FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB-DISTRICT, BOTSWANA

by

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FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB-DISTRICT, BOTSWANA

I declare that the dissertation above 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.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution

15 November 2022

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ABSTRACT

Unintended pregnancies are the root cause of unsafe abortions which place a major financial strain on the health care system. Access to comprehensive safe abortion care service packages by all women who need the service prevents complications of unsafe abortions. In countries where abortion is legally restricted like Botswana, women with unintended pregnancies opt for illegal and unsafe procedures which lead to maternal morbidity and mortality associated with sepsis, septic abortion and haemorrhage. As for the Ngami sub-district, little is known regarding the circumstances that lead to unsafe abortions among women, hence the need for research to gain a deeper understanding of the contributory factors to unsafe abortion and the development of measures to curb unsafe abortion.

Aim: The purpose of the study is to gain in-depth understanding of the contributing factors to unsafe abortions in order to develop possible measures to reduce unsafe abortions among women in the Ngami sub-district.

Methodology: In this study, a qualitative, descriptive, and exploratory phenomenology research approach was used. Relevant permissions and consent to conduct the study were obtained for the study to be ethical. COVID-19 pandemic preventative measures were also adhered to ensure continuous mitigation of potential harm to participants. The population included women of all ages who resided in the Ngami sub-district and were admitted to the gynaecological ward for unsafe abortions during the data collection period from June 2021 to August 2021. Convenience sampling technique was applied. Collection of data was through audio-taped face-to-face semi-structured interviews and analysis was done using the five steps of content analysis. Data saturation was reached with the 12th participant.

Study findings: Three themes and 18 sub-themes emerged from the interviews conducted. The major themes are participants' reasons for unsafe abortions, effects of unsafe abortions and interventions to reduce unsafe abortions. Factors contributing to unsafe abortion include fear of violating family values and women's lack of autonomy; family planning concerns; perceived lack of options; political viewpoint and human rights components; economic reasons; unstable relationships; and a desire to continue studying.

Contribution to the body of knowledge: The insights that the study has brought out are a steppingstone to interventions that the district health management team (DHMT) in the Ngami sub district should consider going forward to mitigate the prevalence of unsafe abortions.

Conclusion: Women in the Ngami sub-district have proposed psychosocial counseling, youth-friendly services, economic empowerment, and legalize abortion to reduce unsafe abortions and prevent unintended pregnancies. Life skills can help women gain confidence, advocate for their sexual rights, and avoid unexpected pregnancies. The policy implication brought out in this study is the need to review the laws on abortion in Botswana.

Key terms

Contributing factors; development of measures; unsafe abortion; women.

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DEDICATION

This study is dedicated with the utmost respect and affection to my family, friends, and co-workers in appreciation of their support, encouragement, and love.

Most significantly, I dedicate it to God, who created everything and gave me life, knowledge, wisdom, and the capacity to do this study.

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LIST OF ABBREVIATIONS

DAC	District AIDS coordinator
DALYS	Disability adjusted life years
FIGO	International Federation of Gynaecological and Obstetrics
FP	Family planning
HSREC	Health Studies Research Ethics Committee
LARC	Long-acting reversible contraceptives
LMIC	Low- and middle-income countries
MMRI	Maternal mortality reduction initiative
MoHW	Ministry of Health and Wellness
PPE	Personal protective equipment
RHDM	Reproductive health decision-making
RPOC	Retained products of conception
RSA	Republic of South Africa
SAC	Safe Abortion Centre
SDGs	Sustainable development goals
SSA	Sub-Saharan Africa
SRH	Sexual reproductive health
STDs	Sexually transmitted diseases
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNISA	University of South Africa
USA	United States of America
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Chapter 1 focuses on the background of the research problem globally, regionally, and locally. In addition, the chapter discusses the problem statement, aims, and objectives set for the study, the significance and theoretical foundations of the study, the research methodology and ethical considerations of the study. The structure of the dissertation and the scope of the study are also outlined.

1.2 BACKGROUND INFORMATION ON THE RESEARCH PROBLEM

1.2.1 Source of the research problem

As stated by the World Health Organization (WHO 2021), abortion is the termination of a pregnancy; it can be spontaneous or induced. Induced abortions pose a significant risk to women's health depending on the performance setting, which often depends on socio-economic and cultural factors. Unsafe abortion is when a pregnancy is terminated by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards. Studies have indicated that women's decision to have unsafe abortions is influenced by personal, cultural, religious, and socio-economic factors. (Atakro, Addo, Aboagye, Menlah, Garti, Amoa-Gyarteng, Sarpong, Adatara, Kumah, Asare, Mensah, Lutterodt and Boni's 2019:12-17; Frederico, Michielsen, Arnaldo and Decat's 2018:8-13). Whether these factors contributing to unsafe abortion in these regions are the same for Botswana women remains an open question.

According to a report by Singh, Remez, Sedgh Kwok and Onda (2018:6-44) on abortion worldwide 2017 on uneven progress and unequal access to safe abortion, the main reason for unintended pregnancies is the family planning utilisation gap. Other motives include a lack of women empowerment to make informed decisions over sexual and reproductive health, and rape.

Hawkins, Gerts, Badubi, Sickboy, Mussa, Maotwe, Whittaker, Schreiber, Ramagola-Masire and Morroni (2021:208-209) in the integration of family planning services into health care for HIV-positive women in Botswana study, indicate that in Botswana, the available methods of contraceptives are mostly short-acting methods that require daily or quarterly adherence. At the same time, long-acting reversible contraceptives (LARC) and effective permanent procedures that do not require frequent commitment while having higher continuation rates are available.

According to the Penal Code Amendment Act 1991, Abortion is partially legal in Botswana in certain circumstances to preserve physical or mental health in the case of rape cases, incest, and fetal impairments (Republic of Botswana 1991). Melese, Habte, Tsima, Mogobe, Chabaesele, Rankgoane, Tshiamo, Masweu, Mokotedi, Motana, and Moreri-Ntshabele's (2017:2) study on high levels of post-abortion complication in a setting where abortion service is not legalised suggests that abortion-related complications and deaths are high in this setting where abortion is restricted.

1.2.2 Background to the research problem

Yaecob, Abera and Meleko (2018:2) indicate that estimates from the WHO (2017:3) revealed that about 25% of all pregnancies globally end in induced abortion with approximately 50 million induced abortions performed each year. Globally, untrained providers performed about 20 million abortions under dangerous conditions or unsafe procedures. An estimated 13% of all maternal deaths are due to complications from unsafe abortion.

Gebremedhin, Semahegn, Usmael and Tesfaye's (2018:4) study on unsafe abortion and associated factors among reproductive aged women in Sub-Saharan Africa indicates that Sub-Saharan Africa (SSA) countries with government restrictions on abortion services and political, religious, or cultural issues, for example Botswana, have a gap in reporting unsafe abortions. This gap negatively influences service delivery in these countries**.** Evidence has shown that the maternal mortality ratio due to unsafe abortion is 950 times higher in SSA than the per 100,000 live births in the United States of America (USA).

Atakro et al's (2019:15) paper on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana

found out that in Ghana, unsafe abortions are due to the lack of knowledge on available safe abortion services and poor socio-economic conditions. Other contributing factors include cultural and religious beliefs, a stigma of unplanned pregnancy, and a desire to bear children only after marriage. Attempts to avoid parental or guardian disappointment and resentment, as well as a desire to pursue education, were also cited by participants in Atakro et al's (2019:15) Ghanaian study as situations that contributed to unsafe abortion practices. Similarly, Smith's (2013:26) review on reproductive health and the question of abortion in Botswana cites issues of gender inequalities, low autonomy, stigma and conservative Christian viewpoints as probable contributory factors to unsafe abortion.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The researcher has noted with great concern that a specific public hospital in the Ngami sub-district has experienced increased cases of unsafe abortion which lead to a high workload with limited resources, subsequently resulting in an increased mortality rate. According to the Maternal Mortality Reduction Initiative Annual Report, between 2014 and 2018, six maternal deaths were attributed to unsafe abortion in the Ngami sub-district (Republic of Botswana 2018c). In 2017 alone, according to the admissions statistics, there were 1193 cases of unsafe abortions, and in 2018, the number increased to 1267 cases (Republic of Botswana 2018b). The Statistics Botswana (2019:2-8) for the years 2014 to 2018 interval shows that the causes of maternal deaths due to abortion and abortion complications was 22.5%, a 0.7% increase from the previous report.

The researcher's genuine concern is that despite this increase in unsafe abortion cases, the inevitable deaths, and other severe complications, women still consider the option of this clandestine procedure. No research has been conducted in the Ngami sub-district to explore the contributing factors to incidents of unsafe abortion. Therefore, the researcher aims to understand the contributing factors to unsafe abortions to develop possible measures to reduce unsafe abortions among women in the Ngami sub-district.

1.4 AIM OF THE STUDY

1.4.1 Research purpose

This phenomenological study aims to gain an in-depth understanding of the factors contributing to unsafe abortions so as to develop possible measures to reduce unsafe abortions among women in the Ngami sub-district.

1.4.2 Research objectives

- To identify and describe factors that contribute to unsafe abortion among women in the Ngami sub-district.
- To explore experience associated with unsafe abortion among women in the Ngami sub-district.
- To identify possible interventions to reduce unsafe abortion among women in the Ngami sub-district.

1.4.3 Research questions

- What factors contribute to unsafe abortions among women in the Ngami sub-district?
- What are the experiences associated with unsafe abortion among women in the Ngami sub-district?
- What are the possible interventions to reduce unsafe abortion among women in the Ngami sub-district?

1.5 SIGNIFICANCE OF THE STUDY

The findings of this study will add to the body of knowledge of factors contributing to unsafe abortion in Ngami sub-district. Furthermore, the results will help develop measures that will support women and reduce the rate of unsafe abortion. To address abortion, a multisectoral collaboration between the legal fraternity, health, cultural and religious denominations, political leaders, and policymakers should make informed decisions based on these types of research to protect and improve the standard of living of women.

1.6 DEFINITION OF KEY TERMS

1.6.1 Contributing factors

Contributing factors are indicators that are partly responsible for a development or a phenomenon (WHO 2014:30). In this research, contributing factors would be the reasons that have driven a woman to undergo an unsafe abortion in the Ngami sub-district.

1.6.2 Developmental measures

The WHO (2014:30) defines developmental measures as structures implemented to correct or advance procedures. In this research, a developmental measure means recommended strategies to reduce unsafe abortion activities for women in the Ngami sub-district.

1.6.3 Unsafe abortion

The WHO (2019b:2) defines unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards. In this study, unsafe abortion refers to an abortion done in an area not designated to do abortion.

1.6.4 Women

The *Oxford Advanced Learners Dictionary* (2015:1730) defines women as an adult female, plural of woman. In this research, the term “women” means women who had unsafe abortions.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

1.7.1 Research paradigm

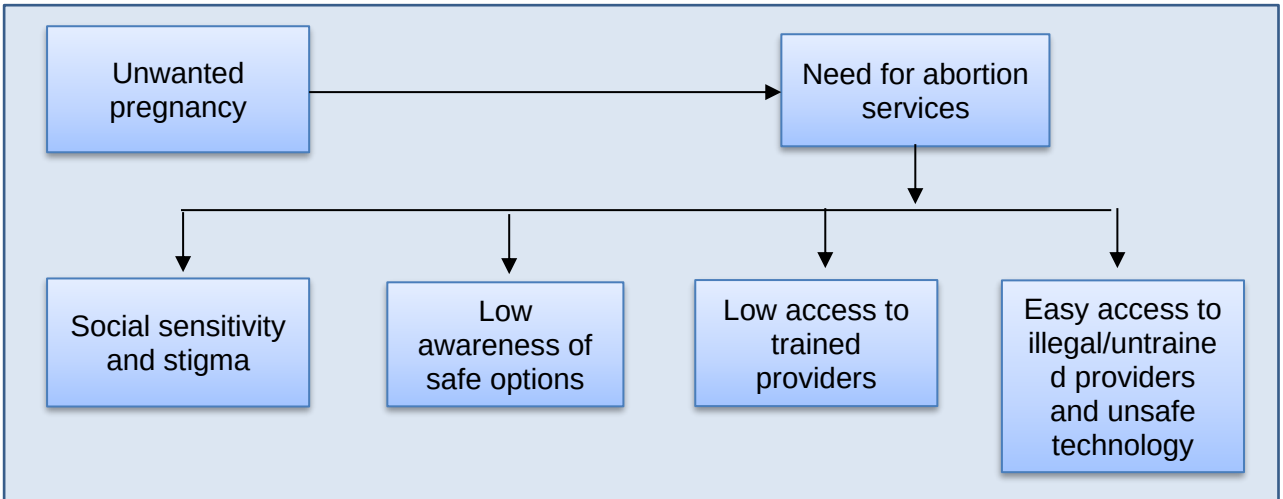
The researcher conducted the research from the constructivist paradigm. According to Polit and Beck (2017:12), the constructivist paradigm is a method of inquiry to explore knowledge acquired by certain subjects from past experiences. Furthermore, as stated

by Creswell and Creswell (2018:7-8), the constructivist focuses on understanding the lived experiences of the world in which they live and work. This paradigm allows the participants to develop subjective meaning with various experiences as they narrate their first-hand experiences and knowledge to the researcher (Polit & Beck 2017:12). The constructivist paradigm is the most suitable for this study. The researcher intends to describe and interpret the factors related to unsafe abortion to identify possible measures to reduce unsafe abortion in the Ngami sub-district. The researcher chose constructivist paradigm since the researcher will construct meaning from the women's answers in semi-structured interviews.

1.7.2 Conceptual framework theory

Banerjee and Andersen's (2017:3) conceptual framework of post-abortion complications states that when women face an unwanted pregnancy, various factors impact their choice of an abortion provider and type of treatment (refer to Figure1.1). Stigma, lack of knowledge about safe services and a scarcity of accessible and trained providers may lead women to seek more convenient providers. People who provide illegal services use hazardous technology such as intrauterine insertion of a foreign body. These include stick, root, leaf, wire, and vaginal abortifacients, including herbal preparations or misprescribed medications (Banerjee & Andersen 2017:3).

The researcher posits that this conceptual framework is relevant to the issue of abortion in the Ngami sub-district because it helps explain how social factors and the lack of cultural acceptance of abortion can lead to increased mortality and morbidity. When women face unwanted pregnancies, there exists the possibility that the social stigma they may experience, combined with the perceived lack of knowledge and options, will push them towards seeking clandestine abortions in unsafe conditions.



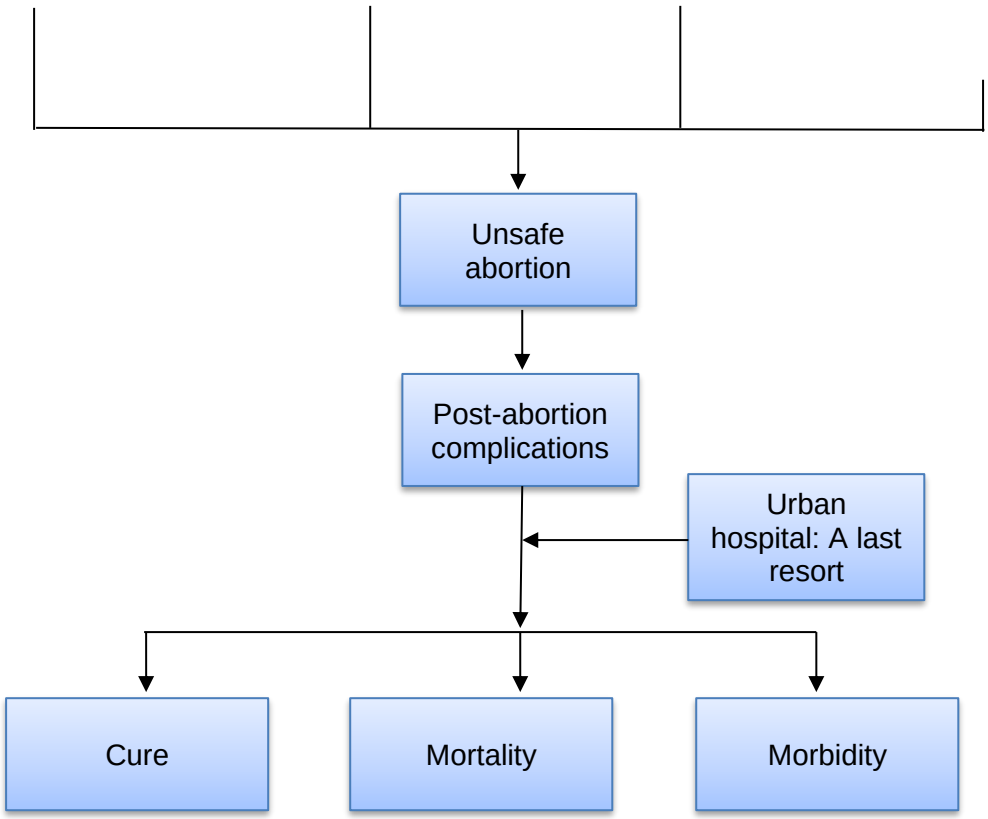


Figure 1.1 Conceptual framework of post-abortion complications

(Banerjee & Andersen 2017:3)

1.8 RESEARCH METHODOLOGY

Gray, Grove and Sutherland (2016:25) as well as Rubin and Barbie (2016:69) illustrated that a qualitative approach is a systematic process that is subjective, interactive, and commonly used to explore, describe and promote human experiences and situations or contexts of the persons involved. Therefore, this study follows a descriptive qualitative approach due to its explorative nature. The researcher used the exploratory approach to discover new ideas, gain new insights and increase knowledge about unsafe abortions in the Ngami sub-district.

Jaikumar (2018:4) indicates that with no manipulation or control, the descriptive approach aims to paint a picture of a situation in its natural environment. The researcher will also use the exploratory approach to discover new ideas, gain new insights and increase knowledge about unsafe abortions in the place of study.

1.8.1 Research design

A research design is a plan or procedure of inquiry on how the study will be implemented to answer the research question (Creswell & Creswell 2018:3). In this study, descriptive phenomenology was the best method to explore contributing factors to unsafe abortion in the Ngami sub-district. According to Polit and Beck (2017:831), descriptive phenomenology involves the careful description of everyday life's ordinary conscious experiences, including hearing, seeing, believing, feeling, remembering, deciding, evaluating, and acting. It involves four steps: bracketing, intuiting, analysing, and describing the lived experiences of individuals about unsafe abortion as related by participants.

1.8.2 Population

According to Christensen, Johnson and Turner (2015:162), the study population is the complete set of elements or people from whom the sample is selected. In this research, the study population includes women of all ages below and above 18 years who resided in the Ngami sub-district and were admitted to the gynaecological ward for unsafe abortions during the data collection period from June 2021 to August 2021 and were willing to participate in the study. The exclusion criteria were women below 18 years admitted to the gynaecological ward, who had unsafe abortions and were not willing to participate in the study.

1.8.3 Sample design

Christensen et al (2015:162) indicate that sampling represents elements from a population to obtain a sample. The study used the convenience sampling method. According to Polit and Beck (2017:516), convenience sampling is a method used when researchers need to have potential participants coming forward and identifying themselves to extract the most meaningful possible information from a few cases in the sample.

Saks and Allsop (2019:96), in support of Polit and Beck (2017), highlight that convenience sampling is an appropriate choice when the topic of the study is susceptible and involves risky or illegal behaviour.

1.8.4 Data collection

Creswell and Creswell (2017:16) described data collection as a systematic process of gathering information to answer the research question. The researcher collected data through individual face-to-face semi-structured interviews. The face-to-face semi-structured interview method was relevant because the researcher intends to collect in-depth, authentic information about factors of unsafe abortion among women in the Ngami sub-district.

1.8.5 Data collection instrument

The researcher chose the face-to-face semi-structured interviews since Creswell and Creswell (2017:190-191) justify that they are not intimidating and allow the participants to express their opinions freely, without the interviewer's pressure. The researcher prepared a written interview tool with two data collection sections for this study. Section A deployed questions related to the participant's demographic data; these questions assisted in analysing the participant's vulnerability. Section B had one main open-ended question, followed by probing to reach the study's objectives.

1.8.6 Trustworthiness

Morgan and Ravitch (2018:1729) define trustworthiness as how an inquirer can persuade their audiences, including self that the findings of an inquiry are worth paying attention to and worth taking into account. It also looks at what arguments can be mounted, what criteria can be invoked, and what questions were asked that would be persuasive on this inquiry issue. The researcher established trustworthiness by using the strategies as outlined by Lincoln and Guba (1985:290-296), namely credibility, transferability, dependability, and conformability.

- **Credibility**

Credibility is defined by Polit and Beck (2017:982) as the confidence in the truth of the data and interpretations thereof. Qualitative researchers must establish confidence in the truth of the findings for the participants and contexts in the research. In this study, the

researcher conducted member checking with each participant; the researcher established credibility through participants confirming and validating their responses.

- **Transferability**

According to Polit and Beck (2017:983), transferability refers to the potential for extrapolation, the extent to which the findings can be transferred to or have applicability in other settings or groups. Protocols undertaken for this study are clearly defined to be reproducible. The researcher provided sufficient descriptive data and comprehensive field notes so that the readers could evaluate the applicability of the data to other contexts. The researcher cannot justify the external validity of this study because the study is specific to one sub-district. Therefore, the researcher provided a thick description necessary to enable interested researchers or readers to judge whether the transfer can be considered a possibility in their settings.

- **Dependability**

Dependability is defined by Polit and Beck (2017:982) as the stability or reliability of data over time and conditions. The researcher kept an audit trail by ensuring proper documentation of data and methods. Accurate decisions were made about the research to allow scrutiny from other researchers. The researcher kept detailed field notes throughout the data collection process as a clear description of how the conclusions were reached.

- **Conformability**

Polit and Beck (2017:983) define conformability as objectivity, the potential for unity between two or more independent people about the data's accuracy, relevance, or meaning. Conformability concerns establishing that the data represents the information participants provided and that the interpretations of those data are not made up by the inquirer. In this study, conformability was obtained through the triangulation of data. An audit trail was kept, which included the raw data, for example, interview transcripts,

methodological notes, topic guides, and data reconstruction products such as drafts of the final report, to allow other researchers to conclude about the data in the future. In order to confirm that the data accurately reflect the information that the participants provided and that any interpretations of the data were not created by the researcher, an external coder was utilized. This was also done to accurately reflect the participants' voices and conditions of the study, instead of the researcher's biases, motives, or opinions.

1.9 DATA ANALYSIS

All interviews were audio-recorded after seeking permission from the participants. Data analysis adopted Creswell and Creswell's (2017:236) qualitative content analysis. Data analysis refers to categorising verbal or behavioural data to classify, summarise and tabulate the data. The data were analysed through the five stages of qualitative data analysis, that is, arranging data, organising data, coding data to form themes on data collected and data validation and completing the analysis process or writing a report. Content analysis was used to analyse responses from interviewees (Creswell & Creswell 2017:236).

1.10 ETHICAL CONSIDERATIONS OF THE STUDY

The researcher, throughout this study, maintained the ethical protection of the participants. Before the study began, the researcher obtained ethical clearance from the College Research Ethics Committee (CREC) of the Department of Health Studies at the University of South Africa (UNISA) (Appendix 1). The institutional consent and site permissions were requested and obtained from the Ministry of Health and Wellness of Botswana after communicating through a formal letter (Appendix 2a and Appendix 2b). Permission was also requested and granted from the Ngami District Health Management Team (Appendix 3a and Appendix 3b). The researcher was responsible to the participants to abide by ethical principles when executing the research. These principles included voluntary participation, confidentiality, autonomy, anonymity, justice, beneficence and non-maleficence, and scientific honesty. Therefore, the researcher obtained informed consent and approval from the participants. The research findings are trustworthy, using the strategies outlined by Lincoln and Guba (1985:296), that is, credibility, transferability, dependability, and conformability.

1.11 SCOPE OF THE STUDY

This study is geographically limited to the Ngami sub-district hospital located in the Northwest of Botswana. The purpose of the study was to gain an in-depth understanding of the contributing factors to unsafe abortions so as to develop possible measures to reduce unsafe abortions among women in the Ngami sub-district.

1.12 STRUCTURE OF THE DISSERTATION

The structure of the dissertation includes the following:

- Chapter 1 presents the orientation to the study.
- Chapter 2 covers the literature review.
- Chapter 3 describes the research design and methodology.
- Chapter 4 describes the analysis, presentation and description of the research findings.
- Chapter 5 shares the recommendations and conclusions.

1.13 SUMMARY

This chapter included the introduction to the study, the research question, the context, the purpose and objectives of the study, its significance and benefits, the theoretical foundations, research methodology, data collection processes, trustworthiness strategies, data analysis, ethical considerations and the scope of the study.

The next chapter (Chapter 2) presents the literature review of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides a comprehensive overview of the types of abortion, the types of unsafe abortions, unsafe abortions, global perspectives on unsafe abortions and factors contributing to unsafe abortions. Furthermore, the chapter discusses the barriers to access safe abortion services, ethical perspectives on abortion, and sustainable development goals versus abortion, the impact of unsafe abortion, complications and lastly, the conclusion.

2.2 TYPES OF ABORTIONS

Alves and Rapp's (2021:2) study on spontaneous abortion indicates that abortion can either be spontaneous or unsafe. Spontaneous abortion is a natural pregnancy loss before 20 weeks of gestation in the first trimester. It is also informally known as a miscarriage or early pregnancy loss to avoid association with induced abortion.

Furthermore, Alves and Rapp's (2021:2) study on spontaneous abortion elucidates that an open cervical os, which signifies the inevitable passage of the fetus' products, distinguishes inevitable abortion from threatening abortion. In a missed abortion, the embryo dies asymptomatically due to the insufficient uterine contractions to force the fetus out of the womb. Threatened abortion, however, is symptomatic. Although the fetus is expelled, the cervical os is still closed and the embryo is still viable. In an incomplete abortion, there is an incomplete passage of the products of conception through the cervical os. The entire passage of all fetal products is referred to as a complete abortion. Three or more consecutive miscarriages constitute recurrent abortion. When the retained products of conception become infected, as typically happens in the context of non-sterile induced abortion, this result in septic abortion.

University of Kansas School of Medicine (2019:31) indicated that complications from any of the above abortion types can include bleeding, uterine perforation, cervical laceration, haemorrhage, incomplete removal of products of conception, and infection.

2.3 UNSAFE ABORTIONS

2.3.1 History of unsafe abortions

Berer and Hoggart's (2019:79-80) study on the progress towards decriminalisation of abortion and universal access to safe abortions: national trends and strategies, elucidates that abortion is still largely illegal virtually everywhere in the world, with certain exceptions. As long as abortion is still illegal, it harms women who need it and poses a threat to healthcare workers who are prepared to assist them, though in various ways and to varying degrees. Because every woman has a right to life and health, it is vital that everyone has access to safe abortion and care for complications from unsafe abortion.

The WHO (2019b:2) defines unsafe abortion as a pregnancy termination either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards. Additionally, the Singh et al (2018:21-22) indicate that the abortion is considered unsafe when self-induced by ingestion of traditional medication or hazardous substances, an object is inserted into the uterus by the woman herself or a traditional healer, the woman is induced through violent abdominal massage, abortion medication is incorrectly prescribed or a pharmacist issues medication with no instruction or follow-up. The following conditions characterise an unsafe abortion: lack of pre-abortion counselling or advice, an unskilled abortion provider, or the abortion being performed in unhygienic conditions or outside of official health facilities.

In the case of unsafe abortion, certain contributory factors lead women to commit the act. In contrast, in cases of spontaneous abortion, there are sometimes unintentional risk factors leading to the loss of the pregnancy, as described below.

Alves and Rapp's (2021:3) study on spontaneous abortion elucidates that when abortion is due to fetal chromosomal abnormalities, advanced maternal age and previous early pregnancy loss, maternal alcohol consumption, smoking, and cocaine use, several chronic diseases, rapid conception after delivery and infections like STIs, exposure to

environmental contaminants and structural uterine abnormalities, women are likely to present with spontaneous abortion. On the contrary, the Singh et al (2018:21-22) suggests that unsafe abortion cases present with a history of insertion of an object or substance (root, twig, catheter or traditional concoction) into the uterus, dilatation and curettage performed incorrectly by an unskilled provider, ingestion of harmful substances and application of external force such as hitting the abdomen or falling, leading to threatened abortion, incomplete abortion or septic abortion.

Furthermore, Alves and Rapp's (2021:6) study on spontaneous abortion indicates that patients with spontaneous and induced or unsafe abortion might be admitted for post-abortion care as though they are experiencing spontaneous miscarriages. This makes it challenging to distinguish between spontaneous and induced abortions before intensive history taking and physical examination. Unsafe induced abortions are likely to lead to multiple complications, including maternal morbidities and mortality. There are different types of abortions classified according to women's symptoms. These include threatened, inevitable, complete, incomplete or missed, and septic abortion.

