CHOICE ON TERMINATION OF PREGNANCY: ITS IMPACT ON THE WOMAN’S HEALTH

by

MATOKGO ELIZABETH MAKUTOANE

submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF TMM MAJA

FEBRUARY 2016
DECLARATION

I declare that CHOICE ON TERMINATION OF PREGNANCY: ITS IMPACT ON THE WOMAN’S HEALTH is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

18 February 2016

.......................................

ME Makutoane      Date
ABSTRACT

Unintended and unwanted pregnancies are major reproductive health problems impacting negatively on women’s health globally. When faced with these pregnancies, many women choose termination of pregnancy (TOP) as their recourse.

The purpose of the study was to explore and describe physical, psychological and social implications of TOP on the woman’s health. A qualitative and descriptive research design was used. The population comprised women who had TOP three months to one year before the study and were willing to participate in the study. A non-probability purposive sampling was used to select participants for the study.

In-depth phenomenological interviews were used for data collection until data saturation was reached with 20 participants.

The findings reveal that women had psychological, physical and social implications after TOP which impacted negatively on their health. Recommendations were made to improve the services of women choosing to terminate a pregnancy to lessen negative implications.

KEY CONCEPTS

Termination of pregnancy; unplanned and unwanted pregnancy; psychological; physical; social implication; women’s health.
ACKNOWLEDGEMENTS

My foremost gratitude and appreciation is expressed to the women who willingly participated in the study, and in this way became a voice for other women. My insight was enriched through them.

My supervisor, Prof TMM Maja, for her unique approach, guidance and patience.

UNISA Department of Health Studies and Gauteng Department of Health (NHRD) for making this study possible.

Dr Rebecca Digamela, for assisting with data encoding.

My brothers and sisters, and especially the women who nurtured and influenced my life, my late mother, Dimakatso Makutoane, and grandmother, Tshiamo Nyoni. My late father, Neo Makutoane, for his unparalleled love for education and personal development.

My daughter, Winnie Makutoane, grandson, Neo, and granddaughter, Lintle, for their understanding and support during my studies.

My cousin, Nthabiseng Mosebe, her unwavering support always highly appreciated.

Barley Mahanyele, a gracious friend and colleague, for her motivation and understanding during this journey.

Agnes Mosobela, a friend, even though she is in London, she was always available. Her insight and knowledge was invaluable in this journey.

Gracious Muleya, for her support and understanding during my studies.
Dedication

The study is dedicated to my daughter, Winnie, grandkids, Neo and Lintle. My parents, Neo and Dimakatso Makutoane, my brothers and sisters, Glory, Minky, Maneo, Thakane, Thabo, Masechaba(late) and Ndondo, and the rest of the Makutoane family.
# TABLE OF CONTENTS

CHAPTER 1 ............................................................................................................................... 1  
ORIENTATION TO THE STUDY ............................................................................................................................... 1  
1.1 INTRODUCTION .................................................................................................................. 1  
1.2 BACKGROUND TO THE RESEARCH PROBLEM ............................................................ 2  
1.3 STATEMENT OF THE RESEARCH PROBLEM ............................................................... 5  
1.4 PURPOSE OF THE STUDY .............................................................................................. 6  
1.5 RESEARCH OBJECTIVES ............................................................................................ 6  
1.6 RESEARCH QUESTIONS .............................................................................................. 7  
1.7 DEFINITION OF CONCEPTS ....................................................................................... 7  
1.7.1 Implications .................................................................................................................. 7  
1.7.2 Termination of pregnancy .......................................................................................... 7  
1.7.3 Unintended pregnancy .............................................................................................. 7  
1.7.4 Unsafe abortion ......................................................................................................... 7  
1.7.5 Unwanted pregnancy ............................................................................................... 8  
1.8 SIGNIFICANCE OF THE STUDY ................................................................................. 8  
1.9 META-THEORETICAL ASSUMPTIONS .................................................................... 8  
1.9.1 Perceived susceptibility .............................................................................................. 9  
1.9.2 Perceived severity ..................................................................................................... 9  
1.9.3 Perceived benefits .................................................................................................... 9  
1.9.4 Perceived barriers .................................................................................................. 10  
1.10 RESEARCH DESIGN AND METHOD ...................................................................... 10  
1.11 POPULATION ............................................................................................................. 11  
1.12 SCOPE AND LIMITATIONS OF THE STUDY .......................................................... 12  
1.13 STRUCTURE OF THE DISSERTATION .................................................................. 12  
1.14 CONCLUSION ........................................................................................................... 12  

CHAPTER 2 ............................................................................................................................. 14  
RESEARCH DESIGN AND METHODS .................................................................................... 14  
2.1 INTRODUCTION ........................................................................................................... 14  
2.2 RESEARCH DESIGN .................................................................................................... 14  
2.2.1 Phenomenological approach ................................................................................. 16  
2.2.2 Advantages of phenomenology ............................................................................. 17  
2.2.3 Indications for the use of phenomenology ............................................................. 17  
2.3 RESEARCH METHODS ............................................................................................ 18  
2.3.1 Population .............................................................................................................. 19  
2.3.2 Research setting ..................................................................................................... 19  
2.3.3 Sampling ................................................................................................................ 19  
2.3.3.1 Eligibility criteria .............................................................................................. 20
LIST OF TABLES

Table 3.1  Biographic information of participants............................................................ 35
Table 3.2  History of termination of pregnancy ............................................................... 36
Table 3.3  Themes, categories and subcategories ......................................................... 37
Table 3.4  Negative implications of TOP ................................................................. 38
Table 3.5  Justification for TOP .............................................................................. 41
Table 3.6  Self-limiting behaviour before TOP ............................................................. 42
Table 3.7  Coping mechanisms after TOP .................................................................. 43

LIST OF ANNEXURES

Annexure A  UNISA ethical clearance certificate ............................................................ 70
Annexure B1 Application to conduct the study (GDOH)............................................. 71
Annexure B2 Application to conduct the study (BMM) .............................................. 73
Annexure C1 Letter of permission to conduct study (GDOH) ....................................... 74
Annexure C2 Letter of permission to conduct study (BMM) ......................................... 75
Annexure D  Participant consent form ......................................................................... 76
Annexure E  Interview guide ..................................................................................... 79
### LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTOPA</td>
<td>Choice on termination of pregnancy Act no 92 of 1996, as amended by (Act 1 of 2008)</td>
</tr>
<tr>
<td>GDOH</td>
<td>Gauteng Department of Health</td>
</tr>
<tr>
<td>GNHRD</td>
<td>Gauteng National Health Research Database</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development goals</td>
</tr>
<tr>
<td>PAC</td>
<td>Post-Abortion Care</td>
</tr>
<tr>
<td>PAIA</td>
<td>Promotion of Access to Information Act</td>
</tr>
<tr>
<td>PAS</td>
<td>Post-Abortion Syndrome</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>REC</td>
<td>Research Ethics Committee</td>
</tr>
<tr>
<td>SADAG</td>
<td>South African Anxiety and Depression Group</td>
</tr>
<tr>
<td>TFHMA</td>
<td>American Psychological Association’s Task Force on Mental Health and Abortion</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Unintended and unwanted pregnancies are major reproductive health problems impacting negatively on women’s health globally. When faced with these pregnancies, many women choose termination of pregnancy (TOP) as their recourse. TOP is universally practiced and no other elective procedure has evoked more political, moral or emotional debate than TOP (Mbokane & Ehlers 2007:44).

Women, being unaware of their rights and the availability of legal TOP services or the requirements for gaining authorisation may be presented with significant barriers. As a result, some women may opt for self-induced TOP with unskilled providers. The resulting immediate and longer term sequel of unsafe abortion is a major component of maternal mortality and morbidity and a neglected public health issue in many parts of the world (Ahman & Shah 2006:126-131).

South Africa’s Choice on the Termination of Pregnancy Act (CTOPA), Act No 92 of 1996 (South Africa 1996) as amended by Act No 1 of 2008 (South Africa 2008) is heralded as one of the most progressive abortion laws in the world. An outlier from its African counterparts, the CTOPA gives a woman of any age the right to a government funded abortion until the twelfth week of pregnancy. Women’s right activists, as part of the South African movement to eradicate the discrimination policies of apartheid and to incorporate international human rights norms, exerted significant influence in drafting the CTOPA and rights in the Constitution.

The implementation of the CTOPA, however, is not inspiring. The number of illegal terminations has not changed significantly since the CTOPA’s enactment. Although rates of maternal mortality associated with illegal abortion have decreased, indications of maternal morbidity (illness of negative health effects) remain fairly constant. Contradicting the expectations of the CTOPA drafters, the passage of a law that
enunciates a right to abortion has not substantially improved women’s reproductive health (Rebouché 2012: 298-299)

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Unwanted pregnancies may be substantially reduced if couples can plan their pregnancies through effective contraceptive use. However, it must be emphasised that contraception can greatly reduce but never eliminate the need for induced abortions because not all pregnancies can be avoided (Grimes, Benson, Singh, Romero, Ganatra, Okonofua & Shah 2006:1908-1919). The International Conference on Population and Development (ICPD) held in Cairo in 1994 attended by representatives from 179 countries was the first global forum where an agreement was reached that unsafe abortion should be recognised and addressed as a community health problem (Grimes et al 2006:1908-1919).

In most developed countries, TOP is a legal procedure and women have access to safe comprehensive services. Most TOPs are performed early in pregnancy, in hygienic settings, by well-trained providers and with safe surgical or medical procedures. Under these conditions, the risk of suffering complications from induced TOPs is very low and deaths are rare. A key element in avoiding TOPs is the prevention of unwanted pregnancies by improving access to quality reproductive health services and consistent use of contraception.

In South Africa, the CTOPA, Act No 92 of 1996 (South Africa 1996) as amended by Act No 1 of 2008 (South Africa 2008) legalised termination of pregnancy to reduce and ultimately eradicate the burden of morbidity and mortality resulting from unsafe TOPs. In terms of the Act, TOP services can be accessed on request by a woman during the first 12 weeks of pregnancy without giving any reason for the request. These services include pre- and post-procedure counselling, contraceptive services and the TOP procedure. Pre-procedure counselling is paramount to ensure that when the TOP procedure is done, the woman will have made a well informed decision. Post procedure counselling assists the woman to cope with the aftermath of TOP.

Women may experience physical, psychological and emotional impacts after a TOP, as well as ambivalence about the decision and concerns about possible future impact on
fertility. Poggenpoel and Myburgh (2006:6) reported that some women in their study were initially uncertain and confused about the decision to terminate their pregnancies hence, they experienced psychological discomfort after TOP.

According to Major and Appelbaum (2008:1), several factors that predicted negative psychological responses following TOP in the first trimester among women in the United States of America (USA) included:

- Perception of stigma and need for secrecy.
- Prior history of mental health problems.
- Personality factors such as low self-esteem and use of avoidance and denial coping strategies.
- Characteristics of a particular pregnancy including the extent to which the woman wanted and felt committed to it.

A relatively new aspect of the abortion debate is ‘post-abortion syndrome (PAS). Professionals who counsel women who have had an abortion report that these women often suffer from emotional and psychological problems as a result of the experience, comparable to the trauma suffered by victims of violent crimes and similar wrenching experiences.

Pro-abortion activists reply that this is anti-choice propaganda and just an attempt to frighten women away from exercising their constitutional right. They insist that abortion is a liberating experience, and that the most common emotional after effects are relief or even feelings of empowerment (Is Abortion Syndrome for Real 2000). A woman’s mental health before an abortion is a strong predictor of her mental health afterwards. Some women without prior mental health problems experience post abortion distress. It is important therefore to consider interpersonal and psychosocial factors prior to TOP (Kimport, Foster & Weitz 2011:103).

Globally, an estimated 46 million termination of pregnancies are performed each year, 19 million of them are outside the legal system and considered unsafe as they are performed by people who lack the necessary skills or in places that do not meet minimal medical standards (Mesce 2006:5). Women have resorted to abortion to terminate an
unwanted pregnancy despite legal and religious sanctions and personal risks involved due to various reasons.

