ASSESSING THE QUALITY OF POST-ABORTION CARE IN PUBLIC HOSPITALS IN THE CAPE PENINSULA: the perceptions of women who had an induced termination of pregnancy on request

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A mini-thesis submitted in partial fulfilment of the requirements for the degree Masters in Public Health in the Department of Community Health Sciences, the School of Public Health, the University of the Western Cape.

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KEYWORDS

Termination of pregnancy

Abortion

Post-abortion service

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Satisfaction with services

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ABSTRACT

Title: Assessing the quality of post-abortion care in public hospitals in the Cape Peninsula: the perceptions of women who had an induced termination of pregnancy on request

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Minithesis for Masters in Public Health, School of Public Health, University of the Western Cape.

The aim of the research is to describe the socio-demographic characteristics of women seeking an abortion on request, their pregnancy history and previous contraceptive usage and to ascertain their satisfaction with post-abortion care at public health services in the Cape Peninsula.

The study method was a cross-sectional descriptive survey. The research design incorporated a quantitative survey conducted in health services providing termination of pregnancy. All women age eighteen and older attending the termination of pregnancy (TOP) clinic were approached to participate and the study was explained and written consent obtained. A face-to-face interview was conducted to eligible women post-abortion to ascertain knowledge of women via a semi-structured questionnaire. The questionnaire was administered on the day of the procedure before the women were discharged from health service. 133 participants were enrolled.

The age range of women was 18 to 43. Most women were young, single women with a good educational level. There was an equal distribution amongst women employed 65(48.87%) and unemployed 68 (51.13%). 45 (36.39%) of women had never been pregnant before this pregnancy. The majority of women were exposed to contraceptive use prior to the termination, 120 (90.23%). 84 (63.15%) of the women had been told of complications on leaving the health facility. 93 (69.92%) had the contact details of health facilities to approach if complications arose. 127 (95.48%) of women knew the importance of immediate contraception. 117 (87.96%) chose to commence a contraceptive method before discharge.

Women felt that they had a lot of confidence and trust in the health personnel (113, 85%), and most felt they were treated with respect and dignity (116, 87%). 95 (71.4%), of women felt positive about their decision to terminate the pregnancy. Only a third, 44 (33%), were asked about their concerns and fears about the procedure. Even fewer women, 18 (13.53%),

were asked about how they were feeling physically and emotionally before discharge, and only 4 (3%) were offered follow-up counselling. 94 (70.67%) of women felt they could recommend the service. Most women felt that the care was very good to good (87, 65.4%) and a third felt that it was excellent (41, 31%). Women gave high ratings but left room for improvement.

Recommendations

1. Improving family planning services in providing quality care to single, young women commencing a family planning method within an environment conducive to make informed choices.
2. Improve and increase knowledge of women in the effectiveness of the contraception and counselling women that if they should become dissatisfied with a method to approach the family planning service immediately.
3. Provide women with the knowledge of 'emergency contraception' in the case of method failure and to women who have had unprotected sex.
4. Involve nongovernmental organisations to assists with pre and post abortion counselling and ensure the resident social worker is available on the days when abortions are undertaken.
5. Formulate an educational checklist administered on discharge from the facility, which includes enquiring about women's physical and emotional state.
6. Monitor and evaluate the pilot sites where the checklist is been used on the post-abortion service effectiveness and efficiency by conducting focus groups of health care providers and the health care users.

These recommendations address medium term goals to create an environment that meets women's sexual and reproductive needs.

DECLARATION

I, Saint Phebe Gribble, hereby declare that the work in *ASSESSING THE QUALITY OF POST ABORTION CARE IN PUBLIC HOSPITALS IN THE CAPE PENINSULA: the perceptions of women who had an induced termination of pregnancy on request* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Saint Phebe Gribble

April 2003

Signed:.....

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Chapter 1

The reform on the legislation of abortion

1.1 Introduction

Globally, abortion mortality accounts for at least 13% of all maternal mortality. According to the World Health Organisation (WHO, 2000) in Africa the mortality from unsafe abortions is 110 deaths per 100 000 births which is twice that of the developed world. In South Africa before the Choice of Termination of Pregnancy Act no. 92 of 1996 was enacted, a situation analysis undertaken by the Medical Research Council estimated that 20 000 abortions were undertaken each year. Of these abortions, 1000 to 1500 were legal abortions and although illegal abortions were difficult to assess, figures from a research findings by the National Incomplete Abortion Reference Group estimated them to range between 6000 and 120 000 performed annually (Rees *et al*, 1977).

The Reproductive Rights Alliance report showed that by the end of January 2002, a total of 220 888 abortions had been performed since the legalising of abortion came into effect in February 1997. The availability of abortion has given women an opportunity to make informed decisions about their reproductive health.

1.2 Rationale / Background in South Africa

In 1994 the United Nations International Conference on Population and Development (ICPD) held in Cairo addressed unsafe abortion(Huntington *et al,* 1998). There was an increased awareness of reproductive rights and the role unsafe abortions have on maternal mortality. Therefore, it was concluded that restrictive laws violated women's rights and legal limitations on abortion constituted a form of gender discrimination (Gerhardt, 2000).

In a published document of the ICPD paragraph 8.25 of the conference's Programme for Action, it states:

> *In no case should abortion be prompted as a method of family planning... Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have access to reliable information and compassionate counselling... in circumstances where abortion is not the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from an abortion. Postabortion counselling, education and*

family planning services should be offered promptly which will also help to avoid repeat abortions (and unwanted pregnancy) (pg. 264) (Hardee *et al*, 1997).

The South African Government was signatory to the ICPD Programme for Action in 1994. Hence, the newly elected South African democratic government enacted and implemented the Choice on Termination of Pregnancy Act no.92 of 1996 by the National Department of Health in the Reproductive Health Programme. The enactment of the Choice on Termination of Pregnancy Act (CTOP) gave women the recognition as a human being, morally and legally capable to choose when and if to have children (Barometer, 2002). The abortion law in South Africa liberalised and decriminalised abortion and has a strong foundation in human rights and is arguably the most progressive abortion law. It not only allows women access to legal abortion, it also provides minors under the age of eighteen no requirement for parental consent or spouse consent of a married women (Stevens, 2000).

Good laws and policies on abortion, in addition to being a legal instrument, are signs of public acceptance of fertility control and women's need for abortion. The acknowledgement of unwanted and unplanned pregnancies constitutes a serious public health responsibility. Therefore, no woman should be forced to continue an unwanted pregnancy, and no woman should be forced to resort to an unsafe surgical procedure (Orr, 1995). Public health practitioners therefore agree that women who have experienced abortion, whether a miscarriage and/or induced abortion must have access to high quality post-abortion care (Greenslade *et al,* 1998). Women need safe, high-quality reproductive health care, including post-abortion care.

Women who have recently had an abortion have special needs that influence their contraception options. Health care providers should be aware of these issues so they can provide appropriate counselling. Most importantly, post-abortion women may face immediate, acute and possibly life threatening medical problems. In the post-abortion period women also experience a rapid return to fertility (IPAS, 1997). Therefore post-abortion care strategy is a public health approach that focuses on identifying and correlating critical deficits in emergency medical service delivery and management (Ghosh, 1999).

1.3 The post-abortion approach

A post-abortion approach therefore involves three integrated components:

- emergency treatment of abortion complications,
- post-abortion family planning services and counselling to prevent and reduce the risk of future unwanted and unintended pregnancies and repeat abortions,
- links to other reproductive health services as needed for emotional support and follow-up counselling as required. (Ghosh, 1999 & Greenslade *et al,* 1999)

However, health care providers should individualise their counselling post-abortion because women's experiences differ. Some women's immediate needs could be to alleviate pain, emotional and physical stress. Therefore, an appropriate moment for information and counselling with respect to family planning must/should be established once the woman's condition is stabilised.

1.4 A sustainable abortion service

The emphasis on the sustainability of the abortion service in public sectors is on the access to services, women knowing their rights and the support of the health care providers at health facilities. Successful programme implementation requires continuous monitoring and evaluation of the programme. Assessing 'quality of care' in health services sometimes has different meanings for policy makers, programme managers, health care providers and health care users (Gijsbers Van Wijk *et al,* 1996). Quality of care refers to safety, effectiveness and appropriate health care. This is one of many definitions for quality of care. A general prerequisite for quality of health care is the availability, accessibility and affordability of basic health services (Bruce, 1990).

1.5 Factors that influence women's decisions

Women with different religious beliefs may not seek an abortion, as born-again Christians and Catholics may be less likely to obtain abortions than mainstream Protestants. In the Islamic religion, a general view of abortion is to save a woman's life as acceptable (Bankole *et al*, 1999). Within the Muslim faith there are various schools of thought concerning the ensoulment of the fetus and abortion. If an abortion is performed for reasons other than saving the woman's life, then the woman and the health care provider are subject to religious persecution. These characteristics should be considered pre-abortion and in the post abortion stages of women seeking an induced abortion on request, to understand and bear in mind the background of the woman (Huntington *et al*, 1998).

1.6 The aim of the research

The aim of the research is to describe characteristics of women aged eighteen years and older seeking abortion, their socio-demographic characteristics, their pregnancy history and any previous exposure to contraceptive usage, and to ascertain their satisfaction with post-abortion services and lastly, possibly, the psychosocial needs of women post-abortion in the Cape Peninsula.

1.7 Research hypotheses/ study questions

The objectives include to:

1. Determine the socio-demographic characteristics of women seeking an abortion in the Cape Peninsula.
2. Ascertain women's understanding of post-abortion care and family planning.
3. Assess women's perception on satisfaction with post-abortion services.
4. Identify possible psychosocial needs of women in the post-abortion stage.
5. Make recommendations on women's 'wants' and 'needs' in post-abortion care.

1.8 The structure of the research study

This research study assesses the quality of post-abortion care in the Metrople area of Cape Town whilst investigating a clientele perception at public health facilities. The researcher interviewed women after the abortion procedure, before leaving health services. The information obtained will provide policy makers, programme managers and health care providers with the characteristics of women seeking induced abortion on request, the age of women seeking an abortion, their marital status, educational level, their employment status, and the religious affiliation of the women.

In this research study pregnancy history will be investigated. The information is obtained whether it is nulliparous women having first time abortion or whether the woman has had one or more pregnancies or children. Another characteristic of interest is the exposure of women to contraception prior to the abortion and the possible reason for the failure of a contraceptive method. The second part of the questionnaire has more descriptive information on women's perspective about having had an abortion and on their satisfaction of service provision at the health facility. It focuses on women's physical and emotional state at the time before leaving the health facility and whether the health care provider has given any information on fertility, and the commencement of contraception, where to access family planning services, and the return on emergency care if any complications should occur.

The outcomes of the research study will serve as a source of information to improve service provision in post-abortion care focus on the 'needs' of the women attending the TOP clinic. At the time of compiling the research proposal, the need arose to separate women seeking abortion into less than 12 weeks gestation age and more than 12 weeks gestational age. This could possibly be considered for further research. The information of the study will provide the stakeholders with information on whether their post-abortion care strategies are acceptable to the service user and whether woman seeking an abortion at a public health services would recommend the service to other women who might want to use the service for a termination of pregnancy (TOP).

Chapter 2

Literature review on the Transformation of Reproductive Health in South Africa

2.1 The definition of Reproductive Health

Reproductive Health can be defined as a complete physical, mental and social well being in all matters related to the reproductive system (Rees *at al*, 2002). This implies that people are able to have satisfying and safe sex lives and that they have the capacity to have children and the freedom to decide if, when and how often to have them (Rees *et al*, 2002). In line with this definition of reproductive health, the definition of reproductive health care adds on to be a constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases' in ICPD (1994). Reproductive health is therefore central to general health and is incorporated across the life span of all individuals.

2.2 The definition of abortion

The term 'abortion' refers to the termination of pregnancy, from whatever cause, before the fetus is capable of extrauterine life. An 'induced abortion' refers to termination of pregnancy through a deliberate intervention intended to end the pregnancy (WHO, 2000). An induced abortion, or the voluntary termination of pregnancy, involves the performance of a procedure that ends an established pregnancy. Unsafe, an illegal abortion, or a 'back street' abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking necessary skills or in an environment lacking the minimal medical standards or both (Rees *et al*, 1997). Abortion services should be made as safe as possible so that they do not pose undue risk to women's health (WHO, 1999) Throughout the document the term 'abortion' is used referring to the termination of pregnancy (TOP).

2.3 The Choice on termination of pregnancy Act No 92 of 1996 and the Abortion and Sterilization Act No. 2 of 1975

In women's reproductive health it is crucial to achieve gender equality and enhance the role and status of women in society (Khanna, 1994). The enactment of the Choice on Termination of Pregnancy Act No 92 of 1996 was South Africa's democratic government legal framework

'to protect the right of persons to make decisions concerning reproduction and to security in and control over their bodies' and improving the women's lives (Gerhardt, 1997). In legalising abortion, a safe medical procedure makes sure that unsafe abortions do not occur. In preventing mortality and reducing morbidity in association with unsafe, illegal and 'back street' abortion, women now need access to a wide range of reproductive health services to help them safely control their own fertility. Therefore good laws and policies on abortion are signs of public acceptance of fertility control and a women's need for abortion as expressed (Berer, 2000). There are new standards, protocols and guidelines needed as a result of the new law.