2.4 GLOBAL PERSPECTIVES REGARDING UNSAFE ABORTIONS

The WHO Factsheet (2021:2-3) elucidates that each year, there are about 73 million induced abortions performed worldwide. Three out of ten pregnancies (29%) and six out of ten (61%) unplanned pregnancies result in an induced abortion. About 97% of unsafe abortions occur in Africa, Asia and Latin America, whereas in North America, 99% of procedures are safe. This report shows that countries with less restrictive laws have high safe abortion procedures. The vast majority of abortions in Africa were categorised as least safe, meaning they were conducted by untrained persons using dangerous methods, such as introducing foreign objects and herbal concoctions.

The 2017 report by Singh et al's (2018:6) on uneven progress and unequal access of abortion services worldwide indicated that currently, six per cent of the world's 1.64 billion women of reproductive age live in a country where abortion is restricted by law, without clear and detailed exceptions (in Andorra, Angola, Congo-Brazzaville, Congo-Kinshasa and Egypt). About 21% of reproductive-aged women live in a country where abortion is allowed as an attempt to save a woman's life. An additional 11% of women reside in countries that legalised abortions to safeguard a woman's physical health. Only four per

cent of the countries allow abortions in order to preserve a woman's mental health, whereas 21% of the countries allow abortions for socioeconomic reasons. The specifics vary by country, for example, age, union and economic status, and the ability to care for existing children. An estimated 37% of the world's women of reproductive age live in countries where abortion is available without restriction, with maximum gestational limits specified in almost all.

Gebremedhin et al's (2018:1) study on unsafe abortion and associated factors among reproductive-aged women in Sub-Saharan Africa highlighted that unsafe abortion is a neglected public health problem contributing to 13% of maternal deaths worldwide. Ninety-nine per cent of abortions in Africa are unsafe, resulting in one maternal death per 150 cases and abortion-related morbidities. Atakro et al's (2019:2) study on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana, illustrates that deaths from unsafe abortions contribute to 14% of all maternal deaths in Africa. Other health problems that lead to hospitalisation from unsafe abortions include complications which affect about five million women from less developed countries. The adverse effects of unsafe abortions are higher in Africa. In Sub-Saharan Africa, the maternal death rate due to unsafe abortion remains high. There is no evidence of unsafe abortions which negatively influence the current service delivery (Gebremedhin et al 2018:1)

Botswana is among countries with restrictive abortion laws, which could factor into the reasons for high unsafe abortions. Abortion was illegal in Botswana until 1991, when amendments were made to the Penal Code Bill (1991) (Republic of Botswana 1991). According to the Penal Code Bill (1991) of Botswana, women can legally terminate a pregnancy within 16 weeks of conception if the pregnancy is caused by rape or incest, to save the mother's life or in the instance of fetal impairment (Republic of Botswana 1991).

The Ushie, Juma, Kimemia, Ouedraogo, Bangha and Mutua's (2019:1) study on community perception of abortion, women who abort and abortifacients in Kisumu and Nairobi counties in Kenya, indicates that abortion still receives substantial objection in SSA, which is supported by moral, ethical, socio-cultural, and medical grounds. Women and adolescent girls continue to turn to unsafe abortion procedures or those provided clandestinely, primarily by unqualified providers, as a result of cultural and religious

intolerance towards abortion among communities and service providers, which is most visibly manifested as abortion stigma.

Ngwako and Banke-Thomas' (2020:3) study on 'I guess we have to treat them, but … ': health care provider perspectives on management of women presenting with unsafe abortion in Botswana, concurs that the burden of abortion in Botswana may be underestimated, as the incidence of abortion is not well documented or known due to the restrictive abortion law of the country.

2.5 FACTORS CONTRIBUTING TO UNSAFE ABORTIONS

The WHO (2019b:2) reported that developed countries have seen a decline in the number of unsafe abortions. It is estimated that 30 women die for every 100 000 unsafe abortions in developed countries, compared to 220 deaths per 100 000 unsafe abortions in developing countries and 520 deaths per 100 000 unsafe abortions in Sub-Saharan Africa. In comparison to developed countries, developing countries had a higher abortion rate. Over half of all estimated unsafe abortions globally were in Asia. Three out of four abortions performed in Latin America and Africa were unsafe. The continent of Africa had the greatest mortality rate from unsafe abortions. Unsafe abortions are responsible for 4.7% to 13.2% of maternal deaths per year. Every year, almost 7 million women in developing nations are admitted to hospitals as a result of unsafe abortion (WHO 2022c:1). Among other countries where induced abortions were legal, the prevalence of induced abortion was 22 percent in France, 21.1 percent in Nepal, and 10.2 percent in Australia, while the prevalence of repeat induced abortion was 8 percent in France and 11.9 percent in the United Kingdom (Kang, Liu, Ma, Jing, Zhang & Liu 2022:1).

The Bearak, Popinchalk, Ganatra, Moller, Tunçalp, Beavin, Kwok and Alkema (2020:1) report indicates that the 31% decline in the unsafe abortion rate and a 12% decline in unplanned pregnancies ending in abortion in developed countries is attributed to the broader legal status of abortion and access to modern and highly effective contraceptives. In the United States of America (USA), abortions are conducted in 50 states. Furthermore, Nash, Mohammed, Cappello and Naide's (2019:1-8) policy analysis report on state policy trends on abortion reported that in the beginning of May 2019, USA politicians began passing abortion bills restricting the accessibility of abortion services, such as the Heartbeat Bill. Such restrictions on safe and legal abortions can compel vulnerable

women to seek unsafe abortions and thus potentially increase the incidence of maternal morbidity and mortality. The 2017 report by Singh et al's (2018:6) on uneven progress and unequal access of abortion services worldwide elucidated that the US decline in abortions cannot only be attributed to abortion restrictions. The 2011 to 2017 decline can have several explanations, including changes in abortion attitudes and stigma, contraceptive use, sexual activity, infertility and self-managed abortion.

Calkin and Berny's (2021:1) study on legal and non-legal barriers to abortion in Ireland and the United Kingdom indicates that costs may prohibit a woman from accessing comprehensive safe abortion services. For poor women, the cost to procure safe abortion services can be very high, pushing women to cheap unhygienic settings. Additional costs of abortion can include the cost of travel and other social expenses, such as unmet family responsibilities or lost time from work. These may lead to economically disadvantaged women deciding to self-induce or obtain an abortion from an unskilled provider or in an unhygienic setting. Many residents of remote or island settlements lack access to neighbourhood services. The most affected groups are those who lack access to abortion services. Those living in rural communities may find it difficult to get access to healthcare due to the financial burden and other obstacles connected with travelling to the mainland. Abortion restrictions are in and of themselves violations of human rights, because without access to safe, legal, and nearby abortion services, people seeking abortions are unable to exercise their right to bodily autonomy and integrity.

The prevalence of induced abortion in China has decreased due to a gradual relaxed fertility policy, but the prevalence of repeat induced abortion is still high. Women with children are more likely to have induced abortions due to satisfied fertility intention, and postpartum unintentional pregnancy and induced abortion should not be neglected. Despite the high prevalence of contraception, large numbers of induced abortions still exist, calling for more attention to inappropriate contraceptive use and contraceptive failure. China's new three-child policy could lead to a further decline, since there are great numbers of women of childbearing age who have unintentional pregnancies and subsequent induced abortions on account of the large population in China (Kang, Liu, Ma, Jing, Zhang & Liu 2022:9).

Yokoe, Rowe, Choudhury, Rani, Zahir and Nair's (2019:12) study on unsafe abortion and abortion-related deaths among 1.8 million women in India indicated that in India, socio-

economic vulnerability, teenage pregnancy and inadequate access to healthcare services leave large numbers of women at risk of unsafe abortions and abortion-related deaths. Despite abortion being legal, the high estimated prevalence of unsafe abortions demonstrates India's significant public health problem. The study also reported an increased number of abortions in India, but the population-level rates of unsafe abortions and their risk factors are not well understood.

Every year, over 25 million unsafe abortions are estimated to occur worldwide, mostly exclusively in developing countries (WHO 2019b:2). The Guillaume & Rossier (2018:253) study on abortion around the world, an overview of legislation, measures, trends, and consequences indicated more than 75 percent of abortions are unsafe in almost all sub regions. The worst situation is in Africa, where most abortions are highly unsafe and where women continue to use the most dangerous and invasive procedures. The most serious situation is in Central Africa, followed by West, East, and North Africa. Due to the fact that 75 percent of abortions performed there are safe, Southern Africa stands out from the rest of the continent.

A study by Gebremedhin et al (2018:1) on unsafe abortion and associated factors among reproductive-aged women in Sub-Saharan Africa indicates that in Africa, the prevalence of unsafe abortion is associated with restricted abortion law, poor quality of health service, and low community awareness. The findings of this review showed that unsafe abortion is not yet reduced significantly in SSA, and the maternal death rate due to unsafe abortion remains high. Zafar, Ameer, Fiaz, Aleem and Abid's (2018:4-7) study titled low socio-economic status leading to unsafe abortion-related complications: a third-world country dilemma, indicated that low socio-economic status is a dominant cause of unsafe abortion. As such, women who undertake abortion are economically disadvantaged, which leads to an inability to afford the cost of abortion with qualified medical personnel. This then tempts women to use unsafe ways which are mostly less costly. This is also attributed to the low cost of abortion through herbalists and certain pharmaceutical drugs.

Atakro et al's (2019:15-17) study on factors contributing to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana found that in Ghana, a developing country, despite the existence of abortion law and a safe abortion policy, 15% of all women in the reproductive age group 15 to 49 years, have practiced unsafe abortions. The evidence available suggests that unsafe

abortion is attributed to a lack of knowledge of safe abortion services, poor socio-economic conditions, and cultural and religious beliefs. The research also alluded to the stigma of unplanned pregnancy, a desire to bear children only after marriage, attempts to avoid parental/guardian disappointment and resentment, and a desire to pursue education as situations that contributed to unsafe abortion practices.

Yogi, Prakash and Neupane (2018:1) in a cross-sectional study of the prevalence and factors associated with abortion and unsafe abortion in Nepal, found that unsafe abortion is one of the leading factors of maternal death in low- and middle-income countries. Researchers' evidence shows that abortion is still high in Nepal, and unsafe abortions are alarming. Lack of knowledge about legal abortion on different grounds and the stigma attached to abortion, prompted women to opt for unsafe abortions. Being rich protects women from unsafe abortions since they can access good abortion services.

Yogi et al (2018:2), in a cross-sectional study of the prevalence and factors associated with abortion and unsafe abortion in Nepal, indicated that women of childbearing age mentioned child spacing, unintended pregnancy associated with child sex, the child's father not wanting the child and satisfied parity. Economic disadvantages such as unemployment and no income to take care of the child were some of the factors women cited that prompted unsafe abortion. Therefore, as developing countries move towards adopting smaller family sizes, including spacing preferences, choosing one item to address unsafe abortion will not produce the desired impact on eliminating unintended pregnancies and unsafe abortions.

Smith's (2013:7-9) review on the reproductive health and the question of abortion in Botswana indicated that criminalising abortion contributes to economic injustice in developing countries. In Botswana, more women make the expensive and time-consuming journey to South Africa to procure an abortion in a legal setting. Access to safe abortion and quality aftercare is usually restricted to women with access to funds. Those without such means become the victims of dangerous, unsafe procedures.

2.6 BARRIERS TO ACCESSING SAFE ABORTION SERVICES

The WHO (2022a) indicates that when made available at the woman's request, safe abortion services are widely available, inexpensive, and easily accessible. Treating

abortion as essential health care is a crucial step forward. The WHO (2022a) has revealed that first trimester abortions can be provided safely and effectively at the primary and community level by trained mid-level providers and provision of medical abortion pills by trained pharmacy workers.

The 2017 report by Singh et al's (2018:6) on uneven progress and unequal access of abortion services worldwide reveals that safe abortion services availability and accessibility vary by state. Some women travel to obtain abortion services in other states that are not restricted or limited.

Jerman, Frohwirth, Kavanaugh and Blades' (2017:9-11) qualitative study on the barriers to abortion care and their consequences for patients traveling for services discusses barriers to safe abortion care as costs, resistance, knowledge gaps, gender inequalities, low autonomy, lack of knowledge and education, unavailability of abortion services, stigma and legal restrictions are barriers to safe abortion care. Barriers are grouped into five categories, namely travel-related logistical issues, system navigation issues, limited clinic options, financial issues and state or clinic restrictions. The consequences of these barriers were delays in care, adverse mental health impacts and considering self-induction. Individual barriers that delay access to abortion include difficulty in raising funds to cover the costs of the procedure and travel, late pregnancy recognition, lack of insurance coverage, difficulty locating a provider, and distance and arranging travel plans. The consequences of these barriers are severe and at times fatal to women as they delay women from obtaining care.

2.6.1 Women's lack of autonomy

Frederico et al's (2018:8-10) study on factors influencing abortion decision-making processes among young women indicated that women's lack of autonomy to make their own decisions regarding the termination of an unintended pregnancy could be a barrier to safe abortion care (SAC), which makes them vulnerable to pressure. In this study, women indicated that the decisions to have an abortion were mostly taken by their parents, family members, partners, and providers. Sometimes, this decision was taken against their will. This lack of autonomy in abortion decision-making is linked to power and gender inequality. Gender inequality is the power imbalance between men and women where a partner decides to terminate the pregnancy. The power of others, such

as parents/family, can influence women's decision to induce an abortion if they are being threatened to be kicked out of their homes. Besides this, women's economic dependence on family or partners makes them more vulnerable, dependent and subordinated in decisions to have an abortion.

2.6.2 Women's lack of knowledge

Calkin and Berny's (2021:1) study on legal and non-legal barriers to abortion in Ireland and the United Kingdom illustrates that, the WHO guidelines urge the removal of medically unnecessary policy barriers to safe abortion, such as criminalisation, the requirement that consent be obtained from other people or institutions, and restrictions on when an abortion may be performed, in addition to the clinical and service delivery recommendations. These obstacles can cause serious delays in receiving treatment, increase the risk of unsafe abortion, stigmatisation, and health issues, as well as cause more disruptions in both school and employment for women and girls.

A study by Frederico et al (2018:1-2) on factors influencing abortion decision-making processes among young women indicates that women's lack of autonomy is closely linked to their lack of knowledge. Women do not know where abortion services are provided and are not fully acquainted with the legal procedures and sexual rights. This lack of knowledge among women contributes to the high prevalence of pregnancy termination outside health facilities and not per legal procedures. The vulnerable population will be left with the option of unsafe abortions.

Harries, Daskilewicz, Bessenaar and Gerdts' (2021:6) qualitative study on understanding abortion seeking care outside of formal healthcare settings in Cape Town, South Africa, concurs that a lack of knowledge about accessing a safe, legal abortion in the public health sector and the fear of mistreatment by healthcare workers are among the main reasons for the continued high rates of illegal abortion procurement.

A study by Frederico et al (2018:8-10) on factors influencing abortion decision-making processes among young women, revealed that illiteracy as a cause of unsafe abortion is closely associated with ignorance. Therefore, ignorance is viewed as the consequence of illiteracy. In addition, a low level of knowledge of laws on abortion is one of the reasons why women opt for unsafe abortions when they could have sought legal abortions.

Women know that abortion is a dangerous procedure, but regardless of the complications, they resort to dangerous means to get rid of the pregnancy.

Another study by Khatri, Poudel and Ghimire (2019:2) on pooled analysis of the factors associated with unsafe abortion practices in Nepal between 2011 and 2016, revealed that in low and middle-income countries and Latin American countries, poor women, ethnic minorities and women with lower education had a high prevalence of unsafe abortion.

2.6.3 Lack of safe abortion services

Lack of resources such as safe abortion facilities can be the leading cause of women opting for unsafe abortions. When women can access effective contraception and safe abortion services, they can better safeguard their health and well-being. Evidence shows that many women and girls continue to suffer and die due to a lack of access to safe abortion and post-abortion care (WHO 2019c:2-4).

In a study by Frederico et al (2018:1-2) on factors influencing abortion decision-making processes among young women, it is indicated that in Mozambique, women reported that abortion services are absent locally. Some, not all, Mozambique tertiary or quaternary health facilities are authorised to perform abortions. The fact that some health facilities do not perform abortions creates a shortage of abortion centers to cover the demand. Women who are well educated and those with an extensive social network have access to legal and proper abortion procedures.

Findings of a study by Atakro et al (2019:15-17) on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana revealed that women in Ghana appear to blame the occurrence of unsafe abortion on society. Abortion is stigmatised in this society, and women who opt for safe abortion cannot access these services freely without judgment.

2.6.4 The attitude of abortion service providers

In a qualitative study of safe abortion and post-abortion family planning service experiences of women attending private facilities in Kenya by Penfold, Wendot, Nafula and Footman (2018:6-7), it was indicated that one of the barriers to safe abortion services

is providers' attitudes, competencies and skills in providing abortion care to their clients. When seeking care, clients' concerns are of quality and safety of the service. The perceptions of the procedure's safety, cleanliness, competency, and staff attitude also influence where the clients access services. Most clients also consider the speed of service, availability of post-abortion care services and privacy, and service providers' ability to keep abortion services confidential at all times.

Furthermore, Penfold et al (2018:6-7) indicate that clients prefer providers who will not only conceal the abortion but also shield them from the laws and costs of the procedure. If providers are not discreet in providing abortion services, there is a lack of clarity about the legality of abortion and stigma; this may increase the value placed on discrete service provision and the possibility of informal abortion services and unsafe abortions.

A study by Frederico et al (2018:9) on factors influencing abortion decision-making processes among young women corroborates that there are obstacles related to the availability of services and providers' attitudes towards safe abortion, although the law grants the population this right. The study revealed that national abortion laws exist on paper only as providers and women still do not utilise them. Therefore, it is necessary to clarify and inform women and providers of the current legislation and ensure that abortion services are available in all circumstances described in the law to promote safe and legal abortion and avoid double autonomy deprivation. Women who need abortion services depend on healthcare providers to decide on the location, the methods used, and the legality of abortion procedures. The reluctance by providers to refer clients to the reference health facility or inform them of the legal policies creates a gap between the law and practice, which increases criminal and unsafe procedures.

2.6.5 Stigma of abortion

In a study by Faundes, Comendant, Dilbaz, Jaldesa, Leke, Mukherjee, De Gil and Tavara (2020:101-112) on the importance of openly discussing abortion for the protection and promotion of women’s health, it was found that stigma is one of the main barriers to constructively dealing with induced unsafe abortion due to political implications. The word "abortion" on its own is a heavy stigma on women who had an abortion, the abortion providers, and those who would like to discuss the issue of abortion constructively. This stigma affects how policymakers and opinion leaders deal with and act regarding

abortion, especially in developing countries with a long tradition of abortion prohibition. In many countries, policymakers are guided in dealing with abortion by political, moral, and religious considerations rather than evidence-based approaches.

Atakro et al's (2019:11-13) study on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana corroborates that even though abortion is common in Ghana, it remains inaccessible for many. The rates of abortion access show that women continue to have abortions despite pro-choice social mobilisation and changes in moral codes that define abortion as wrong and immoral.

A systematic review by Munakampe, Zulu and Michelo (2018:1-13) on contraception and abortion knowledge, attitudes and practices among adolescents from low and middle-income countries suggests that healthcare providers' stigma attached to youths' sexual health leads to a high risk of unsafe abortion in this group. As health providers shun them, the youth does not have full access to reproductive health information and services like modern contraceptives. Furthermore, the youths are not expected to be engaging in sexual activity at their age, which increases the likelihood of unsafe abortions.

2.6.6 Political, religious and cultural belief systems

Makleff, Wilkins, Wachsmann, Gupta, Wachira, Bunde, Radhakrishnan, Cislaghi and Baum's (2019:50-60) study on exploring stigma and social norms in women's abortion experiences and their expectations of care indicated that cultural beliefs, a reliance on self-medication for other problems, and stigma around abortion, could provoke women to opt for unsafe abortion. Women continue to choose illegal abortion providers because they offer privacy and immediacy, which are frequently lacking in the public sector. Masses of women terminate their unwanted pregnancies, but usually in ways that uphold the norms of silence and secrecy.

A study by Atakro et al (2019:11-12) on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana found that some women's commitment to religious values and beliefs affects their decision and the likelihood of undergoing a criminal abortion. This is due to the interpretations in these religions that are strongly against abortion. People who indulge in

sexual relations before marriage are not willing to raise children as single parents. When they break up with their partners in the early periods of pregnancy, they are tempted to abort these pregnancies. Besides, they may want to abort pregnancies to continue satisfying their sexual needs, which they cannot often do during pregnancy periods or at birth. Therefore, women with unplanned pregnancies are likely to choose unsafe abortion due to religious beliefs and commitment.

2.6.7 Gender inequalities

The WHO's (2020a) report indicated that there is a strong association between gender equality, education and family planning. According to the WHO (2020a:1153-1161), it has been demonstrated that women are more likely to have their demand for modern contraception met in countries where gender equality and educational opportunities improve. For example, for every rise in a country's gender development index, there is a rise in women who are sexually active and do not want to conceive.

The United Nations Human Rights Office of the Commissioner's (2020) report showed that gender inequalities and restrictions on abortion disadvantage pregnant women and girls (vulnerable group) in accessing safe abortion services, putting them at risk of unsafe abortions. Women and girls face physical and mental injuries, violence, and deprivations of liberty worldwide, leading to unintended pregnancy and unsafe abortion, especially in developing countries. A significant challenge to gender equality reveals deep inequities in women and girls' current non-enjoyment of sexual and reproductive health rights. Socio-economic, political, and environmental crisis leads to breakdowns in health systems, lack of information, and increased risk of unintended pregnancy, resulting in cases of unsafe abortion and forced continuation of pregnancy, worsening these gender inequities. Women face significant discrimination and gender power struggle subjecting them to a patriarchal agenda that instrumented women's bodies and systematically denied them timely access to safe abortion services. Patriarchal oppression, restrictions, and bans on abortion renounce women to full access to reproductive and sexual health-based services as a fundamental human right. Political leaders worldwide have used their power to deny women and girls their constitutionally protected rights and freedoms despite evidence showing that unsafe abortions are increasing due to these restrictions, bans and politicising abortion, causing more harm.

2.6.8 Lack of modern effective contraceptives

Munakampe et al (2018:1-2) on a systematic review on contraception and abortion knowledge, attitudes and practices among adolescents from low and middle-income countries report severe limitations in the access to safe and effective methods of contraception and safe abortion services among childbearing women. The unmet need for effective pregnancy preventative measures results in adverse health effects of early pregnancy and childbirth.

2.6.9 Legal restrictions

Faundes et al (2020:25) in a study on preventing unsafe abortion, achievements and challenges of a global International Federation of Gynecological and Obstetrics (FIGO) initiative, elucidate that more recently, the observation of the abortion rate in different countries with more liberal or restrictive laws has allowed understanding that criminalising abortion is insufficient to reduce its rate. Instead, it effectively increases abortion-related morbidity and mortality.

Evidence as stated by the WHO Factsheet (2021:2) illustrates that restricting access to abortions does not reduce the number of abortions, however, it does affect whether the abortions that women and girls attain are safe and dignified. The proportion of unsafe abortions is significantly higher in countries with highly restrictive abortion laws than in countries with less restrictive laws.

The WHO Factsheet (2021:2) further states that high costs of procuring safe abortion services, stigma against both people seeking abortions and healthcare providers, and healthcare professionals who refuse to perform abortions out of personal beliefs or religious conviction, are all obstacles to obtaining a safe and respectful abortion. Access is further hampered by restrictive laws and regulations that are not medically necessary, such as those that criminalise abortion, impose waiting periods, offer biased information or counselling, require third-party authorisation, and place limitations on the kinds of medical facilities or providers that can perform abortions.

The 2017 report by Singh et al (2018:6) on uneven progress and unequal access of abortion services worldwide reveal that in countries where abortion is completely banned

or not allowed only to save the women's life or physical health, only one in four abortions was safe. In contrast, in countries where abortion is legal on broader grounds, nearly nine in ten abortions were safe. Melese, Habte, Tsima, Mogobe and Nassali's (2018:2) study on the management of post-abortion complications in Botswana: the need for a standardised approach, indicates that women's higher morbidity and mortality have been observed in the regions with restrictive abortion laws.

Singh et al (2018:849) highlights that due to the extremely high level of underreporting of abortion experience in population-based studies that directly interview women, one major obstacle to research on the effects of unsafe abortions and on other aspects as well is the difficulty in gathering data that is representative of all women having an abortion.

A study by Melese et al (2018:1) on the management of post abortion complications in Botswana, indicated that the burden of abortion in Botswana may be underestimated as the incidence of abortion is not well documented or known due to the restrictive abortion law of the country. Abortion-related complications and deaths are also high in settings where abortion is illegal. If there is no data or research, then there is nothing to inform the policymakers on the magnitude of unsafe abortion, and there will be no planning and service delivery to the women. This will further increase the burden of unsafe abortion and its consequences on the healthcare system.

2.7 ETHICAL PERSPECTIVES OF ABORTION

Buye's (2021:2-8) study on abortion and ethical considerations, ethical aspects and prerequisites for abortion in Uganda, indicates that the major ethical question in abortion is whether it is ethically appropriate to regulate abortion in light of its nature, circumstances, and avoidance of endangering a child's life or upsetting the expectant mother. Furthermore, what are the unborn child's legal rights? Do the parents always choose to end the pregnancy because they can do so at any time? And does the baby only have rights after delivery or when one's brain can support decision-making? On the other hand, moral philosophy systematises, justifies, and suggests ideas of appropriate and inappropriate behaviour, hence the need of reconciliation of both the ethics and moral issues surrounding abortion.

Furthermore, Buye (2021:9-11) elucidates that applying the well-known health disparity lens to abortion care could be a way out of abortion exceptionalism and assisting in developing a just case for changes to state and policies that would increase timely access, as well as for the preservation or expansion of access to safe abortion within our institutions and communities. More than actual abortion experiences, people often discuss the concept of abortion. The idea or sensation that everything about abortion care is unique compared to other medical or societal issues may be the cause of the extent to which focusing patient values and experiences is uncommon in abortion ethics. However, giving in to this exceptionalism hinders our ability to approach abortion ethics issues with fresh eyes, in fact, with the same eyes we use to approach related issues.

According to Steinbock (2022:2-6), ethical issues of abortion can be divided into four, that is, ethical issues with women, issues with family, respect to the fetus and society in general.

- **Ethical issues with women:** Both the physical and mental health of women get impacted because of unintended pregnancy. Women have rights and freedom; no woman who voluntarily chose to get pregnant is likely to seek abortion, unless there are some serious compelling circumstances. Apart from losing reproductive choices, restrictions on abortion might lead to illegal and unsafe abortions. This goes against the women's right to privacy and bodily autonomy.
- **Ethical issues with the family:** Husband's/in-laws choices: As both parents conceive a child, choosing to have an abortion might have to be a decision of both the parents involved. Conservative versus liberal values followed in a family may offer differing opinions regarding abortions.
- **Ethical issues with respect to the fetus:** The fetus has the right to life; abortion amounts to the murder of a living being. Motherly care is a unique unspoken bond shared between two lives, which cannot be questioned or regulated by laws.
- **Ethical issues with respect to society in general:** The State has the responsibility of valuing each life. Inclusion of all meanings of abortion should not become a mechanism of social control for avoiding the appearance of differences or disabilities. Many times parents want abortion to be able to give a good life to existing children instead of dividing their meagre resources between more children.

The abortion debate has typically been framed in terms of "pro-life" and "pro-choice" viewpoints, but for Christians, it is a much more complex subject. Christians who support life say that conception is the beginning of human existence and that every human life is sacrosanct. According to Christians who support life, killing an unborn child is the same as aborting a fetus. The legalisation of abortion is nothing more than the approval given to an adult by a court of law to take the lives of children who are still in the womb and so unable to defend themselves. Many believe that abortion should never be performed, while others might make an exception in cases of rape, incest, or extreme threat to the mother's life. Women sometimes use abortion as their family planning method, which gives opponents or people against safe abortion a point to illegalise abortion. The following aspects address ethical perspectives of abortion.

2.7.1 Autonomy of mother versus fetus

Proponents support that every woman should be able to determine her pregnancy. They argue that when a woman has voluntary and unprotected sex and becomes pregnant, she has signed a contract with the fetus, and the fetus has the right to live. At the same time, the woman has the right to decide for herself and her body. Just as the fetus has the right to live, the woman still has the right to decide for herself and her body. She also has to decide in the best interest on behalf of the fetus (Steinbock 2022:6-7).

