

THE EXPERIENCES OF WOMEN WHO UNDERGO TERMINATION OF PREGNANCY IN MPUMALANGA PROVINCE, SOUTH AFRICA

R.E. Mookamedi, PhD

Doctoral student, Department of Health Studies, University of South Africa

S.M. Mogotlane, PhD

Emeritus Professor, Department of Health Studies, University of South Africa

Corresponding author: Sophie.mogotlane@vodamail.co.za

J.H. Roos, PhD

Department of Health Studies, University of South Africa

ABSTRACT

The *Choice of Termination of Pregnancy Act, 92 of 1996* (South Africa 1996) is aimed at improving the lives of all women, stipulating that every woman has the right to make choices about her own body, including being pregnant. This act was welcomed by many health professionals as it was seen as a way to increase access to safe abortion services and thus prevent morbidity and mortality associated with unsafe and illegal 'back street' abortions. The purpose of the study was to explore and describe the experiences of women who undergo termination of pregnancy (TOP) at TOP services in the Mpumalanga Province, South Africa. A

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qualitative, descriptive, explorative and contextual research design was utilised. Participants were included in the sample through convenience sampling. Data was collected from nine individuals using semi-structured interviews. Tesch's method of data analysis was used to analyse the qualitative data. Measures to ensure trustworthiness were applied throughout the research and ethical considerations in the conduct of research adhered to. The findings revealed that health care consumers in Mpumalanga Province experienced emotional, physical and psychological discomfort in the TOP services received. Recommendations include community education for the support of the TOP programme, better integration of the TOP programme into other medical and social services and timely counselling, control and pain management for women who undergo TOP.

Keywords: experiences, termination of pregnancy (TOP), women who undergo TOP

INTRODUCTION AND BACKGROUND OF THE STUDY

The South African *Choice on Termination of Pregnancy Act* (CTOP) (No.92 of 1996) provides all South African women with the freedom to have an early, safe and legal abortion (Harries, Stinson & Orner, 2009:2). The *CTOP Act, 92 of 1996* is aimed at improving women's quality of life. The Act stipulates that every woman has the right to make choices about her own body and about being pregnant. By allowing all women the right to choose whether to terminate their pregnancies within the specified parameters or not, the South African government is increasing access to safe abortion services for all women and is thus preventing morbidity and mortality associated with unsafe, illegal 'back street' abortions.

In Mpumalanga, TOP is part of sexual and reproductive health services (MDOH, 2009a:7). The TOP programme was introduced in Mpumalanga in 1997 to address gender issues where women are supported to enhance self-determination. As a government initiative and commitment, the programme further aims to reduce the morbidity and mortality due to unsafe abortion practices. The province developed a policy known as the Mpumalanga Termination of Pregnancy Implementation Policy (MTOPIP) for implementing the programme.

As indicated by Trueman and Magwentshu (2013:399), a 'liberal abortion law in a country does not mean that there is automatic access to safe abortion services', where less than 50% of the 260 facilities registered by the authorities to provide legal abortions are providing these services to the communities. One of the reasons might be the focus that the government places on the implementation of the Prevention of Mother to Child Transmission of the Human Immunodeficiency Virus (HIV), with less focus on the TOPs programme.

PROBLEM STATEMENT

The provision of reproductive health services, especially TOP services, was identified as a national priority in South Africa due to escalating morbidity and mortality rates as a result of unsafe backstreet abortions. Years after the legalisation of TOP, illegal backstreet abortions are still taking place, putting the lives of women at risk due to infections, bleeding and perforation of the abdomen and uterus (Medley, 2011:5). It is difficult to obtain statistics about illegal abortions, but Gresh and Maharaj (2014:681) estimated that from the 45 million pregnancies per year that end up in abortion, an estimated 20 million are performed in unsafe circumstances.

According to Engelbrecht (2005:4), poor organisation of the health system in relation to referrals, geographic distribution of facilities offering TOP, the lack of trained TOP service providers as well as the negative attitude and stigmatising of TOP service providers and the women who received TOP services alike by communities have all contributed to the poor service delivery in this regard. Table 1 provides statistics of pregnancies terminated in the earlier years of the inception of the TOP programme. The figures show a significant fluctuation from 2002.