Before 1996, in South Africa there were groups of medical practitioners lobbying for the liberalisation of the Abortion law on the basis of the huge cost of hospitalisation of women who have undergone an unsafe abortion or commonly referred as a 'backstreet' abortion and increasing the maternal and morbidity rate of unsafe abortion. This group, also known as "The National Incomplete Abortion Reference Group" consist of medical practitioners in Obstetrics and Gynaecology and a women's organisation known as Abortion Reform Action Group (ARAG) (Fawcus *et al*, 1997).

The previous abortion Act in South Africa known as the Abortion and Sterilisation Act No. 2 of 1975 provided an abortion under very specific conditions. These conditions under which abortions could legally be performed were:

- only when a pregnancy could seriously threaten a woman's life or her mental health;
- could cause severe handicap to the child;
- or was the result of a rape (which had to be proved), incest or other unlawful intercourse, such as a woman with permanent mental handicap.

The woman seeking abortion had to receive approval from two independent medical practitioners neither of whom could perform the procedure. In certain cases, there had to be approval from a psychiatrist or a magistrate before permission was granted. Approved abortions had to be performed in public hospitals, and strict records had to be kept. The Act had restrictions and made abortion services inaccessible (Rees *et al*, 1997). The impact of the Act was an increasing number of incomplete and septic abortions. The maternal morbidity and mortality increased as a result of septic abortions. Furthermore, women who died from unsafe abortions before reaching the hospital and poorer women had little or no access to health

services. Rich women had more access to TOP services under the old Act (Guttamacher *et al,* 1998).

2.4 The trends and implementation of the Choice on termination of pregnancy Act No. 92 of 1996

With South Africa's first democratically elected government and the appointment of the new health minister, a new Health Policy was developed. An abortion law was developed with numerous role-players giving input to the law from the legal fraternity, medical practitioners, non-governmental organisations, leaders from urban interest groups and rural organisations, religious leaders etc. There was major debate on replacing the law. The vote in the National Assembly to pass the legislation was 209 to 87 and the law was passed with a wide margin. The Choice on Termination of Pregnancy Act 92 of 1996 as discussed throughout this research is historically six years old.

The key findings in monitoring the CTOP Act in health service provision by the Reproductive Rights Alliance (RRA) in 2002 were:

- 220 888 legal TOPs were performed nationally, and in the Western Cape 30 302 over the five year period,
- 73% of TOP service provision was under 12 weeks gestation age,
- 12% of TOP service provision was to minors (excludes Guateng figures),
- Access was uneven with rural women having less access to services because of fewer health facilities providing legal abortion (Makoala, 2002 and Jacobs *et al.*, 2000).

The Choice on Termination of Pregnancy Act came into effect in February 1997 and permitted women seeking to have an abortion on request throughout the first trimester (the first three months) of pregnancy, without an approval of doctors, psychiatrist or magistrates (CTOP, 1996). Minors who are in this category are counselled to notify their parents or guardian of their decision to terminate the pregnancy but are not required to acquire their consent for the procedure. For victims of rape or incest incidences, women are not required to provide any documentation in order to obtain an abortion.

The woman between thirteen and twenty weeks of gestation period of pregnancy can obtain an abortion if a medical practitioner believes that the pregnancy threatens the mental or physical health of the woman or the fetus. These conditions also apply if the pregnancy resulted from rape or incest and when the pregnancy has an affect on the socio-economic situation of the

women. After the twentieth week of gestational period of pregnancy, a termination of pregnancy is permissible if a doctor or trained midwife finds the pregnancy would threaten the health of the women or cause handicap to the fetus.

Table2.1 The conditions under which a termination of pregnancy may be undertaken according to the Choice on Termination of Pregnancy Act no 92, 1996

Gestation period	Conditions under which a pregnancy may be terminated	Who may perform the procedure	Consent for the termination of pregnancy
up to 12 weeks (inclusive)	• On request of the pregnant woman	Trained registered midwife or a Medical practitioner.	Informed consent of the pregnant woman
13 -20 weeks	• pregnancy threatens the mental and physical health of the woman and the fetus • a pregnancy as result of rape or incest • the pregnancy affects the woman's socio-economic situation.	Medical Practitioner	In consultation and informed consent of the pregnant woman.
After 20 weeks	• the pregnancy threatens the life of the woman • and cause severe handicap to the fetus	Medical Practitioner	In consultation with another medical practitioner or trained midwife and informed consent of the pregnant woman.

The fact that abortion services have been legalised has contributed significantly towards destigmatising abortion. Providing the service to women seeking abortion is now seen as a legitimate health service, and not as a subversive criminal activity. The legislation has been crucial in protecting women's health and their lives.

2.5 The South African challenges

The topic of abortion still gives rise to different arguments. Two viewpoints emerge from these arguments. The first viewpoint is a moral or religious issue with the view of an abortion

procedure as being murder. The second views abortion as a human rights issue that the religious and moral groups have no right to impose their beliefs on those who do not share their view. The groups or individuals supporting the availability of legal abortion consider themselves pro-choice and those opposing the legalisation of abortion consider themselves as anti-choice or pro-life (Orr, 1995 & Bankole *et al*, 1998).

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In South Africa, the Christian Lawyers Association has challenged the CTOP Act. The first challenge in 1998 was based on whether the fetus had a Constitutional right. The claim was dismissed because based on the Constitution of South Africa (Act 108 of 1996) the fetus was not viewed as a legal person and that the Constitution did not limit the right of the woman to control her body in reproduction (Barometer, 2002). The second legal challenge was in 2000, in granting minor adolescents (under eighteen years of age) permission to terminate an unwanted pregnancy. It was ruled that minors have a constitutional right of choice on what they would want to do with an unwanted pregnancy. These minors then are counselled to inform their parent or legal guardian on their decision but consent is not necessary from the parent or guardian (Turner, 2001).

In countries where it has been measured, half of all pregnancies are unintended and half of these end up in terminations (WHO, 2000). The important fact is to minimise the unsafe abortions. A study undertaken by the Medical Research Council of South Africa and the Reproductive Health Research Unit in 2003, demonstrated a decrease in morbidity from unsafe abortions, despite there being no decrease in the number of women presenting incomplete abortion. Overall the study reflected a reduction in unsafe abortion.

The success of implementing the law is ultimately measured by the extent to which women are able to access the service. In South Africa, women in rural settings have remained disadvantaged in relation to accessing abortion services. This is due to the uneven distribution of social services from the historical apartheid system and the resistance of health care providers. Decentralisation of abortion services provision through primary health care is possibly a strategy in addressing the problem. Providing education to women who are disempowered within relationships and are reluctant to seek the services in reproductive health is also needed
(Adler *et al*, 2000).

2.6 The types of Abortion Procedures

There are two methods for inducing an abortion for the evacuation of the uterus depending on the duration of the pregnancy. These are a surgical abortion and a medical abortion. The gestation is usually determined by the date of the last menstrual period and the findings on pelvic examination. If this is not decisive, an ultrasound investigation can be done to determine the gestational age or on whether there is an ectopic pregnancy. The present practise in the health services provides surgical method by manual vacuum aspiration and there are different management protocols for first and second trimester abortions.

2.6.1 The surgical method

The surgical method is undertaken up until the 12th week of pregnancy by a trained midwife or a medical practitioner and can be done at primary health care level, as hospitalisation is not necessary after the procedure has been performed. The abortion would be induced with misoprostol (a prostaglandin) preparing the cervix. After about plus or minus four hours then the products of conception would be evacuated by manual vacuum aspiration under conscious sedation or oral sedation. The health care practitioner uses a para cervical block locally as anaesthesia of the cervix before the procedure is undertaken. The entire procedure is undertaken in surgically clean conditions.

The women in the second trimester undergo the same assessment as in the 1st trimester. Certain public health facilities admit women into hospital and at other health facilities the 'roving' team of qualified doctors perform the procedure with a longer observation of the women before discharge from the health facility on the day of the abortion.

2.6.2 The medical method

The medical abortion is defined as the use of drugs to terminate pregnancy that is a less invasive procedure (Winikoff, 1994). Women are to present at health services before the eighth week (56 days or less by ultrasound) of pregnancy. In a study conducted in Vietnam (WHO, 1999), the service providers commented that the benefits of this process were that it avoids potential infection, uterine perforation and cervical laceration, that it is non-invasive, and enhances women's privacy. The fact of concern for providing this method is the cost of the drugs (mifepristone). In a medical abortion cost is more than that of a surgical abortion (misoprostol) (de Pinho, 1997).

Presently, in South Africa, the termination of pregnancy is offered as a free health services in public health facilities. In the study conducted by the Population Council in the Western Cape on 'The access of Medical abortion', it indicated an overall support for the approach in which women will have more control of the process and need not rely on the health services (cited in de Pinho, 1997 and Kay *et al*, 1997).

The advantages of the medical abortion method of termination in this study concluded that:

- privacy is maintained as women initiates the abortion herself,
- there is less risk of infection and trauma complications.

To reinforce the above method, studies show that latter method is non-invasive and could be seen as an easier and faster process as there is less pain involved and seen as more natural process (Winikoff, 1994).

2.7 The concept of Post-abortion strategy

The abortion process is composed of three phases in which each process has its own characteristics and possible effects on the woman's physical and mental state.

The phases are:

- the pre-abortion phase, the decision taken to approach health services requesting an abortion,
- the intervention, the abortion procedure is undertaken,
- and the post-abortion period after the abortion before discharge from the health service (Kapor-Stanulovic, 1972).

Any woman having undergone an abortion is at risk of another unwanted pregnancy and should be counselled with regard to controlling their fertility. The health care providers have a professional responsibility to women post-abortion in conjunction with the termination of pregnancy. This is to provide knowledge on how to avoid repetitive abortions and to assist in how to seek for immediate health services should complications arise (Wolf *et al*, 1994).

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The South African Constitution requires the state to progressively fulfil the health needs of its people. The integral part of health service provision would be specific to TOP are:

- A long-term goal should be to decrease the need for terminations of pregnancy.
- In the medium term goal to create an environment that enables the realisation of women's reproductive and sexual rights.

This will include the responsibility of health care providers to provide services that are efficient and effective to overcome the reasons for unwanted pregnancies.

2.7.1.The quality of post-abortion services

The World Health Organisation (WHO) has a freely available document as a practical guide for programme managers on 'Post- abortion Family Planning'. The guidelines are intended to assist programme managers of abortion facilities and family planning programmes to learn more about the need for post-abortion care and have a framework in which to improve abortion care and family planning linkages. A national survey done in the United States by the Kaiser Family Foundation (1999) showed that there is a fair amount of research studies covering the technical aspect of quality of care but fewer are available on the clientele's perception on quality of abortion care (Henry Kaiser Family Foundation, 1999). One broad reason given was the aspect of abortion being a controversial topic and the difficulty women have of wanting to speak out. Another reason for fewer surveys on women's view in satisfaction with care is the stigma associated with abortion causing many women to keep the procedure a secret. There is major difficulty in follow-up of the women and conducting interviews.

2.7.2 The factors influencing women post-abortion

Women who recently have had an abortion have special needs that influence their contraception options. Most importantly post-abortion women may face immediate, acute and possibly life threatening medical problems. An essential part in high quality post-abortion services is the family planning counselling and services offered to all women treated for abortion complications and their partners when appropriate. The counselling of women who have had an abortion presents special challenges because of the physical and emotional stress associated with the unwanted pregnancy and the abortion (IPAS, 2000). The counselling of post-abortion clients needs to be flexible and not fixed to an aspect of service delivery. Each woman's situation differs from another. A challenge is to ensure that each client receives pertinent counselling under appropriate circumstances. In the South African CTOP law it states that the state shall promote 'non-mandatory and non-directive counselling before and after the termination of pregnancy' (CTOPA, 1996).

Most women appreciate being given a range of information before, during and after the abortion procedure (Hord, 1995). Post-abortion period research indicates that skilled communication and an interest in making sure women have the necessary information are essential parts of high quality

post-abortion services (Girvin, 1993). A population report by the John Hopkins School of Public Health (1997) emphasised that a post-abortion strategy is a combined approach to both treatment and prevention. These strategies involve treatment of current emergencies of abortion complications, providing appropriate family planning and in preventing unwanted pregnancies and linking women to other reproductive health services. This, according to the report, can reduce repetitive abortions, unwanted pregnancies and the number of abortion related deaths. Therefore a post-abortion strategy is an important public health approach that focuses on health services delivery and management of health services.

Below is a schematic diagram on how to break the cycle of abortion.