Buye (2021:2-8) suggests that, although focusing on pregnant women in discussions of abortion ethics does not neglect the moral status of embryos and fetuses, the necessity for abortion treatment as a matter of health inequities causes a shift from the ethics of the act of abortion to the ethics of access to abortion care. Instead, it shifts the emphasis to the patient's conscience, treating them with respect as moral beings and attributing those judgments to them. More than 33 million American women and the medical professionals who treated them have voted with their feet since 1973, stating that abortion is ethical or, at the very least, ethical enough to be chosen over motherhood. They are refusing to take part in either forced pregnancy or forced abortion, supporting the provision of prenatal and delivery care or abortion care based on patient values, and taking up the fair solution of pluralism. Ethicists and clinicians who accept patients' moral reasoning about their bodies, lives, and pregnancies are not "taking a side" in the abortion debate. Rather, they are standing in the middle ground of pluralism.

2.7.2 Nonmaleficence

Abortion has lifelong complications and devastating physiological and psychological effects, whereas safe abortions are not injurious to women's health. Abortion advocates say that abortion is just like any other invasive procedure, and it carries no risk if done correctly (Steinbock 2022:1).

2.7.3 Debate on soul insertion

If a woman engages in sexual intercourse to have a child, the resulting fertilised egg has a right to mature and be born. It means the right to be born crystallises at the moment of voluntary and intentional fertilisation. Opponents support the idea that the soul enters the fetus from conception, thus, abortion is analogous to killing. Different literature supports the various times of entrance of the soul in the fetus. The pro-life group insists that the fetus is an individual itself and no one should violate its rights (Steinbock 2022:3-6)

Society is divided on whether abortion is wrong or right. The pregnant mother and fetus's rights are conflicted. Although society has put these arguments on when, how and why abortion cannot be done, women decide whether to keep the fetus or have the abortion. Moral issues and ethical dilemmas, stigma and legal status of abortion in our society lead to unsafe abortions, which can be detrimental to women's reproductive health (Steinbock 2022:1-4).

2.8 SUSTAINABLE DEVELOPMENT GOALS (SDGS) VERSUS ABORTION

Seidu, Ahinkorah, Ameyaw, Hubert, Agbemavi and Armah-Ansah (2020:11-12) highlight that to achieve the third SDG of ensuring healthy lives and promoting well-being for all women at all ages, pregnancy termination (abortion) should be prioritised by 2030. Reproductive health decision-making (RHDM) empowers women to make informed decisions that favour positive reproductive health outcomes such as the abortion procedure. In 2015, the United Nations launched the 2030 Agenda for the SDGs. SDG3 goal aims to reduce maternal mortality and improve reproductive health. This implies that people should enjoy safe and satisfying sexual life, procreate and freely decide if, when and how often. Abortion is prioritised because globally, about 830 women die from

pregnancy and childbirth-related causes annually, and 99 per cent of such deaths occur in low- and middle-income countries (LMICs). The major contributing factor to this high maternal mortality is unsafe abortion worldwide. Hence, the need to enhance universal access to sexual and reproductive health services for all women of reproductive age.

Seidu et al (2020:11-12) indicate that the myriad cultural and socio-economic factors affect women's capacity to make decisions about their lives, including reproductive health. The cultural traditions and beliefs in SSA support the hierarchical role of men in sexual relationships, making it difficult for women to be the critical deciders of their reproductive health.

Botswana has domesticated some sustainable development goals to meet the 2036 target. According to Botswana Domesticated SDGs Brief, SDGs related to reducing maternal mortality are two, SDG 3 and 5 (Republic of Botswana 2018a). The following is the discussion of these SDGs to achieve human and social development in Botswana by 2036.

In summary, these domesticated SDGs cater for safe abortion services. However, the country still sees abortion as an illegal procedure unless it is done for specific reasons stipulated by the law. Like other countries in the world, Botswana wants to achieve the targets of sustainable development goals (SDGs) 3 and 5. According to Botswana Domesticated SDGs Brief, these SDGs relate to the reduction of maternal mortality. SDG 3 seeks to ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes (Republic of Botswana (2018a:15-24). The SDG 5 aims to achieve gender equality and empower all women and girls to end all forms of discrimination against women and girls. These SDGs support women's empowerment with knowledge of sexual reproductive health services, including safe abortion services upon request. There should not be any restrictions on informed decisions made by women concerning reproductive choices to reach these targets. If interventions to achieve these SDGs are limited, it may lead to unintended pregnancies, unsafe abortions, and serious complications, including maternal deaths.

2.9 IMPACT OF UNSAFE ABORTION

Moore, Dennis, Anderson, Bankole, Abelson, Greco and Vwalika (2018:12-13) in a study on comparing women's financial costs of induced abortions at a facility versus seeking treatment for complications from unsafe abortions in Zambia, found that costs associated with self-induced abortion are very high compared to spontaneous abortion. This is due to higher hospital expenditures for treating abortion complications in women with induced abortion than in women with spontaneous abortion, including the high costs incurred in terminating the pregnancy in the first place. These unaffordable payments lead to some economic consequences and consume significant resources for households, for example, using the entire household savings and borrowing money with high-interest rates. It takes time to acquire medical assistance due to lack of payment means, especially for poor women, which may lead to higher expenditures due to more significant deterioration of their health. Poor women may be less able to afford skilled care along the road to the hospital, essential for maternal mortality reduction.

The WHO (2019b:3) concurs that unsafe abortion does not only cause deaths and disabilities, but it may lead to significant financial and social consequences for women, families, communities and health systems. In 2006, it was estimated that $553 million was spent treating serious consequences of unsafe abortion. An additional $375 million would be required to fully meet the unmet need for treatment of complications from unsafe abortion.

The WHO (2020a:1) elucidates that 121 million abortions are unintended each year, and six out of ten unintended pregnancies end in induced abortion. When an unsafe abortion is carried out to terminate a pregnancy, there can be devastating and long-term physiological, financial, and emotional costs to the woman, her family, and her community. Physical complications of unsafe abortion negatively impact women's health and well-being. One in four women who have an unsafe abortion develops temporary or lifelong disability requiring medical care.

Singh et al (2018:29-31) highlight that, surgery to remove the uterus is necessary in some severe abortion complications like perforations, significant physical injuries, and septic shock. Long after an abortion, issues including anaemia and persistent weakness may still exist. Some chronic symptoms brought on by botched abortions, such as discomfort, rudimentary tract inflammation, and pelvic inflammatory disease, may persist

permanently, seriously endangering the health of women. Secondary infertility may also be caused by these disorders and other post-abortion consequences.

2.9.1 Impact of COVID-19 on unsafe abortion practice

International Federation of Gynaecological and Obstetrics (FIGO) (2020) indicated that due to imposed COVID-19 preventative measures like curfews, total and compulsory quarantine, the pandemic resulted in higher levels of unintended pregnancies in Panama, placing women at a greater risk of unsafe abortion and maternal death. In Panama, access to safe abortion is restrictive, posing a challenge even before COVID-19. Domestic and sexual violence against women cases has increased in Panama, resulting in unplanned and unwanted pregnancies. Suppose these victims/survivors of domestic violence and sexual violence do not access safe abortion care services. In that case, many women will resort to unsafe abortions, which puts them at risk of maternal death.

Kumar, Daly, De Plecker, Jamet, McRae, Markham and Batista (2020:1-4) posit that the COVID-19 pandemic limits access to sexual and reproductive healthcare, including contraception and safe abortion care (SAC), which are essential services in the prevention of maternal deaths and morbidity worldwide. Due to lockdowns and quarantines imposed by governments due to COVID-19, there was a drastic shutdown or delays in the provision of contraceptives and SAC, which severely affected the vulnerable populations, including women and girls in low-income and middle-income countries. This led to numerous preventable death and lifelong disability due to unsafe abortions related to unintended pregnancies.

The COVID-19 pandemic had its fair share of increasing the number of unsafe abortions worldwide due to laws in place to contain the spread of infectious disease. Therefore, each country must learn from the effects of this pandemic and develop concrete measures to counter the limited supply of contraceptives and reduce women's abuse to reduce unwanted or unplanned pregnancies and unsafe abortions during pandemics.

2.10 COMPLICATIONS OF UNSAFE ABORTIONS

Findings by Yogi et al (2018:2) in a cross-sectional study of the prevalence and factors associated with abortion and unsafe abortion in Nepal showed that abortion, especially

unsafe abortion, may have serious health consequences and cause complications such as haemorrhage, sepsis and uterine perforation. Other disastrous conditions that may occurs include shock, infections, organ failure, chronic pelvic inflammatory disease, infertility, or even death (Zafar et al 2018:2).

Reardon's (2018:2) study on the abortion and mental health controversy, a comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities elucidates that there are some women who do suffer from serious mental health conditions that are brought on by, aggravated by, or complicated by their abortion experience. This is frequently the result of feeling pressured into having an abortion or choosing one without paying enough attention to maternal desires or beliefs that could make it difficult to reconcile one's choice with one's sense of identity.

The WHO (2021:4) adds that other physical health risks associated with unsafe abortion include incomplete abortion, failure to remove or expel all pregnancy tissue from the uterus, and damage to the genital tract and internal organs as a consequence of inserting dangerous objects into the vagina or anus.

Singh et al (2018:42) explain that unsafe abortion can cause a spectrum of harmful complications in addition to mortality. Women may also suffer from feelings of guilt, hopelessness, and social stigmatisation.

As stated by the WHO (2019b:3-4), prevention of complications leads to reduced costs incurred in managing them and therefore advocates for SAC to reduce unsafe abortions. Complications resulting from unsafe abortions are more expensive for healthcare systems and the households in which women live and their countries' economies than providing safe abortions. Thus, in countries with high numbers of unsafe abortions, investing in comprehensive abortion services will likely decrease maternal mortality and reduce overall healthcare costs.

2.11 SUMMARY

This chapter covered the introduction, types of unsafe abortion, history of unsafe abortion, the extent of the unsafe abortion globally, factors contributing to unsafe abortion, barriers

to accessing safe abortion services, ethical perspectives of abortion, sustainable development goals versus abortion, the impact of unsafe abortion and finally, the complications of unsafe abortion.

The next chapter (Chapter 3) discusses the research design and method.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on research methodology and describes the paradigm, research design, population and sampling, data collection and analysis. Ethical considerations applied in the study are described as well as trustworthiness.

3.2 RESEARCH DESIGN

A research design is a plan that outlines how the study will be implemented to answer the research question. It provides specific direction for procedures in a research study (Creswell & Creswell 2018:11). In this study, a qualitative, descriptive, and exploratory research design was used to describe factors contributing to unsafe abortion in the Ngami sub-district.

3.2.1 Qualitative research approach

The qualitative research approach is a systematic process that is subjective, interactive, and commonly used to describe, explore, and promote human experiences and situations or contexts of the people involved (Gray et al 2016:25).

In this study, descriptive phenomenology was used, which involved the careful description of ordinary conscious experiences of everyday life, including hearing, seeing, believing, feeling, remembering, deciding, evaluating, and acting as stated by the author. The descriptive approach also explains contradictory issues such as unsafe abortion in real-life situations (Polit & Beck 2017:831-832). Thakur (2021:56) concurs that the descriptive method is theory-based and allows the researcher to present the problem statement to enable others to comprehend the need for this research. Therefore, the researcher adopted the descriptive approach because it occurs in the natural setting where human behaviour and events occur. The descriptive part of this study allowed the participants to

provide in-depth descriptions of their experiences of unsafe abortions and to discover the factors that contributed to their opting for unsafe abortions.

The researcher also used the exploratory approach to discover new ideas, gain new insights, and increase knowledge about unsafe abortions in the study context (George 2022:1). Creswell and Creswell (2018:104) suggest that exploratory research is often used to probe a topic when variables and theory bases are unknown. For example, unsafe abortion has to be explored because it has not been thoroughly examined in almost all districts in Botswana.

Unsafe abortion is also illegal in Botswana, hence the need to explore the ideas and measures to avert this procedure from participants. The researcher achieved this through interaction, joining the participants' world, and seeking the participants' perspectives and meanings of the phenomenon under study.

All these characteristics make these qualitative research designs the most appropriate research methods for the phenomenon under study that can yield or answer the research questions.

3.3 RESEARCH METHOD

Research methods are strategies or procedures for conducting studies that range from general hypotheses to specific techniques for gathering, analysing, and interpreting data. They are used to collect data or examine evidence to learn new facts or gain a more profound knowledge of a topic (Creswell & Creswell 2018:3). In this study, the researcher adopted the qualitative research approach and used the semi-structured, face-to-face interview data collection technique.

3.3.1 Research setting

There is only one site in the sub-district where study participants could be found or recruited. Therefore, there was no need for a selection criterion for the site of the study. The study was conducted in a public hospital's gynaecological ward in the Ngami sub-district, located in the northern part of Botswana. The public hospital offers preventative and curative services to the community in the sub-district.

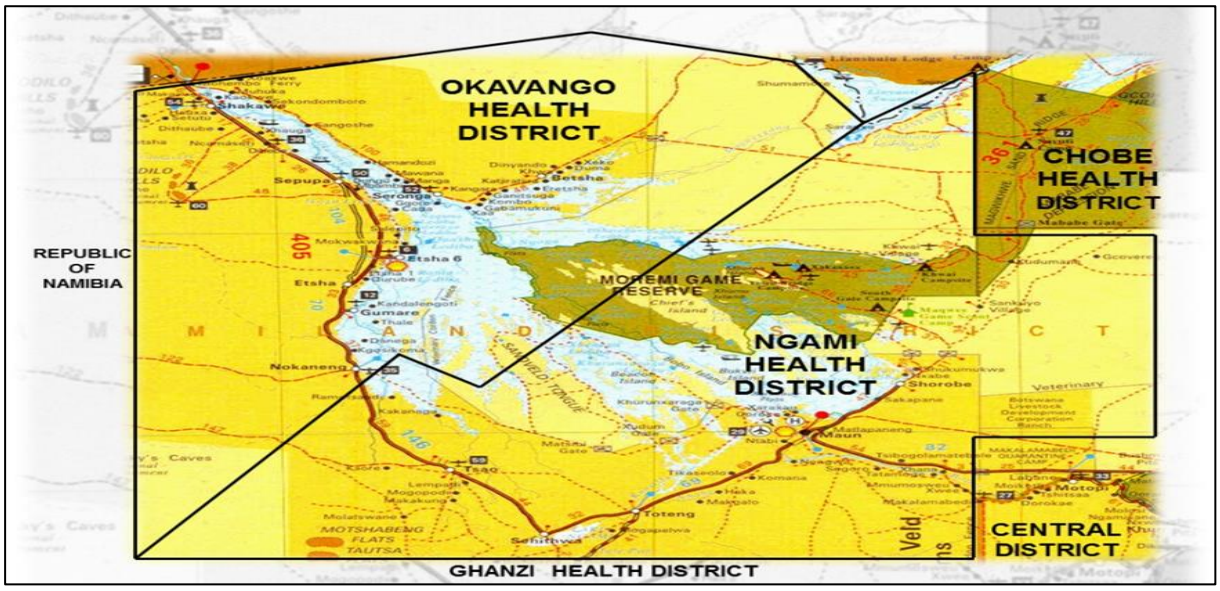


Figure 3.1 Research setting map

(Ngami District AIDS Coordinator's (DAC) Office 2017)

The above map, Figure 3.1, illustrates the research setting Ngami sub-district, which has a geographic area of 86,400 km², which includes the urban area of Maun and 17 surrounding villages.

According to the Ngami District AIDS Coordinator's (DAC) Office's (2017) report, the total population of the Ngami sub-district is 90 334, with 65 693 (73%) of the people residing in the urban area of Maun, where the public hospital is. This diverse population includes the Batswana, Bayer, Bambukushu, Baherero, and Basarwa. Service providers face unique challenges as each tribe has culturally different practices.

Service delivery is also affected by the varying languages spoken in the district. Setswana and English are the second and third languages of most people. Referring to the community resources of the profile, clients have access to two hospitals, one public and one private in Maun, 10 clinics, five with maternity wards, 19 health posts, and 76 mobile stops visited monthly (Republic of Botswana 2017:1-2).

3.3.2 Sampling

Sampling procedure refers to choosing a sample from a population (Shukla 2020:7). Sampling is discussed under the following headings: population, sampling procedure, ethics of sampling, including ethical principles, sample and sample size, respectively.

3.3.2.1 Research population

The population is the set or group of all the units to whom the research findings are applied. It comprises every unit that can be used to apply research findings. In other words, a population is a collection of all the teams that share the variable characteristic that is being studied and for which research findings can be generalised (Shukla 2020:2). For this research, the study population included women of all ages below and above 18 years who resided in the Ngami sub-district and were admitted to the gynaecological ward for unsafe abortions during the data collection period from June 2021 to August 2021 and were willing to participate in the study.

The study included all types of abortions, including inevitable abortion, septic abortion, and incomplete abortion as a diagnosis upon admission (Mouri, Hall & Rupp 2022:2). Also, the criteria did not specify that this should be a first, second, or third abortion to be eligible for the study. This was done to avoid bias concerning the population.

3.3.2.2 Sampling procedure

As stated by Shukla (2020:7), a sampling procedure involves choosing a sample from a population. Depending on the goal of their research, researchers can choose from a variety of sampling techniques. A non-probability sampling technique was used to select a sample in this study. This technique of sample selection lacks a scientific foundation, so it increases the chances of selecting a biased sample. Most of the time, a sample like this does not accurately represent the characteristics of the entire population. In this approach, there is no predetermined or guaranteed likelihood that all units will be chosen for the sample. This method is classified as a non-probability sampling method for this reason. In a sample, participants are chosen in a subjective manner.

The researcher selected the participants in this study using a convenience sampling method. According to Polit and Beck (2017:516), convenience sampling is used when researchers need to have potential participants come forward and identify themselves to extract the most excellent possible information from a few cases in the sample. Saks and Allsop (2019:96) also state that it is an appropriate choice when the topic of the study is susceptible and involves risky or illegal behaviour. In convenience samples, participants more readily accessible to the researcher are more likely to be included.

To ensure that relevant participants are included in the study, only those participants who met the following criteria were selected:

Inclusion criteria

- Women admitted in the gynaecological ward aged below 18 years and above, within the childbearing reproductive age, currently have an unsafe abortion and are willing to participate in the study.

Exclusion criteria

- Women admitted in the gynaecological ward aged below 18 years and above, within the childbearing reproductive age, currently have an unsafe abortion and are unwilling to participate in the study.

3.3.2.3 Ethical issues related to sampling

The data collection process commenced after the researcher obtained ethical approval from the research ethics review committee of the South African Health Studies Research Ethics Committee (HSREC) at UNISA (Appendix 1). Permission was requested and granted from the Ministry of Health and Wellness Research Unit (Appendix 2a and Appendix 2b). Permission was also requested and granted from the Ngami District Health Management Team (Appendix 3a and Appendix 3b). On receipt of approval from these institutions, the researcher requested permission from the gynaecological ward unit manager to distribute information leaflets (Appendix 4) to women coming in for admission to the gynaecological ward for possible participation in the study.

Creswell and Creswell (2018:89, 92, 185) suggest that the researchers must first get permission from those in positions of power, such as gatekeepers, to access study sites and participants. Permission to conduct the study was therefore obtained from the district coordinator and the ward manager to access the study sites and eligible participants.

Ethical considerations occur at the three phases of participant selection, namely sampling, the principle of "fairness in distribution", invitation-negotiation on-boarding;

voluntary participation and absence of coercion; and lastly, choice of data access and storage.

The researcher needed to consider these research ethics to respect the privacy and anonymity of participants (Creswell & Creswell 2018:89-97). The researcher followed guidelines to assist with recognising, understanding, and resolving ethical issues that may arise throughout the research process. These guidelines also provided a framework to apply principles of ethical research so that research involving human participants can achieve its aims while protecting the safety, rights, welfare, and dignity of those involved. There are five ethical principles for research, namely autonomy and voluntary participation, beneficence and justice, confidentiality, and anonymity (Resnik 2018:81-84). The following ethical principles were adhered to during the sampling procedure:

3.3.2.3.1 Autonomy and voluntary participation

According to Resnik (2018:81-84), the first protective principle stems from the principle of respect for persons, also known as human dignity. According to the Belmont Report (1978), “an autonomous person is an individual capable of deliberating about personal goals” (Resnik 2018:27-28). Therefore, researchers should aim to protect research participants' autonomy while also ensuring full disclosure of factors surrounding the study.

In this study, to ensure participants have the autonomous right to self-determination, the researcher ensured that potential participants understood that they have the right to decide whether or not to participate in the research study voluntarily and that declining to participate will not affect their access to current or subsequent care in the healthcare facility or study site. Participants were offered an opportunity to ask the researcher questions and comprehend questions asked by the researcher. The researcher also informed the research participants that they may stop participating in the study at any time without fear of penalty with reference to the principle of autonomy (Resnik 2018:81-84).

As noted in the Belmont Report definition, not all individuals have the capacity to be autonomous concerning research participation. Therefore, for the purposes of this study, participants below the age of 18 had to sign the assent form in order to participate in the study. This is because of their individual developmental level and the requirement for

appointing a third-party guardian to allow their participation as they are vulnerable individuals. In this research, there was no coercion of potential participants into agreeing to participate in the study.

Coercion refers to threats of penalty, whether implied or explicit, if participants decline to participate or otherwise opt out of a study. No rewards were given to potential participants for agreeing to participate or for coercing them. Additionally, to uphold the aspect of respecting potential participants' self-determination, the researcher had to fully disclose information about the study and explain the voluntary nature of participation including the right to refuse without repercussion and possible benefits and risks related to study participation. This was also done to enable potential participants to make a truly informed decision on participation in the study (Resnik 2018:81-84).

3.3.2.3.2 Beneficence and justice

According to Resnik (2018:81-84), the second Belmont Report principle is the principle of beneficence. Beneficence refers to acting in a way that benefits others while promoting their welfare and safety. Nonmaleficence (do no harm) is also within the principle of beneficence. The beneficence principle includes two specific research aspects: (1) participants' right to freedom from harm and discomfort; and (2) participants' right to protection from exploitation.

The researcher analysed potential risks and benefits to research participants when seeking Institutional Review Board (IRB) approval and conducting a study. The risks involved in this study were of category 3, medium risk, meaning that direct humans were involved. However, the participants told their lived experiences freely, with the researcher listening while the participants narrated their experiences. The researcher assumed all answers were correct as they were their life experiences and did not judge them. The study could cause psychological discomfort as there is potential to trigger emotions from the past. In such instances, the researcher involved the district psychologist and counselling department.

During interviews, the researcher arranged for the clinical psychologist to be on standby, should the need for psychological or counselling and emotional therapy arise. Possible benefits for participation in the study were also stated in the minor assent form, parent or

guardian consent, and the information sheet. These included increased understanding of a medical condition, unsafe abortion, and satisfaction of helping others with similar issues. The researcher implemented specific protections discussed above to minimise all forms of discomfort and harm to align with the principle of beneficence. The researcher also protected participants from exploitation, that is, any information provided by participants through their study involvement was protected.

The other principle contained in the Belmont Report discussed by Resnik (2018:81-84) was the principle of justice, which pertains to participants' right to fair treatment and right to privacy. The selection of the types of participants desired for a research study was guided by the research questions and requirements or inclusion criteria so as not to exclude any group and to be as representative of the overall target population as possible. The selection of research participants was determined through the inclusion and exclusion criteria as outlined in the approved proposal document. Those who declined to participate in the study were treated fairly without any prejudice.

3.3.2.3.3 Confidentiality and anonymity

Resnik (2018:149-150) indicates that the right to privacy also falls under the Belmont Report's principle of justice. The researcher and the research assistant kept all shared information in their strictest confidence. Upholding the right to privacy involves procedures for anonymity or confidentiality. For participants' data to be completely anonymous, the researcher did not have the ability to connect the participant to their data since data collection tools were labelled with letters of the alphabet (pseudonyms were used in place of personal identifiers: participant A–I were used). Participants' confidentiality was assured through locking, including locking all paper-based records. These records are kept in a secure locker for a period of five years, and these records are only accessible to the research team. Computer-based records are only available to the research team involved in the study by using access privileges and passwords. All computer files and data from the study will be locked for a period of five years with passwords. The proposed study will adhere to the above principles throughout the study process. Participants were informed of the above efforts to maintain a trusting relationship.

During the recruitment process, the researcher made first contact with participants, and special precautions were taken to protect individuals during this preliminary data

collection stage. These protections generally apply to any data collection stage − from participant sampling and selection to data analysis and reporting. This study explicitly asked women to discuss some personal information about their unsafe abortion experiences. This therefore means that protecting the identities of the women who participate in this study was of paramount importance to the researcher hence the need to utilise the above measure to protect them.

At the beginning of each interview, the participants were informed about the study's objectives, and confidentiality was assured. Unsafe abortion, as discussed in the literature review chapter, is illegal and socially unacceptable in Botswana (Smith 2013:66). Therefore, the researcher anticipated challenges as participants may be afraid or uncomfortable discussing unsafe abortion for fear of victimisation or imprisonment.

3.3.2.4 Sample

A sample is the limited number of community members selected to participate in a study (Polit & Beck 2017:250). According to Saks and Allsop (2019:96), the sample size reflects those who were available at the moment, recruited from a homogeneous group of individuals. A sample should produce adequate data on the phenomena under study such that credible findings that allow generalisation of results can be made from the data. For this research, the study population included women aged below 18 years and above admitted to the gynaecological ward, within the childbearing reproductive age, currently having an unsafe abortion and willing to participate in the study during the data collection period from June 2021 to August 2021.

The researcher referred to data saturation in this study regarding sampling size. Data saturation, as described by Creswell and Creswell (2018:186), is a principle that states that data collection should stop when fresh insights or ideas are no longer disclosed. The saturation concept was employed to ensure that the data gathered was sufficient for concluding the phenomenon under investigation. The researcher interviewed each participant until data saturation was reached with the 12th participant.

3.3.2.5 Data collection

In this study, data was collected through the individual face-to-face semi-structured interview method from women who had unsafe abortions.

3.3.2.6 Development and testing of the data collection instrument

A pilot testing, as described by Creswell and Creswell (2018:154) and Lowe (2019:117-118), is one of the critical stages in a research project, defined as a small study to test research protocols, data collection instruments, sample recruitment strategies, and other research techniques in preparation for a more extensive examination. The purpose of pilot testing was to identify potential problem areas and deficiencies in the research instruments and protocols before implementation during the main study. It also helps the research team to become familiar with the procedures in the protocol and the study methods.

The researcher decided to conduct a minimum of four interviews initially. Still, due to the challenges encountered, only two interviews were conducted to determine the validity and reliability of the interview guide. These two participants met the inclusion criteria as those involved in the study. Their feedback, thoughts, and feelings about the interview questions were considered and integrated into the final version of the interview tool. This testing was essential to establish the content validity of the device, improve the question sequence, and assess the possible duration of the interview. The pilot interviews were not part of the main study during data analysis.

3.3.2.6.1 Findings of pilot testing

The time it took the researcher to explain the research project and obtain consent from the participants was about 10-15 minutes. Unsafe abortion is a sensitive topic, therefore, participants were not easily convinced that confidentiality would be maintained since they were audio recorded. This was overcome by explaining that the researcher and research assistant always adhere to university protocols and work ethics (Creswell & Creswell 2018:90). The participants were informed of all data collection devices and activities. A confidentiality agreement for the research assistant was also provided (Appendix 8). Only one research assistant was utilised throughout the study. The participants were advised to refrain from using names during interviews. The researcher contacted the supervisors regarding the language barrier issue to have the interview administered in English and

the native language, Setswana (Appendix 9a and Appendix 9b). The English version of the interview questions was translated into Setswana to obtain data from the study participants and to ensure their proper understanding of the contents.

The participants took about 40 minutes to complete the interview. The researcher had to probe more to get adequate and relevant answers. This pilot testing has demonstrated that the study protocol was feasible. The tool testing did not appear too disruptive to the ward routine and it did not significantly impact staff time since it was done in the afternoon and afterward rounds when most procedures were done. It was possible to recruit participants based on the study's inclusion criteria, although only a few were included. Verbal consent to record the interview was also obtained.

This tool testing has demonstrated the effectiveness of a pilot study in identifying flaws in the interview guide that, after appropriate amendments, could be utilised in the main study. It has also provided a better understanding of how to conduct the interview. In this case, the research assistants' presence during the discussion must be acknowledged, and the confidentiality agreement must be maintained. Barrow, Brannan and Khandhar (2022:2) elucidate that participants need to be reassured of confidentiality during the entire interview, and their possible withdrawal from the discussion guaranteed without prejudice. This pilot testing revealed crucial information: it will not be easy to recruit participants for the study.