Table 1: Number of TOPs and annual accumulated increase/decrease in Mpumalanga, 1998–2008

YEAR	NUMBER OF TOPs	PERCENTAGE INCREASE/DECREASE
1998	1642	
1999	1893	15.28%
2000	2344	23.82%
2001	3802	62.20%
2002	3151	-17.12%
2003	2767	-12.18%
2004	1962	-29.09%
2005	1381	-29.61%
2006	3735	170.45%
2007	3772	0.99%
2008	1687	-55.2%

Source: MDOH (2009b:1)

The experiences of women who undergo TOP in Mpumalanga Province regarding TOP services received have not been explored yet. An exploration of the experiences of the receivers of TOP services might help us to understand the reason why there is a decrease in the percentage of women using the TOP facilities in the Mpumalanga Province.

PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the experiences of women who undergo TOP at TOP services in the Mpumalanga Province. This information could then be used to improve the service delivery to women who use the TOP facilities in Mpumalanga. The ultimate purpose of this study was to support the women using TOP facilities and to remove possible barriers that could prevent them from using the TOP facilities

DEFINITIONS OF TERMS

For the purpose of this study, the following terms are defined as follows:

Experience: The *Concise English Dictionary* (2004:303) defines experience as ‘something personally encountered or undergone’. In this study, experiences refer to the participants’ experiences about TOP services.

Programme: Booyens (2014:483) defines a programme as ‘a single-use plan designed to carry out a special project in an organisation that, if accomplished, will contribute to the organisation’s long-term success’. In this study, programme refers to the TOP programme in South Africa in which health professionals offer TOP services to women upon request, on the basis of conditions that might be dangerous to the life of a pregnant woman or the foetus as well as on the basis of choice by the affected woman to enhance the woman’s self-determination.

Termination of pregnancy: The *CTOP Act, Act No. 92 of 1996* (SA, 1996:2) defines termination of pregnancy as ‘the separation and expulsion (by medical or surgical means) of the contents of the uterus of a pregnant woman’. In this study, termination of pregnancy means assisted expulsion of the contents of the pregnant uterus by a medical practitioner or by a professional nurse trained in TOP in accordance with the stipulations of the *CTOP Act*.

Women who undergo TOP: A woman who undergoes TOP is any pregnant woman using the services of facilities designated to provide TOP services in Mpumalanga. In this study, a woman who undergoes TOP refers to any female of childbearing age requesting termination of pregnancy in one of the seven active facilities designated to provide TOP services in Mpumalanga and has this procedure done.

RESEARCH DESIGN AND METHODOLOGY

A qualitative, explorative, descriptive and contextual research design was used to explore the participants' experiences regarding TOP services in Mpumalanga, South Africa. The explorative approach was considered suitable for the study because participants' experiences were not known and the approach would allow the participants to express their lived experiences in their own words.

Research setting

The study took place in the seven active facilities that provide TOP services in Mpumalanga Province. The province serves people from diverse cultural spheres. Languages spoken include Ndebele, Tswana, Pedi, Zulu, Swazi, Tsonga and Southern Sotho. The culture is also influenced by the influx of people from neighbouring provinces and cross-border countries that further impact on the utilisation of TOP services and how abortion is perceived. The province has 28 public hospitals serving a population of 3 399 000, of which 52% are women and 32% of these women are of child-bearing age (MDOH, 2009b:1; DOH, 2005:69). Although all the public hospitals in Mpumalanga are designated to provide the service in terms of the *CTOP Act*, at the time of the study only seven of these were actively participating in delivering TOP services.

The MDOH (2009b:1) reported that between 2005 and 2008, 10 575 TOPs were performed, indicating an average of 220 TOPs per month, in the Mpumalanga Province.

Population and sample

The population for this study were women who made use of the TOP health care facilities. A non-probability sampling technique was used to purposively select facilities, which were active in the provision of TOP services. Convenience sampling was used to select women who underwent TOP to participate in the study. The sample size was not predetermined and data collection continued until data saturation was reached.

Data collection

Data collection took place during September and October 2010 by means of individual interviews in a private room at the TOP facilities. The interviews lasted for approximately 30 minutes. While the interviews were in progress, a sign 'Do not disturb, interview in progress' was placed on the closed door. All interviews were conducted in English. Data collection was done using one core question: What is your experience regarding TOP service provision and facilities? Probing questions were also asked, for example: How did you know about the legality of abortion in South Africa? How do you feel about it? What does this mean to you? Women who used the TOP facilities were approached and requested to participate in the study. A tape recorder was used to record the interview held by the first author of the article.

Data analysis

After the interviews, the tape-recorded interview was transcribed verbatim and analysed. According to Corbin and Strauss (2008:367), data analysis involves a dynamic process in which researchers brainstorm data presented in an effort to arrive at a conclusion. Tesch's (Creswell, 2009:155) method of data analysis was used to analyse the transcribed interviews.

