes?

P: Only labour ward and clinic.

I: Okay, and in the clinic do you sometimes get inquiries regarding TOP's

P: Yes

I: Okay

P: And we refer them next door

I: Okay, so next door would be?

P: The sister next door, Sister (name of person), that is the sister doing the TOP's there

I: Okay.

P: Ye, I think she was here, yes, this morning also (talk about this sister) she was here this morning. She's working in the theatre, doing the TOP's. And she brought a folder around of a patient that was there yesterday, who wanted to do a TOP. But apparently the patient was twenty four weeks and it was too late for…because normally they do a scan first to see how far pregnant the lady is. And I she did a scan, I think yesterday or when ever, the lady was twenty four weeks and they did the scan, but apart doing the scans, they see that the lady was twenty-four weeks. In any case, they picked up some other problems with a baby also.

I: Okay

P: So she came around saying that number one, they cannot do the TOP because she's very far and number two is because there's issues with the baby also. So I think she said (I don't know, I didn't see the patient) but she said she's gonna bring the patient around and ask…or found out if the patient if the patient is still there, or whatever. But she was going to bring the patient around and she must come book by us. So that we need to send the patient to (name of tertiary level hospital) for a more intense ultrasound and I…maybe the findings of that ultrasound can be that there's some abnormalities and then it's going to be a medical TOP at the end of the day.

I: Okay

P: You know what I'm saying?

I: Ya, you never know.

P: You never know.

I: So in that instance, when a patient is brought to you into the antenatal clinic if they are too late for a TOP here. Do you initiate antenatal care, or refer to a social worker, or…?

P: Uhm, sometimes when it is too late for them for a TOP, the sisters will send them around to come and book. I mean, obviously the sister gave them counselling saying it is too far along to do the TOP. But at the end of the day I think they get solutions of giving up the baby for adoption.

I: Okay

P: Because at the end of the day, the first thing they didn't want this baby in the first place.

I: Yes

P: You know what I'm saying? Or for some other medical reasons they will be referred to the level…the next level hospital where they do a medical TOP.

I: Okay, okay! That's very good. Thank you. It seems like you're doing good work in the community and you're having the appropriate referral systems in place

P: Ya, so there's always an option

I: There's always an option, ya!

P: There's always a option so that we can keep them, yes

I: Sister..! Thank you for your time and I appreciate your knowledge that you have shared for me. It's very helpful and I appreciate it a lot. Thank you so much.

P: It's a pleasure.

Appendix 7: Declaration by language and technical editors

Retha van den Berg **Language Practitioner**
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November 2019

To whom it may concern

Re: Editing of academic paper for ELCALIEN BENADé (married surname: Kotze)

I confirm that I have edited the following document for Elcalien Benadé

Research title	**THE UNDERUTILISATION OF TERMINATION OF PREGNANCY (TOP) SERVICES BY WOMEN WITH UNINTENDED PREGNANCIES: A DESCRIPTIVE CASE STUDY IN COMMUNITY HEALTH CENTRES WITHIN THE CAPE METROPOLE, SOUTH AFRICA**
Document type	M Thesis
Editing services	Editing of chapters 1 – 5: correcting spelling, punctuation and grammar errors, editing for consistency, style and flow.

The edited document was emailed to Ms Benadé in November 2019 with all changes marked up in colour.

Ms Benadé is responsible for the quality and accuracy of the final submission.

Yours faithfully

Jean Margaretha (Retha) van den Berg BA (Hons)
PROFESSIONAL EDITOR