3.3.2.7 Characteristics of the data collection instrument

In this study, the researcher prepared a written interview guide or tool (Appendix 9a and Appendix 9b) using research objectives as guidelines to formulate relevant questions. The registered data collection tool ensured that data was collected systematically without leaving important information. This data collection tool is comprised of two sections. Section A deployed questions related to participants' demographic data; these questions assisted in the analysis of the participant's vulnerability. Durdella (2019b:7-43) states that participants' identities and backgrounds are explored through these background and demographic questions. These are usually direct questions, and they can cover conventional identifying categories like ethnicity or race, gender, age, and education.

Section B has one main open-ended question followed by probing questions to get to the study's objectives. The open-ended questions in the interview ensured that more information was yielded since participants had the opportunity to describe their experiences and factors contributing to unsafe abortions. The interview tool was used consistently in all interviews. According to a study by Weller, Vickers, Bernard, Blackburn, Borgatti, Gravlee and Johnson (2018:1-18) on open-ended interview questions and saturation, open-ended questions lead to the most valuable feedback and rich insights. The other benefit is that an open-ended question may receive a response that addresses something the researcher had not thought of before, which is a significant benefit of qualitative research.

Furthermore, Weller et al (2018:2) describe probing as asking follow-up questions when one does not fully understand a response, when answers are vague or ambiguous, or when one wants to obtain more specific or in-depth information. When used appropriately, probing ensures the interview stays on topic, allows the participants to speak, asks relevant follow-up questions, and stops. Probing questions help keep the interview on track while allowing the participant to think in a different direction. Example of probing question used; "could you explain your response more?" (used when asking for an explanation). Therefore, the researcher chose both the use of open-ended questions and probing in the data collection tool to gain more insight into unsafe abortion experiences by women in the Ngami sub-district.

Field notes were used to capture the behaviour and activities of individuals at the research site (Creswell & Creswell 2018:186-187). These notes helped the researcher to reveal the events or activities that took place during the entire interview. The researcher asked general questions and made observations, allowing participants to speak freely or provide their views. This study's field notes captured the setting, the researcher's ideas and concerns, and the participants' emotions and actions. In addition to taking handwritten notes, audiotaping was also used in data collection. All audiotapes were transcribed verbatim after each interview.

During the data collection, the researcher conducted 12 personal interviews with women who had unsafe abortions and were admitted to a gynaecological ward. Data collected during the interviews are at the centre of this study and provide an opportunity to learn about what one cannot see and to explore alternative explanations of what one does see.

Therefore, the open-ended questions allowed the participants to interpret and respond in their way.

3.3.2.8 The data collection approach, method, and process

Creswell and Creswell (2017:190-191) indicate that the researcher chooses the face-to-face semi-structured interviews since they are not intimidating and allow the participants to express their opinions freely without pressure from the interviewer. Qualitative semi-structured interviews generally contain a few open-ended questions that intend to elicit views, opinions, and experiences from the participants in a non-judgmental way (Creswell & Creswell 2018:187). Face-to-face semi-structured interviews are preferred because the researcher intends to collect in-depth, authentic information about factors contributing to unsafe abortion among women in the Ngami sub-district.

The face-to-face semi-structured interviews provide detailed information on the research topic, and participants can be relaxed and feel more comfortable about the phenomenon under study than answering a questionnaire. The face-to-face semi-structured interviews also allow the researcher control over the line of questioning. The limitations of face-to-face interviews are that the researcher's presence may cause bias in the participants' responses. This may restrict the amount of information gathered from specific participants (Creswell & Creswell 2018:188).

In this study, data collection was conducted in a private room in the gynaecological ward allocated by the ward manager to ensure privacy and anonymity of participants. All the interviews were conducted in the same room. The interviews were conducted after the ward patient rounds, at 2 pm, and during weekends, to avoid inconveniencing ward routines. The researcher checked on potential participants daily, and those who wanted to participate in the study notified the ward staff and the researcher of their interest in participating, using the contact details provided. The researcher then arranged an appointment to meet with the participants after self-identification. The research assistants' presence during the interview was always acknowledged and the confidentiality agreement kept at hand all the time. The research assistants' main duties were to record the interviews and write participants' responses to questions in the interview tool. He also assisted maintaining the Covid 19 principles by constantly sanitising the participant and

the researcher. During the data analysis process the research assistant assisted in data coding and data entry.

The researcher ensured that once a participant had identified themselves, the psychologist was informed and readily available for pre- and post-counselling for eligible participants. Resnik (2018:171) asserts that the researchers should ensure that participants who suffer discomfort may access counselling services for studies which ask participants about unpleasant experiences they have experienced, hence the involvement of the psychological services in this study. During the interviews, the researcher continued to explain the contents of the consent form and that the participants may decide to stop the discussion should they feel so at any time.

In addition to the individual semi-structured face-to-face interviews, which were 40 minutes long, the researcher took field notes during the session.

Data collection was done over three months, from June to August 2021. In this study, the data collection process was based on the concept that women's voices should be appreciated and heard on multiple levels. On subsequent ward visits, the researcher would meet with the potential participants to discuss the study and answer related questions. In addition, the researcher spoke about the interview guide (Appendix 9a and Appendix 9b), minor assent forms, parent consent forms (Appendix 7), consent forms (Appendix 6), and the setting of appointments for interviews.

Rutakumwa, Mugisha, Bernays, Kabunga, Tumwekwase, Mbonye and Seeley's (2020:567) study on conducting in-depth interviews with and without voice recorders, illustrated that the researcher needs to ask for permission to audio-record the interview from the participant and reiterated that all confidentiality would be protected, as described in the guide and consent form during each interview. Consent forms (Appendix 6) were signed by the researcher and the participants, with the senior nurse on duty as the witness. For confidentiality purposes, consent forms were kept separate from all paper-based documents. Participants could choose to use their native language, Setswana or English during interviews. The participants' and the research team's cell phones were muted throughout the discussions. The research assistants also helped take notes as the participants answered the questions. After the interviews, the researcher listened to the recordings, transcribed them, and translated them into English.

As this was conducted during the coronavirus pandemic, all COVID-19 protocols were observed during and post interviews. Specific measures were applied during the face-to-face interviews to prevent the spread of diseases as outlined by the WHO (2019a:1-3), for example, using PPE and disinfectants on surfaces and keeping a social distance of 1.5 meters. The researcher and the participants had to adhere to COVID-19 protocols outlined by WHO which affected the interview length, audibility, and clarity.

A basic procedure was followed during all the interviews. The researcher started by recording the interview date and labelling the interview tool and the audio recording (e.g., Participant A). Then the researcher introduced herself and discussed the purpose of the study, the general structure of the interview and that it should take less than an hour to complete. The researcher also allowed the participants to ask questions before beginning the interview. Signing the consent form meant the participant voluntarily wanted to participate in the research. Still, they had the right to refuse participation or any question and withdraw at any time without any consequence whatsoever. It also permitted the researcher to use the participants' information in making conclusions about the research topic, audio tape and taking notes during the interview (Creswell & Creswell 2018:93, 191).

The interviewer or researcher defined "unsafe abortion" to the participants to gain a shared understanding before the interviews. After this short introduction, the researcher established rapport to put the interviewee at ease. The researcher included a welcome in the pre-interview phases of an interview session.

The researcher emphasised the benefits of involvement in the study with gatekeepers and participants and stated that no incentives would be provided during recruitment (Creswell & Creswell 2018: 93). The researcher also had the chance to reply to what the participants had to say empathetically, conveying concern and interest in what they had to say. In this interview context, active listening mattered a lot to women, and nonverbal communication played a role in interview dynamics. Openness also involved a non-judgmental approach in which the researcher communicated care for what they had to say and stood in support of what they shared. Sufficient rapport building assisted the researcher in making participants naturally inclined to opening up and sharing sensitive information.

The researcher then proceeded to collect the demographic information of the participant, followed by the central question and sub-questions to understand the phenomenon under study — unsafe abortion.

Whenever the interview questions were completed, and the session was winding down, the researcher had one more chance to close the discussion with a brief wrap-up statement, a final open-ended general question, and a quick reminder of human participant protections. Finally, the researcher provided the participants with a chance to ask any questions that they might have about the interview. Cell phone numbers were also collected in case of a follow-up interview or member checking and feedback. Data saturation was reached with the 12th participant.

Follow-up conversations with some participants helped the researcher fully understand and confirm ideas that emerged in the interviews. These follow-up member checks were typically conversations during data collection (Carl & Ravitch 2018:1050). Following the member check, the researcher included all edits and changes requested by the participants. Only five participants provided member check feedback.

Concerning documenting responses and reflections in interviews, the researcher decided to use audio recorders as they are an efficient and effective way to capture what interviewees say in an interview. Two mobile devices with apps were used − primary and backup − just in case one failed to function. The researcher also recorded vital phrases or text from interviews, leading to more insightful descriptions of patterns and reflections on experiences during the discussion, by taking notes.

Simultaneously, the researcher began with transcription, data analysis, and interpreting findings from interviews.

3.3.2.9 Ethical considerations related to data collection

The primary aim of collecting qualitative data is to provide materials for an empirical analysis of a phenomenon that a study is about. Due to the personal nature of qualitative data collection, when qualitative methods are applied, complex ethical considerations are brought to the surface as they expose researchers to the complexity of cultural norms,

beliefs, values, and actions (Mertens 2018:34). In this sensitive study, the following ethical principles were adhered to during the data collection process:

Consent to participate was obtained voluntarily. Creswell and Creswell (2018:93) suggest that consent from participants should be continuously obtained during the whole study. Instead of making participants sign an informed consent form under coercion, the researcher should stress in the consent form's instructions that participation in the study is entirely voluntary and that participants are free to withdraw at any time. Before the interviews, the research assistant's role was to help participants to sign consent forms and to keep them away from other data collection tools to preserve confidentiality. The research assistants' presence during each interview was always acknowledged and the confidentiality agreement kept at hand all the time. The research assistants' main duties were also to record the interviews and write participants' responses to questions in the interview tool. He also assisted maintaining the Covid 19 principles by constantly sanitising the participant and the researcher.

In this study, participants were not subjected to any physical harm. Only two participants were referred to the psychologist for counselling due to the psychological discomfort they had due to reliving the unsafe abortion process during the interview. COVID-19 pandemic preventative measures were also considered to ensure continuous mitigation of potential harm to participants.

The direct benefits of participating in the study were discussed with potential participants. The participants were informed that the final research product or findings would be disseminated to the Ministry of Health and Wellness, UNISA, participants, colleagues or workmates, community-based organisations, and other programme officers aspiring to further research women's health. This study was solely for academic purposes; therefore, the research had no conflict of interest. Creswell and Creswell (2018:87-97) mention that the researcher should identify a research problem that would be beneficial to the participants and meaningful for others besides the researcher. There were no direct benefits or compensation offered to participants as individuals.

As stated by Durdella (2019a:261), when analysing data, the researcher should report multiple perspectives, including contrary findings, respect the privacy and anonymity of

participants, and provide copies of the research report to participants and stakeholders, including other researchers. The researcher also discloses the funders for the research and who will profit from the study. In this instance, the researcher is self-funding. Finally, the researcher demonstrated complete proof of compliance with ethical issues and a lack of conflict of interest when publishing the research findings.

The contact details of the researcher, the supervisor, and the co-supervisor were shared with the participants in case they needed further clarification on the study. The participants were always thanked for their time and contribution to the research project.

The researcher also safeguarded the participants, built their trust, upheld the integrity of the research and also prevented misconduct and improper behaviour that could reflect poorly on UNISA and the hospital.

3.3.3 Data analysis

Saldana (2018:1707) states that, in qualitative research, data analysis should begin as soon as the data is obtained and continue as long as there are any significant questions regarding the data's interpretation and implications.

In this study, the researcher was the one who conducted the interview, and also transcribed the recordings. This is because the researcher was intimately aware of the field site surroundings and had selective recollections of the casual encounter, resulting in a potentially faster transcription process and a more accurate record. To improve understanding, the researcher used Microsoft Excel to summarise the thoughts of each interviewee according to each interview question during the data analysis phase. Audiotapes were transcribed verbatim by hand. After that, all transcriptions and notes were categorised into themes and sub-themes. Themes are representations of the participants' narratives, displaying their perceptions and experiences that the researcher perceives as answers to the study question, and are identified through the coding procedure. These themes appear as significant study findings and are utilised as headings in the findings section. Themes represent participants' viewpoints, frequently backed by specific evidence from past studies (Creswell & Creswell 2018:194).
The stage of data analysis at this point is stage 1, where the researcher organized and prepared the data for analysis. It involves transcribing interviews, scanning materials,

typing field notes, sorting and arranging data depending on the sources of data (Creswell & Creswell 2018:193). In order to confirm that the data accurately reflect the information that the participants provided and that any interpretations of the data were not created by the researcher, an external coder was utilized. This was also done to accurately reflect the participants' voices and conditions of the study, instead of the researcher's biases, motives, or opinions.

In this study, qualitative content analysis, as described by Creswell and Creswell (2014:245-251) was used. Content analysis refers to categorising verbal or behavioural data to classify, summarise, and tabulate the data. The study of the data collected was done using thematic analysis. Emerging themes from the discussions by the participants were drawn and used to build substantial arguments toward answering the research question. Data were analysed through the five stages of qualitative data analysis, namely arranging, organising, coding data to form themes for data collection and validation. Finally, the researcher completed the analysis process or writing a report. Content analysis was used to analyse responses from interviewees (Creswell & Creswell 2017:236).

3.4 TRUSTWORTHINESS

Demetri and Ravitch (2018:1729) define trustworthiness as a general idea used in qualitative research to describe the steps researchers take to guarantee a study's quality, rigour, credibility, and investigation. Trustworthiness is relevant to educational research, measurement, and evaluation since the associated procedures are vital tasks that qualitative researchers must respond to.

Trustworthiness was accomplished by using the strategies outlined by Lincoln and Guba (1985:290-296), namely credibility, transferability, dependability, and conformability.

3.4.1 Credibility

This refers to confidence in the truth of the data and their interpretations. Qualitative researchers must strive to establish trust in the validity of the findings for the participants and contexts of the research (Polit & Beck 2017:982). In this study, member checks happened informally during data collection, for example, during an interview to ensure

understanding and formally during a follow-up interview or meeting. Credibility was also established as participants could confirm and validate their responses. Credibility was further enhanced by conducting repeated interviews until data saturation was reached. All participants were interviewed using the same questions and their responses were recorded accurately. Audiotapes and transcriptions were kept safe for adequate referral should the need arise.

3.4.2 Transferability

It refers to the potential for extrapolation - the extent to which findings can be transferred or have applicability in other settings or groups (Polit & Beck 2017:983). The protocols undertaken for this study were clearly defined to be reproducible. The researcher used a thick description to show that the study's findings apply to other contexts, circumstances, and situations. The researcher described the study setting and the context in which the research was conducted so that the readers or other researchers could gain enough information to judge the applicability of the findings to different settings.

3.4.3 Dependability

This refers to the stability or reliability of data over time and conditions (Polit & Beck 2017:982). In this study, the research records will be kept for five years and available for use by other researchers to ensure the dependability of the research findings. By keeping copies of the research process, tape recorders, transcribed data, and reports containing collected information, the researcher improved the dependability of this study. The study's methodology was also described in great detail by the researcher.

For the purpose of acknowledging and temporarily suspending the researcher's opinions and biases on unsafe abortion while doing qualitative analysis on this subject, bracketing was used to improve dependability of the study. In qualitative research, bracketing is a technique intended to mitigate the potentially harmful impacts of preconceptions that could taint the research process. It is a process of identifying and holding preconceived beliefs and opinions about a phenomenon under study. To maintain bracketing, the researcher kept a reflexive journal containing 10 tips by Ahern. These tips included making note of interests, clarifying personal values, identifying areas of potential role conflict, recognizing gatekeepers' interest, and identifying any feelings that may indicate a lack of neutrality Ahern (1999:407-411).

3.4.4 Conformability

Polit and Beck (2017:983) define conformability as objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning. Conformability concerns establishing that the data represent the information participants provided and that the interpretations of those data are not invented by the inquirer. In this study, an audit trail was kept, including the raw data like interview transcripts, methodological notes, topic guides, and data reconstruction products like drafts of the final report, to allow other researchers to conclude the data in the future.

3.5 SUMMARY

This chapter has given an overview of the research design and methods of the study. It has also outlined the sampling procedure, data collection, and a detailed description of the analysis of the research findings in the study. The ethics of sampling and ethical consideration of the study were also discussed.

The next chapter analyses, presents and describes the research findings.

CHAPTER 4

ANALYSIS, PRESENTATION, AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The findings of the study are presented and discussed in this chapter. The research findings are supported by relevant literature from previous research studies. The participants' demographics are provided first, followed by a discussion of the three primary themes and sub-themes with pertinent quotes from participants.

4.2 DATA MANAGEMENT AND ANALYSIS

Face-to-face interviews were conducted and audiotaped in this study. The researcher took field notes throughout the discussions to generate meaning from the participants about the phenomenon of unsafe abortion. Data collection and analysis were carried out simultaneously. The research was carried out in Letsholathebe II Memorial Hospital in the Ngami sub-district, located in the north-western part of Botswana. The study sample included women of all ages below and above 18 years who were admitted to the gynaecological ward, had an unsafe abortion, and were willing to participate.

The sample size in this study was determined using the data saturation principle, which states that data collection should stop when fresh insights or ideas are no longer disclosed (Creswell & Creswell 2018:186). The saturation concept was employed to ensure that the data gathered was sufficient to respond to the study questions. The researcher interviewed each participant until data saturation was reached with the 12th participant.

To improve understanding, the researcher used Microsoft Excel to summarise the thoughts of each interviewee according to each interview question during the data analysis phase. Audiotapes were transcribed verbatim by hand. After that, all transcriptions and notes were categorised into themes and sub-themes. Themes are representations of the participant's narratives, displaying their perceptions and experiences that the researcher perceives as answers to the study question and are identified through the coding procedure. These themes appear as significant study findings and are utilised as headings in the study's findings section. Themes represent participants' viewpoints, frequently backed by specific evidence from past studies (Creswell & Creswell 2018:194). Comprehensive field notes were also attached to each interview transcript and incorporated with the verbatim quotes especially given the sensitive nature of the topic to enhance study findings.

Qualitative data analysis is a process that requires sequential steps to be followed, from the specific to the general, and involving multiple levels of analysis (Creswell & Creswell 2018:193-195):

Step 1: Organize and prepare the data for analysis. This involves transcribing interviews, optically scanning material, typing up field notes, and sorting and arranging the data into different types depending on the sources of information- audiotapes and field notes.

Step 2: Read or look at all the data. The researcher had to make a general sense of the information and also had an opportunity to reflect on its overall meaning. Questions the researcher wanted to answer included; what general ideas are the participants saying? what is the tone of the ideas? what is the impression of the overall depth, credibility, and use of information? The researcher wrote notes in margins of transcripts including additional information from observational field notes and started recording general thoughts about the data at this stage.

Step 3: Start coding of all data. Coding is the process of organizing the data by bracketing chunks (or text segments) and writing a word representing a category in the margins. It involves taking text data gathered during data collection, segmenting sentences (or paragraphs) into categories, and labelling those categories with a term (also in participant's language-*in vivo term*)-for example words coded were; complications, reasons, financial problems, *itsholelo, loso,* prevention, stress, boyfriend, the pill etc.

Step 4: Generate a description and themes. The researcher used the coding process to generate a description of the setting or people as well as categories or themes for analysis. Description involved a detailed rendering of information about participants, or events in a setting. The researcher generated codes for this description. This analysis was useful in designing detailed descriptions for narrative research project. The researcher used coding as well for generating a small number of themes or categories- 3 major themes and 17 subthemes for the study. These theme are the ones that appear as major findings in this qualitative studies and were used as headings in the findings section of this dissertation or thesis. They display a multiple perspective from participants and were supported by diverse quotations and specific evidence from literature. Themes were analysed for each participant or shaped into a general description (phenomenological approach).

Step 5: Representing the description and themes. Advance how the description and themes will be presented in the qualitative narrative. The approach used by the researcher was to use a narrative passage to convey the findings of the analysis. The researcher gave a detailed discussion of several themes, including subthemes, specific illustrations, multiple perspectives from participants, and quotations. The researcher also used figures, and tables as adjuncts to the discussions.

4.3 RESEARCH RESULTS

Three themes and 18 sub-themes emerged from the 12 interviews conducted, as previously mentioned.

The major themes are:

- Participants' reasons for unsafe abortions
- Effects of unsafe abortions
- Interventions to reduce unsafe abortions

The qualitative study findings were presented in this data analysis report using alternative writing techniques or ways of expressing and summarizing ideas. These include quotes from participants, either short or long embedded passages or sentences, comparison tables or figures, and the use of pronouns I, we, and they.

4.3.1 Sample characteristics

Table 4.1 Characteristics of study participants (N=12)

Characteristics of study participants	Number of participants (N-P)
Age	
16-20	03
21-30	04
31-40	05
Marital status	
Single	12
Level of education	
Secondary – BGCSE	06
Secondary – JCE	03
Tertiary – Brigade	02
Secondary – BGCSE (Schooling)	01
Employment status	
Employed	02
Unemployed	09
Self-employed	01
Number of abortions	
1st time	06
2nd time	05
>15th times	01

4.3.1.1 Age (N=12)

Twelve participants presented with an age range of 16 to 37. The majority of the participants – seven – were of reproductive age, with three teenagers and two young adults among them. This finding indicates that 83.3% of the study's participants are highly likely to perform unsafe abortions. According to the participants, this is due to child spacing, schooling, and a lack of financial resources.

This finding is consistent with that of Singh et al (2018:1), highlighting that unintended pregnancies occur mainly at 15-44 years of age. According to Yogi et al's (2018:1) study, unsafe abortion is greater among women aged 25-34 years, followed by those aged 15-24 years. Child spacing, the stigma linked to abortion norms, early marriages, and a lack of financial resources to care for the child are all factors leading to unsafe abortion practices.

4.3.1.2 Marital status

According to the findings of this study, women choose unsafe abortions when facing breakups with partners, are unwilling to go through single parenthood, and are sexually active. In this study, all women are unmarried and face a significant risk of unintended pregnancy and unsafe abortion.

Similar findings were shared by Loi, Lindgren, Faxelid, Oguttu, and Klingberg-Allvin (2018:9-12) in their study on decision-making preceding induced abortion: a qualitative study of women's experiences in Kisumu, Kenya. The findings indicate that single women were afraid to raise a child alone, hence the need for unsafe abortion.

Bankole, Remez, Owolabi, Philbin and Williams' (2020:32) report on unsafe to safe abortion in Sub-Saharan Africa, slow but steady progress — executive summary, concurs that cultural expectation that childbearing occurs within marriage increases the rate of unsafe abortion. 4.3.1.3 Level of education (N=12)

Most of the participants had low-level educational backgrounds, with junior secondary students accounting for three (n=3), Botswana General Certificate of Secondary Examination (BGCSE) students for six (n=6), tertiary graduates for two (n=2), and schooling for one (n=1).

This suggests that the women in this study are most vulnerable to unsafe abortion practices because of their low levels of education and probably higher levels of poverty, which is in line with previous research. For example, Khatri, Poudel and Ghimire's (2019:11) study on pooled analysis of the factors associated with unsafe abortion practices in Nepal between 2011 and 2016 revealed that in low and middle-income countries, unsafe abortion is more common among lower-educated and lower-income women. Yokoe et al's (2019:4) study on unsafe abortion and abortion-related deaths among 1.8 million women in India corroborates that in India, education is inversely associated with abortion. Women with no education were 48% more likely to have an unsafe abortion than women with tertiary schooling. The study found a higher prevalence of unsafe abortions among uneducated women.

4.3.1.4 Employment status (N=12)

Two (n=2) participants were employed, one (n=1) was self-employed, and eight (n=8) were unemployed, including one (n=1) student. Because they wish to limit their family size and avoid difficulties raising children, women with low socio-economic status or financial fragility owing to unemployment are forced to opt for unsafe abortions. Yokoe et al (2019:5-7) corroborate this finding that financial barriers could be a factor in the choice of unsafe abortion. Unsafe abortion practices were higher in women with the lowest wealth status than in wealthy women. It was revealed that safe abortion is a privilege of the rich, while the poor resort to unsafe practices.

4.3.1.5 Frequency of abortions (N=12)

The majority of the participants, six (n=6), reported that abortion was done for the first time, whereas five (n=5) did it more than once, with one participant (n=1) reporting having done unsafe abortion more than 15 (n=>15) times in her lifetime. When women face unintended pregnancies, they may resort to numerous unsafe abortions to maintain their desired family size. As the desire for a smaller family grows, so does the demand for modern, effective contraception to restrict and space pregnancies and eliminate the need for unsafe abortions (Bankole et al 2020:20).

4.4 DISCUSSION OF THEMES AND SUB-THEMES

Unsafe abortion is a sensitive topic, as discussed in the literature review chapter, and therefore the researcher had to protect the participants' identities. Chamberlain and Hodgetts (2018:8-9) concur that if people in the participants' work environment, community, or family identify them, participating in a research project can have a variety of undesirable effects. The best way to keep them safe is to keep their identities confidential. To guarantee anonymity, care must be taken to identify all participants in all of the acquired data using a set of symbols or pseudonyms.

In this study, each participant was assigned a code, Participant A–L, abbreviated as P-A and so on in the discussion section, to maintain participants’ anonymity throughout the study.

Table 4.2 Major themes and sub-themes

Themes		Sub-themes	
1	Reasons for unsafe abortions	1.1	Family values and women's lack of autonomy
		1.2	Family planning issues
		1.3	Perceived lack of options
		1.4	Political standpoint and human rights aspect
		1.5	Economic reasons
		1.6	Unstable relationships
		1.7	Desire to continue with studies
2	Effects of unsafe abortions	2.1	Excessive bleeding and death
		2.2	Infertility
		2.3	Predisposing factor for cervical cancer
		2.4	Psychological trauma or depression
3	Interventions towards the reduction of unsafe abortions	3.1	Psycho-social counselling on sexual reproductive health
		3.2	Strengthening provision of youth-friendly services
		3.3	Intensify protection for young girls who grow-up without parents or guardians
		3.4	Women's economic empowerment
		3.5	Government should legalise abortion
		3.6	Abstinence

4.4.1 Theme 1: Reasons for unsafe abortion

Several factors have been discovered that predispose women in the Ngami sub-district to unsafe abortions. Although each woman might have a specific driving reason, they all point towards some form of commonality. Therefore, these factors have been grouped into the following sub-themes as follows:

4.4.1.1 Sub-theme 1.1: Family values and women's lack of autonomy

Families have values and principles that the children must follow. Participants reported that they are afraid of their parents and even their male brothers being furious. These principles also demand that young women not become pregnant in an unstable relationship or before marriage.

One of the participants reveals this when she says:

> "Firstly, sometimes it is because of family. Most of the time, if we can go to parents, they will feel I am still young to fall pregnant and have brought down the family dignity". (P-A).

She continues to say,

> “When my brother brought me some items here, he started slashing me with words. I had his messages and deleted them. He was telling me how fearless I was. I am not afraid of them. I have a two-year-old baby. He said they are taking care of the baby, and they can’t be burdened with my other child and all that stuff. Even now, I was talking to the old woman, and I asked where Mothusi was my brother, and she said he was there, and when he heard that I was at Letsholathebe, he said, I must not have terminated the pregnancy again.” (P-A).

When young women learn they are pregnant, their family values influence their decisions. They believe they have wronged the family and will be shunned or stigmatised negatively by their own families. A participant reveals this when she says,

> “The real problem, to me, is parents, family. I have a rigorous family, both on my mother’s and father’s sides … They are very strict, especially with my elder brother. They think they are so protective of us; they are very strict. They will be telling you; that you are not working; you just stay home. What will you eat? What will you feed your kid? When you don’t work, what are your life plans? Instead of going to school, you will be home and getting pregnant. These are just words that are not good as they did when I had my first child. That is why I had to do this.” (P-D).

This implies that when it comes to abortion, women lack autonomy. These young women's decisions are primarily impacted by their family values and relatives. Frederico et al’s (2018:8-13) study on factors influencing abortion decision-making processes among young women concur that women’s lack of autonomy to make their own decisions regarding the termination of an unintended pregnancy can be a barrier to safe abortion care and renders them vulnerable. This lack of independence in abortion decision-making is linked to power and gender inequality, which directly affects reproductive health issues. The freedom of a woman to say "no" to her partner if she does not want to have sexual intercourse, as opposed to decisions made "by the husband or wife alone" on contraception use, is perfectly linked with the concept of sexual autonomy.

This finding is consistent with the Atakro et al’s (2019:1) study in Ghana, on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region. The study indicated that many pregnant young women want to maintain peace and good relationships with their family members or guardians by

terminating unintended pregnancies. Furthermore, women's fear of being judged or shamed does not only lead to unsafe abortions, but reduces women's access to safe abortion care (SAC) (Singh et al 2018:42). Bankole et al (2020:20) concur that the other reason women cited as the reason for unsafe abortion was associated with fearing their parents' adverse reaction to the unintended pregnancy.