Trustworthiness of the study

Trustworthiness is the 'degree of confidence qualitative researchers have in their data' (Polit & Beck, 2012:768). In this study, trustworthiness was achieved by observing the principles of credibility, transferability, dependability and confirmability.

Prolonged engagement with data was undertaken to ensure credibility where the first author conducted the interviews, listened to the tapes repeatedly and transcribed the interviews verbatim.

Transferability/applicability is concerned with the probability that the research findings have meaning in similar settings (De Vos, Strydom, Fouchè & Delpont, 2011:420). According to Babbie and Mouton (2011:278), the researcher can improve applicability of a study by providing an audit trail of rich descriptions of the research process so that anyone interested in a replication of the study has a base of information. Transferability of findings was not possible due to the uniqueness of the cases under study. The researcher improved the applicability of the study by providing an in-depth description of the research process undertaken so that anyone interested could transfer the findings to other settings or groups.

Dependability or consistency refers to the extent to which the findings are credible (Babbie & Mouton, 2011:278). Dependability was achieved through the audit trail where other researchers could scrutinise or follow the research methods, the researcher's interpretation and conclusions made.

Polit and Beck (2012:740) refer to confirmability as a neutral criterion used to measure the trustworthiness of qualitative research. To ensure confirmability, the researcher engaged an external analyst to code the data. The findings were also supported by literature.

ETHICAL CONSIDERATIONS

The research proposal was reviewed by the Research and Ethics Committee at the University of South Africa and the relevant authorities in the Department of Health, Mpumalanga Province, to ensure that the required ethical standards were maintained and approval was granted for the research. Further permission was sought and obtained from the chief executive officers of the hospitals concerned.

The participants were informed of the purpose of the study and voluntary participation was emphasised before giving informed consent. The researcher also respected the rights of those participants who were approached but did not want to participate. Anonymity, privacy and confidentiality were also adhered to.

RESULTS

Data was collected from participants willing to participate in the research. Data saturation was attained after the ninth interview when no new information emerged. All nine women were single and unemployed and five were below 25 years of age. The reasons for requesting TOP varied. The six participants who were still at school wished to pursue their studies. Similar responses were reported by Engelbrecht (2005:158, 165), whereby pregnant minors opted for TOP because they wanted to complete their studies or were unmarried. Others were concerned about those around them. In a study conducted by Shellenberg and Frohwirth (2009:4), some participants indicated that their parents would be disappointed if they learn of their pregnancy and subsequent abortion. In this study one participant stated that:

I don't want my mom to have a heart attack because when my sister got pregnant, she did not take it well at all. She became sick (P4).

FINDINGS AND DISCUSSIONS

Participants' experiences

In the qualitative data analysed, three themes with related categories emerged.

Table 2: Results relating to the experiences of women who undergo TOP services

Main theme	Categories
Theme 1: Health considerations	Emotional factors Physical factors Spiritual factors
Theme 2: Support system	TOP service providers' support Support by other personnel in the facilities not involved in the provision of TOP services Community members' support of TOP services
Theme 3: Challenges in the provision of TOP services	-

Theme 1: Health considerations

This theme reflected on the experiences of the participants and the impact of these experiences on their health, and is discussed under the three categories, which are emotional, physical and spiritual factors.

Category 1: Emotional factors

The participants explained the termination of pregnancy as a very emotional and exhausting exercise. They expressed long-lasting and deep emotional feelings of regret, guilt, self-blame and inability to make decisive decisions. This is captured in the following remarks by participants:

I regret about the whole thing ... including the decision to fall pregnant ... and ..., to terminate this pregnancy. This is a big lesson for me (P4).

It's not an easy decision.... It was not easy to decide ... I still blamed myself for being so negligent (P3).

[I]t is difficult to make a decision to abort ... you just do not feel comfortable and the community out there ... if they come to know..., they do not want to associate with you ... you become sore inside ... you feel unwanted by society (P9).

These responses express the emotions related to TOP and the perceived stigma. To this effect, Shellenberg and Frohwirth (2009:1) reported on internalised or perceived stigma manifesting as feelings of guilt, shame, anxiety or other negative feelings about the self.

Category 2: Physical factors

Participants reported pain and discomfort during the TOP procedure even though the MTOPIP mandates TOP service providers to provide comfort and pain relief to clients during and after termination of pregnancy. Failure to control pain when it is mandatorily provided for in the policy is a constitutional infringement of the TOP health care consumers' rights to access medication when needed. Responses from participants were that

The procedure is painful.... It is painful. The 5 minutes are like having severe labour pains, but after that it's fine (P7).