One of the Millennium Development Goals, formulated in 2001 by the United Nations General Assembly, called for global efforts to reduce maternal mortality by three quarters in 2015. Worldwide, 358,000 maternal deaths occurred in 2008 which means a modest decline of 34% since 1990; the mortality associated with unsafe abortion-related complications — which is entirely preventable — also declined but accounted for 13% of overall maternal deaths (Zureich-Brown, Newby, Clou, Mizoguchi, Say, Sizuli, Wilmoth 2013:32-41).

The CTOP Act 92 of 1996 as amended by Act No 1 of 2008 opened doors for women and girls in South Africa who opt for safe abortions in the case of an unwanted pregnancy. In some instances, women are unable to access birth control which may lead to unwanted pregnancies, TOPs or unwanted births (South Africa 1996:2008).

In these situations, the reasons for the pregnancy could be, contraception is not used or used incorrectly and/or inconsistently, or they are forced into non-consensual sex. Where abortion laws are restricted, or safe TOP services are not widely accessible, or are of poor quality, women resort to unskilled providers risking serious consequences to their health and wellbeing. According to Guttmacher Institute (2012a) the annual number of induced abortions in Africa rose between 2003 and 2008, from 5,6 million to 6,4 million. In 2008 most abortions occurred in Eastern Africa at 2,5 million, followed by West Africa at 1,8 million. Northern and Middle Africa at 0,9 million, Southern Africa 0,2 million. This increase in the number of abortions is due largely to the number of women of reproductive age. Of the 6,4 million abortions carried out in 2008, only 3% were performed under safe conditions.

The lowest sub regional abortion rate in Africa was in Southern Africa at 15 per 1000 women of reproductive age, where 58% of procedures were unsafe. Abortion is liberal in the sub region’s largest country South Africa Guttmacher Institute (2012b). It is also essential to consider the context in which women seek abortions when discussing the mental health implications of abortion. Women typically seek an abortion because they are faced with an unplanned and unwanted pregnancy. To compare mental health of women who gave birth (typically of a planned, wanted pregnancy) to those who have
abortion (typically of an unintended unwanted pregnancy) is to compare apples to oranges.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Abortion rights opponents increasingly claim that many, or even most, women who have an abortion eventually regret it. Despite empirical findings that the proportion of women who experience regret is small, even among adolescent populations. Nonetheless, some women do experience negative emotions after abortion and need emotional care. Research has shown that while most women experience relief following abortion, some experience regret (Kimport et al 2011:103).

Pro-life groups report that women have flashbacks and regrets after a termination of pregnancy. While pro-choice groups found that women experience relief after abortion.

Women may experience psychological and emotional factors involved in TOP, as well as ambivalence about the decision and concerns about possible future impact on fertility. In addition, TOP has been reported to increase a woman’s chances of experiencing negative mental health outcomes later in life, insomnia and memory loss (Pud & Amit 2005:144).

In addition, Guttmacher Institute (2006:9) found that some women experience pain and sadness either shortly after having had an abortion or even many years later. These emotions, however, are not unique to women who have had an abortion or necessarily more or less common than the pain and sadness felt by many women who have placed a baby for adoption, or raised an unplanned child under adverse conditions.

These conflicting reports encouraged the researcher to embark on the study. The researcher has contact with women who’ve had a termination of pregnancy two weeks after the procedure and when they come to the health care centre for follow up contraception including other women’s health related procedures, like Pap smear. After the procedure, they are encouraged to come to the health care centre whenever they felt they wanted to talk about their TOP experience. Most women seemed to be content with the decision they made at the time. They managed to continue with their careers and keep their relationships. Some women reported that they were able to achieve
things they always wanted to achieve because they did not have an economic burden of having an unplanned child in the family.

Most women seemed to have economic reasons as to why they decided to terminate a pregnancy. However, some have reported a delay in falling pregnant after terminating a pregnancy or pregnancies. As a result, they shopped around different doctors when they failed to conceive and thus attributed this to TOP. Based on all the empirical evidence, the researcher intended to confirm if there was any scientific evidence of psychological, physical and social implications on women’s health three months to a year after TOP.

1.4 PURPOSE OF THE STUDY

The research purpose is a concise, clear statement of the specific goal of the study (Burns & Grove 2005:71). Women who have TOP either through legal or illegal means are sometimes not informed of the negative implications that might follow a TOP. When they have made that decision, it is the duty of the health provider to go through proper TOP counselling before and after the procedure so that the woman makes an informed decision. This will also enable her to contact the health care provider if she experiences negative implications after TOP. The purpose of this study was to explore and describe the physical, psychological and social implications of termination of pregnancy on women who had a pregnancy terminated, in order to develop intervention strategies for improvement services for women who choose to terminate their pregnancies.

1.5 RESEARCH OBJECTIVES

The objectives of the study were to

- explore and describe the implications of TOP as experienced by women
- describe how TOP affects the woman’s health
- recommend strategies to improve services in order to lessen negative implications after the TOP
1.6 RESEARCH QUESTIONS

In view of the above background, the following questions are posed:

- What are the experiences of women after terminating a pregnancy?
- What are the implications of TOP on the woman’s health?
- What strategies can be used to lessen the occurrence of negative implications after TOP and improve the services?

1.7 DEFINITION OF CONCEPTS

1.7.1 Implications

The conclusion that can be drawn from something although it is not explicitly stated. For the purpose of this study the researcher refers to the experiences of women who had their pregnancy terminated.

1.7.2 Termination of pregnancy


1.7.3 Unintended pregnancy

Defined as a pregnancy that is mistimed, unplanned or unwanted at the time of conception (Concise Oxford English Dictionary 2006).

1.7.4 Unsafe abortion

The WHO 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. This definition embodies concepts first outlined in a 1992 WHO Technical Consultation (Ganatra, Tuncalp, Johnston, Johnson & Gulmezoglu 2014:155).
1.7.5 Unwanted pregnancy

A pregnancy that is not desired by one or both parents (McGraw-Hill Concise Dictionary of Modern Medicine 2002).

1.8 SIGNIFICANCE OF THE STUDY

Polit and Beck (2008:86) describe the significance of a study as a crucial factor in selecting a problem to be studied, being its significance to nursing. Evidence from the study should have the potential of contributing meaningfully to nursing practice.

The findings of this study could contribute and benefit society by making men and women aware of the impact of termination of pregnancy in their lives. The study will also assist health professionals who come into contact with women who choose to terminate a pregnancy to be conscious of their relationship during the procedure. It is envisaged that the knowledge gained from the study will enable them to lessen the impact of negative implications from termination of pregnancy.

Nurses are constantly challenged to stay abreast of new information to provide the highest quality of patient care (Institute of Medicine [IOM] 2011). They should thus expand their ‘comfort zone’ by offering creative approaches to old and new health problems as well as designing new and innovative programmes that make a difference in the health status of our citizens (Lobiondo-Wood & Haber 2014:6).

1.9 META-THEORETICAL ASSUMPTIONS

Assumptions are a principle that is accepted as being true based on logic or reason, without proof (Polit & Beck 2008:748).

The study was based on the Health Belief Model (HBM). According to Polit and Beck (2008:150), HBM has become a popular conceptual framework in nursing studies focused on patient compliance and preventive health practices.
The theory has proved that a person’s willingness to change his/her health behaviour primarily depends on their perceived susceptibility to the condition, perceived severity of the disease/condition, perceived benefits from healthcare actions and perceived barriers to access services.

1.9.1 Perceived susceptibility

People will not change their behaviour unless they believe they are at risk. Women who think they might be at risk of having physical, psychological and social implications from having a termination of pregnancy will use contraception reliably and protect themselves from having an unplanned pregnancy by all means. Unless if a method has failed for some reason.

1.9.2 Perceived severity

Individuals who perceive a given health problem as serious are more likely to engage in behaviours to prevent health problems from occurring, or reduce its severity. With TOP, this will lead to women using contraceptives to avoid having an unplanned pregnancy. If an unplanned pregnancy does occur, they are likely to have a legal and safe procedure rather than unsafe and illegal means, give up a baby for adoption or continue with the pregnancy.

1.9.3 Perceived benefits

Perceived benefits are described as a person’s perception of the good things that could happen from the change in behavior, especially with regard to reducing the threat of the disease (Daddario 2007:364).

For the purpose of this study, if an individual believes that using contraception will prevent and unplanned pregnancy, she is more likely to use it than someone who believes using contraception will not prevent an unplanned pregnancy.
1.9.4 Perceived barriers

This refers to a belief about the tangible and psychological costs of the advised action (Glanz, Rimer & Viswanath 2008:45-51).

An individual may be faced with barriers in trying to access contraceptive services because of time constraints and overcrowding in the public facilities. Services might also not be accessible. With economic migrants, language barriers can also pose a perceived barrier. Perceived benefit must outweigh perceived barriers in order for behaviour change to occur.

1.10 RESEARCH DESIGN AND METHOD

The design for this study was qualitative, exploratory and descriptive. Qualitative design refers to inductive, holistic, emic, subjective and process-oriented methods used to understand, interpret, describe and develop a theory on a phenomena or setting. It is a systematic approach used to describe life experiences and give them meaning (Burns & Grove 2003:356).

According to Polit and Beck (2008:69), in this design researchers begin with a broad topic area focusing on an aspect of a topic that is poorly understood and about which little is known. They therefore may not develop hypotheses or pose refined research questions at the outset. It is often the only methodology used when the aim is to get in-depth sense of what people think of a particular object or event (Katzenellenbogen & Karim 2007:318-319). The goal is to describe ordinary conscious experiences of everyday life. In this study, participants related their physical, psychological and social, experiences following a termination of pregnancy.

A non-probability purposive sampling was used to select participants. The population under study was pregnant women, who chose to terminate a pregnancy, in Johannesburg, Gauteng Province. Specific sites were chosen because they provide safe abortion services. The pregnancy was terminated three months to one year before the study was undertaken. Data was collected by one on one unstructured interviews also referred to as self-report. Polit and Beck (2008:766) define a self-report as, a method of collecting data that involves a direct report of information by the person who
is being studied. Handwritten notes and tape recording were used to allow for a much fuller record of notes.

The women should, exhibit signs of psychological, physical and social implications after a TOP. Women who met the above criteria, were requested to participate.

The principle of saturation of data decided the sample size. This means that the researcher will continue with data gathering from multiple participants until the information becomes repetitive or a full understanding has been achieved (Donalek & Soldwich 2004:356).

1.11 POPULATION

It is an aggregate of all the individuals or objects to be studied with some common defining characteristics (Polit & Beck 2008:738). The study population comprised women who had a TOP at two clinics in Johannesburg, Gauteng Province.

These women had to meet the following inclusion criteria:

- Have had a TOP in the past three months to a year before the study.
- Must present with psychological, physical and social implications after TOP.
- Must be willing to participate in the study.

Data was collected by one on one unstructured interview. Unstructured interviews are conversational and interactive and are the mode of choice when researchers do not have a clear idea of what it is they do not know (Polit & Beck 2012:536).

Handwritten notes and tape recordings were used to allow a fuller record of notes. Data transcription was done to avoid reliance on handwritten notes. According to Polit and Beck (2012:534), notes tend to be incomplete, and may be incomplete, and may be biased by the interviewer’s memory or personal views.
1.12 SCOPE AND LIMITATIONS OF THE STUDY

Polit and Beck (2008:73-74) describe limitations of a study as the sample deficiencies, design problems, weaknesses in data collection and so forth.

It demonstrates to readers the limitation that the author was aware of and took into account when interpreting the findings of the study.

The study was conducted at two health care facilities in the region of Johannesburg, Gauteng Province.

It cannot therefore be generalised owing to sample size and non-probability sampling technique of the study. The advantage of using this type of study though, is the convenience and economy (Polit & Beck 2008:344).

1.13 STRUCTURE OF THE DISSERTATION

Chapter 1: This chapter introduces the background and orientation to the study.

Chapter 2: Research design and methods, measures to enhance trustworthiness and ethical considerations of the study.