Figure 2.1 Breaking the Cycle of Abortion *adapted from workshop notes on Abortion Value Clarification by the Provincial Administration Western Cape: Department of Health.*

2.8 Improving the safety and quality of abortion services

Improving the Safety and Quality of Abortion Services

Quality of care refers to the overall safety, effectiveness, and appropriateness of health care. Although there is no single definition or measurement of quality, a framework of fundamental elements in the quality of care is becoming generally accepted in the area of reproductive health and family planning (Greenslade *et al*, 1998). In the past decade, huge emphasis was placed on the quality of health care services and on how to improve it. Feedback from service users has been increasingly acknowledged as a critical component in assessing the quality of care in abortion services

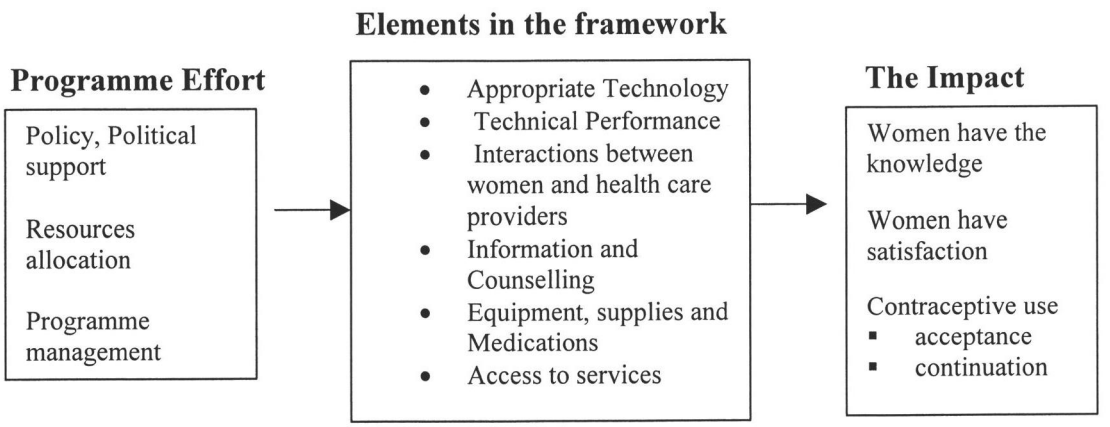
In different studies fundamental elements have been provided within a framework for assessing the quality of care. In an article by Bruce (1990), a framework is provided to assess the quality from the patient's perspective with the focus on family planning, service provision, and the tools to use in measuring the quality of health care services. Another study of interest was a research study done by Leonard and Winkler (1991). This study provided a specific framework in 'Quality of Care for women who have undergone an Abortion'.

2.8.1 An outline on quality of post-abortion care

Leonard and Winkler (1991) outlined six main points around which programme managers and health care providers could devise strategies to improve the quality of post-abortion care:

- Appropriate technologies; the provision of high quality post-abortion services require treatment of abortion complications at every level of health care system.
- Technical performance; the proficiency of the health care providers to perform the task by having the training and skills relevant to post-abortion care on all levels of the system within health facilities.
- Interaction between women and health care providers; health care providers can assist in creating an atmosphere of trust, keep the counselling private and confidential and respecting the woman's rights to make informed choices.
- Information and counselling; This aspect is a crucial element providing women with information and counselling on reproductive health care and these are specific for each women. The emphasis here for post-abortion care would be that;
    - women can become pregnant immediately after the abortion procedure,
    - women can delay or avoid another pregnancy by using family planning,
    - where services are available to start a family planning method immediately or as soon as possible.
- Equipment, supplies and medications; the availability of the essential and appropriate equipment, supplies, medications and contraceptive methods is central to the provision of the safety, effective and integrated reproductive health care.
- Access to services; Women's access to care is based largely on the availability of the service. The goal of high quality postabortion services is not simply that the services be available, but that the largest possible number of women are able to benefit from the high-quality care.

Figure 2.2 The Post-abortion Framework for Quality of Post-abortion Care adapted form by Leonard & Winkler, 1991 and Bruce, 1990.



It is important that health care providers are also able to provide or refer women to local clinics as an important source of reproductive health services other than contraceptive care. At primary health care level, services may include prevention and diagnosis or treatment of sexually transmitted infections or Human Immunodeficiency virus (HIV), cervical cancer screening, prenatal care, treatment of infertility and appropriate social services. The referral to other reproductive health services is important because of the comprehensive nature of women's health. The abortion service in isolation is rarely completely addressing overall health care needs of the women.

2.9 The Psychosocial factors

There are emotions experienced in the different phases of the abortion process. Although these can range from negative feelings to emotions of relief and happiness, it is generally thought not to be severe and do not cause any serious pathology (Adler, 1979). In the 1960's there was the assumption that serious emotional problems follow induced abortion. More than 250 studies done during the late 1980's were undertaken to review this fact and found there was insufficient evidence to support a post-abortion syndrome (Adler, 1979). In the early 1990's research done on the emotional impact of abortion concluded that 'legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard to a woman' (Adler *et al*, 1992). In further research undertaken by Adler *et al.* (1992) as well as Major *et al* (1990), researchers described feelings of relief and happiness. The negative emotions of sadness, regret, anxiety and guilt are generally mild when they occur. These were observed amongst women soon after an abortion in health facilities and in a three-month period post-abortion. (Adler *et al*, 1992; Major et al, 1992). A research study by Suffla (1997) highlighted the complexity of the abortion experience and the

post-abortion responses of women. The manner in which the women responded to the procedure is a combination of the function of their psychological state and the social environment in which the abortion occurred.

Induced abortion remains a controversial topic and some health care providers object to providing this service. Walker (1997) in this instance commented that this rejection by health care workers to providing abortion services is linked to their identification as mothers, or nurses, and wives and they are unable to separate these roles. Harrison *et al.* (1999), further remarked that nurses indicated that their professional commitment is to save, not to take away lives and hence the stance against abortion. It is the utmost importance that women have positive contact in the post-abortion period for the commencement of the healing process. The influence of social stigma has inhibited women's interpretation of the abortion experience (Jewkes *et al*, 1997& McCulloh, 1996).

In general the incidence of negative reactions is low and the most common feeling found is to be experienced post-abortion is that of relief and happiness. There are feelings of sadness, regret, anxiety and guilt but these are usually found in a mild form.

2.10 Conclusion

The women approaching health care facilities seeking a termination of pregnancy and having undergone the procedure of a termination should be provided with the appropriate information by the health care provider before leaving the health facility on post-abortion care to prevent infertility, death, future unwanted pregnancy, and a repeat abortion. An important part of the abortion process is therefore a post-abortion care strategy as a public health approach that focuses in identifying and correlating critical deficits in emergency service delivery and health service management (Berer, 2002)).

Good laws and policies on abortion in addition to being a legal instrument, are a sign of public acceptance of fertility control and women's need for an abortion. The majority of women who seek an induced abortion do so to end an unwanted or unplanned pregnancy and are therefore motivated to control their own fertility (Fawcus *et al*, 1997). Emphasising the importance of post-abortion care has been an integral part of the induced abortion service. On the basis of these factors, the interest arose to investigate the standard of service provision from the perspective of the service user.

Chapter 3

The research design and methodology

3.1 Introduction of the study to the health facility study sites

The research has been prepared for an examination as a mini-thesis in partial fulfillment of a Master's degree in Public Health. The researcher is part of a Women's Health Unit within the Faculty of Health Sciences, Department of Public Health and Primary Health Care at the University of Cape Town, and for many years been involved in research studies in women's health issues having keen interest in this field.

Meetings were arranged to see the different health facility managers to be granted permission to enter the health facility at the study sites to conduct the research without interfering with the health service delivery. Prior to the (actual) research period, copies of the proposal approved by the University of the Western Cape Higher Degrees Committee were given to the health facilities managers. Formal contact meetings were arranged by the researcher to express the purpose of the research was not for 'policing', i.e. that the study was not an assessment of the health care providers quality of service provision, but to investigate the perceptions of services users.

The study sites selected included two academic hospitals. The procedure undertaken to conduct research at these site required that the research proposal and the questionnaires used for data collection had to be submitted for approval to the Faculty of Health Sciences, Research Ethics Committee. Firstly, a formal application with was made to conduct research study, secondly approval had to be granted from the committee to conduct the research. Thereafter, the researcher had to be granted approval of the Head of the Department of Obstetrics and Gynaecology and the Director of Nursing services, Social Worker and the necessary introduction to health care providers in the clinics.

3.2.The public health services and study sites

The public health facilities offering termination of pregnancy services include Community Health Service Organisations (previously known as the Day Hospital Organisation), Regional hospitals, and Tertiary hospitals in the Obstetrics/ Gynaecology departments in the Western Cape. The initial research proposal, selected six study sites in the Metropole Region in the Western Cape. The study sites were accessible by motor vehicle and public transport. The study sites were selected from the monthly statistics available from the Director of Reproductive Health programmes in the Western Cape for the year 2001 and of January 2002.

Subsequently, to the approved research proposal, one of the study sites had to be eliminated due to the fact that all health services were discontinued at the hospital as part of the restructuring process of health services in the Western Cape (Conradie hospital). The number of women assisted at this health care facility was between 48 to 115 women in a period of one month.

Thereafter, three aspects were undertaken before entering health facilities to enrol study participants. Firstly, a personal introduction was undertaken to the Medical Superintendents, the Heads of Obstetrics and Gynaecology Departments and other individual who have contact with the service providers such as registered nurses and administrative personnel. A formal presentation was made on the research project. Secondly, health care managers introduced the researcher to site staff where terminations of pregnancy were conducted. This made a difference regarding the perception of the researcher's presence in the termination of pregnancy clinics. Lastly, the researcher was able to steer the way out of awkward situations where health care providers thought their clinical practise was being assessed.

Table 3.1 The profile of selected public health services providing Termination of Pregnancy in the Cape Peninsula: Metropole Region- the year 2001 and January 2002.

Health service	The number of years provision of TOP services	Annual TOP statistics January to December 2001	Monthly TOP Statistics Dec 2001 and Jan 2002	Monthly statistics Age >18
Groote Schuur Hospital	4 years	783	December 2001 31 January 2002 53	December 2001 30 January 2002 50
*Conradie Hospital	4 years	305	December 2001 17 January 2002 28	December 2001 16 January 2002 25
GF Jooste Hospital	4 years	706	December 2001 55 January 2002 104	December 2001 50 January 2002 93
Tygerberg Hospital	4 years	566	December 2001 35 January 2002 48	December 2001 27 January 2002 36
New Somerset Hospital	4 years	262	December 2001 33 January 2002 12	December 2001 32 January 2002 12
Mitchells Plain *CHC	4 years	270	Decmber2001 35 January 2002 23	December 2001 27 January 2002 20

Key: *CHC =Community Health Centre

*Conradie Hospital

3.3 Study setting

The final study sites included were five sites within the Metropole Region of the Cape Peninsula. The sites varied from primary health care level, to secondary health care to tertiary health care facilities. The women reach these health care facilities, offering a termination of pregnancy service, on different referral systems and by different modes of transport. At the selected study sites the procedure undertaken to do a TOP is the surgical method. Most

women are 'booked' for an elective procedure and there are only a certain number of women per day for a clinic. The procedure is undertaken on specific days at different health facilities. At one site TOP's are undertaken Monday to Friday but the facility only has a six-bed capacity. The women are admitted at six o'clock in the morning. Most health facilities offering an abortion admit women that early. At the first contact visit of the women to the health facility, they are assessed by a medical practitioner and counselled by health personnel with instruction of commencement of the abortion process with misoprostol.

There are certain health care facilities offering TOP in the second trimester. The second trimester abortion procedure follows the same surgical method as in the first trimester terminations with the possibility of alternate drugs provided if the cervix fails to dilate.

At the community health service study site in Mitchells Plain, the health care facility does not offer second trimester abortion. The woman seeking a TOP in the second trimester will receive a date for GF Jooste hospital for the procedure to be undertaken at the health facility by the 'roving' team. The observation period prior to the abortion is longer for women in their second trimester of pregnancy. Rarely do women have to stay overnight in the hospital. The observations done on women who have had a TOP are the blood pressure, vaginal bleeding and pain. The procedure is regarded as a minor procedure.
Below is a table of the study sites and the service provision of TOP at each site.

Table 3.2 TOP service provisions at Public Health facilities selected as study sites.

Study sites	Procedure up to 20 weeks	Health personnel procuring TOP	Days of TOP Service provision
Tygerberg Hospital (academic hospital)	1st and 2nd trimester	Doctors of Dept. O&G*	Monday to Friday -6 elective cases daily.
Mitchells Plain CHC (the day hospital)	only 1st trimester	Medical Practitioner from Marie Stopes	Tuesday 12 elective 1st trimester cases
GF Jooste Hospital (regional hospital)	1st and 2nd trimester	Trained Midwives do the 1st trimester TOP and Doctors of the 'roving' team do the 2nd trimester TOP	Wednesday 15 elective 1st trimester and, 2nd trimester cases. Thursdays only 2nd trimester cases.
Somerset Hospital (secondary hospital)	1st and 2nd trimester	Doctors of Dept. O&G*	Admission to an O&G ward on Mondays or Tuesdays mornings.
Groote Schuur Hospital (academic hospital)	1st and 2nd trimester	Doctors of Dept. O&G* do the 2nd trimester TOP and Doctor of the 'roving' team do 1st trimester abortions.	Wednesdays 12 elective cases 1st trimester and the 2nd trimester cases are admitted into the O&G wards, as beds are available.

*O&G is Obstetrics and Gynaecology.

One of the study sites selected had to be eliminated due to the fact that all health services were discontinued at this hospital. At another health service facility the waiting time for women

seeking abortion took up to two weeks and due to the time constraints of the research study, the remaining sites' sample sizes were increased.

3.4 Study design

The study is a cross-sectional descriptive survey of women using public health facilities providing abortion services.

3.5 The Study Sample and Sample size

The study population is women attending a public health facility, who have undergone a termination of pregnancy by request and who are age 18 years and older on the days the researcher visited the clinic. Younger women less than 18 years old were excluded from study due to stricter ethical procedures regarding informed consent.

The calculation on the sample size was done with assistance of a Bio-statistician using the computer programme EpiInfo version 6. The approximate sample size based on the 95% confidence interval (CI) with an expected frequency of between 45% to 47% of women who have had an abortion know where and when to access health care services and to have immediate family planning, and if when complications occur post-abortion. The expected sample size was between 120 to 130 study participants.