4.4.1.2 Sub-theme 1.2: Family planning challenges

The primary cause of unsafe abortion, according to this study, is a potential contraceptive failure, which results in an unintended pregnancy. Inability to meet the contraceptive needs of all women at risk of unintended pregnancies and contraceptive failure is associated with an increase in unsafe abortions (Atakro et al 2019:14).

According to the findings of this study, women have access to family planning services where they can obtain various contraceptives such as Depo Provera injections, implants, and condoms. Some methods have failed because they are not entirely practical and not a hundred per cent effective. Participants who utilised the implant method said they had to remove it since it interfered with their menstrual cycle. Some of the participants became pregnant due to these contraceptive failures, and because they did not want the pregnancies, they decided to terminate them in unsafe ways.

Women in the Ngami sub-district have stated that one method to solve the issue of unsafe abortions is to recognise the difficulties that women have faced when using contraceptives. The participants also showed a lack of knowledge of contraceptive side effects.

When asked about the use of the family planning method as a way to prevent unwanted pregnancy, participants shared the following:

> "For me, I was using an implant, which I had removed in April this year when I was sick. I would have prolonged periods, and it would even double in a month. That is why I cannot use it anymore." (P-A).

> "Those things I was using before, I once used them, and for me to stop using them this year, March on the 19th, I inserted a loop, and I removed it because it was not

> treating me well. I would have prolonged periods or go without my periods for almost three months; then, I opted to remove them. Then I fell pregnant after removing it." (P-D).
>
> "Prevention methods are not hundred percent, so when someone falls pregnant while using the contraceptives, you must see what to do, because for sure the reason for prevention is that they don't want to fall pregnant, but when one falls pregnant while on those methods, you must see how to help that person to terminate the pregnancy because she was not ready, it was an unplanned pregnancy." (P-G).

The above statements show a lack of knowledge of how family planning methods work. Women need to make informed decisions regarding these methods based on the education or expertise they get from service providers. Education is also a crucial nursing intervention. Education can provide anticipatory guidance regarding method failure and side effects of family planning methods and reduce anxiety about the possibility of an unplanned pregnancy (Behulu, Fenta & Aynalem 2019:1). Munakampe et al (2018:2-4) found similar results in their studies in Sub-Saharan Africa (SSA), that unsafe abortions are mainly due to failure to prevent unwanted pregnancies due to severe limitations in access to safe and effective methods of contraception and securing abortion services among childbearing age women. The unmet need for effective pregnancy preventative measures results in the highest burden of unsafe abortions, 57% among young women, especially in SSA.

Singh et al (2018:13) corroborate that low satisfaction with available contraceptives and limited access to high-quality contraceptive services lead to ineffective contraceptives or no use. This increases the risk of unintended pregnancies and, consequently, unsafe abortions. The significant contributors to unintended pregnancies and possible unsafe abortions in Nepal are the lower contraceptive prevalence rate and the higher unmet need for family planning. In addition, women tend to use unsafe abortion practices to prevent child spacing and delay childbirth due to poor access to and utilisation of family planning services (Khatri et al 2019:2).

The family planning issues go further to include child spacing. Participants in this study disclosed that they were forced to have unsafe abortions since their babies were still too young to have siblings, and the only option was to abort the pregnancy. When asked

about the use of unsafe abortion as a way to prevent unwanted pregnancy as opposed to available family planning methods, participants shared the following:

> "I was not ready for another baby." (P-G).

> "My baby is still young, two years old, and I am not working." (P-K).

Similar findings were revealed by Yogi et al (2018:8-10) from a study in Nepal that found child spacing is the main reason women opt for unsafe abortion. A higher prevalence of unsafe abortions was reported among women in the younger age group and illiterate women. Bankole et al (2020:20) concur that the desire to have small families has increased worldwide. To achieve small families, women need modern, effective contraceptives to limit and space their pregnancies. If this does not occur, unintended pregnancies become rife and are mostly resolved through unsafe abortions.

Loi et al (2018:2) confirm that sometimes contraceptives are underutilised due to their limited availability and the social stigma surrounding young women's contraceptive use. These contraceptives play a significant role in preventing unintended pregnancies and child spacing. Therefore, modern contraceptives can be utilised as a preventative strategy to avoid unsafe abortion practices in communities.

The other option women in the risky age of terminating pregnancies should consider is abstinence. Participants have indicated that abstaining means that you can stay free from falling pregnant, which one will later regret.

> "For one not to fall pregnant, it would require them to use protection with a condom, use contraceptives, or abstain totally." (P-D).

The researcher was surprised since it did not attach an age restriction like in other studies that maintained that sexual intercourse must be delayed until a mature age and children be born after marriage (Atakro et al 2019:6-7; Yokoe et al 2019:7).

4.4.1.3 Sub-theme 1.3: Perceived lack of options

When faced with an unintended pregnancy, women can panic and perceive an unsafe abortion as the only available option. When asked why she had an unsafe abortion, she said,

> "I panicked at first because I had not planned anything. I was scared, asking myself what I would do; was I fit to be a parent given my status? Then I decided. I realised that I was not fit enough, and I had not agreed with the partner that we could have a baby or anything." (P-D).

Loi et al's (2018:7) study reveals that women sometimes terminate the pregnancy without notifying their partners due to the fear of the possible consequences, disagreement, or abandonment. Atakro et al's (2019:5) study also verified that non-readiness to cater for a baby could be a reason for unsafe abortion. Bankole et al (2020:20) corroborate that unsafe abortion can be the only available option when a woman is not ready to be a mother. Furthermore, the woman can decide not to inform the partner about the pregnancy or even the abortion decision for fear that he would not support such a decision.

4.4.1.4 Sub-theme 1.4: Political standpoint and human rights aspect

One of the participants in this study criticised the illegality of abortion in Botswana for contributing to unsafe abortion practices. This supports the United Nations Human Rights Office of the Commissioner's (2020) findings that patriarchal oppression, restrictions, and bans on abortion deny women full access to reproductive and sexual health-based services as a fundamental human right, escalating unsafe abortion numbers worldwide. When one of the participants was asked what she thought might be done differently to prevent unsafe abortions, she said:

> "The thing is, in Botswana, abortion is illegal. Would it be better if it was legalised based on personal reasons? All these illicit abortions would not be happening. Because not all of us use the pills, some use traditional medicines because they are scared to buy the drugs. That would be better if reasons why so and so wants to have an abortion." (P-A).

As stated in the literature review chapter, Botswana belongs to a group of countries that allow abortion under specific circumstances. One of the participants said that safe abortion treatment should be available when a woman requires it or has compelling reasons for doing it. That the government should make a provision for the woman's reasons and terminate the unintended pregnancy. She expressed the following:

> "I think the government must consider women's reasons for wanting to terminate it." (P-G).

She also said,

> "At least when someone comes within a month, a woman must be provided with an abortion in the clinics."

The Human Rights Committee has confirmed that states have adopted measures to restrict the voluntary termination of unplanned pregnancies. Still, such actions should not impede a woman's right to life (of a pregnant girl or woman) or other rights under the covenant. Therefore, preventing unsafe abortions remains a core obligation of the state to fulfil the request for girls' and women's sexual and reproductive health (United Nations Human Rights Office of the Commissioner 2020). Denying women access to SAC also violates the right to health, privacy, and the right to be free from cruel, inhumane, and degrading treatment (WHO 2021). The United Nations Human Rights Office of the Commissioner's (2020) report concurs that political leaders worldwide have used their powers to deny women and girls their constitutionally protected rights and freedoms, despite evidence showing that unsafe abortions are increasing due to these restrictions and bans, and politicising abortion is causing more harm.

Bankole et al (2020:9) revealed that some SSA countries bear a high burden of unsafe abortions due to restrictive abortion laws. Women cannot openly and legally access safe abortion services, so they opt for whatever type of abortion they can.

The WHO's (2021) report states that the lack of access to safe, timely, affordable, and respectful abortion care violates the human rights of women and girls. It is also a violation of a series of rights, including the right to life; the right to the highest attainable standard of physical and mental health; the right to benefit from scientific progress and its

realisation; the right to decide freely and responsibly on the number, spacing, and timing of children; and the right to be free from torture, cruel, inhumane, and degrading treatment and punishment. Faundes et al (2020:102) concur that, more recently, the observation of the abortion rate in different countries with more liberal or restrictive laws has allowed an understanding that criminalising abortion is not effective in reducing its rate, instead, it is very effective in increasing abortion-related morbidity and mortality.

4.4.1.5 Sub-theme 1.5: Economic reasons

Findings from this study have shown that participants consider socio-economic status as a serious challenge and that many women, especially those without any source of income, may not be able to overcome. This has challenged their capacity to make informed decisions over their sexual reproductive health. In some cases, women reported that they committed abortions because their families were too poor to help them keep and support the baby. This finding is consistent with SSA studies from India and other low- and middle-income countries that attributed unsafe abortion to poverty or economic disadvantage and vulnerability (Yokoe et al 2019:12). The participants highlighted this as follows:

> "It is because of the financial status at home."(P-H).

She continued to say,

> "I was not going to be able to take care of them, looking at the fact that I'm struggling to take care of my siblings; it has been difficult and my kids, so it was going to be difficult. Oh, my boyfriend is there, but even on his side, it is difficult." (P-H).

Other participants shared the same sentiment as participant H when they said:

> "Yes, I was not going to manage. Again, when that baby was to come, I had nothing because all the money I was working for I had spent on constructing my bachelor pad. I had no money at all." (P-C).

> "I am not working." The men I live with do not cooperate, especially regarding finances." (P-K).

> “I told her that I didn’t want this baby. I am not financially stable. I have a small baby and am paying for the baby’s school fees, so what will I do with this one? And she said the baby has a father, and I told her I didn’t want the baby. So, I was forced to see how I could get rid of the pregnancy.” (P-G).

She continued to say:

> “So, usually, when you go to the nurses asking for it, they tell you to go to the private, and you don’t have money to go there, you don’t work, and you are looking at what you will support your baby with, and you end up doing this "backstreet abortion.” (P-G).

Studies by Khatri et al (2019:2) and Yogi et al (2018:1) on the prevalence and factors associated with abortion and unsafe abortion in Nepal found an association between the wealth index and unsafe abortions. They revealed that poor women, ethnic minorities, and women with lower education had a higher incidence of unsafe abortion in low- and middle-income countries and Latin American countries. This finding suggests that more affluent women are less likely to undergo unsafe abortions than poor women. These results also corroborate the findings of a Ghanaian study on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region, showing higher chances of safe abortion among women in the affluent quintile. Many participants cited financial difficulties as reasons to indulge in these dangerous practices (Atakro et al 2019:5).

4.4.1.6 Sub-theme 1.6: Unstable relationships

Another factor for women in the Ngami sub-district conducting unsafe abortions is being in unstable relationships. Participants indicated that they were forced into this situation after being rejected by their spouses, who had previously expressed an interest in having children but had altered their minds. Participants indicated that their partners abandoned them when they were pregnant because they had children and could not handle having another child. Some participants stated that their partners would cut off communication and utterly ignore them. They sought a solution by terminating the abortion in an unsafe

way due to the frustration and anxiety of raising a child alone. Participants were quoted verbatim.

> "I was being abandoned or ignored by my boyfriend. He was no longer talking to me. Even when I sent him messages, he would ignore them. That showed me that he would not take care of me during my whole pregnancy. He was cheating a lot." (P-F).

> "The person I was staying with when he approached me told me he did not have a partner. And after falling pregnant, when I told him that I missed my periods, he started changing. After two weeks, he told me that he had a wife and kids. And I said OK, it's okay, and then what should I do because you told me that you don't have a wife and you need a baby? He then changed and stopped talking to me. In the second month, I asked him his stance regarding the pregnancy he initially said he wanted. He maintained that he had a kid and a wife. Then I realised that this issue was complicated for me, which stressed me out." (P-J).

> "He didn't love me, and there was no need for me to always be after him; there was no need to keep the baby because my aim has always been to have a child with someone I would be able to raise the child with until the child does standard one and I realised that it was not going to go that way." (P-C).

According to the Bankole et al's (2020:19-20) study, it is revealed that if men are not involved or supportive of their partner's need for an abortion, then unsafe abortions occur. This can be worsened by the man's denial of responsibility for the pregnancy since the woman will make this decision alone without involving the partner.

At times, the instability of the relationship leads to unsafe abortions due to the woman being in a relationship with more than one boyfriend. When they fall pregnant, they do not know who the father is. In this confusion from unstable relationships, some resort to unsafe abortions in the hope of solving the problem they are experiencing at the time. Some of the participants supported this notion by stating that:

> "I was not ready for another baby. Again, I didn't know who the father was." (P-G).

> "All these times, you will be finding a boyfriend and you will become crazy, and all of a sudden, you tell the person you are pregnant, and then the guy just leaves

> you like that. So, it pains us a lot, women, so we have to go through an abortion. One can tell you that I have a girlfriend, and then he can give you money to go and tell you what to do. This time, yes, I am involved with a married man, so he said, You know, we can't have a baby, and again, I am not working. My business is not doing well. So, see how we can resolve this." (P-I).

The participants above are in consenting relationships, which might quickly terminate in a breakup, leaving the woman with an unintended pregnancy and forcing her to choose an unsafe abortion. Behulu et al's (2019:1) study on repeat induced abortion and associated factors among reproductive age women who seek abortion services in Debre Berhan town health institutions, Central Ethiopia revealed that women with more than one sexual partner in a year are seven times more likely to have repeated induced abortions than those with one sexual partner. Alhassan, Abdulai and Akaabere (2016:101) agree that unmarried couples indulge in sexual activities and do most things together as married couples would. Unmarried couples easily break up, sometimes when a woman has an unintended pregnancy. The unintended pregnancy often leads to an unsafe abortion in these cases. This situation can be worsened if the woman does not want to raise a child as a single parent and, at times, is in a new relationship where they want to satisfy their sexual needs, which can be compromised by pregnancy.

4.4.1.7 Sub-theme 1.7: Desire to continue with studies

One participant stated a desire to pursue education as a factor that led her to commit an unsafe abortion:

> "I was supposed to go to school, and I couldn't imagine dropping out of school because of my pregnancy." (P-L).

Similar findings from Bankole et al's (2020:20) study revealed that many women cited being young and wanting to continue studying as the main reasons for indulging in unsafe abortion practices. In a study by Singh et al (2018:13), women in SSA cited wanting to continue with schooling as a reason for unsafe abortions.

4.4.2 Theme 2: Effects of unsafe abortions

Participants in this study indicated that they were aware of the negative consequences of unsafe abortions despite having them. Effects of unsafe abortion that were cited by participants included; excessive bleeding and death, infertility, psychological trauma and other participants chose not to answer the question.

4.4.2.1 Sub-theme 2.1: Excessive bleeding and death

Nine (n=9) of the participants believed that unsafe abortion causes excessive bleeding, which may lead to women losing a lot of blood and subsequently causing death. Women were quoted as saying:

> "I know that there is a possibility of someone dying in the same spot." (P-D).
>
> "Losing a lot of blood, you don't eat. And death." (P-H).
>
> "I realised it is not good because it can kill you because of bleeding." (P-K).
>
> "I know it is illegal, but reasons must be listened to because we are dying at a higher rate because of this unsafe abortion and cervical cancer." (P-G).

Melese et al's (2018:1-2) study in Botswana on the management of post abortion complications shared similar findings, that unsafe induced abortion is very likely to lead to multiple complications resulting in maternal disabilities and deaths. Yogi et al (2018:2) in a cross-sectional study of the prevalence and factors associated with abortion and unsafe abortion in Nepal, corroborate that abortion may have serious health consequences and cause complications such as bleeding, sepsis, and uterine perforation. Gebremedhin et al's (2018:2) study on unsafe abortion and associated factors among reproductive aged women in Sub-Saharan Africa highlights that women who have had unsafe abortions develop complications that lead to hospitalisation. These may include, among others, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs, which may cause death. Bankole et al (2020:25-27) concur that informal abortion services lead to avoidable reproductive organ injuries and deaths. Preventing these deaths remains a priority for SSA countries to reach the targeted sustainable development goal (SDG) 3 by 2030.

4.4.2.2 Sub-theme 2.2: Infertility

Findings in this study noted another effect of unsafe abortion as infertility. Six (n=6) participants reiterated that women who have unsafe abortions are most likely not to bear children again because they will have damaged their wombs. Participants are quoted as saying,

> "It can damage the internals of a woman. I started having some dirt from inside; I started having some odour, and I am not someone who has ever had that odour; I felt that it was not me, and that's why I decided to come to the hospital." (P-G).

> "You may be infertile or have damaged your womb." (P-K).

> "According to my understanding, backstreet abortion can lead to pelvic-related diseases and cause infertility." (P-L).

Singh et al (2018:28-29) shares the same finding that unsafe abortion results in long-term conditions like pain, inflammation of the reproductive tract and pelvic inflammatory disease (PID), leading to secondary infertility.

Khatri et al (2019:2) concur that an unsafe abortion predisposes a woman to post-abortion septicemia, leading to infertility and possibly death.

4.4.2.3 Sub-theme 2.3: Predisposing factor for cervical cancer

Two (n=2) participants also indicated that unsafe abortions predisposed one to cervical cancer, complicating women's health and chances of survival.

> "And death and sickness: I heard that the womb could have dirt on it and you can kill someone if you have sex with him when like that." (P-G).

> "I know cancer of the cervix; you can even die from it." (P-I).

Charach, Sheiner, Beharier, Sergienko, and Kessous (2018:1) retrospective population-based study on recurrent pregnancy loss and future risk of female malignancies concurs that individually, there was a greater risk of breast and uterine cervix cancer, but as a

group, individuals with recurrent pregnancy loss had a significantly greater risk of being diagnosed with female malignancies. Stoicescu, Bungău, Ţiţ Muţiu, Purza, Iovan and Pop (2017:1429) elucidate that the carcinogenic risk for uterine carcinoma is directly proportional to the increased number of unsafe abortions and inversely proportional to age. It was observed that endometrial cancer was 95% prevalent in cases studied in developing countries. This cancer appears in menopausal women and women aged 50 years or more, with an average onset of 63 years. Furthermore, it was revealed that the carcinogenic risk factors of endometrial cancer are engaging in early sexual life and repeated unsafe abortions. Early sexual life exposes women to unintended pregnancies and unsafe abortions, which could be the beginning of many others. Repeated abortions in the past then become a carcinogenic risk for carcinoma of the uterus in the future.

4.4.2.4 Sub-theme 2.4: Psychological trauma or depression

Two (n=2) participants acknowledged that unsafe abortion results in lifetime trauma or depression as they will never forget the experience. This is because of self-blame and seeing abortion as the wrong thing to do.

> "You will not live well. When you see kids playing, you will be thinking your baby would be there playing and you'd be asking yourself what I did. It brings terrible memories to someone." (P-H).

> "I was not doing the right thing, wondering that I have three kids. My heart was painful, asking myself if I would manage or not ... you can have stress, always thinking that you killed a human being." (P-J).

Loi et al's (2018:2) study shares similar findings in that women express guilt and distress following abortion. They experience shame and self-blame because abortion was perceived as immoral and improper. Biggs, Brown and Foster's (2020:2-3) study reveals that abortion stigma hurts women who seek abortions or those who have had abortions. These women are labelled as inferior to ideals of womanhood. Perceived abortion stigma leads to abortion secrecy, increasing thought suppression, and intrusive thoughts about abortion. These intrusive thoughts and their suppression are associated with psychological distress. Abortion secrecy also leads to a psychological burden and contributes to anxiety.

Zhang, Wang, Hu and Creedy (2022:1) concur that an unintended pregnancy and an unsafe abortion are both stressful life events that can affect a woman's psychological well-being. This can be worsened by a previous history of mental disorders, low self-esteem, low resilience, stigma, low social support from partners and family, and a low perceived ability to cope with the abortion. These factors can cause psychological trauma to a woman before and after an unsafe abortion procedure. This study revealed a high prevalence of perceived stress and depression among women seeking unsafe abortions, especially in the first trimester.

4.4.3 Theme 3: Interventions towards the reduction of unsafe abortions

The participants have proposed various intervention strategies that can be utilised to mitigate both the prevalence and impact of abortion in the district and individual lives. Participants suggested the following methods:

4.4.3.1 Sub-theme 3.1: Psychosocial counselling on sexual reproductive health

It was revealed that at times, women do not have adequate knowledge about contraceptives on demand, such as emergency contraceptives that can be given on request. This lack of knowledge hinders access to contraceptives and the prevention of unintended pregnancy and unsafe abortion, hence the need for intensified public education on contraceptive options and use. Counselling can be used for educating women on the available contraceptives; some of the participants suggested this by saying,

> "I don't know if it happens with older people, but for the youths who are most affected, education can help." (P-L).

> "Counselling would do much better. I can't abstain, and I don't know what will treat me well because I once used depo and gained weight. My asthma was triggered, and I had diabetes and high blood pressure, so I quit." (P-I).

Silumbwe, Nkole, Munakampe, Milford, Cordero, Kriel, Zulu and Steyn (2018:6) corroborate that healthcare providers (HCPs) need training in communication and

counselling skills to enhance contraceptive use. Furthermore, couple counselling is essential in promoting male involvement in contraceptive choices and use. Males are critical decision-makers in contraceptive use, hence the need for couple counselling services to help educate and encourage the male partner to support their spouse in using family planning services. Community engagement and family planning interventions lead to commitment and sustainable health actions toward contraceptive use.

Comprehensive post-abortion care (CPAC) is an essential strategy as its primary goal is to reduce maternal deaths by treating complications of unsafe abortion. The elements of CPAC are high-quality abortion services that women have access to and affordable CPAC in the communities where they live and work, which includes contraception, post-abortion care, and pain management. CPAC is a strategy to reduce unsafe abortion and advocates for post-abortion counselling for women.

Therefore, HCPs should possess the skills to provide post-abortion family planning counselling and services to prevent repeated unplanned pregnancies and unsafe abortions (Sayami 2019:2-3).

According to the WHO (2021), to create an enabling environment for quality comprehensive abortion care (CAC) to promote the availability and accessibility of information on family planning methods and unsafe abortion, there should be the provision of evidence-based, comprehensive sexuality education that is accurate and unbiased. Bankole et al (2020:36-38) confirm that educating women and providing highly effective contraceptives empowers women to act on their reproductive preferences. A higher level of women's empowerment also means more agency in reproductive decision-making, often associated with the desire to have fewer children.

SDG 3 seeks to ensure universal access to sexual and reproductive healthcare services, including family planning information and education, and the integration of reproductive health into national strategies and programmes. According to the Botswana domesticated SDGs brief, communication and teaching form an integral part of service provision to the community since women will be empowered with knowledge (Republic of Botswana 2018a:6-60).

Psychosocial counselling to help women accept themselves should be adopted since women can resort to unsafe abortions because they feel rejected by their partners. Therefore, these women must be put through psychosocial counselling on the unintended pregnancies and decisions concerning these pregnancies. These are some of the quotes from participants:

> "I can say there must be a counsellor whom a woman can feel comfortable with to tell her their conditions and that they are pregnant but cannot keep the baby, so they need your help." (P-E).

> "If one has problems, I think one must see counsellors before making such a decision." (P-K).

Women need psychosocial counselling due to a variety of factors, for example, reduced quality of life, stigma, and mental health outcomes such as depression, anxiety, and adjustment disorders. Zia, Mugo, Ngure, Odoyo, Casimir, Ayiera, Bukusi and Heffron (2021:9) reveal that women possess the reproductive right to choose when and how to parent. As an aspect of prevention and SRH promotion, women need to be empowered to decide about their reproductive health. Education and services that promote condom use and sexual efficacy may improve women's sexual decision-making and consent. Sexual health education, a patient-centered healthcare system, non-judgmental care, advocacy, and social support can improve women's access to SRH services and prevent unintended pregnancies and unsafe abortions.

4.4.3.2 Sub-theme 3.2: Strengthening provision of youth-friendly services

Participants argued that youths are the most affected by unsafe abortions. This is due to a lack of access to contraceptives because kids are afraid of healthcare provider (HCP) victimisation. They end up engaging in unprotected sex, falling pregnant unintended pregnancy, and later opting for unsafe abortions. Having access to youth-friendly services would help improve their reproductive health and avoid falling into the dangerous abortion trap. Where possible, the participants argued that youth debriefing camps must be arranged where they will be taught about issues of sexuality and unsafe abortions. The participants continued to say that this will create an opportunity for youth health service providers and youth to exchange ideas and experiences, empowering the young while

educating youth health providers about youth issues throughout their sexual lives. Therefore, these participants' comments show a need for advocacy for youthful healthcare providers and youth-friendly facilities.

The participants stated:

> "... someone of my age going there to look for contraceptives and finds the elderly full there, they shame you, that I am the only kid here, and what will people say, what will society say when they see me as a child taking these contraceptives? They start thinking that this kid at this age is sexually active; it is going to raise eyebrows. Even if some might have been given education, it cannot be effective somehow because they will fear that shame even if they want to access it." (P-L).

Sometimes contraceptives may be available, but service providers deny women the pills. This lack of access to contraceptives is revealed when the participant says,

> "Because it is said that you can go to the clinic and get an emergency pill when someone has had unprotected sex within the first three days. Sometimes maybe you'd be far or not know about this emergency pill. So, normally when you go to the nurse asking for it, they tell you to go to private, and since you don't have money to go there, you don't work, and looking at what you will support your baby with, you end up doing this "backstreet abortion." (P-D).

> "I can say, looking at the fact that most people committing abortions are young, let us find those that we feel can be comfortable with. If they come and find someone like me, they would not be scared but feel free to speak out and together decide on what can be done. That is, it's youth you can be comfortable talking to, looking at the background of those who would have terminated the pregnancy, looking at their lives at home, where the baby's father is, and whether they go to school. We can also consider the support groups going to places like Sedie, where we can target some youth. Some young people are into commercial sex work. We can take them and sit down with them and find out how we can help them to keep busy. Some can be taken back to school, and some can be counselled that sex work is not part of life. And for those with babies, we can register them with welfare services and schools, and they can ask for donations of clothes to help them. This will help reduce the burden of abortion resulting from pregnancies." (P-E).

A study by Thompson, Undie, Amin, Johnson, Khosla, Ouedraogo, Nkurunziza, Rich, Westley, Garcia, Birungi and Askew (2018:2) revealed that young people should have easier access to emergency contraceptives (EC), including through youth-friendly services at local clinics. Some public clinics in Botswana, for example, have established a “youth corner” staffed with younger nurses (both male and female), which has boosted access to EC in this context.

To combat the stigma and "culture of silence" around EC and sexual violence (SV), young people need more thorough and accurate information about sexuality, contraception, and SV. Healthcare providers as well as creative use of social media, can help to promote more open conversation about these topics. Munakampe et al (2018:2) showed that stigma attached to youth’s sexual health by health providers leads to a high risk of unsafe abortion in this group. Young people do not have full access to reproductive health information and services like modern contraceptives, as health providers shun them. The reason is that they are not expected to be engaging in sexual activity at their age, which increases the likelihood of unsafe abortions. The Atakro et al’s (2019:10-13) study on contributing factors to unsafe abortion practices among women of reproductive age at selected district hospitals in the Ashanti region of Ghana revealed that most women who have an abortion are below 25 years of age and are either at senior school or tertiary level. In this Ghanian study, 91% of these students called for an on-campus reproductive health counselling centre. These centres should provide services that help prevent unintended pregnancies or ensure a healthy outcome for those who experience such pregnancies. They should also include education on abortion laws and services, sex, and family planning.

4.4.3.3 Sub-theme 3.3: Intensify protection for young girls who grow-up without parents or guardians

It has emerged that some victims of unsafe abortions are young girls being taken advantage of by men because they do not have any parental guidance or protection. As a result, these girls fall pregnant and are forced by these men to have abortions since they fear they will be traced and charged with blasphemy. This resonates well with one of the reasons a sixteen-year-old participant stated that she decided to have an abortion to protect her boyfriend from being arrested and charged with blasphemy. The participant said,

> “Again, the guy who gave me the pills said he didn’t want school kids, but the pills were not effective.” (P-L).

Another participant believes that women's empowerment with life skills can boost their confidence, fight for their sexual rights, and avoid unintended pregnancies in relationships. She said,

> “Another is skills, like if there can be some activities. I don’t dispute that it is Covid times, but if you could take kids out for camps and talk them into confidence, the confidence to stand and speak, because when they see others stand up, they will get the courage to stand and talk as well, which is good.” (P-C).