Chapter 3: Presents the research findings.

Chapter 4: Describes the research findings and literature control.

Chapter 5: Presents the conclusion, limitations and recommendations of the study.

1.14 CONCLUSION

Women all over the world are often challenged when faced with an unplanned and unwanted pregnancy. Even though some countries have relaxed laws around termination of pregnancy, many other countries have still outlawed the practice. This doesn’t make it any easier for the women who have to make the decision to terminate or not.
This chapter outlined the overview of the study, the research problem, purpose and objectives, significance, theoretical foundation and a brief methodology.
CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

This chapter discusses the research design and methodology used to describe the implications as experienced by women who had TOP three months to a year before the study. The main purpose was to describe and explore the psychological, physical and social implications of TOP in order to develop intervention strategies for improvement of services for women who choose to terminate a pregnancy.

The following details are discussed:

- Research paradigm/design utilised
- Study settings
- Population and sampling techniques
- Data collection process
- Data analysis procedures
- Measures that enhance trustworthiness
- Related ethical principles

The study was meant to answer the following questions:

- What are the experiences of women following TOP?
- What are the implications of TOP on the woman's health?
- Which strategies can be used to lessen the occurrence of negative implications after TOP and improve TOP services?

2.2 RESEARCH DESIGN

According to Grove, Burns and Gray (2013:214), a design is the blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings as it gives the researcher greater control.
Glasper and Rees (2013:127) assert that, there is a clear compatibility between qualitative approaches to research and nursing. In addition, Holloway and Wheeler (2010:11) point out that it takes a ‘person-centred and holistic perspective’, which is the same as health care professionals such as nurses’ approach to nursing care. This approach provides insight into the experiences of patients and clients of health services so that practitioners who have experienced particular situations can begin to appreciate how it is for those concerned, and provide a more sensitive and understanding form of care.

The study was exploratory, descriptive and qualitative in nature, with a phenomenological approach. According to Grove et al (2013:66), “an exploratory and descriptive qualitative research often indicates that a study is needed with a specific population to understand the needs of, desired outcomes of, or views on appropriate interventions held by the members of the group. The goal is to create a programme or an intervention to benefit the population. Exploratory-descriptive qualitative researchers identify a specific lack of knowledge that can be addressed only through seeking the viewpoints of the people most affected.”

The objectives of this study were to explore and describe the physical, psychological and social implications of women who had TOP three months to a year before the study was conducted. The purpose was to determine intervention strategies that can be implemented to lessen the negative impact of TOP on women.

Terre Blanche, Durrheim and Painter (2010:563) define a research design as a strategic framework or plan that guides research activity to ensure that sound conclusions are reached. Polit and Beck (2008:765) describe research methodology as the technique used to structure a study, gather and analyse information in a systematic manner.

This knowledge is quite different from quantitative studies as they are located more in the social world of health and illness rather than a medical model’s focus on the body and the fight to regain health through interventions carried out by health professionals. The methods used by researchers are just as systematic as quantitative researchers, although very different in their characteristics, and the methodology sections of research articles should be just as transparent in revealing how the study was undertaken, especially the data analysis (Glasper & Rees 2013:131-132).
Qualitative research design has the following advantages:

- Issues and subjects covered can be evaluated in depth and in detail.
- Interviews are not limited to particular questions and can be redirected or guided by researchers in real time.
- The direction and framework of research can be revised quickly as soon as fresh information emerge.
- The data in qualitative research depends on human experience and this is more compelling and powerful than data gathered through quantitative research.
- Complexities and subtleties about the subjects of the research or the topic covered is usually missed by many positivistic inquiries.
- Data is usually gathered from few individuals or cases therefore findings and outcomes cannot be spread to larger populations. However, findings can be transferred to another setting.
- With this type of research, the researcher has a clear vision on what to expect. They collect data in a genuine effort of plugging data to bigger picture (Occupy Theory 2014).

The researcher has, for this study, selected the design that is appropriate and feasible given realistic constraints as well as its effectiveness in reducing threats to design validity.

**2.2.1 Phenomenological approach**

A phenomenological approach was the most appropriate to the aim of the study, which was to explore and describe the implications as experienced by women who had TOP three months to a year before the study was done.

Phenomenology aims to gain a deeper understanding of the nature of the meaning of our everyday experiences. The phenomenological approach allowed participants, through in-depth interviews, to elicit their own meaning of their experiences after TOP. Phenomenology aims to describe a person’s lived experiences (phenomena) in an attempt to enrich lived experience by drawing out its meaning (Holloway 2005:47).
According to Creswell (2007:58), the philosophical assumptions of a phenomenological study are:

- The focus of the study is on the experiences of the participants.
- The experiences of the participants are conscious experiences.
- The essence of these experiences is the focus of the research, and the experiences are described and interpreted rather than explained or analysed.

The assumption, in this study was that the experiences of women who had their pregnancies terminated will give insight into the hypotheses that women do suffer negative implications after TOP. Furthermore, the assumption was that the critical truth can be found through in-depth interviews from women who had a TOP done.

Women were expected to share how TOP impacted their lives and health three months to a year after the procedure. The experience could include, apart from individual experiences, relations with her partner and other people close to her. A descriptive phenomenological approach allowed for a description of the experiences shared by the women. The focus in this study was the experiences of women in order to describe how TOP affected them.

### 2.2.2 Advantages of phenomenology

In addition to general advantages of qualitative research, phenomenology has the following advantages:

- It is a highly appropriate approach to researching human experience.
- As a research method, it is a rigorous, critical, systematic investigation of phenomena (Streubert Speziale & Carpenter 2003:53).

### 2.2.3 Indications for the use of phenomenology

The purpose of phenomenology enquiry is to explicate the structure or essence of the lived experiences in the search for meaning that identifies the essence of the phenomena, and its accurate description through every day’s lived experience. Qualitative phenomenology is employed for the purpose of:
• Clarifying the nature of being human.
• Expanding awareness about a certain phenomenon.
• Fostering human responsibility in the construction of realities.
• Tightening the bond between experiences and the concepts and theories used to explain those experiences (Streubert Speziale & Carpenter 2003:48).

Most nursing researchers adopt the phenomenological approach because of the nursing profession’s philosophical beliefs about people. Nursing also grounds its practice in a holistic belief system that cares for mind, body and spirit (Streubert Speziale & Carpenter 2003:56).

2.3 RESEARCH METHODS

Research methods are the techniques researchers use to structure a study and to gather and analyse information relevant to the research question. The two alternative paradigms have strong implications for the research methods to be used to develop evidence (Polit & Beck 2008:15).

A qualitative research method was used for this study. This method allowed researchers to understand how the research participants experienced their situation including health related behaviour and their role within this context. Qualitative research helped to find out why these behaviours occurred or why people held these views. It is often the only methodology used when the aim is to get in-depth sense of what people think of a particular object or event. (Katzenellenbogen & Karim 2007:318-319).

The aim was to explore and describe the implications of TOP as experienced by women who had TOP. Their experiences were recorded three months to a year before the study at two health centres in selected for the study in Johannesburg, Gauteng Province.

The following explain the population from which the sample was drawn and the sampling process.
2.3.1 Population

A population is the entire aggregation of cases in which a researcher is interested (Polit & Beck 2008:337). In this study, the population consisted of all pregnant women who terminated a pregnancy in Johannesburg, Gauteng Province.

An accessible population is the aggregate of cases that conform to designated criteria and that are accessible as subjects for a study (Polit & Beck 2008:338). The accessible population was women who had TOP three months to one year at the two selected health care centres in Johannesburg, Gauteng Province, at the time of data collection period.

2.3.2 Research setting

Research can be undertaken in a variety of settings and in one or more sites. Some studies take place in naturalistic settings, in the field, such as in people’s homes or places of work. Researchers make decisions about where to conduct a study based on the nature of the research question and the type of information needed to address it (Polit & Beck 2008 57).

In this study, some participants were interviewed at their homes and others were interviewed at a health facility where TOP was done. Where a woman wasn’t comfortable at her home or clinic, the researcher interviewed her at some private place. There was no modification of the natural setting.

2.3.3 Sampling

Sampling is the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made (Polit & Beck 2008:33).

The key elements of a qualitative study revolve around the attempt to construct a view of the social world of the participants in a study from their own perspective and by concentrating on the richness and depth of information that is possible from the processes (Glasper & Rees 2013:128).
Through gatekeepers, the participants were identified through client records kept at the clinic. They were chosen depending on the dates they had TOP done. Eligibility criteria states, TOP must have been done three months to a year before data was collected.

### 2.3.3.1 Eligibility criteria

This refers to the criteria designating the specific attributes of the target population, by which people are selected for inclusion in the study (Polit & Beck 2008:752).

Inclusion criteria were:

- Women willing to participate in the study.
- Must have had TOP three months to one year before the study.
- Must have had TOP at the two health care centers selected for the study, in Johannesburg, Gauteng Province.
- Must be experiencing negative implications after TOP.

Exclusion criteria:

- Unwilling to participate in the study.
- Not had TOP in the past three months to one year.
- Had TOP elsewhere, not at the selected health care centers.
- Not experiencing any negative implications from TOP.

### 2.3.3.2 Sampling approach

Non-probability sampling refers to the selection of sampling units from a population using non-random procedures (Polit & Beck 2008:759). A non-probability purposive sampling design was used for the study. Purposive sampling is a method in which the researcher selects participants based on personal judgment about which ones will be most informative (Polit & Beck 2008:763). The participants met the criteria as described in 2.3.2.1.
The size of the sample was controlled by saturation of information, which means the point at which repetition or confirmation of previously collected data occurs, thus there was no specific number of participants prior to data collection (Streubert Speziale & Carpenter 2003:25).

The design was also chosen because the researcher intended to develop a rich or dense description of experiences regarding TOP, rather than use techniques that support general data (Streubert Speziale & Carpenter 2003:25). Purposive design provided cases rich in information for in-depth study. The judgement in this study was based on the fact that women who had TOP would provide rich experiences regarding implications of TOP three months to a year after TOP.

2.3.3.3 Sample size

There are no rules for sample size in qualitative research. Sample size should be determined based on informational needs. Hence a guiding principle in sampling is data saturation, that is, sampling to the point no new information is obtained and redundancy is achieved (Polit & Beck 2008:357). In this study, saturation was reached when the 20th participant was interviewed.

2.4 PILOT STUDY

A pilot study refers to a small scale version, or trial run, done in preparation for a major study (Polit & Beck 2008:761).

The researcher conducted a small scale version of the study to test the methods to be used in a larger more rigorous study. Two participants were used for that purpose. The outcomes of a pilot study are ‘lessons’ that can inform subsequent efforts to generate strong evidence for nursing practice (Polit & Beck 2008:214).

Pilot study can serve a number of important functions in planning a study, including the following:

- Adequacy of study methods and procedures.
- Likely success of a participant recruitment strategy.
• Potential problems, such as loss of participants during the course of the study.
• Extent to which the preliminary evidence justifies subsequent, more rigorous research.
• Strength of relationships between key variables so that the number of needed study participants can be estimated. (Polit & Beck 2008:214).

The results of the pilot study were:

• Some of the questions were similar, that led to the researcher not asking them on noticing that they were already answered. They were deleted from the interview guide.
• Some participant's voices were not clear on the recorder. The researcher had to ask them to speak up.
• The interview lasted 30-45 minutes on average, to complete, which was acceptable.

The pilot study confirmed that the exploratory, descriptive method was suitable as a design for the main study to achieve its objectives. The interview was also found to be an appropriate method of data collection.

2.5 DATA COLLECTION

Data gathering is a precise, systematic gathering of information relevant to the research sub-problems, using methods such as interviews, participant observation, focus group discussion, narratives and case histories (Burns & Grove 2003:373). According to Matthews and Ross (2010:181), data collection is a practical activity carried out within time, spatial and resource constraints.