All women having undergone an abortion and before discharge from the health service were included to have sufficient numbers to make meaningful statistical inferences and due to time constraints.

3.5.1 The selection criteria of study participants.

Inclusion criteria is:

- These are women attending the health service sites for an abortion on request
- Women age 18 years and older
- Women who speak English and Afrikaans or have the fluency of either of these languages.

The language English, Afrikaans and Xhosa are the three commonly spoken languages in the Cape Peninsula. The researcher has written and spoken fluency of English and Afrikaans language.

- Women who have completed the abortion procedure and have been discharged by the health care provider,
- Women who have given written consent to be interviewed.

Exclusion criteria is:

- Women who have not undergone an abortion procedure.
- Women who are younger than 18 years of age.
- Women who are unable to speak or have fluency of English or Afrikaans.
- Women experiencing any form of discomfort and pain.

The table below (Table 3.2) is an in-depth outline of the 17 (10%) women missed to the study and the reasons, as well as women who had to be excluded according the study criteria 23 (13%), the number of refusals to be interviewed 2 (1%), and the total number of women interviewed 133 (76%). The number of refusals decreased after the interviewer-changed strategy by making an introduction before the woman have undergone the procedure.

The women were willing to come to the private area before leaving the health service to be read the full consent and sign, giving voluntary acceptance to participate or not having their future health care being affected at the health facility. The researcher offered all study participants a list of individuals and telephone numbers for when they were discharged (Appendix 4).

Table 3.3 An account of the interview sessions and the percentage of women missed to possible inclusion, the exclusions according to study criteria, and the refusals rate of the women at health facilities.

Day	No. of women Missed and the reason	No. of women Excluded and the reason	No. of women Refusals and the reason	No. of women Interviewed	Total cases per day
1		1 age 17		4	5
2	2 patients had been discharged	1 age 17	2 - Both refused, they did not feel like talking and wanted to be left alone	6	11
3	1- cervix failed to dilate	2 -were experiencing lots of pain 5 - Xhosa speaking 2- age 17		11	21
4	1- cancelled 1- emergency done @7am.			3	5
5				5	5
6	1- cancelled writing exams 1- made no contact	1- age 17		2	5
7	*1- Discharged, theatre staff refuse to do abortion	1- age 16 1- age 17		11	14
8		3- Xhosa speaking 1- age 16		17	20
9	Sit-in on interviews	*@NSH- 4 booked			
10	1- cervix not dilated			2	3
11	1- cervix not dilated	1- age17		2	4
12	1- cervix not dilated			3	4
13	1- did not attend			4	5
14		1- age 15		11	12
15	No appointments for pre-	TOP's counselling @ NSH			
16	1- cervix not dilated			3	4
17	1- did not attend	1- age 17		2	4
18		2 age 17		5	7
19	Only 1 needed for *GFJ. 2- cervix not dilated	@*TBH		1 1	1 3
20	Sat-in on pre -TOP	counselling @NSH, 4 cases booked for 1week away.	Reviewed data collection @ NSH.		
21	No TOP cases @	TBH			
22	Set-up data collection @ *GSH	Meeting with Nursing Service Manager.	Ethical Approval received on research an introduction to	health personnel	
23	Only need 4 @ *MP			4	4
24	Start *GSH no missed women.			11	11
25	2- cervix not dilated			4	6
26	Only 2 needed for TBH			2	2
27		1- French speaking refugee		11	12
28	Only 8 needed for GSH	1- French speaking refugee		8	9
Total	**17 (10%)**	**23 (13%)**	**2 (1%)**	**133 (76%)**	**175 100%)**

TOP- termination of pregnancy
*NSH, New Somerset Hospital
TBH, Tygerberg Hospital
GSH, Groote Schuur Hospital
GFJ, GF Jooste Hospital
MP, Mitchells Plain CHC

3.6 Data collection

The tool used for data collection was a semi-structured questionnaire. The data collection commenced immediately after the logistics were in place on the times and days that terminations were conducted, during a period of about one month- from October 2002 to mid November 2002. The researcher did the data collection as the research interviewer. Women were approached individually and written consent was obtained from all participants.

Reassurance was given to women on the confidentiality of the information and the sensitivity and possible stigmatisation on the procedure. The research interviewer made it known that there was no personal acquaintances or connection with health personnel at any facility but was rather a research study undertaken as keen personal interest in the quality of service provision on post-abortion services and for the completion of a Master's degree.

The method used for interviewing was conducted in the form of face-to-face interviews in comfortable and private surroundings. The private areas varied from a private room or area with a door, or at the bedside with the screen drawn. The researcher checked all questionnaires after each interview for completeness and a colleague, as a method of quality control for any missing data, later rechecked questionnaires.

3.7 Questionnaire development

The researcher designed the tool for data collection. The questionnaire was modified and adapted from various questionnaires in the form of related reproductive health studies. These studies were a case control studies done by Shapiro *et al.* (1998), a qualitative study done by the Picker Institute (1998), and a World Health Organisation study funded assessment on abortion in Vietnam (1999).

3.7.1 Translation of the questionnaire

The original design of the questionnaire was in English. It was translated from English to Afrikaans and back to English. The method was done to verify that the translation was correct and the original sense was not altered. Most respondents had no problem in speaking the language that themselves and the researcher were fluent in. The researcher piloted ten questionnaires at the different study sites for the flow and for the understanding of the questions. Thereafter the questionnaire was revised in the English and Afrikaans version. The piloting of the questionnaire was also used as an opportunity for training with the questionnaire.

3.7.2.Types of questions and variables in the questionnaire

A semi-structured questionnaire was used in data collection and it consisted of quantitative and qualitative questions. The rationale behind using open-ended questions was to have a broad idea of women's needs for support in post-abortion and their knowledge of where to seek assistance for complications, family planning and other reproductive services in the future. In the two sections of the questionnaire, the questions consisted of descriptive data.

The variables in the questionnaire consist of socio-demographic data, to establish the characteristics of women seeking abortion. The pregnancy history, the number of pregnancies prior to the interview (gravidity) and in the number of children prior to the interview (parity), and whether the woman had a termination of pregnancy before. In the contraceptive history (past and present), whether the woman had been exposed to contraceptive usage, and family planning services before seeking an abortion was also queried.

The second half consisted of qualitative information with mostly open-ended questions on the satisfaction with abortion care (for example the knowledge obtained from health personnel of what problems could possibly arise on discharge and what health services to approach for care). Lastly, the questionnaire asked how women were feeling emotionally and physically before leaving the health services. (see questionnaire- Appendix 1)

3.8.Validity

Validation is an important process in minimising error and to provide information that is as accurate as possible. The researcher has extensive experience as a fieldworker and research interviewer including the use of structured and semi-structured questionnaires to obtain the highest quality data. The researcher also has the knowledge of woman's health issues and an understanding of sensitive issues in reproductive health. The researcher completed workshops in the Termination of Pregnancy Values Clarification and in Counselling on the Termination of Pregnancy and was familiar with methods of crisis intervention (Marais, 1997).

In addition, the questionnaire- was designed for certain questions to be reinforced by the information given by the woman to the medical practitioner and found in the woman's hospital folder. The research interviewer at no stage made the woman uncomfortable if there were any differences in information. A limitation in the study was in questions asked on satisfaction with service provision and women's feelings before leaving the health facility, responses could have been biased as women were still at the health service. The decision to interview women before leaving health facilities was because most women are lost to follow-up after discharge. The study findings in Vietnam suggested that for example only 2% of women returned on a given date for follow-up at health facilities (WHO, 1999).

3.9 Reliability

Reliability has to do with reproducibility of study results and the consistency of results across study sites or different interviewers. The questionnaire was semi-structured and pilot-tested prior to initiation of the study period. The same data collection tool was used in all five study sites in the language of preference of the interviewee. Only one interviewer conducted all interviews allowing the standardisation of the questionnaire.

An experienced researcher in qualitative methods accompanied the researcher during the pilot phase of the questionnaire at all the study sites. The interobserver status was done during the pilot phase with ten questionnaires. The adjustments were made to the flow of questions and accuracy of response to questions. The observer provided reliability to the questionnaire in measuring efficiency of the information from study participants (Litwin, 1995 & Abramson, 1990).

3.10 Data analysis

Throughout the data collection period, each and every questionnaire was quality controlled and coded on the day of the interview. Coded data was entered in to the Stata Statistical Software programme, originally from College Station, Texas. (StataCorp, 1997). The researcher with assistance of an administrator undertook data management -data capture, and data cleaning. A completed computed printout was made of all frequency distribution tables and crossed checked with the statistician on the variables and the standard deviation (SD) of age and age range. Any data illegalities in the computer frequency distribution tables were undertaken by the researcher to cross check with the relevant questionnaire.

3.11 Descriptive analysis

The study survey completed on women post-abortion in public health services had 133 study participants consenting to the research study. Quantitative data were analysed using descriptive statistics, e.g. frequency counts and percentages for categorical data and means, range and standard deviation for continuous data. The study findings aided in determining the characteristics of women attending public health services for termination of pregnancy on request. A further study priority was to investigate women's perceptions in understanding post-abortion care, their knowledge of service provision and where to return should complications arise after discharge. Post-abortion counselling emphasises the return to fertility immediately after the procedure. Therefore the commencement of family planning contraception and where services are accessible was included in the analysis. The last section investigated in this study

was that of the psychosocial needs of these women during the early phase of post-abortion care. The focus is on immediate support emotionally before leaving the health service or where there are resources available after discharge from the health facility should the need arise.

The method used for the qualitative analysis is a method of thematic content analysis. This has been adapted from Glaser and Strauss' grounded theory approach and from other research studies as in Suffla (1997) and Mc Culloch (1996), (Glaser & Strauss, 1967 and Berg, 1989). The process consisted essentially of sorting, comparing and/or contrasting and consolidating all the study participants' responses. From this process categories of feelings and knowledge emerged. The sorting into commonality of categories was given for verification to two colleagues who were not connected to the research study. This was undertaken to see whether there was similarity in the categories sorted. Differences were discussed and necessary adjustments made. (Appendix 2)

3.12 Ethical Statement

The researcher recognises the challenging nature of the research topic because of sensitivities involved and social stigma attached to undertaking an abortion in the community. The Act is a fairly new and legalised health service to the community. All study participants are made aware that the primary aim of the research is not to be a counselling session but merely an opportunity to have women express how they perceive health service provision and what their expectations are of quality of services in post-abortion care.

All study participants are reassured that no questionnaire will bear their name or their hospital folder number but a signed consent is necessary. The interviews were conducted with the highest confidentiality and anonymity and all information given by the women will only be used for research purposes (The World Medical Association Inc., 2000).

No study participant name will be mentioned in the final report. The information of this study will assist in improving abortion services provision and allow health care providers to have insight to women seeking abortion and their needs in the post-abortion period. (Consent form Appendix 3).

Chapter 4

The Results

4.1 Introduction

The results were taken from the five study sites in public health services in the Cape Peninsula that offered termination of pregnancy. The results shown are combined with frequency distribution tables.

4.2 The characteristics of study respondents

The data were collected at health services in the Cape Peninsula. The medical superintendents, the Heads of Obstetrics and Gynaecology, the health care managers, and health care providers were informed of the presence of the researcher. All women who were included based on the selection criteria outlined in Chapter 3 attended the termination of pregnancy clinic on that day. Most women were comfortable and gave written consent.

Below is a table of the number of respondents collected from the different hospital sites.

Table 4.1 Number of study participants seeking an abortion on request collected from each public health facility (n=133)

Variable- Hospital code		n (%)
Tygerberg	1	30 (22.56)
Mitchells Plain	2	30 (22.56)
GF Jooste	3	40 (30.08)
Somerset	4	3 (2.26)
Groote Schuur	5	30 (22.56)
Total number of participants		133

4.2.1 Age groups of study participants

Women selected for the study were 18 years and older.

The age distribution of the study participants are within specific age categories and are tabulated as follows:

Table 4.2 The age groups of study participants and profile of women at public health facilities (n=133)

Variable- Age (years)	n (%)
18 to 21	37 (27.82)
22 to 25	36 (27.07)
26 to 29	26 (19.06)
30 to 43	25 (25.56)
Total	133
Range	18 to 43 years
Mean	25.7 years
SD	5.78 years

The last age group 30 - 43 years was collapsed to make the data meaningful to obtain statistical inference. The mean age of women participating in the study was 26 years. Women were included from age 18 years and older. The age of the participants ranged from 18 to 43 years. The reproductive age used in National statistics ranges between 15 and 45 years old. The highest proportion of abortions occurs between the age groups 18 to 25 years and declines among the older women.

4.2.2 Marital Status

The marital status of women was investigated to determine whether there was a partner to share in support of the decision made by the women to terminate their pregnancy. Of the 133 respondents, the largest percentage was single women, which included women who were divorced or widowed, 117 (87.96%). The number of married women and women living with a partner was 16 (12%).

4.2.3 Education Level

The educational level of the women in the study can be broken down as follows. Of the participants, 16 (12%) indicated that they had completed an intermediate level of schooling. The lowest standard undertaken by study participants was grade 5. The proportions increased to 21 (16%) for grade 10, 18 (14%) had completed grade 11, and the largest number, namely 55 (41%) had completed grade 12. The last category refers to tertiary education where 23 (17%) had attended a technikon, college or university.