The findings of Rosen, Kayeyi, Chibuye, Phiri, Namukonda and Mbizvo’s (2022:8-9) study on sexual debut and risk behaviours among orphaned and vulnerable children (OVC) in Zambia, which protective deficits shape HIV risk? indicated that there is a growing body of research relating to educational and financial disadvantages to sexual activity among OVC. Due to overlapping, mutually reinforcing social and structural dynamics, orphaned and vulnerable adolescents are not only impacted by, but also put at risk of HIV and other challenges. Parental death is a traumatic occurrence that causes significant changes in a family structure and a child's larger care environment, including new caregivers. The loss of a parent's salary or the unforeseen adoption of new dependents puts a household's finances under strain, making essential necessities like food, healthcare, and education unaffordable. Orphaned and vulnerable children may face re-traumatising neglect and distress if they are not connected to sources of parental stimulation and psychosocial support in schools and at home. This can affect decision-making and encourage sexual experimentation to cope with emotional and material inadequacies. As a result, OVC are exposed to risks such as early and non-condom intercourse, as well as sexual coercion.

Furthermore, Fite and Cherie (2016:2-7) concur that orphans and vulnerable adolescents may be subjected to sexual coercion, exploitation, and abuse, as well as being forced to engage in high-risk conduct that puts them at risk of unplanned pregnancy and infection with HIV and other sexually transmitted infections. Unplanned pregnancies predispose them to unsafe abortions. It was also revealed that, females were 3.25 times more likely

than male participants to indulge in risky sexual conduct, with orphans having a 4.32 chance of engaging in risky sexual behaviour. Hence, orphan survival training, assertive communication skills, sexuality education, HIV risk perception education, physical, psychological, and human rights protection, social assistance, and economic access for necessity should be considered. As a low-cost risk-reduction method, trained counsellors should initiate dialogue on these sensitive issues between OVC and their caregivers.

4.4.3.4 Sub-theme 3.4: Women's economic empowerment

The participants noted that they usually opt for unsafe abortions because of their poor economic background. Therefore, they must be economically empowered to be financially independent. This would mean devising measures to engage these women to have some form of income and stop relying on men or families for their survival. When these women have some economic muscle, they will be able to make independent decisions and even negotiate safer sex practices without any pressure that they may lose some income from unprotected sexual indulgence.

> "There has been no proper care and support since my mother passed away. I stay with my younger siblings, and since I am the one working, I am forced to take care of my two small kids. I buy food for them; our father does not take care of us; unless someone is sick or you show something to him, that's when he helps. I had to terminate this pregnancy." (P-H).

This quote shows that women depend on family members for survival. There are also insufficient financial resources and poor economic background and support, hence the need to opt for unsafely aborting the unintended pregnancy. This calls for economic empowerment to make life-changing decisions for women.

Kc, Shrestha, Pokharel, Niraula, Pyakurel and Parajuli (2021:2), in a mixed method study on Women's empowerment for abortion and family planning decision-making among marginalised women in Nepal, suggest that women's empowerment involves education, employment, income, reproductive healthcare decision-making, household-level decision-making, and social status. Lack of economic empowerment is also associated with poverty, unemployment, and dependence on spouses. Economic education for

women leads to higher employment opportunities and increased access to financial resources. This empowers a woman to make autonomous decisions over her life issues — increased women's empowerment results in a lower fertility rate and vice versa.

4.4.3.5 Sub-theme 3.5: Government should legalise abortion

Abortion must be legalised to reduce the flood of women going to backstreet abortionists who cause more harm than good to women. The participants also indicated that abortion must be made legal and allow every woman to choose for herself freely.

In addition, women in the Ngami sub-district suggested that individual cases be considered separately, thereby allowing every woman, based on her peculiar reasons, to have a safe abortion. This will help reduce the number of instances of unsafe abortions and save more lives:

> “The thing is in Botswana abortion is illegal, only if it was legalised on the basis of individual reasons that would be better, all these illegal abortions would not be happening. Because it is not all of us who use the pills, some use traditional medicines because they are scared to buy the pills. If reasons for why so and so wants to do abortion that would be better.” P-A.

> “I think the government must consider the reasons of women as to why they want to terminate it. But if when someone was coming and you consider those reasons, maybe someone is coming from a poor background, does not have the mother, no father, so who is going to help you when the baby comes.” P-G.

Vivanco (2020:1) elucidates that penalising abortion does not prevent it since women experiencing unintended pregnancies seek abortions and post-abortion care even in highly restrictive settings. Abortion restrictions also push women from formal healthcare settings into secret locations. These cladenstine abortions are performed unsafely in unhygienic environments, leading to short and long-term health problems or deaths. Criminalising abortion also causes inequalities.

4.4.3.6 Subtheme 3.6: Abstinence

The other way that women in the risky ages of terminating abortions should consider is that of abstinence. Participants have indicated that to abstain means that you are able to stay free from falling pregnant that you will later regret ever having.

> "For one not to fall pregnant it would require them to use protection with a condom or using contraceptives or abstaining totally." (P- D).

Abstinence was a surprising finding to the researcher since it did not attach age restriction like in other studies that maintained that sexual intercourse has to be delayed maturing age and bearing children after marriage (Atakro et al 2019:12-14).

4.5 DISCUSSION OF THE RESEARCH FINDINGS

The study aimed to determine why women in the Ngami sub-district had unsafe abortions. In this study, the majority of the participants were of reproductive age, with three teenagers and two young adults among them. Unsafe abortion was linked to child spacing, schooling, and a lack of financial means in this age group. All participants were unmarried and in unstable relationships, putting them at a higher risk of unplanned pregnancies and unsafe abortions. Unprotected premarital intercourse increases the chance of unintended pregnancies among women. The bulk of the participants had low levels of education, which impacted their employment situation. More than half the participants were unemployed, necessitating a reduction in family size to prevent child-rearing challenges.

The problem of unintended pregnancy was compounded by a lack of contraception use and method failure, leading to an increase in the incidence of unsafe abortions. It was discovered that these women chose to abort their pregnancies to avoid unwanted family reactions. The researcher further discusses the study results using the three major themes that emerged as follows:

- **Participants' reasons for unsafe abortions**

Fear of violating family values and women's lack of autonomy; family planning concerns; perceived lack of options; political viewpoint and human rights components; economic reasons; unstable relationships; and a desire to continue with studies are among these

factors. Some of the women who took part in the study identified more than one reason for unsafe abortion.

Participants' risk of unintended pregnancy rose due to limited contraceptive use due to method failures and other difficulties such as side effects and lack of awareness. This demonstrates that societally desired levels of understanding and willingness to take contraceptives have not been reached. According to this study, women sometimes terminate pregnancies because they believe they have no other options in the case of an unplanned pregnancy. Because of the potential consequences of disagreement or abandonment by their partners, women choose unsafe abortions. Abortion restrictions and bans deny women full access to safe abortion services as a fundamental human right, increasing the number of unsafe abortions. Criminalising abortion has been demonstrated to increase the rate of unsafe abortions as well as abortion-related morbidity and mortality.

Financial vulnerability was cited by nearly half of the participants as the primary reason for unsafe abortion. Women with low socio-economic status cannot care for their pregnancy while also caring for their other children. Unsafe abortion is done to conserve the family's limited financial resources while also providing for the family's existing children. Unstable relationships have also been linked to women in the Ngami sub-district performing unsafe abortions. Participants indicated they were forced into this scenario due to their partners' rejection, the man's denial of responsibility for the pregnancy, the woman's multiple boyfriends, and the unplanned pregnancy.

Due to the frustration and anxiety of parenting a child alone, they sought a solution by terminating the abortion unsafely. According to the study, some women wanted to complete their studies as the primary motivation for engaging in unsafe abortion techniques.

- **Effects of unsafe abortions**

The researcher also looked into the consequences of unsafe abortions. This was done to see if unsafe abortions were performed due to a lack of understanding of the risks associated with the procedure or for other reasons. The majority of the participants in the study were aware of the risks involved with unsafe abortions, but they nonetheless

performed them when necessary. Women in this study cited dangerous abortion effects like death, barrenness or infertility, excessive bleeding, psychological trauma, and cervical cancer. The most mentioned or repeated consequence of unsafe abortion was death by eight (n=8) participants. This proves that results from this study support what other researchers found out in their respective studies. For example, in Loi et al's (2018:8) study, it was revealed that participants who had unsafe abortions were fully aware of the severity of abortion complications, and their decisions were made with this knowledge in mind. This shows that women undergo unsafe abortions not because of ignorance but because of the situations they find themselves in or their reasons.

Four out of 12 participants did not share any responses on the effects of unsafe abortions. No answer was accepted as an answer because no answer is still an answer. In a semi-structured interview, participants are vulnerable to social desirability bias. It occurs when participants give answers to questions that they think will make them look good to others while concealing their true opinions or experiences out of concern that they might be misunderstood by the researcher or by other interviewees. Studies that focus on sensitive or personal topics, including sexual behavior, like this study on unsafe abortion, are frequently affected. Response bias, in which participants do not honestly respond to questions for a variety of reasons, may also be a factor. Reasons can be a result of a lack of interest or a desire to finish interview questions quickly. In actuality, this means that any aspect of a study has the ability to influence a participant's response (Nikopoulou 2022:1). As a result, the researcher respected the participants who chose not to respond to the question on the effects of unsafe abortion because they were aware of the decision they had made.

- **Interventions to reduce unsafe abortions**

Women in the Ngami sub-district have proposed that there be provision of psychosocial counselling to help women accept themselves, strengthened youth-friendly services, improved protection for young girls who grow up without parents or guardians, empowering women economically, and for the government to legalise abortion. There is a pressing need for increased public education and understanding about existing contraceptives and the promotion of their usage. Furthermore, it was shown that the core cause of unintended pregnancies was linked to a lack of contraceptive awareness. To

lower the number of unsafe abortions, more emphasis should be placed on preventing unintended pregnancies through modern, effective contraceptives and increased public education.

Because health providers shun them, young people do not have full access to reproductive health information and services such as modern contraception. The reason for this is that at their age, adolescents are not anticipated to engage in sexual activity, which increases the risk of unsafe abortions, necessitating the need for youth-friendly services. It has been revealed that some of the victims of unsafe abortions are young girls who men use because they lack parental advice or protection. Women's empowerment through life skills, according to participants, can help them gain confidence, advocate for their sexual rights, and avoid unexpected pregnancies in partnerships.

Women's economic empowerment was also a possible technique for reducing unsafe abortions in the sub-district. Empowered women can choose consensual sexual encounters, contraceptive use, and SRH services and fully exercise their reproductive rights, reducing unintended pregnancies and unsafe abortions. Because they feel rejected by their partners, many turn to unsafe abortions. As a result, these women must undergo psychological counselling to accept themselves and their children. The participants also agreed that abortion should be made legal, allowing every woman to make her own decisions. Abortion must be made legal to limit the number of women who seek abortions from unlicensed abortionists who do more harm than good. Finally, participants stated that abstaining from sex means that you can avoid becoming pregnant, which you will later regret. These findings align with those reported in other research in the literature review chapter.

4.6 SUMMARY

Chapter 4 presented the phenomenological approach findings of the participants' lived experiences of the unsafe abortion procedure. The factors that contributed to unsafe abortion were discussed in detail, and the possible effects of the system were stated. Measures to reduce the hazardous abortion rate in the sub-district were also identified. All the discussions were substantiated with evidence from previous literature and quotations from participants' interviews.

Next is Chapter 5, which concludes the study. It discusses its limitations and recommendations for clinical practice and future research.

CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

Chapter 4 described the results of the study, integrated with the literature. This chapter highlights study design, methods, study purpose, objectives and questions, and how the three objectives of the study were achieved. The chapter concludes with recommendations for future research, contributions of the study and limitations of the study.

5.2 RESEARCH DESIGN AND METHOD

In this study, the descriptive and explorative qualitative research design was applied to explore and describe the contributing factors to unsafe abortion in the Ngami sub-district. The study focused on concepts to determine a solution to the research problem. The researcher followed the prescribed process in which the research problem was identified, followed by the research question upon which the data's objectives were based. An interview guide was developed and used to obtain biographical data, followed by a broad question for qualitative data collection with subsequent probing questions to find the solution to the problem.

The study population was all women who had an unsafe abortion(s) and were admitted to a gynaecological ward and were eligible and willing to participate in the study. In this research, the study population included women of ages below 18 and above, who were admitted to a gynaecological ward for an unsafe abortion during the data collection period, from June 2021 to August 2021.

The researcher used a literature review related to the research objectives to develop a questionnaire to obtain data. A pilot test was conducted. The participants answered the questions and elaborated further as probing was applied. The questionnaire also had a cover letter providing information regarding the study and a declaration for the participants to sign. This data collection process was completed within a period of three months,

mainly because this population is among the hard-to-reach population, looking at the nature of the activity they committed, which is unsafe abortion. The interviews were recorded with the verbal consent of those eligible women and later transcribed to ensure that emerging themes are picked and used to guide the study analysis.

A phenomenological approach implies that total objectivity will be difficult as the researcher relies on subjective data. This data is often derived from interviews, first-person observation, and lived research experiences. Qualitative research projects involve the researcher as the conduit for communication from other people's words or actions, without injecting their own biases into the process. Therefore, bracketing becomes a key factor in qualitative research to identify any biases that can affect the results, especially when examining sensitive research topics. It is also used to shield the researcher from the impact of looking at potentially emotionally taxing information due to the close relationship between the researcher and the research topic. Bracketing methods include; reflective journaling, writing analytical memos and bracketing interviews (Ho & Limpaecher 2022:1).

Reflective journaling was used to maintain bracketing by the researcher in this study. It was used to brainstorm the research question before presenting an overall research question. Then, as the researcher proceeded through the research, there was a reflexive process of examining what the researcher uncovered. The journal included the researcher's reasons for undertaking the research, assumptions about gender, sexual orientation, race/ethnicity, socioeconomic status, and the power hierarchy of the research itself. The researcher's personal value system was also taken into account. The researcher Trustworthiness of the study was maintained through strategies as outlined by Lincoln and Guba (1985:296), namely credibility, transferability, dependability, and conformability.

Data were analysed using thematic content analysis on experiences of unsafe abortions. Data analysis was conducted using Creswell and Creswell’s (2017:36) six interrelated content analysis steps of data analysis and interpretation for qualitative research. Three themes emerged associated with factors contributing to unsafe abortions in the Ngami sub-district. Findings were presented, illustrating the details that led women to choose an unsafe abortion.

The researcher further solicited measures that can be adopted to reduce unsafe abortions among women in the Ngami sub-district from eligible participants. The researcher also used the exploratory approach to discover new ideas, gain new insights, and increase knowledge about unsafe abortions in the context of the study.

5.2.1 Research purpose

This phenomenological study aims to gain an in-depth understanding of the contributing factors to unsafe abortions to develop possible measures to reduce unsafe abortions among women in the Ngami sub-district.

5.2.2 Research objectives

In pursuit of answering the research questions, this study's specific objectives were:

- To identify and describe factors that contributes to unsafe abortions among women in the Ngami sub-district.
- To explore experiences associated with unsafe abortions among women in the Ngami sub-district.
- To identify possible interventions to reduce unsafe abortions among women in the Ngami sub-district.

5.2.3 Research questions

Answers to the following questions were sought in this study:

- What are the factors contributing to unsafe abortions among women in the Ngami sub-district?
- What are the experiences associated with unsafe abortions among women in the Ngami sub-district?
- What are the possible interventions to reduce unsafe abortions among women in the Ngami sub-district?

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The study objective was to find out the factors that contribute to unsafe abortions among women in the Ngami sub-district in Botswana. Three major themes emerged from the data analysis and were discussed with relevant quotations from participants. These include:

- Participants' reasons for unsafe abortions
- Effects of unsafe abortions
- Interventions towards the reduction of unsafe abortions in the Ngami sub-district

5.3.1 Reasons for unsafe abortions

The findings from the analysis of this data revealed that there are several factors that predispose women in the district to unsafe abortions. These factors include, among others, the following:

5.3.1.1 Family values and women's lack of autonomy

Families have values and principles that the children must follow. Participants reported that they are afraid of their parents and even their male brothers being furious. These principles also demand that young women do not become pregnant while in an unstable relationship or before being married. When young women learn they are pregnant, their decisions are influenced by their family values. They believe they have wronged the family and will be shunned or stigmatised negatively by their own families. This implies that when it comes to abortion, women lack autonomy. These young women's decisions are primarily impacted by their family values and relatives. Women's lack of autonomy to make their own decisions regarding termination of an unintended pregnancy can be a barrier to safe abortion care and renders them vulnerable to unsafe abortion practices. Parents or family members can influence a woman's decision to induce an abortion if they are threatened with being kicked out of their home.

5.3.1.2 Family planning issues

The primary cause of unsafe abortion, according to this study, is potential contraceptive failure, which results in an unintended pregnancy. Inability to meet the contraceptive

needs of all women at risk of unintended pregnancies and contraceptive failure is associated with increases in unsafe abortions. According to the findings of this study, women have access to family planning services where they can obtain various contraceptives such as Depo Provera injections, implants, and condoms. Some of the methods have failed because they are not completely effective (they are not 100% effective). Participants who said they utilised the implant method said they had to remove it since it interfered with their menstrual cycle. Some of the participants became pregnant as a result of these contraceptive failures, and because they did not want the pregnancies, they decided to terminate them in unsafe ways.

The family planning issues go further to include child spacing. Participants in this study disclosed that they were forced to have unsafe abortions since their babies were still too young to have siblings, and the only option was to abort the pregnancy. It was also revealed that, the other way women in the risky age of terminating pregnancies should consider is abstinence. Participants have indicated that abstaining means that you can stay free from falling pregnant, which one will later regret. The researcher was surprised since it did not attach an age restriction like in other studies that maintained that sexual intercourse must be delayed until a mature age and bear children after marriage.

5.3.1.3 Perception of lack of options

This would resonate well with the other reasons for opting for unsafe abortion for unplanned pregnancies. When faced with an unintended pregnancy, women can panic and perceive an unsafe abortion as the only available option. Unsafe abortion can be the only available option when a woman is not ready to be a mother or to cater to a baby.

5.3.1.4 Political standpoint and human rights aspect

One of the participants in this study criticised the illegality of abortion in Botswana for contributing to unsafe abortion practices. Botswana, as stated in the literature review chapter, belongs to a group of countries that allow abortion under specific circumstances. This participant said that safe abortion treatment should be available when a woman requires it or has compelling reasons for doing it. The lack thereof contributes to a high burden of unsafe abortions due to restrictive abortion laws since women cannot openly

and legally access safe abortion services, so they opt for whatever type of abortion they can.

5.3.1.5 Economic reasons

Findings from this study have shown that participants have seen socio-economic status as a serious challenge and that many women, especially those without any source of income, may not be able to overcome it. This has challenged their capacity to make informed decisions over their sexual reproductive health.

In some cases, women reported that they ended up committing abortions because their families were too poor to help them keep and support the baby.

5.3.1.6 Unstable relationships

Another factor for women in the Ngami sub-district conducting unsafe abortions has been connected to unstable relationships. Participants said they were forced into this situation after being rejected by their partners, who had previously expressed an interest in having children with them but had altered their minds. Participants indicated that their partners abandoned them when they were pregnant because they had children and could not handle having another child out of wedlock. Some participants stated that their partners would cut off communication and utterly ignore them. They sought a solution in terminating the abortion in an unsafe way due to frustration and anxiety of raising a child alone. At times, the instability of the relationship leads to an unsafe abortion as a result of the woman being in a relationship with more than one boyfriend, and when they fall pregnant, they do not know who the father is. In this confusion from unstable relationships, some resort to unsafe abortions hoping to solve the problem they are experiencing at the time.

5.3.1.7 Desire to pursue education

In this study, one participant stated a desire to pursue education as a factor that led her to commit an unsafe abortion.

5.3.2 Effects of unsafe abortions

Participants in this study said they were aware of the negative consequences of unsafe abortions despite the fact that they were having them. Women in this study cited unsafe abortion effects such as death, barrenness or infertility, excessive bleeding, psychological trauma, and cervical cancer. Death was the most mentioned or repeated consequence of unsafe abortion by eight (66.7%) of the participants. This proves that results from this study support what other researchers found out in their respective studies.

5.3.2.1 Excessive bleeding and death

Nine out of 12 participants believed an unsafe abortion causes excessive bleeding, which may lead to women losing a lot of blood and subsequently causing death. Women in the Ngami sub-district acknowledged that they know that unsafe abortions are among the leading causes of death for women who commit them.

5.3.2.2 Infertility

Findings in this study noted another effect as infertility. Six out of 12 participants reiterated that women who commit unsafe abortions are most likely not to bear children again in the future because they will have damaged their wombs.

5.3.2.3 Predisposing factor for cervical cancer

Two out of 12 participants also indicated that unsafe abortions were a predisposing factor to cervical cancer, which complicates women's health and chances of survival.

5.3.2.4 Psychological trauma or depression

Some participants, 2 out of 12 acknowledged that unsafe abortion results in lifetime trauma or depression since one will never forget committing it.

5.3.2.5 No answer

Remaining participants, 4 out of 12 did not give an answer. No answer was accepted as an answer. This is due to social desirability bias, which occurs when participants give answers to questions they think will make them look good to others while concealing their true opinions or experiences. On the other hand, response bias, in which participants do not honestly respond to questions for a variety of reasons, may also be a factor. Furthermore, any aspect of a study has the ability to influence a participant's response (Nikopoulou 2022:1). Therefore, the researcher respected the participants who chose not to respond to the question because they were aware of the decision they had made.

5.3.3 Interventions towards the reduction of unsafe abortions

Although unsafe abortion is a problem that the Ngami sub-district is faced with, the participants have suggested a variety of intervention strategies that can be employed to mitigate both the prevalence and impact of abortion in the district and individual lives. The following strategies were suggested by these women:

5.3.3.1 Psycho-social counselling on sexual reproductive health

It was revealed that at times, women do not have adequate knowledge about contraceptives on demand, such as emergency contraceptives that can be given on request. This lack of knowledge hinders access to contraceptives and the prevention of unintended pregnancy and unsafe abortion, hence the need for intensified public education on contraceptive options and use. Counselling can be used for educating women on the available contraceptives. Women in the Ngami sub-district have indicated that one way to address the issue of unsafe abortion is by first understanding that these women end up at that level because they had challenges with the use of contraceptives. This is due to women having limited information on contraceptives. It is therefore critical to raise awareness about contraceptive use among these women. In doing so, language barriers as well as the level of educational background must be taken into consideration such that the understanding cuts across all levels of understanding for these women.

The health department, especially the sexual and reproductive health unit, must ensure that public education is intensified to save more women from unsafe abortions.

Participants showed a lack of knowledge of how family planning methods work. Women need to make informed decisions regarding these methods based on the education or knowledge they get from service providers. Education is also a crucial nursing intervention and it can provide anticipatory guidance regarding the possibility of method failure, side effects of family planning methods, and reduce anxiety about the possibility of an unplanned pregnancy. Therefore, intensifying public knowledge on contraceptives will help improve knowledge and willingness to use contraceptives since findings show that it has not reached the desired levels in society.

Women resort to unsafe abortions because they feel rejected by their partners. It is therefore important that these women be taken through psychosocial counselling so that they can accept themselves and their babies. Participants indicated that at times, someone needs just to be assured through counselling that what they are carrying is a gift that they must accept. In addition, they indicated that pregnancy is just a process that women should not run away from, and the only way to understand that is when they can have access to psychosocial counselling.

5.3.3.2 Strengthening provision of youth-friendly services

Participants argued that most of the affected ages are youths, and therefore this happens because they would have been afraid to access contraceptives for fear of victimisation by healthcare workers, leading to them engaging in unprotected sex and falling pregnant, which they are not ready for. So, ensuring that these youth have unhampered access to youth-friendly services would help improve their reproductive health so as not to fall for the unsafe abortion trap. Where possible, the participants argued that youth debriefing camps must be arranged where they will be taught about issues of sexuality and unsafe abortions. The participants continued to argue that this will present both the youth health service providers and the youth with the opportunity to exchange ideas and experiences, which can empower the youth while at the same time enlightening the youth health providers on the challenges that the youth come across through their sexual lives.

5.3.3.3 Intensify protection for young girls who grow-up without parents or guardians

It has emerged that some victims of unsafe abortions are young girls being taken advantage of by men because they do not have any parental guidance or protection. As a result, these girls fall pregnant and are forced by these men to have abortions since they fear they will be traced and charged with blasphemy.

5.3.3.4 Women's economic empowerment

The participants noted that the reason why they normally end up opting for unsafe abortion is because of their poor economic background. It was revealed that women depend on family members for survival. Due to insufficient financial resources, poor economic background and lack of support, they opt for unsafely aborting the unintended pregnancy. This calls for economic empowerment to make life-changing decisions for a woman. It is therefore important that women be economically empowered so that they may be economically independent. This would mean devising measures to engage these women so that they have some form of income and stop relying on men or families for their survival. When these women have some economic muscle, they would be able to make independent decisions and even negotiate safer sex practices without any pressure that they may lose some income from unprotected sexual indulgence.

5.3.3.5 Government should legalise abortion

It was revealed that abortion must be legalised to reduce the flood of women going to backstreet abortionists who cause more harm than good to women. The participants also indicated that abortion must be made legal and allow every woman to choose for herself freely. In addition, women in the Ngami sub-district suggested that individual cases be considered separately, thereby allowing every woman, based on her peculiar reasons, to have a safe abortion.

5.3.3.6 Abstinence

The other way that women in the risky ages of terminating abortions should consider is that of abstinence. Participants have indicated that to abstain means that you are able to stay free from falling pregnant that you will later regret ever having. Abstinence was a surprising finding to the researcher since it did not attach age restriction like in other studies that maintained that sexual intercourse has to be delayed maturing age and bearing children after marriage (Atakro et al.2019:12-14).

5.4 RECOMMENDATIONS

Prevention of unsafe abortion is considered to be a critical intervention aimed at reducing maternal morbidity and mortality. As discussed in Chapter 2, deaths due to unsafe abortions account for 14% of all maternal deaths in developing countries in Africa. Unsafe abortions also result in other health problems or complications like haemorrhage, infections, and perforations. Furthermore, unsafe abortion leads to the diversion of limited health resources from other critical healthcare programmes, which further endangers the lives of women and violate their human right to health.

In acknowledging the several factors that contribute to women committing unsafe abortions in the Ngami sub-district, there is a need to articulate the recommendations on what should be done to add a new body of knowledge in the clinical practice, make recommendations to the Ministry of Health regarding policy reforms, improve the unsafe abortion situation in the sub-district and lastly, how to improve the study in the future. As far as improving or addressing the problem of unsafe abortions, the following are recommended:

- **Recommendations to the clinical practice**

  - Intensifying public education on contraceptive use
  - Promoting abstinence
  - Providing youth-friendly services

  The above recommendations will assist practitioners and patients in making decisions about appropriate health care for unsafe abortion. They also offer concise guidance on how to provide healthcare services based on the new available research evidence provided by this study. Stakeholders should consider revising or modifying available standard operating procedures (SOPs), policies, and guidelines on unsafe abortion in light of the new evidence from this study.

- **Recommendations to the Ministry of Health and Wellness**

  - Consider legalising abortion and letting the Ministry of Health and Wellness (MOHW) offer comprehensive safe abortion services to reduce maternal mortality, severe complications, and overall healthcare costs incurred from high numbers of unsafe abortions
  - The state should support women who need abortions on request, which is timely and affordable. Therefore, the researcher submits that policymakers use the findings of this study to lobby for policy reforms regarding the illegal status of abortion and the absence of safe abortion care (SAC) on demand in the country. This submission is essential for the government to align itself with human rights principles and aversion to unsafe abortion.
  - The state can implement support programmes to help women overcome these challenges and make independent decisions about their sexual health if it knows how these unsafe abortions affect women's opinions of themselves and the grave, expensive consequences thereof.

- **Recommendations to the sub-district**

  - A survey can be carried out to determine what special support systems are available in the sub-district for post-abortion care.

- The sub-district needs to facilitate the establishment of community empowerment activities through community awareness and mobilisation.
- It is essential to disseminate the findings of this study to the MOHW, for them to prioritise addressing the barriers and interventions to ensure that women have access to this critical life-saving care and prevention of unsafe abortion.

- **Recommendations to future research**

- A quantitative approach can be utilised to accommodate the generalisability of study findings, which will help develop a more objective policy at a higher level, although it will be customised as it gets to the lower levels.
- Research to explore social behaviour issues that contribute to high unintended pregnancy rates among childbearing age women that lead to unsafe abortions.
- A comprehensive study would be an option to develop strategies to prevent unsafe abortions to involve parents, men, and the community (to define their roles in the prevention of unsafe abortion and involvement in sexual and reproductive health).
- This research was conducted in one sub-district of Botswana and thus, the findings cannot be generalisable to the entire country. Therefore, future studies should be conducted in different sub-districts and research populations can be defined similarly or differently so that unsafe abortion can be overcome in specific ways.