The following characteristics of qualitative research were applied as identified by Creswell (2007:37-39):

• Qualitative researchers tend to collect data in the field at the site where participants experiences the issue or problem under study.
• Qualitative researchers act as a key instrument collect data themselves through examining documents, observing behavior and interviewing participants.
• Qualitative researcher gathers multiple forms of data rather than rely on a single data source.
• In the entire qualitative research process, the researcher keeps a focus on learning the meaning that the participants hold about the problem or issue, not the meaning that the researchers bring to the research or writers from the literature.
• Qualitative research is a form of inquiry in which researchers make an interpretation of what they see, hear and understand. The researcher’s interpretation cannot be separated from their own background, history, context and prior understanding.
• Qualitative researchers try to develop a complex and holistic view of social phenomena.

2.5.1 Factors that influenced data collection

The following factors were considered as crucial during data collection as identified by Burns & Grove 2011:515-517).

2.5.1.1 Cost factors

These may include, printing measuring tools, compensating participants, developing and formatting and postage of questionnaires.

For this study the researcher budgeted for, printing of data collection forms, travel costs, Dictaphone and mobile data costs. Participants were only compensated for their travel costs.

2.5.1.2 Time factors

The researcher determined time for:

• Recruitment and enrolment of participants.
• Getting consent from participants.
• Piloting the study.
• Obtaining permission from the Gauteng National Health Research Database Committee (Annexure C1) and the other health care center selected for the study, BMM (Annexure C2).

2.5.1.3 Consistency

Grove, Burns and Gray (2011:516) state that the specific days and hours of data collection may influence the consistency of the data collected due to variation in energy levels and state of mind of subjects from whom data is gathered.

In order to manage consistency:

• The researcher gave herself time frames for the data collection process.
• Participants were only contacted at time agreed on between them and the researcher.

2.5.2 Field issues in qualitative studies

2.5.2.1 Gaining trust

Researchers who do qualitative research must, to an even greater extent than quantitative researchers, gain and maintain a high level of trust with participants. Researchers need to develop strategies in the field to establish credibility among those being studied. (Polit & Beck 2008:384).

The researcher reassured the participants of confidentiality, considering the sensitive nature of the topic under study. It was important that the researcher and the participant meet where privacy could be maintained. This would enable the participant to express themselves freely.
2.5.2.2 The pace of data collection

In qualitative studies, data collection is often a powerful and exhausting experience, especially if the phenomenon being studied concerns an illness experience or other stressful life event. Moreover, collecting high quality data requires intense concentration and energy (Polit & Beck 2008:384). One way to deal with this is to collect data at a pace that minimises the emotional impact.

The researcher collected data from the participants at a time, day and place that suited them. This was very important considering the sensitive nature of the topic under study. The researcher made maximum use of the time given by the participants so that there were no repeated interviews, in order to minimise the emotional impact.

2.5.2.3 Emotional involvement with participants

Qualitative researchers need to guard against getting too emotionally involved with participants – being referred to as ‘going native’. Researchers who get too close to participants run several risks, including compromising their ability to collect objectively the most meaningful and trustworthy data and becoming overwhelmed with participant’s suffering (Polit & Beck 2008:386).

The researcher used bracketing which, according to Polit and Beck (2012:495), is the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study. In this study the researcher used bracketing to be self-aware of her own values and beliefs to prevent biasness. The researcher maintained this self-awareness throughout the duration of the study.

The subject under study is quiet controversial and almost always emotion ridden. The researcher made sure that she follows all the rules of scientific research and not show any bias in data collection, analysis and reporting.

2.5.2.4 Reflexivity

Researchers need to be conscious of the part they play in their own study, and reflect on their own behaviour and how it affects the data they obtain (Polit & Beck 2008:386).
The researcher was self-aware and conscious of her involvement in the research process in order to enable the process to be as objective as possible. The researcher’s behaviour should not in any way affect the data they collect.

2.6 DATA COLLECTION PROCESS

In this study, data were collected between September 2015 and January 2016 at each participant’s place of residence as this is considered a natural setting. However due to privacy, some participants were interviewed at the area where termination was conducted in order to protect the participants’ wishes of concealing termination of pregnancy from family members. Before commencement of interviews, each participant was assured of confidentiality, anonymity, privacy and informed consent (Annexure D).

Individual one-on-one interviews were conducted in consultation with participants in order to schedule appointment times that were suitable for them. Upon permission to record the interview, a tape recorder was used to capture the interviews (Annexure E). Each interview lasted for 30 to 45 minutes. A total of twenty (20) participants were interviewed. Interviews continued until no more information was received during interviews as data saturation was used to control the sample size. According to Polit and Beck (2012:765), data saturation is the collection of qualitative data to a point where a sense of closure is attained because new data yield redundant information.

2.6.1 Interviewing

According to Polit and Beck (2012:541), the purpose of gathering narrative self-report data is to enable researchers to construct reality in a way that is consistent with the constructions of the people being studied.

In this study, data was gathered by interviewing research participants in a quiet, private, environment, free from disturbances, and where they felt safe. Interviews were held in a specific room within the specific health centre, at their respective homes or other private venue. Interviews were conducted individually for 30-45 minutes. Only the participant and the researcher were in the room.
During data collection, the following steps were followed with each interview:

- Appointment made with each participant at a time that suited them and the health care centre.
- Created a quiet room conducive to private conversation.
- Arranged chairs to enhance face to face interviewing.
- Prepared a dictaphone and a second recorder (if needed).
- Had some water available as an icebreaker.
- Made sure that the participant was comfortable.
- The interviews were only conducted by the researcher.
- Interviews were conducted in English, as all participants understood the language.
- Clarity was sought where necessary.

The most important interviewing skill for in-depth interviews is being a good listener. It is especially important not to interrupt respondents, to lead them, to offer advice or opinions, or to counsel them (Polit & Beck 2012:543). The researcher listened attentively as participants narrated their stories.

Although in depth interviews are unstructured, the following format as suggested by Greeff (2005:29) and cited by Botma, Greeff, Mulaudzi and Wright (2010:207) was followed:

- Opening with introductory pleasantries.
- Explained the purpose of the research.
- Explaining the approximate time required for the interview.
- Emphasis of confidentiality of information.
- Tape recording and taking notes during the interview.
- Signed voluntary consent is confirmed.
- Reminded the participant that she is free to withdraw at any time.

Where there was a need for further counselling, the participant was referred to appropriate professionals.
2.7 DATA ANALYSIS

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2008:751). As common practice in qualitative studies, analysis of data commences soon after data is collected. According to De Vos, Strydom, Fouché and Delport (2011:397), qualitative analysis transforms data findings which involve reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals.

Data were transcribed verbatim by the researcher after each interview in preparation for analysis and data were analysed according to the interpretive analysis of (Terre Blanche, Durrheim & Kelly 2006:326 as cited by Botma et al 2010:226).

The five basic steps followed include:

2.7.1 Familiarisation and immersion

The process started while gathering data, with the researcher developing ideas and theories about the phenomenon. The researcher read through the transcripts in order to understand the data.

2.7.2 Development of themes

Development of themes involved identification of the main and sub-themes whilst reading the text or while listening to taped interviews. The researcher stayed within the language of the participant in identifying themes and subthemes.

2.7.3 Coding

Data were coded and linked to identify relevant themes. The researcher cut and pasted to code and linked the codes to themes.
2.8 DATA ANALYSIS PROCESS

Qualitative data take the form of loosely structured, narrative materials, such as verbatim dialogue between an interviewer and a respondent, field notes of participant observers, or diaries kept by study participant (Polit & Beck 2008:507).

Qualitative data analysis transforms data into findings, which involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. The purpose of data analysis is to bring order, structure and meaning to the mass of collected data (De Vos et al 2011:397).

Data collection was done in English, tape recorded and transcribed verbatim.

Data was stored electronically, following each interview the researcher transcribed the interview and dwelt with the data, continually writing and re-writing and reading transcripts repeatedly. Data was checked for audibility and completeness as soon as the interview was over (Polit & Beck 2012:543). The interviewer listened to the interviews objectively in order to critique their own interviewing style, so that improvements can be made in subsequent interviews (Morse & Field 1995; Polit & Beck 2012:543).

An experienced independent encoder was engaged to check the quality of the initial transcriptions and to give transcription feedback. There was regular contact between the researcher and the encoder to warn about upcoming interviews and give feedback (Polit & Beck 2012:544). The researcher and the coder read each interview several times to gain an understanding of what participants were experiencing.

The transcriber indicated through symbols in the written text, who is speaking, such as ‘I’ for Interviewer and ‘P’ for participant (Polit & Beck 2012:557).

Data analysis for recurring themes was undertaken.
2.9 ETHICAL CONSIDERATIONS

The researcher had a moral obligation to strictly consider the rights of the participants who were expected to provide this knowledge (Streubert Speziale & Carpenter 2003:314).

Actions essential for conducting research ethically include protection of human subjects, balancing benefits and risks in a study as well as obtaining an informed consent from study participants (Grove et al 2013:159).

Ethical considerations were very important in this study based on the sensitive nature of the subject under discussion. Possible risks were continually examined.

2.9.1 Informed consent

The request to conduct the study was done by written request to the Gauteng Department of Health (GDOH) (Annexure B1) as well as the Management of the selected Health Centre, BMM (Annexure B2) after approval of the study from the Research Ethics Committee of Health Studies, UNISA (Annexure A).

Information about the purpose of the study was provided. The study was explained in a language the participants understood. The participants were informed of what type of participation is expected and how long it will take. Information about the funding of the study and the publication plans of the results were also disclosed.

The unintended risk, such as psychological or emotional distress brought about by disclosing private issues to the researcher, was explained. The benefits of the study were that they had access to a beneficial intervention that might otherwise be unavailable to them. Only the participants who met the criteria, signed the informed consent (Annexure D) and took part in the study.

2.9.2 Privacy

Virtually all research with humans involves intruding in personal lives. Researchers should ensure that their research is not more intrusive than it needs to be and that
participant’s privacy is maintained throughout the study. Participants have the right to expect that any data they provide will be kept in strictest confidence (Polit & Beck 2008:174). In this study, data was collected from participants who consented and were aware of the type of data that was needed. Privacy was also maintained by not attaching participant’s names to the information given.

2.9.3 Confidentiality and anonymity

Prospective participants were guaranteed of privacy at all times. If anonymity cannot be guaranteed, this should be noted (Polit & Beck 2008:176). Participants were assured that their names will not appear in any documents.

2.9.4 Right to withdraw from the study

Prospective participants were informed that even after consenting, they have the right to withdraw from the study and to refuse to provide any specific piece of information (Annexure D). Researchers may, in some cases, need to provide participants with a description of circumstances under which researchers would terminate the overall study (Polit & Beck 2008:176-177).

2.9.5 Right to freedom from harm and discomfort

Researchers have an obligation to avoid, prevent, or minimise harm in studies with humans. Participants must not be subjected to unnecessary risks for harm or discomfort, and their participation in research must be essential to achieving scientifically and societally important aims that could not otherwise be realised (Polit & Beck 2008:170).

2.10 MEASURES TO ENHANCE TRUSTWORTHINESS

Qualitative research is not concerned with validity or reliability; its primary concern is trustworthiness. The study was subjected to the following criteria for trustworthiness (Botma et al 2010:292; Luhalima et al 2008:33; Bimenyana; Poggenpoel, Myburgh & Van Niekerk 2009:6).
The following indicators point to the trustworthiness of the study:

2.10.1 Credibility

Credibility refers to the faith that can be put in the researcher. From the point of view of qualitative researchers, the ongoing question must be: How can I be confident that my account is an accurate and insightful representation? (Polit & Beck 2012:584).

The researcher made first contact with some participants on the phone, and set an appointment to meet personally. The researcher then introduced herself and explained the purpose of the meeting. The participants had the researcher’s contact details in order to check credibility. This information and prolonged engagement enhanced credibility to build trust.

2.10.2 Dependability

This refers to the stability (reliability) of data over time and conditions (Polit & Beck 2012:584). The presence of recorded data is evident of the process followed. It gives an indication that the data is credible as it can be rechecked.

The audio tape was transcribed by the researcher and this was cross-checked with the field notes taken. The independent coder checked the data with the researcher to enhance dependability.