4.2.4 Religious affiliation

Protestants represented 108 (81%) of the sample, the Catholic group represented 16 (12%) of the sample, the Moslem faith made up 4 (3%) and the remaining 5 (3%) were unsure of their religious affiliation, meaning they felt they were not affiliated to any of the named categories.

4.2.5 The employment status of study participants

Of the respondents 63 (51.3%) were unemployed and 65 (48.8%) were employed. This is an almost even split between the employed and unemployed women .The factor of unemployment was further investigated to determine the length of time that women had been without a job and their type of unemployment choices.

The number of women unemployed but looking for work was 29 (42.6%), whereas those who were unemployed and not looking for work made up a mere 2 (2.9%) of the overall total. Women who were housewives made up 8.8% of the sample. Another high category was students representing 30 (44.1%) while one person (1.4%) was receiving a state grant/pension.

The categories of social class were coded according to CASS social class index for South Africa as 1-5, (Schlemmer, 1979).

1. White collar workers; these are individuals in top management positions e.g. accountants, school principals, nurses, etc.,
2. Blue collar workers; middle management positions such as clerks, managers, and cashiers,
3. Skilled workers; hairdressers, supervisors or foremen, nurse auxiliaries, etc.,
4. Semi-skilled workers; waitresses, tailors or seamstresses and truck drivers,
5. Unskilled workers; packers, domestic workers and hawkers.

These are but a few examples of the categories for social class. The proportion of those employed in the various categories was as follows: of the sample 9 (14%) were white collar workers (1), 15 (23%) were blue collar workers (2), 5 (8%) were skilled labourers (3), 23(35%) were semi-skilled labourers (4) and lastly 13 (20%) were unskilled (5).

Table 3 below is a summary of the characteristics of the women in the survey done at public health facilities.

Table 4.3 A summary of frequency distribution of the characteristics of women who have undergone an induced abortion at public health facilities (n=133)

Demographic Variables	n (%)	Total
Marital Status		
Married, includes traditional/common-law	11 (8.27)	
Living together	5 (3.76)	
Single	103 (77.44)	
Divorced	11 (8.27)	
Widowed	3 (2.26)	133
Educational Level		
Grade 5 to Grade 9	16 (12.03)	
Grade 10	21 (15.79)	
Grade 11	18 (13.53)	
Grade 12	55 (41.35)	110 (82.7)
Post Schooling	23 (17.29)	23
Religious affiliation		
Catholic	16 (12.03)	
Protestant	108 (81.20)	
Moslem	4 (3.01)	
Other	5 (3.74)	133
Employment		
White collar (1)	9 (13.85)	
Blue collar (2)	15 (23.08)	
Skilled (3)	5 (7.69)	
Semi-skilled (4)	23 (35.38)	65 (48.87)
Unskilled (5)	13 (20)	
Unemployment		
Unemployed looking for work	29 (42.65)	
Unemployed not looking for work	2 (2.94)	
Housewife	6 (8.82)	
Full-time student	30 (44.12)	
Government grant	1 (1.47)	68 (51.13)

4.3 Pregnancy history (past and present pregnancies of all respondents)

Of the 133 respondents, 45 (33%) had never been pregnant before the current index pregnancy and 88 (66%) had previously been pregnant prior to this index pregnancy. The high proportion of first time pregnancies correlates with the young age group of women in the survey. The young age group were found to have a high proportion of women either completing high schooling or still at tertiary institutions. Of the 88 (66%) women who had previously been pregnant prior to the interview, 55 (52%) of them had been pregnant once, 22 (34%) had been pregnant twice, 9 (10%) had been pregnant three times and 3 (3%) had been pregnant between four to six times. The highest number of children that women had recorded in this survey was six.

Of the 88 (66%) of women who had previously been pregnant 52 (59%) had one (live) child, 22 (25%) had two (live) children, 9 (10%) had 3 (live) children and 5 (6%) had between 4 and 5 live children. In probing further into the pregnancy history of the women who had previously been pregnant, an interesting fact was noted that 9 (10%) had previously experienced a miscarriage (a spontaneous expulsion of the foetus from the uterus). All the study participants were asked whether they had had previous abortions in health facilities (public and/ or private) and in 4 cases (5%) the response was positive.

The majority of referrals 77 (57.89%) were from health care providers (these included general practitioners, day hospitals and student health services). 33 (25%) of women were referred by a local clinic in which family planning services are situated. Finally, of the women having an abortion, 23 (17%) were referred by a parent, a friend or a self-referral.

Table 4 below summarises the pregnancy history of women in the survey attending public health services.

Table 4.4 A summary of the frequency distribution of the pregnancy history of the study participants who have had an induced abortion at public health facilities. (n=133)

Variable- Pregnancy History	n (%)	Total
Gravity		
No	45 (36.39)	
Yes	88 (66.17)	133
Parity of women		
One	55 (52.27)	
Two	22 (34.09)	
Three	9 (10.23)	
4 to 6 times	3 (3.41)	88 (66.16)
Previous TOP		
No	84 (95.45)	
Yes	4 (4.55)	88
Sources of referral to services offering TOP		
Local clinic	33 (24.81)	
Parent/friend/spouse	23 (17.30)	
By Health care provider	77 (57.89)	133

4.4 Contraceptive history (usage and exposure to contraceptives)

Of the 133 participants, 120 (90%) responded positively to contraception usage prior to the interview and the other 13 (10%) had never used a contraceptive method. Contraception use does not necessarily provide complete protection against pregnancy. Each method can fail even though it is used as indicated. The study participants had different patterns of contraceptive use. The use of contraceptives varied greatly between the four different methods used. The different contraceptive methods commonly used included the pill, injectable, IUCD, spermicides, condoms and other (meaning contraceptive methods not on code at public health services).

The breakdown of the 120 (90.23%) study participants who used contraceptives was: 26 (22%) of women had only used an injectable contraceptive, 24 (20%) had used an injectable and a condom, 22 (18%) had used a pill, injectable and a condom, 17 (14%) had used the pill and a condom, 16 (13%) had used the pill and injectable contraceptives, 6 (5%) had used a condom only, and 5 (4%) had used only the pill.

The other combinations of contraceptive usage were IUCD with an injectable, the pill and an injectable and a gel, then the pill, injectable and intrauterine contraceptive device (IUCD) and condoms and lastly an injectable IUCD, gel, and condoms. In each category only 1 woman (3%) used the mentioned combination. Overall, a large percentage of women in the survey had had exposure to contraceptive use.

A further investigation was done to obtain the possible reasons for contraceptive failure. It was found that 34 (26%) of the respondents had been using a contraceptive at the time of the current pregnancy whereas the other 99 (74%) of women had not been using contraceptives.

Of the 34 (26%) respondents who were using contraception at the time of pregnancy, 15 (44%) were using the pill, 14 (41%) using condoms, 4 (12%) using the injectable and 1 (3%) using an IUCD.

The 34 (26%) women who had been using a contraceptive method prior to TOP had various reasons why they had become pregnant.

Women responded with a mixture of reasons to the question, 'Do you know why you became pregnant using family planning?'. The primary reason for those using the pill was reported as having missed taking pills; those using a condom said it had become dry and had broken. In the 'Other' category women listed some of the following problems: In those using the pill, reason for failure included the use of a prescribed antibiotic for an infection at the time of using the contraceptive; another group also using the pill said the use of a laxative and slimming pills had neutralized the pill's effect; while another respondent said on starting a new contraceptive she had forgotten the two weeks unsafe period as a first time acceptor.

Below is a table of a summary of contraceptive use by the women in the survey and the patients' perceptions of the possible reasons for contraceptive failure prior to the abortion.

Table 4.5 A summary of the frequency distribution of contraception history of study participants who have had an induced abortion at public health facilities (n=133)

Variable- Contraception History	n (%)	Total
Ever used contraception		
No	13 (9.77)	
Yes	120 (90.23)	133
Contraceptive method used		
Injection	26 (21.67)	
Injection and condoms	24 (20)	
Pill+ injection+ condoms	22 (18.33)	
Pill and condoms	17 (14.17)	
Pill and injection	16 (13.33)	
Only condoms	6 (5)	
Only the pill	5 (4.17)	
Other	4 (3.33)	120 (90.2)
Current contraceptive use before the TOP		
Pill	15 (44.12)	
Condoms	14 (41.18)	
Injection	4 (11.76)	
IUCD (Loop)	1 (2.94)	34 (25.56)
Reason for method failure		
Forgot to take the pill	11 (32.35)	
Condom broke and leaked	11 (32.35)	
Forgot appointment for injection	3 (8.82)	
Don't know why feel pregnant	2 (5.88)	
Did not check strings of the IUCD	1 (2.94)	
Other - a mixture of reasons	6 (17.66)	34 (25.56)

4.5 The satisfaction with abortion care (care the woman has from first contact at health services for TOP until the discharge)

There are some aspects of health that can only be assessed by the consumer. For example, the woman is the best source of information on how the health service is perceived based on knowledge gained from hospital visits, from the health care provider and from the understanding of instructions given about services available when emergencies arise. *Perception is reality*. Also of importance to women attending health services is their privacy and whether they were treated with respect and dignity by the health care providers. Although health care providers assume to know what is best for women, the women are the best source of information describing their needs.

In interviews conducted with 133 respondents who have had an abortion on request, mostly positive responses were reported from women in the post-abortion phase.

On discharge from health services 84 (63%) women had received information on the complications to watch for on leaving the hospital. The question was left open with no prompting. The response was highest to the symptom of infection and various others symptoms but only a small proportion reported bleeding and shock symptoms.

Of the participants interviewed, 93 (70%) women knew where to go when the symptoms arose. The women's knowledge regarding their return to fertility was exceptionally high, 127 (95%) women, i.e. most women in the survey, were aware of their return to fertility. Likewise 130 (98%) women had decided to commence a contraceptive method immediately. The most common choice of contraceptive method to start was injectables for 109 (83.85%) respondents, followed by 18 (13.85%) for the contraception pill, and 1% for sterilization and an intrauterine device. There was 1 (3%) woman that was unsure of the choice of method. Most women, 117 (90%), were prepared to commence the method immediately before discharge. The other 13 (10%) planned to commence family planning as soon as possible. Women knew where and when to access family planning services for the follow-up. On the question of counselling only 27 (20%) women were given information about where to seek resources for counselling.

The aspects of quality of care with respect to health care providers' attitude and for the feeling of confidence and trust in them were rated as 'excellent' by 113 (85%) respondents. Regarding the attitude of health care personnel with regard to respect and dignity, 116 (87%) responded

with 'excellent'. Most women thought that the attitude of health care provider was excellent. 53 (40%) women rated counselling standards received post-abortion as 'excellent', 66(50%) of the respondents rated the counselling as 'very good to good' and 14 (10%) rated the counselling as 'fair to poor'. Many, however, felt that there was still room for improvement in the post-abortion counselling.

The table below has the questions and the responses categorized. The data collected in this section are mostly qualitative information and responses were categorized into sentences. There were occasions when responses were a sentence in length.

Table 4.6 The questions and responses of study participants on their satisfaction with abortion care with frequency distribution (n= 133)

THE STUDY PARTICIPANTS ages 18 to 43 years n=133	**Number of respondents**	**Percentage**
QUESTION and RESPONSE		
Question: Did the health personnel tell you about possible problems/ complications to watch for after leaving the hospital after the abortion? *(YES)*	84	63%
Response: If YES: What were the problems discussed?		
- Bleeding – the amount/the colour/ the length of time,	9	10.71%
- Shock - dizziness/ nausea/abdominal pain/headaches cramps/ fever, (the above mentioned together)	10	11.90%
- An infection - smelly discharge,	23	27.38%
- In a letter given by the sister. I'll read it at home,	*	
- Other – infertility, no exercise, emotional and psychological problems, breast tenderness for a while, uterus can be perforated, abortion can be incomplete, not to wear tampons for a while and could acquire AIDS. (all of the above were mentioned by fewer than 8 participants and include 2 and more clinical signs)	42	31%
* these symptoms were mentioned but together with other symptoms.		
Question: Did you receive any information or telephone numbers as contact details of health services to approach if any problems arise? *(YES)*	93	70%

Response: If YES: Where were you referred/ what telephone numbers?		
1. local clinic	5	3%
2. hospital	56	42%
3. general practitioner	2	1%
4. day hospital	24	20%
5. other - nongovernmental organizations etc.	6	4%
Question: Did any of the health personnel explain the importance of an immediate contraception/ family planning? *(YES)*	127	95%
Question: Have you decided on a method of contraception/ family planning to use? *(YES)*	130	98%
Response: If YES: what is your choice of contraception/ family planning?		
1. Pill	18	14%
2. Injectable	109	82%
3. Don't know/ or have not decided yet	1	1%
4. other e.g. sterilization, intrauterine device.	2	1%
Question: When will you be going for the method?		
Response: 1. Today	117	90%
2. As soon as possible	13	10%
Question: Where will you be going for the method?		
Response: 1. local clinic	83	62%
2. hospital	7	5%
3. general practitioner	3	2%
4. day hospital	14	11%
5. other e.g. pharmacy, work place, student health services and community based distribution.	23	17%
Question: Have you been given information on persons or telephone numbers of individuals you possibly can speak to when the need arises for counselling? *(YES)*	27	20%
Response: Where have you been referred?		
1. local clinic and day hospital	6	4%
2. hospital	5	3%
3. the local clinic, general practitioner and the hospital	2	2%
4. other e.g. non-governmental organizations or a close friend.	14	11%

Question: Did you feel confidence and trust in the health personnel?		
Response: 1. A lot	113	85%
2. Some	12	9%
3. Only a little	4	3%
4. None at all	4	3%
Question: Do you feel the health personnel treated you with respect and dignity?		
Response: 1. A lot	116	87%
2. Some	11	8%
3. Only a little	3	2%
4. None at all.	3	2%
Question: How would you rate the counselling you received today after the abortion?		
Responses: 1. Excellent	53	40%
2. Very good	31	23%
3. Good	35	27%
4. Fair	7	5%
5. Poor	7	5%

The *YES* in italics is the response by the participants.