5.5 CONTRIBUTIONS OF THE STUDY

The study achieved its objective by bringing out the lived experiences of women who went through the unsafe abortion process and are survivors. The insights that the study has brought out are a steppingstone to interventions that the district health management team (DHMT) in the Ngami sub-district should consider going forward to mitigate the prevalence of unsafe abortions since this is the first study concerning this topic in the sub-district. The study has revealed that although different circumstances force women to end up committing unsafe abortions, they know that it is not a good practice since it puts their lives in danger, and the more they want to live, the better ways of handling the unplanned pregnancies they may find themselves having.

Finally, the policy implication brought out in this study is the need to review the laws on abortion in Botswana. As much as women have the right to choose for themselves, the same dispensation must be available regarding unintended pregnancies; women must be allowed to decide whether to terminate their pregnancies or not. This is a proposal that human rights activists can take and use the study findings to drive their agenda on the legalisation of abortion in Botswana. On the intellectual output, the study aims to contribute to the formation of social capital on a contentious issue such as abortion in Botswana.

5.6 LIMITATIONS OF THE STUDY

As indicated earlier, this study has revealed many factors contributing to women in the Ngami sub-district committing unsafe abortions. However, the study had several limitations, such as follows:

- The research methodology does not allow the findings to be generalised to the rest of the sub-districts in Botswana, which could have been able to inform the development of objective policy to address the effects of unsafe abortion in the entire country.
- The study did not incorporate how the cultural and religious beliefs and practices affected these women's decisions regarding terminating unintended pregnancies. However, it is known that culture and religion impact individuals' behaviours.
- The study was limited to only women who had an unsafe abortion(s) and were admitted to a gynaecological ward and were eligible and willing to participate in the study and of ages below 18 and above only, thus depriving the researcher of insight into the experiences of those women who were not admitted and those who remained in their homes and private clinics. They may have had different experiences that could have impacted the study's findings.
- The researcher was charged with the critical responsibility of protecting the participants and the research team during the COVID-19 pandemic. This is one of the principles the researcher is charged with: doing no harm to participants in the study. The research raised concerns such as the potential termination of the state of emergency or the worry of the quick spread of the virus around the village. The research team had to adhere to COVID-19 protocols outlined by WHO, which affected the interview length, audibility, and clarity. The researcher had to think of other

contingency plans, like doing video interviews, if strict measures had to be followed. Because the researcher studies online, the effects of the pandemic on academic studies were minimal. Health professionals had minimal movement restrictions, so the researcher team could continue with the interviews.

- Debriefing was a necessity in the study- for the research team. In this study, following debriefings after the earliest interviews, it became apparent that the main issues hesitancy of women to participate in the study was language barrier and fear of being victimized. This continued to emerge from pilot testing to the actual study data collection process. The challenge warranted pursuit and modification of the data collection tool. The researcher asked for permission to use the native language, Setswana, in the data collection tool, the interview guide. Had the researcher and the research assistant (the research team) not been in regular contact with one another (debriefings), they may have disregarded or downplayed findings related to the language barrier and fear of victimization, which may have disrupted or led to few or no participants for the study.

The debriefings also provided an opportunity for participants to ask any questions they may have had about the study and for the research team to thank them for their participation. Additionally, it allowed the team to gather feedback from participants on how to improve the study in future iterations. In general, debriefings strengthened our study by enhancing the research team's reflexivity, ability to build rapport, and approach to sampling. In the course of the earliest debriefings, it became apparent that both researchers and participants were weary of the data collection endeavor. Both the researcher and the research assistant were shaken following discussions with participants about the whole process of conducting an unsafe abortion and how easy it was to procure abortion pills in the sub-district, which was not known to the team. Debriefings presented an opportunity for the team to talk through their anxiety and devise coping strategies collectively.

The research team also had challenges building trust with participants, given the strained relations between government officials and patients who had unsafe abortions. Participants were not comfortable disclosing how they procure unsafe abortions due to the illegality of abortion in Botswana, which attracts at least a seven-year sentence if found guilty. Several if not all participants were frightened by the audio recorder, concerned that their voice may be shared with a much wider audience, including the police (or used to inflict harm on them or their families).

The presence of the research assistant during data collection also bothered the majority of the participants because it put their confidentiality or privacy at risk. The research team used debriefings to reconsider how to best present the team and explain the purpose of the research to participants (in a manner that would ensure all involved that this was a peaceful endeavor, that there was no ill will or underhanded intention on the part of the research team toward the participants). All permissions letters from the Review Board, the Research Unit, and the District Coordinator, as well as the confidentiality agreement, were also shown to the participant to demonstrate the legality of the study. Debriefings allowed the research team to follow up on participants who were referred to the psychologist for counseling.

- Participants were informed of the intentions of the study, but no deception was necessary, so participants did not have debriefing on deceptions.
- Lastly, unsafe abortion is a sensitive topic, and abortion is still illegal in Botswana unless under certain circumstances, hence the participants' giving out less detailed information and reluctance to participate in the study. The study was also done when movements were limited because of COVID-19 protocols and the topic's sensitive nature, which hindered voluntary participation in the study.

5.7 CONCLUDING REMARKS

This chapter highlighted study design, methods, study purpose, objectives and questions, and how the three objectives of the study were met. The summary and interpretation of the research findings, recommendations to the nursing practice, to the sub-district health department, and recommendation to the government were discussed. The contribution of the study and the study limitations were also explained.

The study has been able to meet its initially set objectives and has been executed as planned and within the fixed timelines. The findings of this study have confirmed that women continue to opt for unsafe abortions despite the high risks that come with the procedure, including severe complications and maternal deaths. The participants are also aware that to achieve a better sexual and reproductive health outcome, they must find better ways of handling the unintended pregnancies they may find themselves having. Psychosocial counselling on sexual reproductive health, strengthening the provision of youth-friendly services, intensifying protection for young girls who grow up without parents

or guardians, women's economic empowerment and legalising abortion can reduce unsafe abortion and its fatal consequences.

Unsafe abortion is a significant sexual reproductive health (SRH) challenge worldwide. It is associated with high morbidity and mortality and long-term sequelae among women of childbearing age, as depicted in this study. Complications related to unsafe abortions are much more costly for the healthcare system than providing safe abortion services.

Comprehensive abortion services should be prioritised to reduce the costs incurred from high numbers of unsafe abortions and maternal mortality due to unsafe abortions. Therefore, the prevention of unsafe abortion is very crucial, and this study addressed an issue of significant clinical relevance. The findings of this study will inform health professionals on how to assist women in preventing unintended pregnancies that lead to unsafe abortions. The interventions proposed will help reduce unsafe abortions in the Ngami sub-district amid the absence of safe abortion clinics and services and restrictive abortion laws in the country.

The purpose of the study was to gain an in-depth understanding of the contributing factors to unsafe abortions to develop possible measures to reduce unsafe abortions among women in the Ngami sub-district. The findings of this study have confirmed results from other research studies. Therefore, knowledge obtained from this study can be implemented to improve healthcare services for women.

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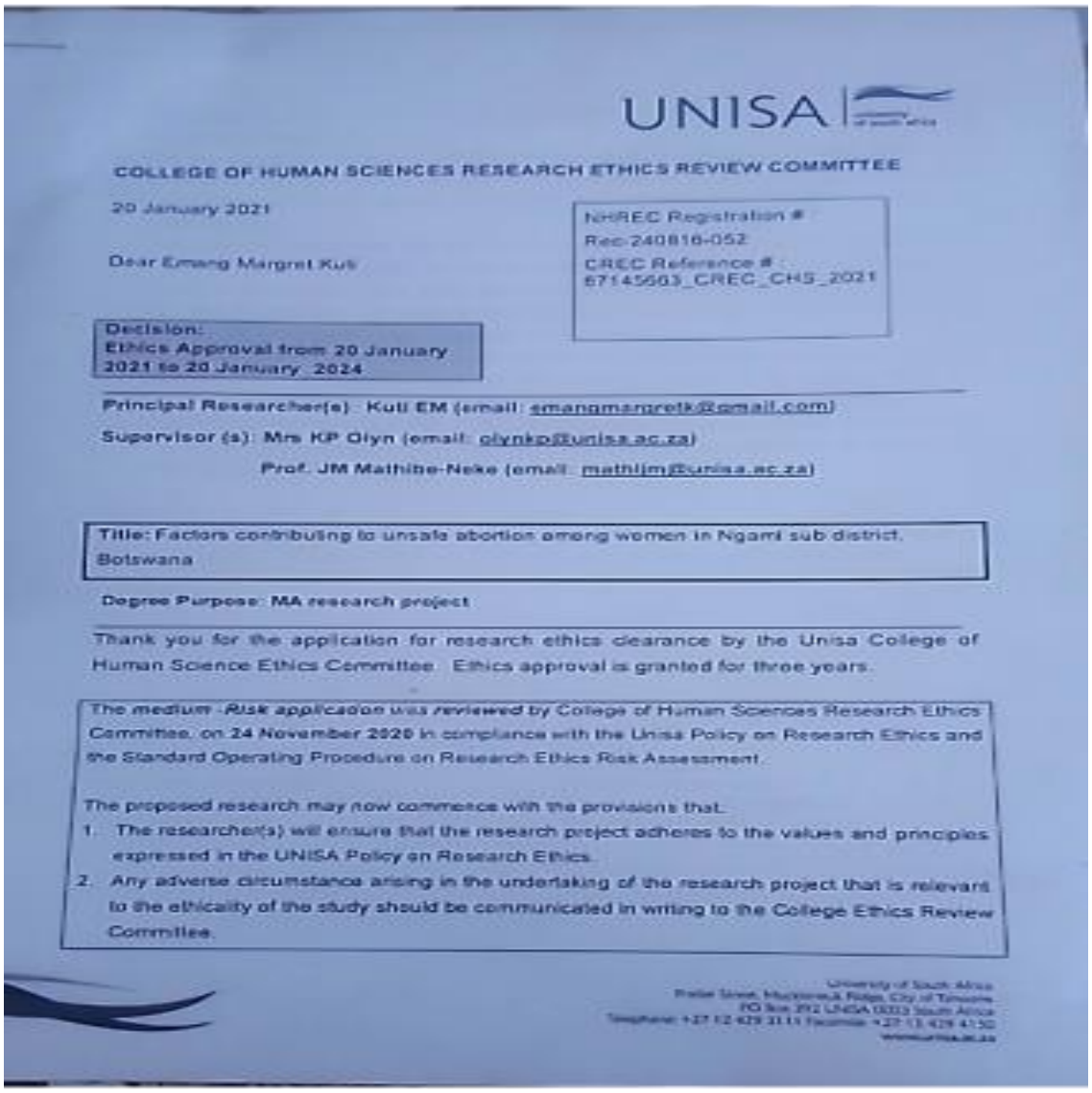
APPENDICES

APPENDIX 1: Ethical Clearance Certificate from the University of South Africa



UNISA

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

20 January 2021

NHREC Registration #:
Rec-240816-052
CREC Reference #:
67145503_CREC_CHS_2021

Dear Emang Margret Kuli

Decision:
Ethics Approval from 20 January 2021 to 20 January 2024

Principal Researcher(s): Kuli EM (email: emangmargretk@gmail.com)

Supervisor (s): Mrs KP Glyn (email: glynkp@unisa.ac.za)

Prof. JM Mathibe-Neke (email: mathijm@unisa.ac.za)

Title: Factors contributing to unsafe abortion among women in Ngami sub district, Botswana

Degree Purpose: MA research project

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for three years.

The *medium -Risk application* was *reviewed* by College of Human Sciences Research Ethics Committee on 24 November 2020 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's Act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (**20 January 2024**). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number **67145663_CREC_CHS_2021 should** *be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours Sincerely,

Signature

Dr. K.J. Malesa
CHS Ethics Chairperson
Email: maleskj@unisa.ac.za
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Signature pp

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APPENDIX 2a: Permission requested from the Ministry of Health and Wellness, Health Research and Development Division to conduct the study

Ms Emang M Kuti
PO Box 2047
Maun
02 June 2020

The Director
Ministry of Health and Wellness
Health Research and Development Division
PO Box 0038
Gaborone
Postal code: 12345/00000

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I, Emang M. Kuti, a UNISA Master's in Public Health student, would like to request for permission to conduct a research study in Ngami sub-district.

The title of the study is: Factors contributing to unsafe abortion among women in Ngami sub- district, Botswana.

The purpose of the study is to gain in-depth understanding of the contributing factors to unsafe abortions in order to develop possible measures to reduce unsafe abortions among women in Ngami sub-district.

Objectives of the study

The study geared towards achieving the following objectives:

- To identify and describe factors that contributes to unsafe abortions among women in Ngami sub-district.

- To explore experiences associated with unsafe abortion among women in Ngami sub-district.
- To identify possible interventions to reduce unsafe abortions.

Research questions

This study will answer the following questions:

- What are the factors contributing to unsafe abortions among women in Ngami sub-district?
- What are the experiences associated with unsafe abortion among women in Ngami sub-district?
- What are the possible interventions to reduce unsafe abortion in Ngami sub-district?

Methodology

The study will follow qualitative descriptive research design. In this research the study population will include women who will be admitted in gynaecological ward for unsafe abortion during data collection. Purposive sampling will be used to select participants from the Gynaecology ward in the Hospital in Ngami sub-district. Semi-structured, face to face semi-structured interviews will be used as data collection method.

All respondents will be interviewed face-to -face by the researcher. All interviews will be tape recorded at the permission of participants and later transcribed verbatim. This research is of medium risk to the participants. The foreseeable risk of harm is the potential discomfort or inconvenience because of the age group and that the information imparted could trigger previous memories of trauma and psychological harm.

Should the participants have some psychological discomfort; counselling will be done and can be referred for further management by the social workers within the facility.

Anonymity and identity of the respondents will be of high priority as all research information will only be accessed by the researcher and kept under lock and key.

Currently, in Ngami sub district, the contributing factors of unsafe abortion are unknown, including the experiences and complications attached to unsafe abortions.

The findings of this study will be used to develop measures to reduce abortions and abortion-related complications in Ngami sub-district. Additionally, the district will learn the adequacy of care given to women undergoing unsafe abortions before, during, and after the operation in order to improve the quality of care. Finally, the analysis from the study can be used to further inform stakeholders and policy makers on how to best prevent adverse health effects from unsafe abortion in the future.

As you are aware of the corona pandemic that is affecting our day to day living, we have to adjust the lifestyle and adopt preventative measures to prevent the spread of the disease. The following measures will apply during face-to-face interview to prevent the spread of diseases as outlined by WHO (2019a) (corona virus and others infectious diseases).

The researcher will request provision of the PPE materials from the hospital within the genecology ward in which data collection will be conducted.

- Interview venue to be cleaned with disinfectant (Biocide solution is used for cleaning in public health establishment).
- Table and chairs will be disinfected with sanitiser that contains 70% alcohol.
- Hand wipes and sanitiser will be available and utilised to decontaminate the hands frequently though out the process.
- Facemasks will be provided and to be worn by both the participants and the researcher throughout the process.
- Social distancing of 1.5 metre will apply throughout the process.
- Disposable plastic aprons will be utilised by the researcher and the participants to prevent the spread of diseases.
- Sterile wipes will be used to sanitise the equipment such as tape recorder, pen and other equipment that may be necessary.

Should there be lockdown that restrict the movement of people form one place to another, arrangement for virtual interview such as cell phone video calling, and Microsoft team video calling will be done.

The study will be conducted under the supervision of **Ms KP Olyn** from the University of South Africa. Contact details: **(012) 429 6248 olynkp@unisa.ac.za**. I undertake to share the study findings and recommendations with your department upon completion.

Kindly find herewith attached my study proposal for the ease of reference in anticipation that my request will receive your favourable consideration.

Yours faithfully

Kuti EM
Master's of Nursing Student
Student Number:67145663

Supervisor	Mrs KP Olyn	012-429 6248	olynkp@unisa.ac.za
Co-supervisor	Professor J Mathibe-Neke	012-429 6443	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		

APPENDIX 2b: Permission granted from the Ministry of Health and Wellness, Health Research and Development Division to conduct the study

PRIVATE BAG 0038
GABORONE
BOTSWANA
REFERENCE:

TEL: (+267) 363 2500
FAX: (+267) 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

REPUBLIC OF BOTSWANA
MINISTRY OF HEALTH AND WELLNESS

REFERENCE NO: HPDME 13/18/1 **20 May 2021**

Health Research and Development Division

Notification of IRB Review: **New application**

Emang Margret Kuti
P.O.Box 60361
Gaborone
Botswana

Dear Emang Margret Kuti

Protocol Title: FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB DISTRICT, BOTSWANA

HRDD Approval Date:	20 May 2021
HRDD Expiration Date:	19 May 2022
HRDD Review Type:	Expedited Review
HRDD Review Determination:	Approved
Risk Determination:	Minimal risk

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

In consideration that your study involves an illegal activity, reference is made to CIOMS Guideline 4 commentary, page 11. You are therefore granted exemption from requirements to report information about this illegal activity (unsafe abortion) of study participants. This exemption is made in consideration of the value of the prospective results of the research.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health and Wellness within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments
During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A 7 or Ministry of Health website: www.moh.gov.bw or can be requested via e- mail from Mr. Kgomotso Motlhanka, e-mail address: kgmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting
Other events which must be reported promptly in writing to the HRDC include:
- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. K. Motlhanka at kgmmotlhanka@gov.bw, Tel +267-3632751. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

Dr P. Masokwane
for /PERMANENT SECRETARY

MINISTRY OF HEALTH AND WELLNESS
RESEARCH DIVISION
20 MAY 2021
P/BAG 0038
GABORONE
REPUBLIC OF BOTSWANA

APPENDIX 3a: Permission requested from the Ngami District Health Management Team to conduct the study

Ms Emang M Kuti
PO Box 2047
Maun
01 June 2020

Ngami District Health Management Team Head
PO Box 12
Maun
Postal code: 12345/00000

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN NGAMI SUB-DISTRICT

I, Emang M. Kuti, a UNISA Master's in Public Health student, would like to request for permission to conduct a research study in Ngami sub-district.

The title of the study is: Factors contributing to unsafe abortion among women in Ngami sub-district, Botswana.

The purpose of the study is to gain in-depth understanding of the contributing factors to unsafe abortions in order to develop possible measures to reduce unsafe abortions among women in Ngami sub-district.

Objectives of the study

The study geared towards achieving the following objectives:

- To identify and describe factors that contributes to unsafe abortions among women in Ngami sub-district.
- To explore experiences associated with unsafe abortion among women in Ngami sub-district.
- To identify possible interventions to reduce unsafe abortions.

Research questions

This study will answer the following questions:

- What are the factors contributing to unsafe abortions among women in Ngami sub-district?
- What are the experiences associated with unsafe abortion among women in Ngami sub-district?
- What are the possible interventions to reduce unsafe abortion in Ngami sub-district?

Methodology

The study will follow qualitative descriptive research design. In this research the study population will include women who will be admitted in gynaecological ward for unsafe abortion during data collection. Purposive sampling will be used to select participants from the Gynaecology ward in the Hospital in Ngami sub-district. Semi-structured, face to face semi-structured interviews will be used as data collection method.

All respondents will be interviewed face-to -face by the researcher. All interviews will be tape recorded at the permission of participants and later transcribed verbatim. This research is of medium risk to the participants. The foreseeable risk of harm is the potential discomfort or inconvenience because of the age group and that the information imparted could trigger previous memories of trauma and psychological harm.

Should the participants have some psychological discomfort; counselling will be done and can be referred for further management by the social workers within the facility.

Anonymity and identity of the respondents will be of high priority as all research information will only be accessed by the researcher and kept under lock and key.

Currently, in Ngami sub district, the contributing factors of unsafe abortion are unknown, including the experiences and complications attached to unsafe abortions.
The findings of this study will be used to develop measures to reduce abortions and abortion-related complications in Ngami sub-district. Additionally, the district will learn the

adequacy of care given to women undergoing unsafe abortions before, during, and after the operation in order to improve the quality of care. Finally, the analysis from the study can be used to further inform stakeholders and policy makers on how to best prevent adverse health effects from unsafe abortion in the future.

As you are aware of the corona pandemic that is affecting our day to day living, we have to adjust the lifestyle and adopt preventative measures to prevent the spread of the disease. The following measures will apply during face-to-face interview to prevent the spread of diseases as outlined by WHO (2019a) (corona virus and others infectious diseases).

The researcher will request provision of the PPE materials from the hospital within the genecology ward in which data collection will be conducted.

- Interview venue to be cleaned with disinfectant (Biocide solution is used for cleaning in public health establishment).
- Table and chairs will be disinfected with sanitiser that contains 70% alcohol.
- Hand wipes and sanitiser will be available and utilised to decontaminate the hands frequently though out the process.
- Facemasks will be provided and to be worn by both the participants and the researcher throughout the process.
- Social distancing of 1.5 metre will apply throughout the process.
- Disposable plastic aprons will be utilised by the researcher and the participants to prevent the spread of diseases.
- Sterile wipes will be used to sanitise the equipment such as tape recorder, pen and other equipment that may be necessary.

Should there be lockdown that restrict the movement of people form one place to another, arrangement for virtual interview such as cell phone video calling, and Microsoft team video calling will be done.
The study will be conducted under the supervision of **Ms KP Olyn** from the University of South Africa. Contact details: **(012) 429 6248 olynkp@unisa.ac.za**. I undertake to share the study findings and recommendations with your department upon completion.

Kindly find herewith attached my study proposal for the ease of reference in anticipation that my request will receive your favourable consideration.

Yours faithfully

Kuti EM

Master's of Nursing Student

Student Number:67145663

Supervisor	Mrs KP Olyn	012-429 6248	olynkp@unisa.ac.za
Co-supervisor	Professor J Mathibe-Neke	012-429 6443	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		

APPENDIX 3b: Permission granted from the Ngami District Health Management Team to conduct the study

TEL: + (267) 6879000
FAX: + (267) 6860819
TOLL FREE: 0800 600 897

Republic of Botswana

MINISTRY OF HEALTH AND WELLNESS
NGAMI REGIONAL HEALTH MANAGEMENT TEAM
P O BOX 12
MAUN
BOTSWANA

NGAMI DHMT

REFERENCE NO: NDHMT 6/17/1 II

11th June 2021

FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB DISTRICT, BOTSWANA

Name of Applicant: Emang Margret Kuti

Date of Decision: 11/06/2021

Validity: 11/06/2021 up to 19/05/2022

The Ngami DHMT is pleased to inform you that your request to conduct a research study is approved for Ngami DHMT. The Research approval is for academic fulfilment only.

You are therefore authorized to start and collect data in the site identified within the district. Consent from identified individuals should be obtained all times.

The research should be conducted as an authorized in the approval proposal. Any changes to the proposal must be submitted to the Research and Ethics Committee Ngami DHMT. Furthermore you are requested to submit at least one hard copy and one soft copy of the report to Research and Ethics Committee within three (3) months of completion.

Thank you.

Yours faithfully

Dr S. Maripe
Agt NGAMI DHMT COORDINATOR

SM/TMK

APPENDIX 4: Participant information sheet

TITLE: FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB-DISTRICT, BOTSWANA

Dear Participant

INTRODUCTION

You are invited to take part in this research project under the title; Factors contributing to unsafe abortion among women in Ngami sub- district, Botswana. You are invited because you meet the eligibility criteria, that is, you are having or had an abortion and I need to know more about it. This information sheet will tell you in brief about the research project that I am currently conducting. It will help you to know what this research entails and help you to make an informed decision to either participate in it or not. If you decide to take part in this research, you will remain anonymous, confidentiality will be highly maintained throughout the research process. For you to participate in this research, you will have to sign a consent form. Signing the consent form means you voluntarily want to participate in the research, you understand what you have read about the research in this information sheet, you consent to the researcher to use information about you as described in this sheet and you will receive a copy of this information sheet to read at your own time with or without your family members.

The aim of this research is to explore and describe the contributing factors related to unsafe abortions to develop measures to reduce unsafe abortions amongst women in Ngami sub-district.

Before deciding whether to take part in the study or not, please read the following information carefully and ask questions if you do not understand or need clarity on anything.

WHO I AM AND WHAT THIS STUDY IS ABOUT?

I am a Master's student at University of South Africa (UNISA); currently doing research as my course of study at UNISA. The title of the research as stated above is on factors contributing to unsafe abortion in Ngami sub – district. With the gathered information, the

study will aim to provide information on the contributing factors of unsafe abortion and to develop measures to address unsafe abortion in Ngami sub-district. The study will help improve the standard of care for women who have had unsafe abortions. Furthermore; the findings of this research will be available for future researches to build upon the research findings.

WHAT DOES PARTICIPATING IN THIS RESEARCH INVOLVE?

Prior to taking part in this research you will be expected to sign a consent form if you choose to participate in the study, together with the researcher as your witness. In this study, only women who had or are having an unsafe abortion and were admitted in gynaecological ward in Ngami sub – district during the time of the study will participate. The researcher will interview you on an agreed date and time in a private area that is comfortable for you. There is a list of questions to be covered within a maximum of an hour. This interview will be audio-taped with your permission and I will be taken notes as well during the interview. After I have interviewed you and other participants, I will have to write a report on my findings and measures to prevent unsafe abortions in the Ngami sub-district.

DO YOU HAVE TO TAKE PART IN THIS RESEARCH PROJECT?

Your participation in this research is completely voluntary and you have the right to refuse participation or refuse any question and withdraw at any time without any consequence whatsoever.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS RESEARCH?

There are potential benefits of this research; that is; it will help develop knowledge about unsafe abortions beneficial to society such as receiving clinically significant information on unsafe abortion and pregnancy preventive measures can be used to influence the care provided. Additionally, you will be empowered with knowledge on unsafe abortion and can possibly share such information with family and your community. The district programs will be better placed to come up with interventions as part of the research outcome that may improve the women's health status. More specifically, if the district determines the prevalence rate of unsafe abortion in Ngami, it will be able to monitor the

rate quarterly and recognize if prevalence is increasing or decreasing. Furthermore, knowing the most common complications experienced by women undergoing unsafe abortions will help healthcare workers to better recognize and treat such complications, hopefully leading to reduced morbidity in the future. Lastly, the findings from this produced can be used to influence new measures and interventions towards women of child-bearing age to reduce unsafe abortion in the district. The measures that are going to be recommended at end of the research will benefit the participants, the district health management team and communities.

WHAT ARE THE POSSIBLE RISKS OF TAKING PART IN THIS RESEARCH?

There are possible risks with participating in this study, that is mainly, psychological discomfort. Psychological discomfort includes; fear, stress, guilt, triggering of past emotional experiences which you can experience during the interview. If that happens, the researcher will refer you for counselling or Psychologist arranged within the hospital depending on your individual need.

As we are facing the corona virus pandemic, the following measures will be in place to prevent the spread of disease: The following measures will apply during face-to-face interview to prevent the spread of diseases as outlined by WHO:2019 (corona virus and others infectious diseases):

The researcher will request provision of the PPE materials from the hospital within the genecology ward in which data collection will be conducted.

- Interview venue to be cleaned with disinfectant (Biocide solution is used for cleaning in public health establishments).
- Table and chairs will be disinfected with sanitiser that contains 70% alcohol.
- Hand wipes and sanitiser will be available and utilised to decontaminate the hands frequently throughout the interview process.
- Facemasks will be provided and to be worn by both the participants and the researcher throughout the interview process.
- Social distancing of 1.5 metre will apply throughout the process.

- Disposable plastic aprons will be utilised by the researcher and the participants to prevent the spread of diseases.
- Sterile wipes will be used to sanitise the equipment such as tape recorder, pen and other equipment's that may be necessary.

Should there be lockdown that restrict the movement of people form one place to another, arrangements for virtual interview such as cell phone video calling, and Microsoft team video calling will be done.

WILL TAKING PART BE CONFIDENTIAL?

All data obtained from you and other participants will remain confidential and will only be shared with UNISA and Ministry of Health & Wellness Research Department of Botswana. A written permission to carry out the study on participants will be sought from public hospital management and the district research committee to carry out research in the public hospital. Paper-based records will be kept in a secure location and should only be accessible to the researcher and the research assistant. This also includes computer-based records will only be accessible using access privileges and passwords. Only the researcher and the research assistant will have access to computer files of the study. All computer files and data of the study will be locked with passwords. Personal identifiers will not be used in data collection tools. All identifier written on the consent form will be stored separately from the data collection tool. Electronic data and computer files of the study will be locked under password for files, folders and the computer. Data and electronic copies will be kept for a period of five years after which all paper – based consent forms which have personal identifiers will be burned and discarded by the researcher

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

The final research product or findings will be disseminated to the Ministry of Health and Wellness, UNISA, participants, colleagues or workmates, community=based organisations, and other program officers aspiring to do further research on maternal or women health.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

Researchers contact details: Emang Margret Kuti Cell: 0027 71131737 Student No: 67145663

Email: emangmargretk@gmail.com

Supervisor	Mrs KP Olyn	012-429 6248	olynkp@unisa.ac.za
Co-supervisor	Professor J Mathibe-Neke	012-429 6443	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		

Thank you

Emang Margaret Kuti

Student No: 67145663

APPENDIX 5: Request to participate in the study

Ethics clearance reference number: _____
Research permission reference number (if applicable): _____
<date>

TITLE: FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB-DISTRICT, BOTSWANA

Dear Prospective Participant

My name is Emang Margret Kuti, and I am doing research with Ms KP Olyn lecturer the Department of Health Studies towards a MA Degree, at the University of South Africa. The study is not funded. We are inviting you to participate in a study entitled “Factors contributing to unsafe abortion among women in Ngami sub-district, Botswana”

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out the in-depth understanding of the contributing factors to unsafe abortions in order to develop possible measures to reduce unsafe abortions among women in Ngami sub-district.