2.10.3 Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data’s accuracy, relevance, or meaning (Polit & Beck 2012:585). The presence of recorded data, and the use of an experienced independent coder makes it a transparent process. This indicates how data was collected, analysed and interpreted. The use of bracketing also contributed to the objectivity of the study. The availability of raw data on tape and transcriptions to verify themes, was another way of proving confirmability.
2.10.4 Transferability

This refers to the potential for extrapolation, that is, the extent to which findings can be transferred to or have applicability in other settings (Polit & Beck 2012:584). Purposive sampling, which is selecting cases that will most benefit the study (Polit & Beck 2012:517) was seen as the most relevant to provide a thick description necessary to make it transferable.

2.11 CONCLUSION

This chapter described the research design, research methods, population, sampling, ethical issues relating to sampling. Data collection and measures to enhance trustworthiness of the study were also discussed.

The next chapter will discuss research findings.
CHAPTER 3

RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter presents research findings in terms of themes, categories and sub-categories that emerged from the analysed data. The report is presented according to the following: Biographic information of participants and research findings.

3.2 DATA ANALYSIS

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2008:751) as common practice in qualitative studies, analysis of data commences soon after data is collected. According to De Vos et al (2011:397), qualitative analysis transforms data findings which involve reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals.

Data analysis was done in two phases.

The first phase was done by analysing field notes to find clear patterns that helped in developing common themes and sub-themes for the second phase.

During the second phase audio-recorded data was transcribed verbatim and edited for accuracy. Themes and codes were developed by means of a line-by-line analysis of each interview transcription. Data was then analysed in line with the objectives of the study

3.3 RESEARCH FINDINGS

3.3.1 Sample characterisation

The study sample consisted of adult women who had terminated a pregnancy three months to a year prior to the commencement of the study at two facilities in
Johannesburg, Gauteng Province. The participants were all female between the ages of 19 and 35 years. A total of ten participants had TOP at a public institution and the other 10 at a private institution.

Ten of the participants had the procedure done four months before the study was conducted, while the other ten, the period varied between six months to one year since the procedure was done. Table 3.1 depicts the biographic profile of participants.

Table 3.1: Biographic information of participants

<table>
<thead>
<tr>
<th>Ages of participants</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>19–21 years</td>
<td>6</td>
</tr>
<tr>
<td>22–35 years</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of education of participants</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td>9</td>
</tr>
<tr>
<td>Tertiary</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>18</td>
</tr>
<tr>
<td>Coloured</td>
<td>1</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>12</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
</tr>
<tr>
<td>Living together</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>14</td>
</tr>
<tr>
<td>Unemployed</td>
<td>5</td>
</tr>
<tr>
<td>Part time work</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religious background</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>18</td>
</tr>
<tr>
<td>Muslim</td>
<td>2</td>
</tr>
<tr>
<td>No religion</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>1-2</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>
Table 3.2: History of termination of pregnancy

<table>
<thead>
<tr>
<th>Number of previous TOPs</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3 or more</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of terminated pregnancy</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>4−9 weeks</td>
<td>12</td>
</tr>
<tr>
<td>9−12 weeks</td>
<td>8</td>
</tr>
<tr>
<td>12 weeks and more</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

Interpretive method was used to analyse data. Identified codes were collated resulting in patterns which used themes, categories and subcategories. These themes were used to represent the opinions of participants regarding ‘Choice on termination of pregnancy: Its impact on the woman’s health’.

Upon completion of data analysis, clean transcripts were given to an independent analyst. After the analysis of data by the independent analyst, a meeting between the researcher and the independent analyst was arranged to compare and reach consensus about the findings.

Four themes were derived from the analysed data, namely:

- Negative implications of TOP
- Justification for TOP
- Self-limiting behavior before TOP
- Coping mechanisms

Refer to table 3.3 for themes, categories and subcategories.
### Table 3.3: Themes, categories and subcategories

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong> Negative implications of TOP</td>
<td>Emotional implications after TOP</td>
<td>• Guilt feelings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Betrayal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lost chance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acceptance</td>
</tr>
<tr>
<td></td>
<td>Physical implications</td>
<td>• Pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Insomnia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Infertility</td>
</tr>
<tr>
<td></td>
<td>Social implications</td>
<td>• Partner relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Friends</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family</td>
</tr>
<tr>
<td><strong>Theme 2:</strong> Justification for TOP</td>
<td>Absenteeism and loss of employment</td>
<td>• Lack of income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dependency</td>
</tr>
<tr>
<td></td>
<td>Unplanned pregnancy</td>
<td>• Unplanned motherhood</td>
</tr>
<tr>
<td></td>
<td>Fear of losing partner</td>
<td>• Single parenthood</td>
</tr>
<tr>
<td><strong>Theme 3:</strong> Self-limiting behaviour before TOP</td>
<td>Ignorance regarding contraceptive use</td>
<td>• Unwanted and unplanned pregnancy</td>
</tr>
<tr>
<td></td>
<td>Resistant to seek counselling</td>
<td></td>
</tr>
<tr>
<td><strong>Theme 4:</strong> Coping mechanisms after TOP</td>
<td>Partner support</td>
<td>• Partner involvement throughout TOP</td>
</tr>
<tr>
<td></td>
<td>Family support</td>
<td>• Family encouragement and availability</td>
</tr>
<tr>
<td></td>
<td>Self-defense</td>
<td>• Spiritual healing through prayers</td>
</tr>
<tr>
<td></td>
<td>Counselling services</td>
<td>• Benefits of pre- and post-TOP counselling</td>
</tr>
</tbody>
</table>

### 3.4 THEMES

#### 3.4.1 Theme 1: Negative implications of TOP

From this theme negative emotional, physical and social effects surfaced. All participants expressed bad feelings after termination of pregnancy which impacted negatively on their lives. Social isolation afterwards was also a problem for some of the participants resulting from TOP.
Table 3.4: Negative implications of TOP

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
</table>
| Theme 1: Negative implications of TOP | Emotional implications after TOP | • Guilt feelings  
• Betrayal  
• Lost chance  
• Acceptance  

|       | Physical implications | • Pain  
• Insomnia  
• Infertility |
|-------|-----------------------|-------------|
|       | Social implications   | • Partner relations  
• Friends  
• Family |

- **Emotional implications after TOP**

Most participants expressed unpleasant feelings after termination of pregnancy which haunted them emotionally. These ranged from guilt feelings, betrayal, lost chance and acceptance. Some participants said:

“I am ashamed of myself for having terminated my pregnancy. I regret having gone through the procedure … I did not know that I would feel this way. It is disturbing me at times. My partner also feels guilty and blames himself for the pregnancy.”

“Whenever I see a pregnant woman, I think about my loss and my baby. I feel like turning the clock back and keeping my pregnancy … now it’s too late.”

“My partner was going to make my life difficult if he had been aware that I was pregnant. He is married and did not want us to have a baby yet. I still owe it to him though, but don’t know how to explain this to him.”

“Why didn’t I share it with my mom, maybe she could have advised otherwise? I feel empty and full of regrets.”

A few participants cited a lost chance as a negative implication they experienced, as well as accepting that it has happened and that they will have to live with it. Some narrated:
“I worry about having lost a chance to bring up a child I had conceived. It cannot be replaced ... even if I can fall pregnant again.”

“I denied my parents that special chance to bring up my child. When I see how grandparents take care of their grandchildren, I feel deeply touched … thinking that mine could also be pampered.”

“I have no choice but to accept what has happened. It is not easy just to forget.... hmm. I hope to complete my studies and be a better person.”

- Physical implications

Almost half the number of participants reported to be physically affected after terminating a pregnancy. They indicated that although there were no observable wounds after TOP, some were negatively affected in the following ways:

“I have bad dreams which affect my sleep a lot since I terminated my pregnancy. I ignored this thinking that it will disappear as time went by but it seems these nightmares will be with me for a long time since it has been nine months now after TOP.”

“I always dream of small children playing around me or looking directly into my eyes. This makes me uncomfortable during the day as if everybody knows that I have terminated my pregnancy.”

“I felt a lot of pain during the procedure, I still do. It's on and off.... I am just wondering how long this will take.”

“My body feels different; it doesn’t feel the same ... I feel empty and worthless.”

“I can’t sleep without thinking about my terminated pregnancy every day. This gives me sleepless nights. Before I can sleep I take sleeping pills, otherwise I’ll be awake, thinking of my loss and all the effects … each ... It’s a nasty feeling.”
Most participants mentioned that they have fears of ever having babies when they were ready or married. They said it is something that worries them all the time. Some participants stated:

“I am worried that it may have affected my future fertility as this was not my first TOP. I was forced by circumstances in both instances … (looking down and shy).”

“My concern is that maybe this was going to be my only child. I would not even tell my partner that I once terminated a pregnancy…. oh…it’s tough…What if that was the only child I would have?”

“I have been married for five years and we’ve been trying and shopping around fertility clinics to get a baby. It is so painful because I have terminated two pregnancies to complete my studies but now I have my degree but have difficulty to conceive. Can this be linked to my previous TOPs?”

From the interviews, it becomes evident that women who had TOP have deep emotional and physical scars.

- Social implications

Some participants felt isolated after having undergone TOP. They stated that it was hard to socialise with friends and were always suspicious. They expressed different views as cited below:

“I avoided meeting with people for a while after terminating my pregnancy. It seemed as if they knew about it and I did not want to be stigmatised.”

“After terminating my pregnancy, my partner wouldn’t talk to me, our relationship was strained afterwards.”

“I am still alone and aloof as all my friends have disappeared since I terminated my pregnancy. I could not disclose to my family, so I am not sure if they know about it. I sometimes feel so lonely and have no one to share my feelings.”
3.4.2 Theme 2: Justification for TOP

Almost all participants cited different reasons for terminating their pregnancies. They insisted that they were forced by circumstances to terminate their pregnancies. Common reasons were loss of income, unplanned motherhood, as well as the burden of single parenthood if separated from the partner or he was also not ready for parenthood. Refer to table 3.5 for details.

Table 3.5: Justification for TOP

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
</table>
| Theme 2: Justification for TOP | Absenteeism and loss of employment |  • Lack of income  
  • Dependency |
|       | Unplanned pregnancy |  • Unplanned motherhood |
|       | Fear of losing partner |  • Single parenthood |

The following were the reasons as expressed by participants for having terminated their pregnancies:

“My partner didn’t have a job. So it was going to be my responsibility to raise the child. I couldn’t afford it as everything is expensive … especially baby stuff.”

“I was retrenched. Had just started a business and I was worried that we may not cope with a third child under the circumstances.”

“I just couldn’t afford it … hmm. (shaking head). It is tough as I’m unemployed and I didn’t want to depend on my partner financially.”

“My partner has not been reliable. I could not rely on him to help raise our baby as he always disappears when we have issues. On my own, it wouldn’t have been possible to raise a child”.

“My pregnancy was unplanned; I was too young to be a mother. My parents would be disappointed if I dropped out of school because of pregnancy.”

From the above, it can be deduced that women felt they still have to carry the bulk of the responsibility if they continued with a pregnancy. Some did not want to solely
depend on their partners when they have ended up with an unplanned pregnancy, hence they resorted to TOP.

3.4.3 Theme 3: Self-limiting behaviours before TOP

Some participants seemed to have had limited knowledge on the use of contraception prior to having an unplanned pregnancy. From the findings, there appears to be a great need to educate women on fertility control and proper use of contraception to stem the tide of unplanned and unwanted pregnancies.

Table 3.6: Self-limiting behaviours before TOP

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 3: Self-limiting behaviour before TOP</td>
<td>Ignorance regarding contraceptive use</td>
<td>Unwanted and unplanned pregnancy</td>
</tr>
<tr>
<td></td>
<td>Hesitant to seek counselling</td>
<td></td>
</tr>
</tbody>
</table>

A few participants demonstrated limited knowledge on how to avoid an unplanned pregnancy. Those who had information about contraception, failed to use it for various reasons as cited below:

“I was not using any contraception. I was using a safe method … I had heard a lot of negative stories about contraception. Now I know that all the myths are not true.”