4.6 The healing process (the responses of study participants' feelings)

The majority of women expressed spontaneously what they were feeling during the post-abortion stage.

- 85 (71.43%) felt positive about the decision taken for the termination of the pregnancy.
- The other third, 38 (28.57%), had negative feelings.
- 44 (33%) of the women were asked by health providers whether they had fears or concerns about the procedure.
- Few women, 18 (14%), were asked about how they were feeling physically and emotionally on discharge.
- Only 4 (3%), i.e. a very small number, were offered follow-up counselling.
- On recommendation of the service offered, most women, 94 (71%), felt 'yes'that they could recommend the TOP service, 31 (23%) responded that they would not recommend the service and 8 (6%) responded both 'yes' and 'no'.

The dual responses 'yes' and 'no' were '*lots of love and care here but I won't tell anyone I had TOP', 'good care for those who want the procedure but if they want a TOP it has to*

be [for] a good reason', 'I cannot judge others; it's my first and last time, the procedure is one of the most terrible'.

In rating the care women received before discharge, the proportions were similar to those regarding the counselling after the abortion. 41 (31%) of responses were 'excellent', 87 (65%) thought that the care that day had been 'very good to good' and 5 (4%) found the care to be 'fair to poor'. The women gave the care high ratings but felt there was room for improvement on counselling.

Table 4.7 The questions and responses of study participants on the healing process with the frequency distribution (n=133)

The STUDY PARTICIPANTS age 18 to 43 years n=133	**Number of respondents**	**Percentage**
QUESTION and RESPONSE		
Question: How are you feeling now after the procedure? **Responses**: 1. Remorseful, but not regretful, torn between principle and circumstances. Perhaps ashamed. Remorse, but not regretful as circumstances overrule principle.	23	17.29%
2. Relieved, learning experience been the correct decision taken to have the TOP. Relieved of a burden and this being unequivocally the correct decision.	33	24.81%
3. Cured from anxiety. It was the correct decision. Cured almost as if from an illness and entirely satisfied with the decision taken.	10	7.52%
4. Elated to be out of the pregnancy. No remorse felt and there is a feeling of complete comfort with the decision.	13	9.77%
5. The procedure has reinstated the patient's happiness by relieving them of this burden of 'the pregnancy'.	16	12.03%
6. Conscience. Guilt, uncomfortable and unsure about the decision taken for the TOP. Requires reassurance. The patient is consumed by guilt and perhaps requires reassurance from a third party on their decision taken.	10	7.52%
7. Emotionless, perhaps blocking emotion or too soon to express the emotion. Patient is left with no emotion of the procedure, perhaps there is the blocking of emotions or a delay	21	5.79%

in responses. 8. Afraid, scared and the fear of the correct decision taken. Afraid that the incorrect decision was made; confusion reigns.	7	5.26%
Question: After the procedure did any of the health personnel discuss your concerns or fears you had about the procedure? (*YES)*	44	33%
Response: If YES: What were the responses? 1. They assured me- the pain will be like a menstrual period/ when to worry and not to worry, cramps, the physical state after the procedure. 2. I must remain calm and relaxed. 3. The risk involved with having an abortion.	36 6 2	27% 5% 1%
Question: Did the health personnel ask you how you are feeling physically and emotionally before leaving the hospital? *(YES)*	18	14%
Response: If YES: What were the responses? 1. It is normal to have fears about the procedure and this happens to some people but you have no choice. 2. To see a counsellor at the day hospital, a general practitioner or Pregnancy Help centre in Wynberg or someone to confide in /call here for an appointment. 3. Explained the emotional feelings you could have after the procedure. 4. Other - they comforted me and I feel relaxed and calm, I told the Sister I was all right, she said I could get counselling, I was feeling dizzy and the nurse put me into a chair.	2 7 3 6	2% 5% 2% 5%
Question: Did any of the health personnel offer you a follow-up appointment for counselling? *(YES)*	4	3%
Response: If YES: To which health facility? 1. hospital 2. day hospital (responses were only to the two facilities)	2 2	50% 50%
Question: Would you recommend this hospital to family and friends if they need an abortion? (*YES)* *(NO)* *(BOTH)*	94 31 8	71% 23% 6%

Response: If YES: Why would you recommend the health service?		
1. It is safe and efficient and right to come here ('good / excellent care, treated well, as if you pay for it, it's the best I have experienced, they are thorough and very professional').	20	15%
2. The service that is offered is good ('handle one well, like a human being, will be good for others too')	18	14%
3. The service is good; the nurses treat one with respect and they make one feel relaxed (' there is confidentiality between staff and the patient, never felt degraded or judged or guilt-ridden')	18	14%
4. The service is good and the outcome is good ('treated me nice and fine, felt free, not scared, did not put you on the spot, I never felt threatened')	14	11%
5. They are very helpful, friendly and this makes you comfortable ('the hospital is clean, everyone was supportive, I felt okay, you did not feel as if you are doing a bad thing, the procedure was explained in detail to all the women')	14	11%
6. If it is the woman's choice then I yes, especially if they do not have the means to pay for the TOP, assess the friend's situation before recommending the service, I have had no problems here.	14	11%
Response: If NO: Why would you not recommend the service?		
1. I'll keep it private, I'll not talk to anyone, not even my mother; the matter is between God and me.	18	46%
2. I'll not be able to talk about this, I'm too scared because I did not believe in doing this, the choice is theirs, and I cannot make decisions for others.	9	23%
3. I won't, it's a very bad experience, I won't wish this on my worst enemy.	5	13%
4. There are no pain killers and I was awake throughout the procedure, nobody knows I have had a TOP; I won't be able to talk about the service because how would I know	7	18%

about the service, I'll persuade someone to think twice, treatment is better in private, the problem was the waiting time, I will not recommend an abortion.		
Response: Mixed comments of *YES* and *NO* recommending services. ' Lots of care and love here but no, I won't tell anyone I had TOP', 'good care for those who want the procedure but if they want a TOP it has to be a good reason', 'I cannot judge others its my first and last time, the procedure is one of the most terrible experiences'.	8	6%
Question: Overall, how would you rate the care you received today from the health personnel?		
Response: 1. Excellent	41	31%
2.Very Good	39	29%
3. Good	48	36%
4. Fair	4	3%
5. Poor	1	1%

Chapter 5

Discussion, Conclusions and Recommendations

5.1 Introduction

In 1994 the International Conference on Population Development focused attention on the global need for more and better post-abortion care. In 1996 the South African government, who were signatory to the ICDP document for Action, enacted the Choice on Termination of Pregnancy Act No. 92 of 1996. In 1997 the National Department of Health implemented the termination of pregnancy services in public health facilities. The TOP services were monitored and evaluated by a non-governmental organisation, the Reproductive Rights and Alliance who work closely with the Department of Health's Strategic Programme in Maternal, Child and Women's Health. Health care providers have had special training to practise the carrying out the procedure of abortion. The abortion services are provided in the public sector free of charge to all women, irrespective of their status. The women, with signed consent, have an abortion procedure done under the guidelines in the Choice on Termination of Pregnancy Act. A total of 220 888 abortions have been performed since February 1997 when the implementation of these services began.

The Department of Health Provincial Administration offers compulsory workshops to all health care providers in the Western Cape in the 'Abortion Value Clarification and TOP. counselling' programmes.

5.2 Discussion

In the Western Cape province there is a population of 4,2 million people of which 1 119 481 are women between ages 15 and 49, with a total fertility rate of 2.35. The study objectives were to:

1. Determine the socio-demographic characteristics of women seeking an abortion in the Cape Peninsula.
2. Ascertain women's understanding of post-abortion care and family planning.
3. Assess women's perceptions of satisfaction with post-abortion services.
4. Identify the psychosocial needs of women post-abortion.
5. Make recommendations on women's wants and needs in post-abortion care.

This section will review study results with regard to each of these objectives.

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5.2.1. Socio-demographic characteristics of women seeking an abortion in the Cape Peninsula

Age

The age distribution of women study participants ranged between 18 and 43 years. More than half the women were under the age of 25 years and a large proportion of women were single and unmarried. Most single women were not living with a partner. In urban areas women in the younger age group have opportunities for education, employment and career development. Therefore, young and unmarried women may be more likely to postpone marriage and childbearing.

Marital Status

The determinant of marital status is an indication that women who have unintended pregnancies and seek abortion are not in a stable or permanent relationship and/or are not ready for having a child. Only 16 (12%) of the study participants were married, living with a partner or common-law husband. Bankole *et al.* (1998) found that in Sub-Saharan Africa there are only a small proportion of married women becoming pregnant unwillingly. However, the SADHS (1998) found high levels of premarital fertility among women aged 15 to 25, and marital fertility among women age 15 to 49 in South Africa.

Religious affiliation

Most of the women had a Protestant religious affiliation that is consistent with the census done in 1996, where the majority of South Africans were Christians. The religious aspect was collected from women because of the influence religion and values have surrounding abortion in South African communities. Even though abortion is legalised, women could be reluctant to divulge truthfully to health care providers their religious affiliation. Research done by Huntington *et al.* (1998) and Bankole *et al.* (1999) shows that born-again Christians may be less likely obtain an abortion than Protestants.

Employment status

The employment status of the women is evenly distributed between employed and unemployed. The Western Cape is the most urbanised province in South Africa with only 11% of the population living in rural areas. The unemployment rate is 18.9%, compared to the national average of 32.2%. The number of unemployed women in this study is 68 (51%), which is far higher than mentioned in the census. Women may have valid reasons for remaining unemployed; of the women in this study 23 (17%) were full-time students. The Bankole *et al*,

(1998) study showed that where there are study opportunities and education women perceive a pregnancy as disruptive. The pregnancy will affect their year of study. Improvement of educational level tends to allow women to follow careers and create better conditions for themselves.

History of pregnancies

Two thirds of the women had previously been pregnant before this termination of pregnancy and for the other third this was their first pregnancy. This is consistent with the findings of Bankole *et al.* (1998 & 1999) that childless women obtain fewer abortions than women with children.

Family planning service provisions

As previous contraception users 120 (90%) of women had been exposed to methods of contraception. This is higher than survey data in South Africa which showed three quarters of women in the reproductive age have experience with using a contraceptive method and sixty percent of women in South Africa in their reproductive age use some form of family planning (SADHS, 1998). Most women who have been pregnant before have had medical assistance at delivery and are offered a contraceptive method before leaving the health facility. This occurs more in the public sector than the private sector. Therefore most pregnant women who have been pregnant before have been introduced to family planning methods.

In the SADHS (1998) overall the injectable contraceptive is the most commonly used method of family planning under the age of forty and in women over the age of forty female sterilization. This is consistent with our data, where 73% of women had a history of injectable contraceptive, followed by the pill at 50%. The women who have had contraceptive failure before the termination of pregnancy were 34 (26%) and of this percentage their reasons for method failure varied. Only 11% of contraceptive failures were in women using injectables. The highest percentages were using the pill or the condom. The family planning method of contraception injectable is very effective.

Some of the advantages in using an injectable contraceptive are that it is private, i.e. no one else can tell that the woman is using the method; it can be used at any age; it does not interfere with sex and increases sexual enjoyment because there is no need to worry about pregnancy; there is no daily pill-taking; women can return earlier than the due date for re administration of the method or as many as 4 weeks after the due date and still be safe. Side effects are few. Two types of injectable contraception are available. The difference requires returning to the family

planning service either every 12 weeks or 8 weeks, depending on the type of injectable. Therefore less regular contact with health care providers.

There is a need for effective and efficient provision by the family planning service to decrease discontinuation of contraception use and subsequent unwanted pregnancies with particular attention to correct pill and condom use. Also women should be made aware of emergency contraception, for cases of missed pills or condom breakages.

5.2.2 Women's understanding of post-abortion care and family planning

Post-abortion Care

The impact of service provision is based on the health care provider's interaction with the client. 84 (63 %) of the women had known of the complications to be aware of when leaving the health service. Referral to reproductive health services is one of the strategies in the WHO (1997) guidelines. Women in this study were aware of where to approach health services. A list has been developed on clinical concerns post-abortion that had been included as part of the guidelines in post-abortion care. Health care providers should be familiar with these complications. They are as follows:

1. Infection with a discharge, normally ranging from local pelvic infections to generalised sepsis. The health care provider has to establish whether the infection developed prior to the abortion or whether there was a presence of any smelly discharge after the abortion.
2. Uterine perforation, cervical tears or lacerations to be assessed by observation and the condition to be stabilised before the woman leaves the health service.
3. Haemorrhage or anaemia; the blood loss is to be assessed and the condition is to be stabilised before the woman leaves the health service.
4. Shock, dizziness, nausea, and period pains to be observed and the condition to be stabilised before the woman leaves the health service.
5. No sexual intercourse is recommended until bleeding has stopped.
6. The experience of breast tenderness for a period of two weeks or more can be expected.