WHY AM I BEING INVITED TO PARTICIPATE?

Why did you choose this particular person/group as participants?

In this research the study population will include women of ages below 18years and above, who will be admitted in gynecological ward for unsafe abortion during data collection from March 2021 to July 2021 and agree to participate. The researcher will request the unit manager to identify potential participants from the admissions within the gynecological ward, partially explain the objectives and acquire approval for the researcher to contact the participants. The researcher will then make use of the recommended list of participants, provide with letter of information and explain further the purpose and objective of the study. Data will be collected until data saturation is reached. The consent for participation will be explained to the participant and the participant will

be informed that confidentiality and anonymity will be kept in consideration throughout the research project. Should the participant agree to take part in the study, the researcher will request consent form to be signed.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

Describe the participant's actual role in the study.

Data will be collected through individual face-to-face semi-structured interview method. One major question will be asked with a follow-up of probing question to reach the objectives. Audio-recording will be done with the approval of the participants and the interview will proceed for approximately a period of one (1) hour.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Describe the presence or absence of possible benefits for the participant, the participants as a group, the scientific community and/or society.

With the gathered information, findings will add new information to the body of knowledge regarding contributory factors to unsafe abortion and develop measures that can be utilised to support the women and reduce rate of unsafe abortion and improve the standards of care for women who have had unsafe abortion. Participants will be empowered with knowledge on unsafe abortion and can possibly share such information with family and their community to reduce incidents of unsafe abortion among the communities. The district programs may use the measures developed to improve the women's health status. Furthermore, knowing the most common experiences undergone by the participants, healthcare worker will be in better position to render quality care

hopefully leading to reduced morbidity in the future. COVID-19 pandemic preventative measures will also be taken into consideration to ensure continuous mitigation of potential harm to participants.

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

The foreseeable risk of harm is the potential for discomfort or inconvenience about the information to be revealed, the information could trigger sensitive memories, trauma and put participants in an uncomfortable and psychologically harmful situation. Should the participant have some psychological discomfort, counselling will be provided and would be referred for further management by the social workers within the facility.

As we are facing the corona virus pandemic, the following measures will be in place to prevent the spread of disease: The following measures will apply during face-to-face interview to prevent the spread of diseases as outlined by WHO:2019 (corona virus and others infectious diseases):

The researcher will request provision of the PPE materials from the hospital within the genecology ward in which data collection will be conducted.

- Interview venue to be cleaned with disinfectant (Biocide solution is used for cleaning in public health establishments).
- Table and chairs will be disinfected with sanitizer that contains 70% alcohol.
- Hand wipes and sanitizer will be available and utilised to decontaminate the hands frequently throughout the interview process.
- Facemasks will be provided and to be worn by both the participants and the researcher throughout the interview process.
- Social distancing of 1.5 meter will apply throughout the process.

Disposable plastic aprons will be utilised by the researcher and the participants to prevent the spread of diseases.

Sterile wipes will be used to sanitise the equipment such as tape recorder, pen and other equipment’s that may be necessary.

Should there be lockdown that restrict the movement of people form one place to another, arrangements for virtual interview such as cell phone video calling, and Microsoft team video calling will be done.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

You have the right to insist that your name will not be recorder anywhere and that no one, apart from the researcher and identified members of the research team, no one will be able to connect you to the answers you give. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

If relevant, identify who will have access to the data external coder and they will be required to maintain confidentiality. A confidentiality agreement will be signed by the external coder. Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

A written permission to carry out the study on participants will then be sought from public hospital management and the district research committee to carry out research in the public hospital. The proposal will be submitted to the Health Studies Research Ethics Committee (HSREC) at UNISA for ethical clearance. After approval, the proposal will be sent to Botswana Research Unit, Ministry of Health and Wellness, Gaborone for permission to conduct the study. Permission to conduct the study in targeted areas will be requested and sought from Letsholathebe II Memorial Hospital Research Board and the management. The board will also be given the proposal for approval to conduct a study including the Ethical Clearance Certificate from UNISA. Paper-based records will be kept in a secure location and will only be accessible to personnel involved in the study. Computer-based records will only be available to personnel involved in the study using access privileges and passwords. Only the researcher will have access to computer files of the study. All computer files and data of the study will be locked with passwords.

Personal identifiers will not be used during research report and conference presentations and article of this research.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Personal identifiers will not be used in data collection tools. All identifiers written on the consent form will be stored separately from the data collection tool. Electronic data and computer files of the study will be locked under password for files, folders and the computer. Data and electronic copies will be kept for a period of five years after which all paper-based consent forms which have personal identifiers will be burned and discarded by the researcher. All data obtained from the study site will remain confidential and will only be shared with UNISA and Ministry of Health & Wellness Research Department of Botswana.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

No reimbursements, gifts nor services will be provided for the participants for participating in the study in adherence with the principle of fair procedures.

HAS THE STUDY RECEIVED ETHICS APPROVAL

This study has received written approval from the University of South Africa College Research Ethics Review Committee of the *(HSREC)* Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact the researcher Ms Kuti EM on 09267 71131737 or at emangmargretk@gmail.com.

Should you have concerns about the way in which the research has been conducted, you may contact the supervisor:

(a) Initials and surname:	K P Olyn
(b) Contact details:	(012) 429 6248 olynkp@unisa.ac.za
(c) Department:	Health Studies

Co-supervisor

(a) Initials and surname:	JM Mathibe-Neke
(b) Contact details:	mathijm@unisa.ac.za
(c) Department:	Health Science

Should you have concerns about the way in which the research has been conducted, you may contact the research ethics chairperson of the CREC, Dr KJ Malesa, maleskj@unisa.ac.za, 012 429 6054 if you have any ethical concerns.

Thank you for taking time to read this information sheet. If you are willing to participate in this study, kindly complete the consent form.

Kind regards

Emang Margaret Kuti
Researcher

APPENDIX 6: Informed consent

INFORMED CONSENT

DEAR PROSPECTUS PARTICIPANT:

I, the undersigned here by agree to participate i

(Full Names 0f pat icipant the full Names of participant) research project by Master in Public Mrs. EMMANG M. ICUTA Health student at UNISA as follows:

I confirm that the researcher has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation. The researcher also explained the study design, purpose, objectives, sampling procedure and data collection method as reflected the participation sheet.

I have read (or had explained to me) and understood the study as explained in the information sheet. I have had enough opportunity to ask questions and am prepared to participate in the study. I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the face —to — face semi-structured interviews. I have received a signed copy of the informed consent agreement.

Participant's names: .

Participant's signature: Date 05/07/2021

Witness's names BONOLO GAOGAKWE Date 05.07.2021

Witness's signature . Date 05.07.2021

1

APPENDIX 7: Minor assent consent form

Minor Assent consent request

Project Title: Contributing factors to unsafe abortions among women in Ngami Sub- district Botswana

Investigator: Emang Margret Kuti
Student No: 67145663

I am doing a research study about the contributing factors of unsafe abortions and to develop measures to reduce occurrence of unsafe abortion to improve reproductive health outcomes amongst women in Ngami sub-district. A research study is a way to learn more about people. Should you decide to be part of this study, you will be asked questions in relation to your experience of the unsafe abortion and lastly make recommendations on how health care services can be improved to prevent occurrences of unsafe abortion.

All this information will be collected from you in the form of face-to-face semi-structured interview. All interviews will be recorded at your approval. The interview will take about one to two hours which can be of a discomfort since you are required to answer all questions in the interviews. The researcher is aware of how that could possibly be of an inconvenience to you. It can also be a discomfort since you will have to discuss your sexual history and the whole ordeal of unsafe abortion from the beginning to the end. If you encounter some psychological discomfort, then counseling will be done and you can be referred for further management by the psychologists and social workers within the facility.

There are potential benefits of this research; that is; it will help develop knowledge about unsafe abortions beneficial to society such as receiving clinically significant information on unsafe abortion and pregnancy preventive measures can be used to influence the care provided. Additionally, you will be empowered with knowledge on

1

unsafe abortion and can possibly share such information with family and your community. The district programs will be better placed to come up with interventions as part of the research outcome that may improve the women's health status. More specifically, if the district determines the prevalence rate of unsafe abortion in Ngami, it will be able to monitor the rate quarterly and recognize if prevalence is increasing or decreasing. Furthermore, knowing the most common complications experienced by women undergoing unsafe abortions will help healthcare workers to better recognize and manage such complications, hopefully leading to reduced morbidity in the future. Lastly, the research produced in this study can be used to influence new strategies and interventions towards women of child-bearing age to reduce unsafe abortion in the district. The measures that are going to be recommended at end of the research will benefit the participants, the district health management team and communities.

As we are facing the corona virus pandemic, the following measures will be in place to prevent the spread of disease: The following measures will apply during face-to-face interview to prevent the spread of diseases as outlined by WHO:2019 (corona virus and others infectious diseases):

The researcher will provide with the PPE materials for the period of data collection.

- Interview venue to be cleaned with disinfectant (Biocide solution is used for cleaning in public health establishments).
- Table and chairs will be disinfected with sanitiser that contains 70% alcohol.
- Hand wipes and sanitiser will be available and utilised to decontaminate the hands frequently throughout the interview process.
- Facemasks will be provided and to be worn by both the participants and the researcher throughout the interview process.
- Social distancing of 1.5 metre will apply throughout the process.
- Disposable plastic aprons will be utilised by the researcher and the participants to prevent the spread of diseases.
- Sterile wipes will be used to sanitise the equipment such as tape recorder, pen and other equipment's that may be necessary.

- Should there be lockdown that restrict the movement of people form one place to another, arrangements for virtual interview such as cell phone video calling, and Microsoft team video calling will be done.

After completing interviews with all participants the researcher will write a report about what was learned. This report will not include your name or that you were in the study. Kindly note that you are welcome to excuse yourself from the study at any time you feel like doing so.

If you consider taking part in the study, please sign your name.

I, _____ , want to be in this research study.

Participant Signature

18/08/21

Date

Supervisor	Mrs. KP Olyn	012 -429 6248	olynkp@unisa.ac.za
supervisor	Professor J Mathibe-Neke	012—429	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		

CONSENT FORM FOR GUARDIAN OR PARENT OF A MINOR

INTRODUCTION

I would like to invite your child to join a research study to look at the contributing factors to unsafe abortions among women in Ngami sub district. Please take all the time you need to discuss the study with your child or anyone else you wish to. In this research study, the researcher will be investigating the factors contributing to unsafe abortion among women, to develop measures to reduce unsafe abortions and resulting complications amongst women in Ngami sub-district.

WHAT IS INVOLVED IN THE STUDY?

Should you contemplate on agreeing that your child participate in the study, this is a basic outline of what will happen over the course of your child's participation in the study; there will be a face-to-face semi-structured interview which will be tape recorded then analyzed by the researcher. Only the researcher and the research assistant will have access to this information. Interviews will be anonymous and the child's information will be kept confidential at all times. The interview will take only 1-2 hours only in one day. The interview will take place only when your child has free time to do so.

The researcher may stop the study or take your child out of the study at any time the researcher judge it is in her best interest. The researcher may also remove her from the study for various other reasons. This can be done without your consent. Your child can also stop participating at any time.

ELIGIBILITY CRITERIA

For this research, women of all ages, below and above 18 years, who reside in the Ngami sub-district and are admitted to the gynaecological ward for unsafe abortions during the data collection period and were willing to participate in the study will be allowed to take part in it.

RISKS

This study might have medium risk since your child might experience psychological discomfort as she will have to remember the whole unsafe abortion experience. If that happens, she will be counselled and referred to the psychologist and /or social workers within the facility by the researcher. The interview can be also time consuming for your child. There may also be other risks that we cannot predict.

As we are facing the corona virus pandemic, the following measures will be in place to prevent the spread of disease: The following measures will apply during face-to-face interview to prevent the spread of diseases as outlined by WHO:2019 (corona virus and others infectious diseases):

The researcher will request provision of the PPE materials from the hospital within the genecology ward in which data collection will be conducted.

- Interview venue to be cleaned with disinfectant (Biocide solution is used for cleaning in public health establishments).
- Table and chairs will be disinfected with sanitiser that contains 70% alcohol.
- Hand wipes and sanitiser will be available and utilised to decontaminate the hands frequently throughout the interview process.
- Facemasks will be provided and to be worn by both the participants and the researcher throughout the interview process.
- Social distancing of 1.5 metre will apply throughout the process.
- Disposable plastic aprons will be utilised by the researcher and the participants to prevent the spread of diseases.
- Sterile wipes will be used to sanitise the equipment such as tape recorder, pen and other equipment's that may be necessary.

  Should there be lockdown that restrict the movement of people form one place to another, arrangements for virtual interview such as cell phone video calling, and Microsoft team video calling will be done.

BENEFITS TO TAKING PART IN THE STUDY?

It is reasonable to expect the benefits from this research but the only benefits that will be gained is that from this study. Ngami sub- district will obtain a more complete picture of factors contributing to abortions and experiences thereof. Additionally, the district will learn the adequacy of care given to women undergoing unsafe abortions before, during, and after the operation in order to improve the quality of care. Finally, the analysis from the study can be used to further inform stakeholders on how to best reduce unsafe abortion occurrences and adverse health effects from unsafe abortion in the future. Others may benefit in the future from the information we find in this study.

CONFIDENTIALITY

The researcher will take the following steps to keep your information confidential, and to protect it from unauthorized disclosure, tampering, or damage: all research information obtained from your child will be kept confidential under lock and key and can be accessed by the researcher and the research assistance only. All interviews will be anonymous throughout the study to protect your child.

INCENTIVES

There will be no incentives for participation in this study.

YOUR RIGHTS AS A RESEARCH PARTICIPANT

Participation in this study is voluntary. Your child has the right not to participate at all or to leave the study at any time. Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which she is entitled, and it will not harm her relationship with the hospital. There will be follow up interviews to validate information obtained in first interview.

CONTACTS FOR QUESTIONS OR PROBLEMS?

If you have questions about the study, any problems, unexpected physical or psychological discomforts, any injuries, or think that something unusual or unexpected is happening. Contact the researcher **: Emang Kuti at 6861018/ 71131737 or email: emangmargretk@gmail.com.**

Supervisor	Mrs. KP Olyn	012 -429 6248	olynkp@unisa.ac.za
Co-supervisor	Professor J Mathibe-Neke	012-429 6443	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		

:t
(or Legally Authorized Representative)

Subject or Representative

Date
18/08/21

Signature of witness
P. Maitiso (SZN)

Date

Signature of researcher
18/08/21

Date

APPENDIX 8: Confidentiality agreement of research assistant

Emang Margret Kuti

Student No: 67145663

Title: Factors contributing to unsafe abortion among women in Ngami sub-district, Botswana

RESEARCH ASSISTANT CONFIDENTIALITY AGREEMENT
Botswana Ministry of Health Research Unit

I, [name of research assistant], agree to assist the primary investigator with this study by helping the primary investigator to audio-tape interviews, transcribe interviews, and analyse the resulting data. I agree to maintain full confidentiality when performing these tasks.

Specifically, I agree to:

- keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the primary investigator;
- Hold in strictest confidence the identification of any individual that may be revealed during the course of performing the research tasks;
- Not make copies of any raw data in any form or format (e.g., disks, tapes, transcripts), unless specifically requested to do so by the primary investigator;
- Keep all raw data that contains identifying information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
- This includes:
    - keeping all digitized raw data in computer password-protected files and other raw data in a locked file;

- closing any computer programs and documents of the raw data when temporarily away from the computer;
- Permanently deleting any e-mail communication containing the data; and
- using closed headphones if transcribing recordings;

- Give all raw data in any form or format (e.g., disks, tapes, transcripts) to the primary investigator when I have completed the research tasks;

- Destroy all research information in any form or format that is not returnable to the primary investigator (e.g., information stored on my computer hard drive) upon completion of the research tasks.

Provide the following contact information for research assistant:

Printed name of research assistant.....

Address....THITA WARD, THITA CLINIC STAFF HOUSES

Telephone number: ....72867376.....

Signature of research assistant ..[signature]..Date ..01/07/2021

Printed name of primary investigator...EMANG M. KETI

Signature of primary investigator.....[signature]..... Date...01/07/21

Supervisor	Mrs. KP Olyn	012 -429 6248	olynkp@unisa.ac.za
Co-supervisor	Professor J Mathibe-Neke	012-429 6443	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		

APPENDIX 9a: Interview guide (English)

TITLE: FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN NGAMI SUB DISTRICT, BOTSWANA

INTERVIEW GUIDE

Participant Number: _____

SECTION A

Demographic data: Please indicate with a tick in the box

Age	18 yrs.	
	18 to 20 yrs.	
	21 to 29 yrs.	
	30 to 39 yrs.	
	39 yrs >	
Dependents	None	
	1to 2	
	2 to 3	
	3 to 4	
	4 >	
Marital status	Married	
	Widower	
	Divorced	
	Single	
Level of education	Primary	
	Secondary	
	Tertiary	
	None	
Employment status	Employed	
	Non-employed	
Number of abortions	Once	
	More than once	
Region		

SECTION B

Main Question

Could you kindly describe in your own words what you think mainly contributed to the decision of an abortion?

- Could you please explain your experience of going through an unsafe abortion process?
- What do you think can be done to prevent unsafe abortion?
- Is there anything else you want to share?

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APPENDIX 9b: Interview guide (Setswana)

Emang Margaret Kuti
Student No: 67145663

Setlhogo sa Dipatlisiso: ***Dintlha tse di bakang tshenyo ya boimana e e sa sireletsegang mo go bomme mo Kgaolong ya Ngami mo Botswana***

KAEDI YA POTSOLOSO

Nomoro ya Motsaakarolo: _____

KAROLO YA NTLHA

Ka tsweetswee tshwaela mo lebokosong le le maleba le karabo ya gago

Dingwaga	18 go ya tlase	
	19 - 29	
	30 - 40	
	41 le go feta	
Ao nyetse kana o nyetswe	Ga ke ise ke nyalwe	
	Ke nyetse kana nyetswe	
	Nyalo e fedile	
	Ke tlhokafaletswe ke o neng re nyalane	
Dithuto	Dithuto tse dipotlana	
	Dithuto tse dikgolwane	
	Dithuto tse dikgolo	
	Ga ke a tsena sekolo	
Ao santse o tsena sekolo?	Ee	
	Nnyaa	
A oa bereka	Ke a bereka	
	Ke a ipereka	
	Ga ke bereke	
Palo ya tshenyo boimana	Gangwe	
	Go feta bongwe	

KAROLO YA BOBEDI

Potsokgolo

Go ya ka wena ke eng se se bakileng gore obo o senya boimana ka tsela e e sa sireletsegang?

- Tlhalosa maitemogelo a gago a go itemogela tshenyo ya boimana e e sa sireletsegang?
- O akanya gore go ka dirwa eng go hema tshenyo ya boimana e e sa sireletsegang?
- A go sengwe gape seo eletsang go se arogana mo puisanong e?

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Co-supervisor	Professor J Mathibe-Neke	012-429 6443	mathijm@unisa.ac.za
Ethics committee	crec@unisa.ac.za		
Translator and Transcriber	Mr Oaitse Jobe Bolotsang, *Data Analytics and M&E Specialist, Former Research Lecturer and Principal Investigator* Contacts: +26772814808 Email: noziebolts@gmail.com		

APPENDIX 10: Transcriptions

PARTICIPANT A (English Version)

Interviewer: I would like to know your age
Participant: I am 23 years old
Interviewer: Are you married?
Participant: No
Participant Interviewer: Are you currently studying or not?
Participant: I am not
Interviewer: Which level did you end at school?
Participant: Secondary level
Interviewer: Are your working?
Participant: Yes, I am working
Interviewer: Is this first abortion, second of third?
Participant: For me I will say the first

Interviewer: Now we will go on to the second part of the questions and you will have to explain more

Interviewer: Kindly explain in your own words what mainly contributed to you undertaking unsafe abortion

Participant: Firstly, sometimes it is because of family, most of the time we feel like if we can go to parents, they will feel I am still young to fall pregnant and have brought down the family dignity. Secondly it is peer pressure, I will be coming to you and telling that I am having a situation, instead of you telling me that this is not a big problem, pregnancy is just a process that one can go through give birth and be fine, you will be saying terminate this just terminate it, first what will the baby eat, what will you eat? you are not working, you are not doing anything you just staying home. Some friends will be telling you that we will be having fun while you are in confinement, so friend just terminate. Some terminate looking at their family socio economic background.

Interviewer: ….. so, for...in your case, what do you think is the real problem?

Participant: The real problem to me, is parents, family. I have a very strict family both on my mother's side and father's side…They are very very strict especially my elder brother. They think they are so protective of us; they are very strict. They will be telling you are not working, you just stay home what will you eat, what will you feed your kid, when you don't work, what are your life plans, instead of you going to school, you will be home and getting pregnant, just words that are not good. Last year I was admitted here again, I didn't know I was pregnant, and I was just having my periods, and the following day I started having some heavy flows and went to Maun General, and I was cleaned here. I didn't tell anyone; I was with my cousin who told the old woman. When my brother brought me some items here, he started slashing me with words, I had his messages and I deleted them. He was telling me how fearless, even sicknesses I am not afraid of them. I have a two-year-old baby, he was saying they are taking care of the baby and they can't be burdened with my other child and all that stuff. Even now I was talking to the old woman, and asking me where Mothusi is, my brother, and she said he was here, and when he heard that I was at Letsholathebe, he said, I must not have terminated the pregnancy again. As for them they are always thinking of it in a negative way, when someone tells them I am at gyena, to them the person has terminated the pregnancy.

Interviewer: This time around is it you who decided to end the pregnancy?

Participant: Yes, this time around I am the one who decided. A certain friend of mine got me some pills, the Cytotec and they are the ones I used.

Interviewer: How old was the pregnancy?

Participant: It was one month

Interviewer: I get it that your family is strict, especially your brother. That's why you decided to terminate the pregnancy, So I think it's your second abortion?

Participant: yes

Interviewer: How did you feel as you went through this whole process?

Participant: Hey, at first, I was scared. I always thought like because people's bodies are not the same. I was thinking that this would not treat me well, may be when I go to sleep that will be my end. I had that fear, having second thoughts of whether I should do it or not. But if I don't do, I will face those words back home, and if do if I lose my life, who will remain with my baby. I was having those questions, but I ended saying let me put everything in Jehovah, and I ended up doing.

Interviewer: So, do you know the complications that can happen if you abort a pregnancy, do you what can happen?

Participant: Well, I wouldn't say I know but just as I have stated, this one of losing life is that I know. And that when you continue terminating pregnancies, there are possibilities of being infertile in the future.

Interview: What do you think can be done differently to prevent unsafe abortion?

Participant: The thing is in Botswana abortion is illegal, only if it was legalised on the basis of individual reasons that would be better, all these illegal abortions would not be happening. Because it is not all of us who use the pills, some use traditional medicines because they are scared to buy the pills. If reasons for why so and so wants to do abortion, that would be better.

Interviewer: What do you think about the services that we have in the country that can prevent unwanted pregnancy? Do you know them for example family planning methods?

Participant: Yes, family planning. But you find out that most of the people are not in any of those family planning methods. Even when you tell someone why you are not using a pill at least, she will come up with a reason, use the injection, they tell you no I can't use it because it makes me fat, use a pill, I forget to take the pill, implant is there, no that one puts someone in a continuous period. They come up with reasons that are invalid.

Interviewer: In your case why are you not using these methods?

Participant: for me I was using implant, I removed in April this year when I was sick. It caused me dizziness, I would have prolonged periods, and it would even double in a month.

Interviewer: Is there anything you want to say, anything?

Participant: Well, from my experience with abortion, it is very painful. Of course, I can't dispute those pains are like labour pains, but this one is very painful. Imagine you are with the old woman in the house, and you terminate, even when you want to explain the pain and not wanting to tell her what you have done, she will be busy giving you paracetamol. I endured so much, the pain would come and go, and would develop some dizziness and headache, and shaking. When I am sited, my heart would be beating faster.

Interviewer: how did you end up here?

Participant: Yesterday when I was just sleeping, when I was about to wake up to go and pick the baby from the uncle, I was feeling dizzy and ended up sitting down. And I asked my mother to give me a painkiller, when I tried to leave it was difficult then I asked my elder sibling to take me to Maun General because it is always not that busy. When I got there, I told them that I am having the dizziness, headache, the feeling as if I want to throw but nothing is coming out and the pains on the back and abdomen. I was then referred to Letsholathebe, when I arrived, I did scan and saw a Doctor who told me that I will be admitted, and the womb will be cleaned. It was cleaned last night. SO now I don't feel anything, although I can feel blurry a little bit as if the dizziness and headache will return, but I am just feeling fine.

Interviewer: So, thank you so much for volunteering with so much sensitive information for the study, it is strictly confidential, and I really appreciate your bravery in giving me this private information about yourself …

Participant: Hey, at first, I was scared. I always thought like because people's bodies are not the same. I was thinking that this would not treat me well, maybe when I go to sleep that will be my end. I had that fear, having second thoughts of whether I should do it or not. But if I don't do, I will face those words back home, and if do if I lose my life, who will

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Participant: Well, I wouldn't say I know but just as I have stated, this one-off losing life is that I know. And that when you continue terminating pregnancies, there are possibilities of being infertile in the future.

Interview: What do you think can be done differently to prevent unsafe abortion?

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Participant: Yesterday when I was just sleeping, when I was about to wake up to go and pick the baby from the uncle, I was feeling dizzy and ended up sitting down. And I asked my mother to give me a painkiller, when I tried to leave it was difficult then I asked my elder sibling to take me to Maun General because it is always not that busy. When I got there, I told them that I am having the dizziness, headache, the feeling as if I want to throw but nothing is coming out and the pains on the back and abdomen. I was then referred to Letsholathebe, when I arrived, I did scan and saw a Doctor who told me that I will be admitted, and the womb will be cleaned. It was cleaned last night. SO now I don't feel anything, although I can feel blurry a little bit as if the dizziness and headache will return, but I am just feeling fine.

Interviewer: So, thank you so much for volunteering with so much sensitive information for the study, it is strictly confidential, and I really appreciate your bravery in giving me this private information about yourself …

FIELD NOTES FOR PARTICIPANT A

SET OF INTERVIEW: Initial

DATE: 01/07/2023

TIME: 2pm

LOCATION: Gynaecology ward private room-procedure room

- Face to face interview context
- Conduce venue, silent with air conditioning. Ample space.

FIRST IMPRESSION

- Participant looks uncomfortable, shy ---probably trust issues???sensitivity of the topic??
- Reserved person??? Or is it a personal trait? Just hesitation?
- Open body posture but tight and controlled
- Hardly makes eye contact
- Uncomfortable with recording of interview

GENERAL NOTES

- At first slow to answer questions and answers well thought
- Demographic history questions: offers brief and tom the point answers, interested in answering them??

Second section/main questions

- Gradually opening up
- At times answers questions to please the researcher?? Researcher authority figure??
- Gaining confidence as interview progresses though a bit unsure of answers at times??trust issues
- Very articulate in both languages, English and Setswana

As interview progresses the participant opened up

- Seems knowledgeable about unsafe abortion
- Distances self from actual questions asked, generalises answers
- With redirection form researcher participant opens up about her experience about unsafe abortion
- Demonstrates trauma, voice shaky when talking about ordeal.

- Other emotions scared? regret, sadness, fear???? About the procedure vs own health
- Knowledgeable about Botswana law on abortion? Source of anxiety and disclosure of procedure to research team????

Towards end of interview

- Participant makes sound recommendations to prevent or curb unsafe abortion
- Seems to trust the researcher, answer questions relevantly, maintains eye contact at times
- Willing to do follow up interviews

APPENDIX 11: Editing confirmation

I, Tidimalo Catherine Manyaapelo, confirm that I am a language practitioner and that I edited the thesis titled, **FACTORS CONTRIBUTING TO UNSAFE ABORTION AMONG WOMEN IN THE NGAMI SUB-DISTRICT, BOTSWANA**, authored by Emang Margret Kuti, to be submitted for the degree of MASTER OF PUBLIC HEALTH.

Signed:

APPENDIX 12: Turnitin report