“Personally, I don’t like contraception, because I feel like it upsets my system. I thought if one is in a relationship and we are not yet serious, it was not necessary to use contraceptives. I could have stopped what has happened. I didn’t prevent the pregnancy.”

“I was on the contraceptive pill both times. I am not sure what happened. I felt like I made a big mistake. I was careless at times when taking my pill. I used to forget at times … and just thought I would not fall pregnant”.

“I did not take contraception seriously and thought it would not happen to me. I should have gone to the clinic earlier as I was having a sexual relationship”.

42
‘The pill did not suit me…I did not know much about other contraceptive methods and could not use them”.

3.4.4 Theme 4: Coping mechanisms after TOP

More than half the number of participants seemed to have some coping mechanisms to assist them to deal with the loss. This varied from having a partner or family for support, to a need for counselling services. There’s a clear indication from the participant’s experiences that women need support after making the difficult decision in her life.

Most participants (18 out of 20) were Christian, thus expressing the need to repent, pray and ask for forgiveness about what they did.

Table 3.7: Coping mechanisms after TOP

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 4: Coping mechanisms after TOP</td>
<td>Partner support</td>
<td>• Partner involvement throughout TOP</td>
</tr>
<tr>
<td></td>
<td>Family support</td>
<td>• Family encouragement and availability</td>
</tr>
<tr>
<td></td>
<td>Self-defense</td>
<td>• Spiritual healing through prayers</td>
</tr>
<tr>
<td></td>
<td>Counselling services</td>
<td>• Benefits of pre- and post-TOP counselling</td>
</tr>
</tbody>
</table>

Some participants stated:

“I guess I revived myself by surrounding myself with people that I love, my family, and my daughter. This helps me a lot as I can be myself again and look forward to a brighter life.”

“I am feeling sad and bad about having terminated my pregnancy as I had already terminated one last year. I did not have support and it really affected me. I would hide and cry most of the days … eish … (sobbing).”
“I managed to speak to my husband and my friend about my TOP and they were supportive although they said I should have discussed with them first before terminating my pregnancy. However, I always feel better after talking to them.”

“After terminating my pregnancy, I was feeling pain emotionally, I felt alone because I couldn’t speak to anyone ... I felt small and shy to disclose to anybody.”

“I talk to my partner and I pray about it. My partner also feels guilty but he comforts me and we talk about trying again … this gives me strength that I will conceive again and keep my baby.”

“My boyfriend and my mom gave me a lot of support. Talking to them really helped. Sometimes I’d lock myself in my room and never want to be disturbed. I would call my boyfriend and he’d always comfort me and tell me everything will be ok.”

“When I feel that way, I don't want to talk to anyone except my boyfriend. He always comforts me and tells me everything will be ok.”

- **Pre- and post-TOP counselling**

In terms of the Choice on Termination of Pregnancy Act, women should be afforded pre- and post-counselling to assist in their decision before terminating a pregnancy and help in coping after TOP. Some participants stated:

“"I did not know that I would feel bad afterwards ... but after post counseling, I am gradually recovering and accepting my loss.”

“I did not concentrate much on counselling before termination of pregnancy because I had already decided ... I did not want to be confused and later regret that I should have followed the counsellor’s advice.”

“I was crying because of the pain. The nurse was screaming at me asking if she should stop .... there was no counseling as she had many patients to attend.”

“I cannot afford to go for counselling. So, I just deal with it and get on with my life.”
“Immediately after the procedure I felt relieved of the burden. But that soon changed weeks later when I thought about it more … had sleepless nights and depression. Post TOP counselling was very helpful as I did not have the nightmares and fears which worried me.”

- **Spiritual healing through prayers after TOP**

Some participants felt the need to pray after TOP. They affirmed that TOP was against their church doctrines but argued that they had no choice as it would have been difficult to keep the pregnancy. Some said:

“I go to church every Sunday and pray to be forgiven for my sin with the hope that I will feel better. Indeed, each time I do so I feel a sense of healing.”

“I pray about it every night … I confess and feel better. I do not experience much of the negative feelings I had six months ago … I strongly believe that prayer is the best medicine especially when in such situations.”

“I’m a born again Christian and enjoy the healing process. I don’t think I would cope if I did not resort to prayer … I am still having bad days and nights thinking about my pregnancy and termination but prayer helps me a lot.”

### 3.5 CONCLUSION

This chapter focused on presentation of the research findings. Field notes and audio recordings were transcribed verbatim before being categorised into themes, categories and sub categories. This reflected the experiences of the participants three months to a year after termination of pregnancy. Chapter 4 deals with the presentation and description of research findings and literature control.
CHAPTER 4

PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS

4.1 INTRODUCTION

The research findings presented in this chapter are from the analysis of the participant’s interviews and the researcher’s observations during the interviews.

Field notes regarding observations about the participant’s reactions during the interview and about the natural setting where the interviews were conducted were noted where applicable.

Analysis of data to explore the experiences of women who had termination of pregnancy was done. The research was conducted in Johannesburg, Gauteng Province at two facilities that provide termination of pregnancy services, a public institution and a private facility. The participants had had termination of pregnancy three months to one year before the commencement of the study.

4.2 DISCUSSION OF RESEARCH FINDINGS

The research findings are presented below according to the four themes that emerged out of the data collected. Description of the experiences of participants also reflects the categories and sub-categories. In the end, literature control on the theme was explored for consistency with the study findings.

4.2.1 Biographic data

Of the 20 participants, six were between 19 to 21 years whilst 14 fell within the age range of 22 and 35 years. Slightly more than half the number of participants, 11 had tertiary education and 9 had high school education. Most participants, 12 were single and only 6 were married and 2 were cohabiting. Christians were 18 and only two participants were Muslims. Sedge (2010:1-2) reported similar findings in southern Ghana where urban educated women were more likely than their less educated rural
counterparts to seek TOP and that Christians were likely than Muslim women to seek the procedure. Furthermore, Hlalele (2008:15) asserts that religious constructs play a role in the development of societal attitudes and therefore these constructs may influence the way that women react after termination of pregnancy.

4.2.2 Theme 1: Negative implications of TOP

The experiences of the women were explored in full in order to understand the emotional, physical and social effects that termination of pregnancy had in their lives three months to one year after the procedure.

Most participants reported negative emotional, physical and social effects post-TOP. Emotions reported varied from guilt, regret, shame, to depression and self-blame. Several researchers, Ferguson et al (2006:16-24), Rausset, Brulfert, Se'Jourme, Goutaudier and Chabrol (2011:506-517) and Thevathasan (2010) have concluded that women experience post-traumatic disorder post-termination of pregnancy.

Post-traumatic stress disorder, according to Weiten (2013:582), involves enduring psychological disturbance attributed to the experience of a major traumatic event. A number of researchers, Rausset et al (2011:506-517), McClure-Tone and Pine (2009:275-285) and Weiten (2013:150) regard termination of pregnancy as a traumatic event. Common symptoms according to (Weiten 2013:582) tally with the findings of this study. These include re-experiencing the traumatic event, anger, guilt, self-blame, shame, sleep disturbances and sadness.

These negative emotional effects could also stem from the belief that TOP is morally wrong. Some participants reported having experienced pain during and constantly after the procedure. The fear of being infertile after TOP also stayed in their minds, most participants are worried that they might not fall pregnant again when they try to. A common reaction for those struggling with abortion PTSD is to worry about being able to get pregnant again. Many fear they have aborted the only child they will ever have. Others suspect the abortion could have mutilated their body in some way (Ramah International 2009).
Sleeplessness was reportedly a problem with most participants who found it hard to sleep without thinking about their terminated pregnancies. This finding is supported by Warren, Harvey and Henderson (2010:231) that sleep disturbance is a common feature after TOP. This may be caused by guilt feelings and flashbacks from the whole ordeal.

The physical complications of abortion, however, are overshadowed by psychological effects. Guilt, regret, remorse, suicidal impulses, mourning, nightmares, lower self-esteem, anger, rage, hostility, child abuse, despair, helplessness, promiscuity and loss of interest in sex are all documented consequences of abortions. Teenagers (who are less emotionally mature) and those who are ambivalent about the abortion are most likely to suffer psychological consequences (Africa Christian Aid 2003; Macleod 2010:86).

Previous research indicates that a minimum of 10% of women who opt for an abortion will suffer from serious negative psychological consequences (Adler, Major, Roth, Russo & Wyatt 1990; Adler 1990; Lewis 1997; Zolese & Blacker 1992). Among women who are adversely impacted by an abortion, a number of mental health problems have been documented including anxiety (Cougle et al 2003; Franco et al 1989), depression (Cougle, Reardon & Coleman 2003; Reardon & Cougle 2002; Thorp et al 2003), sleep disturbances (Barnard 1990), and substance use/abuse (Coleman et al 2002a; Reardon & Ney 2000; Yamaguchi & Kandel 1987:104).

Keeping TOP as a secret seemed to be one of the reasons that might contribute to women experiencing negative emotional, physical and social effects after termination of pregnancy. Some women have indicated that they did not want to share the secret with anyone. They therefore carry the secret for the rest of their lives. Some also felt they have betrayed their partners because they did not share the news with them and can therefore not rely on them for emotional support.

Similarly, Van der Walt (2015:28) found that very often women will struggle emotionally following an abortion. This can be for a myriad of reasons, and even if a woman wanted to terminate the pregnancy, she may still feel guilt, anxiety and shame following the procedure. This can occur immediately after she’s had the abortion or even months or years later.
Women may feel this most intensely when they have another child, as they may wonder what their unborn child would have been like, and they feel guilty for choosing to have other children later in life. These intense emotions can surface even if a woman was certain that termination was the right decision. However, every woman is different.

In 2008, the American Psychological Association’s Task Force on Mental Health and Abortion (TFMHA) evaluated all empirical studies on the emotional effects of abortion that had been published since 1989. It concluded that the relative risk of mental health problems is no greater among adult women who resolve unplanned pregnancy with a single, elective, first trimester abortion than it is among those who give birth. Terminating a wanted pregnancy can be associated with negative psychological experiences comparable to those associated with stillbirth or death of a newborn — but less severe than those experienced by women who deliver a child with a severe abnormality. Any association between multiple abortion and mental health problem may be due to co-occurring factors — circumstances, conditions, and behaviors — that may predispose a woman to both multiple unwanted pregnancies and mental health problems.

Perceived and actual social support during and after the abortion experience was also found to affect women’s response (Needle & Walker 2008:124).

In this study, most participants experienced negative emotional, physical and social effects following TOP, even though some had felt relieved immediately after the procedure. Negative emotions surfaced later.

4.2.3 Theme 2: Justification for TOP

Participants cited different reasons why they had termination of pregnancy. They felt that, at the time it was the only option. The majority of the participants cited socio economic reasons.

The fact that they would not have been able to afford another child was the main reason they terminated a pregnancy. Other reasons mentioned were, to further their education, too young to have a child, unemployment, parent’s issues, and lack of income, unplanned pregnancy, and contraceptive failure due to not following instructions or
ignorance on use of contraception, coerced by partner, and the burden of single parenting.

Similarly, Hlalele (2008:19) mentions that factors influencing termination of pregnancy are psychological in nature and include the economic situation and significant others as well as religious beliefs.

Five of the participants were still studying and terminated their pregnancies because they wanted to continue with their studies and felt they were too young to have kids. They also felt they had disappointed their parents.

One participant felt that her job promotion was much more important than an unplanned pregnancy. She’d rather have a TOP than lose out on career progression.

This was confirmed by a study in Canada (Biggs, Gould & Foster 2013:13-29). The main reason cited in the study was:

“Having a baby would dramatically change my life, interfere with my education, employment and ability to take care of existing children and other dependents”

Two partners were coerced by their partners to have a termination despite their unwillingness to do so. This is contrary to the Choice on Termination of Pregnancy Act No 92 of 1996 (South Africa 1996) as amended by Act 1 of 2008 (South Africa 2008) stating that women should make their own decision whether to terminate or not.