Most women had details of health services to approach if any problems occurred after leaving the service. The responses of complications to be aware of and return to health services soon as they experience emotional and psychological problems, breast tenderness, the other was smelly discharge, dizziness, nausea, abdominal cramps headaches, heavy bleeding and

infertility. Most women mentioned the smelly discharge. A clear emphasis on all the six above clinical concerns was not clearly related to women as a cause for immediate return to health services if these complications were to present.

Family Planning

Almost all the women were aware of the importance of immediate contraception. There was a high acceptance of a family planning method before leaving the health service. 104 (82%) of the women accepted the injectable method as a form of contraception and 18 (14%) the pill. All the women knew where to obtain their follow-up contraception method.

Counselling

Very few women had been given information of individuals or telephone numbers to contact when the need arises for counselling.

Interaction between the women and the health care provider is a strategy in the framework for quality of post-abortion service provision. The counselling noted in this study was mediocre.

5.2.3 Satisfaction with abortion care

Most women felt confidence and trust in the health care providers and were treated with respect and dignity. The interaction with the health care provider on the day of the abortion was different from the previous contacts with the health system. There was a very high regard for confidentiality, and trust in health care providers and exceptional respect towards the women and their dignity.

Most women felt they could recommend the health service to women who were family and friends. Of those who would not recommend the service, the majority had reasons related to privacy, with less than 10% overall citing a reason related to dissatisfaction with the care.

5.2.4.Psychosocial needs of women post-abortion

85 (71%) of the women felt positive towards their decision taken to request an abortion. The feelings were for example feelings of relief, happiness and cured of anxiety. The women with negative feelings were emotionless, guilty or afraid of whether the decision had been the right one or not. Few women were given reassurance before leaving the health service and even fewer were asked about their physical and emotional state. Almost none of the women were offered a follow-up appointment for counselling. Women should be approached to determine whether or not they have a system of emotional support should the need for it arise. A small proportion of women had

post-abortion counselling. Women should have access to information to allow them the option to decide whether or not they need to make use of the health facility should the need arise.

Post-abortion care is an important component of family planning that creates an environment that affirms women's reproductive and sexual rights. One of the noted factors that contribute to positive service utilisation is the fact that women have had positive experiences with the service provided by the health care provider. Hence, in the long-term this could decrease the need for women to terminate a pregnancy.

5.3. Conclusions

In conclusion the results of this study indicate that most women seeking abortion are young, single women with a fairly good level of education. The women are found to be Christians with a very small proportion unsure of their religious affiliation. The employment status of women in the study is of a fairly good standard for income purposes with the majority of the women unemployed attending institutions of higher learning.

The standard in the post-abortion family planning counselling was of a level to be commended in that almost all the women were motivated to commence a contraceptive method and were sure of their method of choice before leaving the health facility. Those not commencing the method on that day would go to a family planning clinic as soon as possible. Women had the highest regard for the health care provider in confidentiality and respect shown for their decision made and felt without a doubt that the health care providers were trustworthy and treated them with dignity. This is encouraging to the health care provider as women generally felt their attitude was humane.

The shortcomings of the health care providers were in providing women with a list of possible complications that is of clinical concern to be aware of and to seek the nearest medical assistance on presentation. Women gave complications but there was no consistency in the symptoms in the list provided in the guidelines by WHO.

The women had positive emotions about the decision made to terminate the pregnancy. This was found to be the initial reaction on the day of the TOP before leaving the health facility. The concern is for women that were not feeling to good emotionally about the procedure and would like to have more emotional support prior to leaving the facility. They had not been given an option on possible counselling services to approach for assistance. This research will provide

health care providers with a tool to use in quality service provision. Women could be approached and spoken to about their physical and emotional state and to ensure that they are aware of facilities to seek emotional support and the public health facilities for complications that could be treated effectively. Post-abortion counselling should be made available to all women having an abortion and a list of Pregnancy Help centres and telephone numbers should be made available. All women having undergone an abortion should have knowledge of reproductive health services available in case of possible infections and other clinical situations that could occur.

5.4. Recommendations

Based on the conclusions drawn, the following recommendations can be made.

1. Improved family planning services are to provide for single, young women commencing as new acceptors of family planning, by providing an environment with a wide selection of family planning methods and to make it conducive to make informed choices about available methods.
2. Improve and increase knowledge of the effectiveness of the contraceptive methods and counselling women that if they become dissatisfied with a method to approach the service immediately for assistance.
3. Provide all women with the knowledge of 'emergency contraception' available on method failure and as to available intervention to women who have had unprotected sex.
4. Involve non-governmental organisations to assist with counselling, for example the Pregnancy Help centre, and to ensure that the resident social worker is available on the days when terminations of pregnancy are done.
5. Formulate an education checklist, to guide the interactions that the women have with the health care provider before leaving the facility, which includes enquiring about their physical and emotional state. Pilot the form in certain public health facilities for effectiveness of counselling.
6. Monitor and evaluate the pilot sites where the checklist is being used on the post-abortion service's effectiveness and efficiency by conducting focus groups of health care providers and the health care users.

The above recommendations address the medium term goals to create an environment that meets women's sexual and reproductive needs. These undertaken successfully should decrease the need for termination of pregnancy.

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Appendix 1: Questionnaire in English and Afrikaans

ASSESSING THE QUALITY OF POSTABORTION CARE IN THE CAPE PENINSULA

(for a master's mini-thesis)

A questionnaire and interview guidelines for women who have undergone a termination of pregnancy.

Form number:..... ☐☐☐

Date of Interview:..... ☐☐☐☐☐☐
DD MM YY

Hospital by code:..... ☐

SOCIO DEMOGRAPHIC DATA
(THE CHARATERISTICS OF SURVEY RESPONDENTS)

I'm going to ask you questions about yourself, your age, marital status, schooling, religion and employment.

1. How old are you? ..... ☐☐

2. Your date of Birth?..... ☐☐☐☐☐☐
DD MM YY

3. What is you present marital status?..... ☐

1. Married/ including traditional/ common-law
2. Living together
3. Single
4. Divorced
5. Widowed

4. What is the highest standard you have completed at school?..... ☐

0. Did not attend school
1. Grade 1 (Sub A)
2. Grade 2 (SubB)
3. Grade 3 (STD 1)
4. Grade 4 (STD 2)
5. Grade 5 (STD 3)
6. Grade 6 (STD 4)
7. Grade 7 (STD 5)
8. Grade 8 (STD 6)
9. Grade 9 (STD 7)
10. Grade 10 (STD 8)
11. Grade 11 (STD 9)
12. Grade 12 (STD 10)

5. To what church do you belong?..... ☐

1. Catholic
2. Protestant
3. Moslem
4. Other

6. Are you doing work that you are paid for? (YES/ NO)..... ☐

If NO: Are you:..... ☐

1. Unemployed- looking for work
2. Unemployed –not looking for work
3. Housewife/ Home executive
4. Full- time student
5. On a government grant/ pension

If YES:

What is your job?

Specify_____ ☐

(in the above there will be open text- coding will be done for various jobs)

7. If unemployed: for how long have you been unemployed?..... ☐

1. < than 1year
2. 1- 5 years
3. 6- 10 years
4. 11- 15 years
5. 16+ years

PREGNANCY HISTORY

I will now ask you questions about you past and present pregnancies?

8. Have you ever been pregnant? (YES/NO)..... ☐

If NO: ask question 12

If YES: ask question 9

9. How many pregnancies have you had before this one?..... ☐☐

10. How many living children do you have at present?..... ☐☐

11. Have you had any miscarriages or stillbirths? (YES/NO)..... ☐

If NO: go to Question 12

If Yes: How many miscarriage or stillbirths?..... ☐☐

12. Have you had a termination of pregnancy before to-day? (YES/NO)..... ☐

13. How did you come to know of the abortion service?..... ☐

(PROMPT FOR THE FOLLOWING)

1. Local clinic
2. Parent
3. Friends
4. Boyfriend/ husband
5. Referred by a health care provider
6. Other _____.

CONTRACEPTIVE HISTORY

(THE CONTRACEPTIVE USAGE OF TOP CLIENTS)

I'm now going to asking you about any pills, injectable family planning/contraceptives or any other method of family planning that you have used.

14. Have you ever used any method of family planning/ contraception?

(YES/ NO) ☐

IF NO: go to Question 15.
IF YES: What method/s have you use?
PROMPT FOR THE FOLLOWING FP- METHODS BELOW- as YES/ NO

1. Pill..... ☐
2. Injection..... ☐
3. IUCD (Loop)..... ☐
4. Spermicides or Gel..... ☐
5. Condoms..... ☐
6. Other _____.

15. Were you using a family planning or contraceptive method when you fell pregnant?(YES/ NO)..... ☐

IF NO: do not ask the following two questions, go to Satisfaction of abortion care section.
IF YES: ask Question 16

16. What family planning/ contraceptive method were you using?..... ☐

1. Pill
2. Injection
3. IUCD
4. Spermicide or Gel
5. Condoms
6. Other _____.

17. Do you know why you become pregnant if you were using a family planning contraceptive? (specific to contraceptive method being used)
(PROMPT FOR THE FOLLOWING)

1. Did you forget the pill?..... ☐
2. Did you miss your appointment date for the injection?..... ☐
3. Did you check the strings of the IUCD?..... ☐
4. Did you check the expiry date of the condom?..... ☐
5. Don't know..... ☐
6. Other_____

THE SATISFACTION OF ABORTION CARE
I'm now going to ask you questions on the care that you received in the hospital today.

18. Did you receive counselling on the following:

18.1 Did the health personnel tell you about possible problems/ complications to watch for after leaving the hospital after the abortion?**(YES/NO)**..... ☐
If NO: ask section 19.2

If YES: what were the problems they discussed? (open text)

_____
_____
_____ .

18.2 Did you receive any information or telephone numbers as contact details of health services to approach if any of these problems arise?**(YES/NO)** ..... ☐
If NO: ask section 19.3

If YES: where were you referred/ what telephone numbers? _____

18.3 Did any of the health personnel explain the importance of an immediate family planning/ contraceptive use?**(YES/NO)**..... ☐

18.4 Have you decided on a method of family planning/ contraceptive to use?
(YES/NO).. ☐

IF YES: what is your choice of family planning? _____.
and, when and where will you be going for the method?
_____.

19. Have you been given information on persons or telephone numbers of individuals you possibly can speak to when the need arises for counselling?
(YES/NO) ☐

If NO: ask question 22

If YES: where have you been referred?_____.

20. Did you feel confidence and trust in the health personnel?..... ☐

(PROMPT FOR THE FOLLOWING)

1. A lot
2. Some
3. Only a little
4. None at all

21. Do you feel the health personnel have treated you, with respect and dignity?. ☐

(PROMPT FOR THE FOLLOWING)

1. A lot
2. Some
3. Only a little
4. None at all

22. How would you rate the counselling you received today after your abortion? ☐

(PROMPT FOR THE FOLLOWING)

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

THE HEALING PROCESS

I am now going to ask you about how you are feeling.

23. How are you feeling now after the procedure? ..... ☐

(open text) _____

_____

_____

_____

24. After the procedure, did any of the health personnel discuss your concerns or fears you had about the procedure? (YES/ NO)..... ☐

IF YES: what were the responses?

_____

_____

_____.

25. Did the health personnel ask you how you feel physically and emotionally before leaving the hospital?(YES/ NO)..... ☐

IF YES: what were the responses?_____.

_____.

26. Did any health personnel offer to make a follow-up appointment for counselling?(YES/ NO)..... ☐

IF YES: to which health facility?._____

27. Would you recommend this hospital to family and friends if they need an abortion?(YES/ NO)..... ☐

IF YES: why would you recommend the health service?_____.

_____.

IF NO: why not? _____.

_____.

28. Overall, how would you rate the care that you received to-day from the health personnel?..... ☐

(PROMPT FOR THE FOLLOWING)

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor.

Thank you, for your participation. A complied report of the research project will be presented to health personnel and programme managers at the health facilities. The results will not include participants' names in the report but the report will be used to create and increase the awareness of the importance of counselling after an abortion.

ONDERSTEUNING AANGAANDE DIE KWALITEIT VAN NA-ABORSIE SORG IN DIE KAAPSE SKIEREILAND

(vir 'n meester's mini-tesis)

'n Vraelys en onderhoud riglyne vir vroue wat 'n beenidiging van swangerskap ondergaan het.

Vormnommer:..... ☐☐☐

Datum van onderhoud:..... ☐☐☐☐☐☐
DD MM JJ

Hospitaal kode:..... ☐

SOSIO DEMOGRAFIESE INLIGTING
(DIE KARAKTEREKKE VAN RESPONDENTE)

Ek gaan nou vir u vrae vra oor uself, u ouderdom, of u getroud is, u opvoeding, u geloof en werksomstandighede.