It was sore for about 15 minutes, and 15 minutes for me was like the whole 24 hours (P1).

In a study conducted by Poggenpoel and Myburgh (2006:5), findings revealed that participants experienced pain during TOP as confirmed by participants in this study.

Category 3: Spiritual factors

Participants' spiritual experiences were reported in terms of religious beliefs for those who regarded TOP as 'killing' or 'murder', therefore committing a sin before God.

She (the receptionist) asked me if I am the one who also wants to kill ... (P9).

And every time when I pray, I ask God to forgive me ... (P1).

My church does not approve; but I unfortunately have to do it. I will ask God for forgiveness for that. I know He will forgive. I will also ask that even those nurses who helped me, let them be forgiven ..., they are compromising themselves for our sake (P4).

Nandipha (2008:14) corroborates that religious stigma is attached to those terminating pregnancies and people are vocal about their disapproval, and adds that ironically some of the people who vocally and publicly disapprove of these services nevertheless come to the clinic requesting TOP service, stating that they dislike terminating the pregnancy but do not have any option.

Theme 2: Support system

This theme dealt the lack or availability of support as experienced by health care consumers regarding TOP services received from TOP service providers, other personnel in the facility not involved in the provision of the service and the community. In all instances, this was influenced by attitudes.

Category 1: TOP service providers' support

Some participants expressed their satisfaction with the support they received from TOP services providers.

She really assured me that I made a correct decision and that whatever happened in this unit remains confidential (P1).

They gave me a lot of information here (P2).

The support she gave me was excellent. To rate it ... she is a good sister ..., and dedicated to doing her work (P4).

Some TOP service providers were not perceived as supportive as evidenced by the following:

She was just rough ... like ... she was doing it so that I don't come back here again ... you know. She was just pressurising me, not making me calm you know She knows how to do it ... but has no patience (P6).

Mokgethi, Ehlers and Van der Merwe (2006:37) also reported from their research findings a lack of support from TOP service providers in the North-West Province where patients were said to be left alone to care for themselves, thus not receiving adequate care before and after the TOP procedure.

Other TOP service providers were not impressed with the numbers of TOP seekers. To this effect one of the TOP service providers wanted to know how a TOP health care consumer came to know about the facility. Participants responded as follows:

[S]he (TOP service provider) ..., kept asking me ..., how did I know about the TOP services ..., in this hospital ... I told her I heard from my friends ... because I could not remember reading anywhere about the TOP ... she did not look happy..., I do not know why ... (P8).

Category 2: Support by other personnel in the facilities not involved in the provision of TOP services

The narratives as presented by participants indicated that other personnel who are not in the TOP team did not provide the support required.

I felt very much embarrassed when the clerk at the reception, after I asked where I could go to have the service, said to me, "You are still young and you got involved in sex, now you want to terminate that pregnancy." ... I nearly turned back because I had whispered to him and he just said it loud, not considering that other people are listening (P2).

She asked me if I am the one who also wants to kill. I said to her: "Please show me the way." It was like she didn't want to show me the way; she just pointed in the direction with her finger (P9).

Unsupportive behaviour might hamper the effective use of TOP services, especially if confidentiality is violated. Harries, Orner, Gabriel and Mitchell (2007:5) reported how access to TOP services was blocked by admission clerks. They were told that abortion was immoral and sinful, or even given misleading information on their eligibility for abortion. TOP health care consumers have the right to information, including information about TOP services and where to access the services (Morrone, Buga & Myer, 2006:38). Only one participant reported a favourable experience in the hands of the other personnel in the health facility. This was expressed as follows:

[A]s I did not know where the TOP ward was, I asked one of the workers for directions. She (health worker) accompanied me to the ward and wished me luck ..., I felt good ..., encouraged (P8).

According to Littman, Zarcadoolas, and Jacobs (2009:419), non-judgemental actions and positive attitudes by the general hospital community could help, not only in the utilisation of TOP services, but in the utilisation of all services provided in the hospital.

Category 3: Community members' support of TOP services

The participants viewed the community “judgemental” about TOP, TOP services and women using TOP services as the church community would threaten excommunication from the church should it become known that an individual has procured TOP. For example, in this excerpt:

This is so bad ... The other day in church ... the catechism leader made an announcement ...eh ... to say ... eh ..., “there is an increase in the number of people visiting the wellness clinics ...should it transpire that a church member has done an abortion ... that member will be excommunicated immediately”. Oh..., I was sitting there thinking ... may be ... I should cancel my appointment which was set for the following week ... but then ... I also knew that I did not want this pregnancy. (P8).