4.2.4 Theme 3: Self-limiting behaviour before TOP

The study further revealed that some women were still ignorant on contraceptive use. This had resulted in unplanned pregnancies and later in termination of pregnancy.

This was indicated by the fact that three of the participants fell pregnant while still using contraception, in this case, the pill. They failed to take it consistently and missed pills at times. Arguably, effective contraceptive use is a way to increase women’s autonomy and reduce their exposure to pregnancy and unsafe abortions (Ehlers 2003; Maja & Ehlers 2004:44; Ramathuba, Khoza & Netshikweta 2012:16).
When patients have knowledge and are educated (usually by health care providers) they are likely to seek treatment and adhere to it. According to Molapo (2013:247), health education related to a specific condition does improve a patient’s knowledge regarding a specific condition.

From the interviews, the researcher could deduce that most participants were ignorant regarding contraception and related side effects. Myths around the use of contraception was one of the reasons why some participants did not use contraception or used it inconsistently, hence they ended up with unplanned pregnancies which were terminated. According to the Health Belief Model, perceived susceptibility refer to people who will not change their behaviour unless they believe they are at risk (Polit & Beck 2008:150). Women who think they might be at risk of having physical, psychological and social implications from having a termination of pregnancy will use contraception reliably and protect themselves from having an unplanned pregnancy by all means.

One participant said she never had time to go to the clinic to collect her contraceptive method. The fact that nurses were always busy and had no time to explain was also cited. The majority of the participants expressed the need to use contraception consistently and correctly after TOP in order to avoid having an unplanned pregnancy again. In terms of the perceived severity of the HBM, individuals who perceive a given health problem as serious are more likely to engage in behaviours to prevent health problems from occurring, or reduce its severity. With TOP, this will lead to women using contraceptives to avoid having an unplanned pregnancy. If an unplanned pregnancy does occur, they are likely to have a legal and safe procedure rather than unsafe and illegal means, give up a baby for adoption or continue with the pregnancy.

According to the Promotion of Access to Information Act (PAIA), 2000 (Act no 2 of 2000) Section 32(1) (South Africa 2000), everyone has a right of access to information held by the state which is required for the exercise or protection of his or her rights. It further extends the application of the right to other persons and provides for the enactment of National legislation to give effect to the right which may provide for reasonable measures to alleviate the administrative and financial burden on the state.
Article 10 (h) of the women’s convention states that women have the right to ‘specific education information to help to ensure their and the well-being of families, including information and advice on family planning’ (UN Women 2003). Lack of access to information about reproductive health will prevent women from exercising their right to reproductive decision making which includes making informed choices, and this will consequently limit the control that they have over their bodies. The Choice Act on Termination of Pregnancy Act 92 of 1996, as amended by Act No 1 of 2008, stipulates that medical practitioners and midwives must provide women with information concerning their rights in relation to the Act (South Africa 2008).

A study in the United States (Reuters 2008) revealed that women who were least motivated to avoid pregnancy were far less likely to use birth control pills, or any contraceptive method at all on a consistent basis. Furthermore, a woman’s attitude toward pregnancy, her satisfaction with her method and her experience with gynaecologists and other providers of contraception plays a far bigger role in a woman’s risk of pregnancy than other major risks, such as a poor education and poverty.

The one participant said “I don’t personally like contraception, because I feel like it upsets my system this was her first TOP. “I didn’t prevent a pregnancy” she said. This woman lacked the necessary knowledge about contraception.

Participants who were using contraceptives were hesitant to seek contraceptive counselling for the side effects they were experiencing or the myths around contraceptive use. Some just stopped using the methods without consulting with the health providers.

Another study in the United States by Jones, Darrach and Henshaw (2002:294-303), 46% of women had not used a contraceptive method in the month they conceived, mainly because of perceived low risk of pregnancy and concerns about contraception (cited by 33% and 32% of nonusers, respectively) The male condom was the most commonly reported method among all women (28%) followed by the pill (14%). Inconsistent method use was the main cause of pregnancy for 49% of condom users and 76% of pill users, 42% of condom users cited condom breakage or slippage as a reason for pregnancy.
Participants were also reluctant to seek post-TOP counselling after the termination. They appeared to hope that they would feel better with time. This also heightens the negative implications because it could help them feel better if they had contacted the clinic and discussed the option of being referred for psychological counselling if they feel they want to talk about it. Instead, they suffer in silence (Kalyanwala, Francis, Jejeebhoy & Kumar 2010). Two of the participants were referred to the South African Depression and Anxiety Group (SADAG) for further post termination counselling.

4.2.5 Theme 4: Coping mechanisms after TOP

All participants expressed the need to have a friend, family or partner support at the time they had termination or when they were struggling with the decision whether to terminate or not. Even after the termination.

For some participants, their partners were not aware that they had terminated. So it was a secret they had to keep to themselves forever.

Having someone close is important for disclosure and for one to accept her TOP.

Coleman (2006:903) affirms that high risk depression scores were low among those groups who were most likely to report a termination of pregnancy. Groups who admit an abortion are less likely to experience depression than those who conceal TOP.

This study found that some women were not comfortable discussing their TOP with anybody whilst others felt that sharing their experience with partner, friend or family member would help them cope. Similarly, Major and Gramzow (1999) as cited by Cougle et al (2003:137) state women who conceal their TOP are more likely to suppress thoughts of TOP and feel greater psychological distress.

Supportive partners or parents have been found to improve psychological outcomes for women (Bonevski & Adams 2001; Kapp, White, Tang, Jackson & Brahmi 2013:350-363).

Pre- and post-counselling are equally important in TOP services. According to The Choice on Termination of Pregnancy Act 92 of 1996, as amended by Act 1 of 2008,
non-mandatory and non-directive counselling shall be promoted by the state, ideally, this service should be available before and after the termination of a pregnancy. It also stipulates that; women shall have access to information concerning their rights in relation to the Act.

Women should be encouraged to have someone to talk to before and after the termination of pregnancy. They should also feel free to go to the clinic to speak to the health care professionals. Gemzell, Kopp and Faundes (2014:S55) support by stating that offering women comprehensive post-abortion care (PAC) and effective modern contraceptive methods before they leave the facility where they receive medical care should be an essential component of all PAC services.

Most participants reported to be Christians and had expressed that they felt like they had sinned after terminating a pregnancy. Religious constructs play a role in the development of societal attitudes and therefore these constructs may influence the way that women react after termination of pregnancy (Hlalele 2008:15).

Participants were also reluctant to seek post-TOP counselling after the termination. They appeared to hope that they will feel better with time. This also heightens the negative implications because it could help them feel better if they can contact the clinic and discussed the option of being referred for psychological counselling if they feel they want to talk about it. Instead, they suffer in silence. Two of the participants were referred to SADAG for further post-termination counselling.

4.3 CONCLUSION

The effects of termination of pregnancy on women remain a debatable issue. Most developed and some developing countries have legalised termination of pregnancy in order to stem the tide of unsafe abortions and save women’s lives.

Chapter 5 will discuss the conclusion, limitations as well as recommendations for practice and further research.
CHAPTER 5

JUSTIFICATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter presents the justification, limitations, recommendations and conclusion of this study. The aim of this study was to describe the implications of TOP as experienced by women three months to one year after the procedure. The focus was on women in Johannesburg, Gauteng Province at two facilities that provide TOP services, a public institution and a private institution. The knowledge of such experiences would assist in ensuring TOP services are improved in those facilities, and in many other facilities that provide the service in the country.

5.2 RESEARCH DESIGN AND METHOD

The study was exploratory-descriptive and qualitative in nature, with a phenomenological approach. The goal was to create strategies that can be implemented to improve TOP services for the women. Exploratory descriptive qualitative research identifies a specific lack of knowledge that can be addressed only by seeking the viewpoints of the people most affected (Grove et al 2013:66).

5.3 JUSTIFICATION

The study is justified in relation to its purpose and objectives. Literature revealed that some studies were done worldwide focusing on the immediate implications of TOP on women’s health. It thus appears from such studies that the impact on the immediate post-TOP period differs from the impact months and years later. This implies that women who had TOP need attention after the procedure so as to identify short term and long term implications on their health. Having identified these implications, it becomes crucial that TOP services should be improved. The researcher was interested in exploring women’s experiences three months to a year after TOP. The study is justified, as its objectives have been met.
5.4 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

This study explored and described the implications of TOP as experienced by 20 women who had termination of pregnancy three months to a year before the study was conducted. From the data collected, different themes, categories and subcategories emerged. The main themes identified were:

5.4.1 Negative implications of TOP

From this first theme, categories and sub-categories were further identified. It became clear from the sub-categories that women experienced a multiple of negative emotions after termination of pregnancy. Some women reported that they felt relieved afterwards but later on started experiencing the following emotions, guilt, regret, shame, betrayal, self-defense, lost chance and acceptance. Some women experienced physical pain during and constantly after TOP. Insomnia was also a problem with women who had TOP. They reported bad dreams attributed to the pregnancy they terminated.

Women experienced different social implications after termination. Some felt really alone, especially if they did not disclose the TOP to anyone. Relationships with partners got strained for some women, as there were disagreements on whether to do TOP or not. Being coerced into doing a TOP also causes women a great deal of emotional discomfort and isolation. These findings are supported by literature as indicated in the previous chapter.

5.4.2 Justification for TOP

Participants mentioned various reasons why they resorted to terminating a pregnancy and cited mostly socio-economic reasons. Unemployment, lack of income, burden of single parenting, unplanned motherhood and fear of losing a partner were some of the reasons. Some women also had unplanned pregnancies because of poor compliance to contraceptives.

Most participants cited financial difficulties as the main reason why they had to terminate their pregnancies. A total number of 12 out of 20 women were single and
reported that they would find it hard to raise a child without the support of a partner. Most automatically assumed they’d have had to carry the responsibility on their own. For them, under the circumstances, the best thing to do would have been termination of a pregnancy. Whether the partner agreed or not, or whether he was aware of the pregnancy or not.

Being too young to be a mother was also another reason for some participants who had TOP. Less than half the number of participants, 6 out of 20 participants were between 19 and 21 years. They considered themselves too young to be mothers. If continuing with the pregnancy, they’d have to abandon their studies. They claimed that they could not afford to raise a child.

5.4.3 Self-limiting behaviour before TOP

In this regard, some participants cited reasons that indicated ignorance as far as fertility control was concerned. Not using contraception, but at the same time not expecting to fall pregnant whilst being sexually active. This indicates the need for more education on fertility control and contraceptives. Participants who fell pregnant while still using contraception seemed to be non-compliant on the pill arguing that they had negative information about its side effects.

The women also indicated myths around contraception use. They also were reluctant to go to the clinic for information if they needed to change a method because of side effects or education on proper use of a method, in this case the pill. The study also shows that women are reluctant to ask for help when they are not sure which method to use.

5.4.4 Coping mechanisms after TOP

Participants expressed the need to have support during this period of their lives. Because of the stigma attached to TOP, some participants couldn’t disclose to anyone even if they wanted to. Some avoided discussing with their partners in case the partner expects them to continue with the pregnancy when they wanted a TOP. Those who did have family, partner or a friend for support indicated that it made them feel better talking about it.
The study also highlighted the need for an improvement in pre- and post-TOP counselling. Participants did not show an understanding of what to expect as far as the procedure and what they might experience after the procedure.

5.5 RECOMMENDATIONS

The recommendations for this study emanate from the study findings shared by women who had TOP. They are for practice, nursing education and future research.

5.5.1 Health care providers in TOP facilities

- Pre- and post-termination of pregnancy counselling should be as detailed as possible. Have a checklist on important aspects to cover during counselling. Have standard pre- and post-TOP guidelines.
- Counselling should include post-TOP contraception counselling to discuss all methods including side effects. Give women a chance to ask questions and give a method they choose (if not contraindicated) to increase compliance.
- Make family planning services accessible to all and affordable so that there are no barriers to accessing the services.
- Advice women to have a support system or systems to enable them to find closure by discussing with someone they trust whenever they feel like. If they are comfortable with that.
- Leave the option open for the women to go back to the clinic to discuss their feelings and other impacts with the health professional and for referral if there is a need.
- During pre-counselling, the provider must make sure that there is no pressure being applied on the woman to have TOP. That it is solely her decision.
- Allow women a chance to go home and think about it, if not sure that they want to do TOP.
- Women must be empowered on how to deal with negative implications of TOP if they experience any.
5.5.2 Nursing education

- Institutions should have staff trained on how to deal with women who have negative implications after TOP. Staff dealing with women who decide to have TOP, must be as compassionate as possible. This will make the process less traumatic for the women.
- Termination of pregnancy should be included in reproductive health programmes for health professionals. This should be fully detailed and assessed similar to other programmes.
- In-service education in relation to in-depth pre- and post-TOP counselling should be afforded to staff members regularly, mainly those involved in TOP services.

5.5.3 Further research

- This information could be useful to the policy makers to draft suitable policies and guidelines for service providers to enhance the provision of TOP services.
- There is a need to conduct more phenomenological studies on the subject in different parts of the country in order to make comparison to the findings of this study.
- Explore the reasons why some women do not use contraception when they are not planning a pregnancy.

5.6 LIMITATIONS OF THE STUDY

Several limitations of the present study include the following:

- Termination of pregnancy is a very sensitive and private subject. Therefore, it was difficult to get women to consent to interviews. Some had not disclosed to anyone, and felt uncomfortable talking about it.
- The study was only conducted at two facilities in Johannesburg, Gauteng province, so it cannot be a generalisation of the whole province or the whole of South Africa.
• The participants were mainly black women. Except for one coloured and one Indian women. This caused an over-representation of black women and in turn threatens generalisability.

Except for the above limitations, findings of this study can be used to contribute to the improvement of TOP services in the country with the overall view of lessening the negative implications of TOP on women’s health.

5.7 CONCLUDING REMARKS

The study shows the importance of giving women information on how their bodies work. It also highlights the importance of pre- and post-TOP counselling regarding what to expect before and after termination of pregnancy.

It has also become evident that having a support system is very important for women who are planning to, or have had a TOP. It is crucial that women understand how contraceptives work, the benefits of contraception and the side effects that are not harmful. This study should help women by lessening the negative impact of TOP in their lives. It will also improve the services for the women who choose to terminate their pregnancies.
REFERENCES


ANNEXURES
UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

Date: 18 March 2015

Project Title: Choice on termination of pregnancy: Its impact on the woman’s health.

Researcher: Matokgo Makutoane

Degree: MA in Nursing Science

Supervisor: Prof TMM Maja

Qualification: D Litt et Phil

Joint Supervisor: -

DECISION OF COMMITTEE

Approved [ ] Conditionally Approved [ ]

[Signature]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

[Signature]

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES
ANNEXURE B1: APPLICATION TO CONDUCT THE STUDY (GDOH)

14 March 2015

P O Box 88
Banbury
2164

The Director/ Hospital Administration
Yusuf Dadoo Hospital
Krugersdorp
Gauteng Province

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH TITLED:
CHOICE ON TERMINATION OF PREGNANCY: ITS IMPACT ON THE WOMAN’S HEALTH

I am a Master of Health Studies student of the University of South Africa. It is required of me to conduct a research study as a requirement for obtaining the MA Health Studies degree. It is for this reason that I request your permission to undertake the study at your facility.

I hope that the hospital administration will allow me to recruit women who choose to terminate their pregnancies for the purposes of this research. Due to the nature of the study, I hope to recruit women who had TOP and volunteer to participate, they will be given a consent form to sign and return it to the primary researcher at the end of the survey process.

Your facility is a desirable site for this research because it offers termination of pregnancy services. The study is qualitative in nature, which means, narrative information will be collected from the participants until data saturation is reached and no new information is available. The number of women who will be interviewed cannot be determined at this stage as that will only be decided as the study unfolds.

The aim of the study is to describe the experiences of women after terminating a pregnancy to determine psychological, physical and social implications on their health. There will be two visits in total. The first visit will be women who terminated a pregnancy 3 months ago and the second visit will be a year ago.
Upon completion of the study, I undertake to provide the Department of Health with a copy of the full research report. If you require any further information, please do not hesitate to contact me on 072 754 1811 or 011 781 4308. Thank you for your time and consideration in this matter.

Kind regards
Matokgo Makutoane (MA Health Studies student)
Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH TITLED: CHOICE ON TERMINATION OF PREGNANCY: ITS IMPACT ON THE WOMAN’S HEALTH

I am a Master of Health studies student of the University of South Africa. It is required of me to conduct a research study as a requirement for obtaining the MA Health Studies degree. It is for this reason that I request your permission to undertake the study at your facility.

I hope that the hospital administration will allow me to recruit women who choose to terminate their pregnancies for the purposes of this research. Due to the nature of the study, I hope to recruit women who had TOP and volunteer to participate, they will be given a consent form to sign and return it to the primary researcher at the end of the survey process.

Your facility is a desirable site for this research because it offers termination of pregnancy services.

The study is qualitative in nature, which means, narrative information will be collected from the participants until data saturation is reached and no new information is available. The number of women who will be interviewed cannot be determined at this stage as that will only be decided as the study unfolds.

The aim of the study is to describe the experiences of women after terminating a pregnancy to determine psychological, physical and social implications on their health.

There will be two visits in total. The first visit will be women who terminated a pregnancy 3 months ago and the second visit will be a year ago.

Upon completion of the study, I undertake to provide the Department of Health with a copy of the full research report. If you require any further information, please do not hesitate to contact me on 072 754 1811 or 011 781 4308. Thank you for your time and consideration in this matter.

Kind regards

Matokgo Makutoane (MA Health Studies student)
It is a pleasure to inform that the Gauteng Health Department has approved your research on "Protocol Title: Choice on termination of pregnancy: Its impact on the woman's health, study should be conducted at the following facility;

- Dr Yusuf Dadoo

The Provincial Protocol Review Committee kindly requests that you to submit a report after completion of your study and present your findings to the Gauteng Health Department.
Annexure C2: Letter of Permission to Conduct the Study (BMM)

BMM Health Centre
Randburg
Gauteng Province
5th June 2015

Attention: Matokgo Makutoane

Application to Conduct Research

Research Topic: Termination of Pregnancy: Its Impact on Women's Health

It is a pleasure to inform you that BMM Health Centre has granted approval for you to conduct the study at the above institution.

Date submitted: 21st March 2015
Date approved: 29th May 2015

Kindly share the results of your study on completion.

Signature:
B.B Mahanyele (Director) For and behalf of BMM Health.

Signature: [Signature]
Dr M. S Ismail (Board Member)

Signature: [Signature]
ANNEXURE D: CONSENT FORM TO PARTICIPATE IN RESEARCH STUDY

University of South Africa

Participant's number…………………… Date…………………………

Dear Participant, you are being asked to participate in a research study. Below are details about the research study.

1. TITLE OF RESEARCH
Choice on termination of pregnancy: Its impact on the woman's health.

2. INVESTIGATORS NAME
Matokgo Makutoane. Research Entity: University of South Africa.

3. CONSENTING FOR THE RESEARCH STUDY
By signing this document, you will be authorising the researcher to involve you as a respondent for a research study without disclosing your name.

4. YOUR RIGHT TO PRIVACY AND CONFIDENTIALITY
Specific information on your right to privacy and confidentiality of the use and disclosure of your personal health information can be found at the end of this consent form. We need your authorisation to use and disclose the health information that we may collect about you during this research study without disclosing your name. To be in this research you must read and sign the authorisation of this consent form.

5. PURPOSE OF THE RESEARCH
The aim of this research is to gain an understanding on the Implications of Termination of pregnancy. This will assist programmes on how best to look after such women, if there's evidence of negative implications.

6. PROCEDURES
If you take part in this study:
You will be asked questions about your sexual behavior, pregnancy and termination thereof. This study is limited to completing these questions. All questionnaires will be destroyed after the completion of this study. Information you will share with the researcher will remain confidential and will not be used for any other purpose except this research.
7. RISKS AND DISCOMFORTS /CONSTRAINTS
Psychological or social risks are not intended to occur to you. You may experience some discomfort such as embarrassment, guilt feelings or sadness during the interview. This can sometimes be possible or expected. If for any reason you decide that you do not want to participate in the study, you may withdraw from the study at any time without victimisation.

8. UNFORSEEN RISKS
The study investigators do not anticipate any risks to you in taking part in this study. If any unforeseen risks are noted the professional nurse in charge will be notified. A risk assessment will be done and assistance in the form of further counseling can be arranged depending on what the risk is.

9. For some participants, these interviews might provide an opportunity to think about their overall well-being in a more meaningful manner. For others, there may be no direct benefits from participating in this study. We trust that the information you have shared will enable the study to help women with regard to their reproductive health. It is also anticipated that the results from this study will be used for the good health of women after terminating a pregnancy.

11. VOLUNTARY PARTICIPATION
You should be aware that being in this study is voluntary. Your health care will not be affected in any way if you decline to be in the study or later withdraw from the study. Please contact Ms Makutoane on 0727541811 at any time if you have questions.

12. DISCONTINUING FROM STUDY
You may at any time discontinue your involvement or withdraw your consent to partake in this study. The information that you have provided until such a time as you withdraw can however be used by the researcher.

13. CONFIDENTIALITY AND PRIVACY
This section gives more specific information about the privacy and confidentiality of your health information.

I. Health information that will be collected: Information about your experience on using termination of pregnancy services.

II. Who will see your health information: The investigator will at all times maintain strict confidentiality and your identity will not be linked to the information provided.

III. How your health information will be used and given out: Your health information will be used by the investigator and other authorised individuals involved in the research study to evaluate the results of the study and to write a dissertation.
IV. **If you do not want to give authorisation to use your health information:** You do not have to give your authorisation to use or give out your health information. However, if you do not give authorisation, you cannot participate in this research study.

V. **How to withdraw from the study:** At any time you may withdraw from the study to allow your health information not to be used or given out by sending a written notice.

VI. **When your authorisation ends:** Your authorisation to use and give out your health information will end when the research study is completed.

Participant ……………………………………………………….Date………………
Matokgo Makutoane (Investigator)…………………………… Date………………
Witness to signature…………………………………………….Date………………
ANNEXURE E: INTERVIEW GUIDE

RESEARCH TOPIC:
CHOICE ON TERMINATION OF PREGNANCY: IT’S IMPACT ON THE WOMAN’S HEALTH

Date of interview:
1. The following information will be collected about the woman:

   Age
   Area where she lives
   Level of education
   What she does for a living, and how much she earns if working
   Number of children
   Number of previous TOPs and reasons why she had TOP
   Marital status
   Religious background

Other questions that will be asked:
1. Let’s talk about your decision to consider TOP as an option:
   a. Were you aware that TOP is legal in South Africa, and how did you get to know?
   b. Did you talk to someone about considering TOP as an option? What did they say?
   c. Did you know of other options? Which ones?
   d. How long did it take you to finally decide that you were going to have TOP as an option?
   e. Did you know where to go beforehand? If yes/no: How did you know that Clinic provides such a service?

2. Please describe your experience with the procedure
   a. How far pregnant were you?
   b. Did you receive any counselling?
   c. Which method was used?
   d. Did you have someone accompanying you when you went to the Clinic?
Grand tour question: Describe your feelings with the termination of pregnancy.

3. Please describe your feelings after the procedure (Weeks, months to a year after TOP)
4. Describe any physical implications? Any changes on your body? Any injuries
5. Describe social implications, can you speak to anyone about it? Who is the person who gives you support? What type of support if available?
6. How do you feel about it spiritually? How do you handle it?
7. How long did those feelings last?
8. What was your thinking around prospects of falling pregnant again after TOP? Did you discuss that with anyone?
9. Did you try to fall pregnant again, and what happened?
10. Would you consider TOP as an option if found in the same situation?
11. What would you suggest to other women so that this experience is same/different with the previous one?

CONCLUSION
The information collected in this study will be analysed and the final report will be shared with you.