In line with the findings from a study conducted by Sibuyi (2004:77), the community members manifested their lack of support by harassing, name-calling and intimidating women using TOP services. According to Weitz (2010:161), women using TOP services and TOP facilities became the direct targets of large scale anti-abortion demonstrations where activists blockaded clinics to prevent women from obtaining abortions. Failure of the community to provide support might hamper access to TOP services by the TOP health care consumers who fear retributions from community members.

Theme 3: Challenges in the provision of TOP services

The main challenge experienced by participants was that of attitudes. In this study, TOP health care consumers experienced negative attitudes from TOP service providers, personnel in the facilities and the community at large. Shellenberg and Frohwirth (2009:4) conceptualised the abortion stigma into a three-domain framework. The first domain refers to the perception of how people feel about abortion or women who had an abortion; the second domain includes rejection by spouse, family members or being mistreated in the community or health setting; and the third domain refers to internalised stigma that manifests itself as a feeling of guilt, shame and anxiety about the self.

She asked me if I am the one who also wants to kill ... I said to her, “please show me the way”. It was like she didn't want to show me the way ...; she just pointed in the direction with her finger. (P9).

According to the television documentary, the MNet TV programme Carte Blanche, women who came for TOP services were not treated professionally and with dignity (SABC 23 June 2002 at 12:00).

DISCUSSION

The experiences of women who underwent abortion at the health care facilities in Mpumalanga related around health considerations, the support system and their challenges to find access the TOP services. It is understandable that the decision to use TOP is not an easy one and comes with feelings of regret, guilt and self-blame. If the user has no one to assist and support her and she is afraid that others might find out 'her secret', it could lead to depression. Harries *et al.* (2007:4) found that while some women were able to discuss their decision to abort with their boyfriends, others were afraid that they might be abandoned.

Physical pain was also experienced by some respondents. In a study conducted by Lipp (2008:14), some nursing staff providing TOPs held the opinion that women who are 'going through the process' may not return for repeat abortions because of the pain they experienced. They may experience the abortion as a type of punishment.

Women who grew up in a religious environment might find the decision to use TOP services very agonising. They felt stigmatised and regarded themselves as 'murderers'. They did not want their church to know about the TOPs because they were afraid of the reaction of their church leaders.

Support (or the lack thereof) was experienced by the respondents of this study. While some respondents reported positive experiences from the TOP providers, one experienced them to be rough. Lipp (2008:16) cautions about 'dealing with a woman undergoing abortion' and mentions that it demands great skill and sensitivity.

Staff at admission or the information office have an important role to play to give the correct information to women who want TOP services. They should be discreet and not embarrass them unnecessarily. They should also provide correct information, not like the information received by some women in the study of Orner, De Bruyn and Cooper (2011:787) where a receptionist turned a woman away because she came for a second abortion.

For women making use of TOP service, the necessary support from community members is often lacking as they find the community members as judgemental and they fear the reaction of the church community. Sometimes they did not even have the support of people close to them as reported by the respondents in a study by Mdleleni-Bookholane (2007:255) who received TOP services and who they did not tell anybody, especially their partners and parents about their pregnancies, as they did not expect any support.

The attitude that participants received from staff working in TOP services was highlighted as a challenge for women who wanted to access TOP services. Some of the respondents (staff) who choose not to work in TOP services in the study of Harries *et al.* (2009:6) stated that they would hate to work in TOP services and others did not want to be involved on religious grounds.

CONCLUSION

TOP services are a priority within the reproductive health services. From the experiences of participants, the TOP programme provides an important service, allowing women to exercise their human rights to choose whether to have a baby or not should they find themselves pregnant. In the study, information sourced from participants indicated lack of support from TOP service providers, personnel not involved in the TOP service provision in the facilities and community members. The TOP programme was generally not accepted in communities.

RECOMMENDATIONS

Government must strengthen community education and lobby support for the TOP programme by adequately marketing the programme at appropriate platforms to ensure that the community is well informed and for it to propose implementation strategies that are acceptable to it.

Staff members (medical as well as administrative) should be carefully chosen and receive the necessary interpersonal skills to support women who want to use the TOP facilities.

The TOP programme needs to be well integrated into all other medical and social welfare services to improve its acceptability. All TOP health consumers should receive counselling timeously and receive pain control and management as indicated in the MTOPIP.

LIMITATIONS OF THE STUDY

The sensitive nature of the topic had a limiting effect on the willingness of the participants to participate in the study and also their openness when sharing their experiences with the researcher. This could impact on the quality and richness of the information received.

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