1. Hoe oud is u? ..... ☐☐

2. Wat is u geboortedatum?..... ☐☐☐☐☐☐
DD MM JJ

3. Is u nou getroud?..... ☐

1. Getroud/ insluiting tradisioneel/ gemenereg
2. Bly met mekaar
3. Enkel
4. Geskei
5. Weduwee

4. Wat is die hoogste standerd wat u op skool voltooi het?..... ☐

0. Nog nooit 'n skool by gewoon nie
1. Graad 1 (Sub A)
2. Graad 2 (SubB)
3. Graad 3 (ST 1)
4. Graad 4 (ST 2)
5. Graad 5 (ST 3)
6. Graad 6 (ST 4)
7. Graad 7 (ST 5)
8. Graad 8 (ST 6)
9. Graad 9 (ST 7)
10. Graad 10 (ST 8)
11. Graad 11 (ST 9)
12. Graad 12 (ST 10)

5. Aan watter kerk behoort u?..... ☐

1. Katoliek
2. Protestant
3. Moslem
4. Ander

6. Doen u werk waarvoor u betaal word? (JA/ NEE)..... ☐

Indien NEE: is u:..... ☐

1. Werkloos- soek vir werk
2. Werkloos –soek nie vir werk nie
3. Huisvrou
4. Voltydse student
5. Ongeskikheidstoelae

Indien NEE:
Watter tipe werk doen u?

Spesifiseer_____ ☐
(in bogenaamde sal daar opeteks kodes vir verskillende werke wees)

7. Indien werkloos: vir hoe lank is u werkloos?..... ☐

1. < as 1jaar
2. 1- 5 jaar
3. 6- 10 jaar
4. 11- 15 jare
5. 16+ jare

SWANGERSKAP GESKIEDENIS

Ek wil nou vir u vrae vra oor u vorige en huidige swangerskappe?

8. Was u al ooit swanger? (JA/NEE)..... ☐

Indien NEE: gaan na vraag 12
Indien JA: gaan na vraag 9

9. Hoeveel swangerskappe het u voorheen gehad?..... ☐☐

10. Hoeveel kinders het u wat lewe ?..... ☐☐

11. Het u enige miskrame of stilgebore babas gehad ? (JA/NEE)..... ☐

Indien NEE: gaan na vraag 12

Indien JA: hoeveel miskrame of stilgebore babas het u gehad?..... ☐☐

12. Het u 'n aborsie voorheen gehad, voor vandag? (JA/NEE)..... ☐

13. Hoe het dit gekom dat u van hierdie aborsie diens weet? ..... ☐

(VRA UIT VIR DIE VOLGENDE)

1. Kliniek
2. Ouers
3. Vriende
4. Kerel/ eggenoot
5. Verwys van 'n gesondheidspersoneel
6. Ander_____.

GESINSBEPLANNING GESKIEDENIS

(DIE GEBOORTE BEPERKING GEBRUIK VAN DIE TERMINASIE VAN SWANGERSKAP KLIENTE)

Ek gaan nou vir u vrae vra oor pille, inspuitings vir gesinsbeplanning/ geboorte beperking of enige ander metode van gesinbeplanning wat u gebruik het.

14. Het u ooit enige metode van gesinbeplanning/ geboorte beperking gebruik?

(JA/ NEE) ☐

Indien NEE: gaan na vraag 15.
Indien JA: watter metode/s het u gebruik?
(VRAE OOR DIE VOLGENDE GESINSBEPLANNIG METODES HIER ONDER- as JA/NEE)

1. Pil..... ☐
2. Inspuiting..... ☐
3. Intrauterine apparaat (Loop)..... ☐
4. Skuim of Jel..... ☐
5. Kondome..... ☐
6. Ander _____.

15. Het u 'n gesinsbeplanning of geboortebeperking metode gebruik toe u verwagtend word?(JA/ NEE)..... ☐

Indien NEE: moet nie die volgende twee vrae vra nie gaan na Bevrediging van Aborsie Sorg gedeelte.
Indien JA: vra vraag 16

16. Watter gesinsbeplanning/ geboortebeperking metode het u gebruik?..... ☐

1. Pil
2. Inspuiting
3. Intrauterine apparaat (Loop)
4. Skuim of Jel
5. Kondome
6. Ander _____.

17. Weet u waarom u verwagtend geword het as u gesinbeplanning gebruik het?
(VRA UIT VIR DIE VOLGENDE)

1. Het u die pil vergeet?..... ☐
2. Het u die afspraak datum van die inspuiting vergeet?..... ☐
3. Het u die toutjies van die loop dopgehou?..... ☐
4. Het u die vervaldatum van die kondoom dopgehou?..... ☐
5. Weet nie..... ☐
6. Ander_____

DIE BEVREDIGING VAN ABORSIE SORG
Ek gaan nou vir u vrae vra oor u huidige sorg wat u ontvang het in die hospitaal.

18. Het u berading vir die volgende ontvang:

18.1 Het die gesondheidspersoneel u vertel dat daar sekere probleme/ komplikasie is wat u moet dophou nadat u ontslaan is?**(JA/NEE)**..... ☐
Indien NEE: gaan na vraag 19.2

Indien JA: wat was die probleme wat hulle u vertel het ? (open text)

_____
_____
_____
.

18.2 Het u enige inligting of telefoon nommers as kontak gekry om gesondheid dienste te raadpleeg as daar probleme is?**(JA/NEE)** ..... ☐
Indien NEE: vra vraag 19.3

Indien JA: waarheen was u verwys/ watter telefoon nommer? _____

18.3 Het enige van die gesondheidspersoneel vir u gese van die belangrikheid om onmiddellik met gesinsbeplanning/ geboortebeperking metodes begin?

(JA/NEE)..... ☐

18.4 Het u op 'n metode van gesinsbeplanning/ geboortebeperking al besluit?

(JA/NEE) ☐

Indien JA: wat was u keuse van gesinsbeplanning? _____
en wanneer en waar gaan u die metode kry?

_____.

19. Het u enige inligting gekry van persone of telefoon nommers wat u moontlik kan kontak as u met hulle wil gesels as dit nodig is vir berading?

(JA/NEE)..... ☐

Indien NEE: gaan na 20

Indien JA: waarheen was u verwys?_____.

20. Het u gevoel u kan die gesondheidspersoneel vertrou?..... ☐

(VRA UIT VIR DIE VOLGENDE)
1. Baie
2. 'n Bietjie
3. Baie min
4. Niks

21. Het die gesondheidspersoneel u met respek en waardigheid behandel?... ☐

(VRA UIT VIR DIE VOLGENDE)

1. Baie
2. 'n Bietjie
3. Baie min
4. Niks

22. Hoe sal u die berading beoordeel na die aborsie vandag?..... ☐

(VRA UIT VIR DIE VOLGENDE)

1. Uitstekend
2. Baie goed
3. Goed
4. Middelmating
5. Swak

DIE PROSES VAN GENESING

Ek gaan nou vir u vra vrae oor u gevoelens oop die huidige oomblik.

23. Hoe voel u nou na die prosedure? ..... ☐

(open text) _____

_____

_____

_____

24. Na die prosedure het enige van die gesondheidspersoneel met u gesels oor u bekommernisse of vrese wat u oor die prosedure gehad het? (JA/ NEE)..... ☐

Indien JA: wat was die antwoord?

_____

_____

_____

25. Het die gesondheidspersoneel u gevra hoe u fisies en emosioneel voel voordat u ontslaan is van die hospitaal? (JA/ NEE)..... ☐

Indien JA: wat was die antwoord?

_____

_____

_____

_____

_____.

26. Het enige van die gesondheidspersoneel 'n voorstel gemaak om 'n opvolg datum vir na aborsie berading te reel?(JA/ NEE)..... ☐

Indien JA: na watter gesondheid diens?._____

27. Sal u hierdie hospitaal aanbeveel aan familielede en vriende vir 'n aborsie?

(JA/ NEE) ☐

Indien JA: waarom sal u die voorstel maak?_____.

_____.

Indien NEE: waarom nie? -_____

_____

28. Oor die algemeen, hoe sou u se was die sorg wat u ontvang het vandag van die gesondheidspersonnel?..... ☐

(VRA UIT VIR DIE VOLGENDE)
1. Uitstekend
2. Baie goed
3. Goed
4. Middelmatig
5. Swak.

Baie dankie vir u deelname. 'n Verslag van die navorsingsprojek sal aan die gesondheidspersoneel en die program leiers gegee word. In die verslag sal geen name van die deelnemers verskei nie. Die verslag sal gebruik word om na aborsie sorg te verbeter en te verhoog.

Appendice 2:

CODING LIST FOR ASSESSING QUALITY OF PAC CARE IN THE CAPE PENINSULA- A DESCRIPTIVE STUDY

QUALITY CONTROL PROCEDURES:

1. Check that questionnaires are complete and check for any inconsistencies.

2. All information unknown or missing leave the block blank.

3. All NUMBERS and YES and No are to be circled.
   Y= Yes and N= No in
   In Question 27 responses were Yes and No
   coding will be B= Yes +No

4. Pg 1. HOSPITALS/ HEALTH SERVICES are to be coded
   Tygerberg Hospital = 1
   Mitchells Plain CHC = 2
   GF Jooste = 3
   Somerset Hospital = 4
   Groote Schuur Hospital = 5

5. Pg 1 Question 2
   The age RANGE is 18 to 43 years old.
   The age categories are:
   18- 21
   22- 25
   26- 29
   and 30 to 43 years of age

6. Pg 2 Question 6 If NO
   Coding of jobs are to be done as:
   1= White collar
   2= Blue collar worker
   3= Skilled
   4= Semi-skilled
   5= Unskilled etc.

6. Pg3. Question 12. (TOP)
   When asking the question of TOP before to-day refers to a TOP on request by the woman previously at a health service whether public or private. Y= Yes, N= No.

7. Pg3. Question 13. (REF)
   1= Local clinic , numbering as in question.
   6= Other, can be self referral

8. Pg4. Question 14. 2nd part IF YES: What method
   1= Pill
   2= Injection
   3= IUCD
   4= Spermicide or Gel
   5= Condoms
   6= 1+2, 7= 1+3, 8= 1+5, 9= 2+5, 10= 1+2+5
   11= 2+3, 12= 1+2+4
   13= 1+2+14
   14= 2+3+4+5
   15 =other.

9. Pg. 4. Question 17
   1= did you forget the pill etc.
   7. other, (the condom was dry inside me we removed the condom)

CODING OF QUALITATIVE DATA PG 5 ONWARDS:

10. Pg. 5 Question 18.1 (COMPLPOS)

If YES: What were the problems discussed?

Bleeding for more than 2 weeks (the length of time bleeding various)
1=The amount of bleeding and the colour of the blood
2= Dizziness
3= Nausea
4= Cramps
5= Discharge a sign of infection and smelly discharge.
6= Fever and cold symptoms
7= Abdominal pains like period pains
8= No sex for 6 weeks/ or certain length of time
9= 1+4
10= 1+ 9
11= 1+5, 12= 1+ 7, 13= 1+4+5,
14= 1+8+9, 15= 1+4+9, 16= 1+5+9
17= 1+8, 18= 5+7, 19= 4+7, 20 = 1+6
21= other (all of the below)

**Difficulty in falling pregnant/ or might not conceive to easily one day.
*Fertility problems

** Headaches
* Not to exercise or pick up heavy things for awhile
* Yes in the letter they gave/ I'll read again at home/ complications during the procedure
* The emotional consequences and psychological problems
If breast are still sore for more than 2 weeks to comeback
Can bath but not to use bubble bath
There can be a whole in the womb
Early pregnancy can continue as incomplete.
AIDS
Feeling weak and hungry
No wearing of tampons
** Cannot remember

11. Pg5 Question 18.2 (REFTENO)
    1= local clinic
    2= hospital
    3= GP
    4= DH
    5= other (DH or hospital or other services

12. Pg5 Question 18.4 (CHOICEFP)
    1= Pill
    2= Injection
    3= Don't know/ have not decided yet
    4= other eg. T/L (a sterilization), IUCD

13. Pg. 5 Question 18.4 part there of
    (WHENFP)
    1= to-day
    2= ASAP

Variable 51
    The question asked in this context, as "where would you be going for your follow-up appointment for FP?" (WHEREFP)
    1= local clinic
    2= hospital
    3= GP
    4= DH
    5= other (such as pharmacy, CBD, student health services,work
    6= none

14. Pg 5 or 6 Question 19 (POSTREF) IF YES: 2nd part of question
    1= local clinic
    2= hospital
    3= GP
    4= DH
    5= 1+3
    6= other (such as private organizations or someone close)

15. Pg 7 Question 23. (FEELPOS)

1= Remorseful, but not regretful, torn between principle and circumstances. Perhaps ashamed. Remorse, but not regretful as circumstances overrule principle.

2= Relieved, learning experience been the correct decision taken to have the TOP. Relieved of a burden and this being an equivocally the correct decision.

3= Cured, from anxiety. It was the correct decision. Cured almost as if from an illness and entirely satisfied with the decision taken.

4= Elated to be out of the pregnancy. No remorse felt and there is a feeling of complete comfort with the decision.

5= The procedure has reinstated the patients happiness by relieving them of this burden ' the pregnancy'.

6= Conscience, guilt, uncomfortable and unsure about the decision taken for the TOP. Requires reassurance. The patient is consumed by guilt and perhaps requires reassurance from a third party on their decision taken.

7= Emotionless, perhaps blocking emotion or to soon to express the emotion. Patient is left with no emotion of the procedure 'perhaps there is the blocking of emotions or a delay in responses'.

8= Afraid, scared, and the fear of the incorrect decision taken. Afraid that the incorrect decision was made 'confusion reigns.

Below are the response given on this question by the women.

'Actually I feel very sad. I've never experienced something like this before and because of health I had to do this. Perhaps if I had got the blood to bury it would of made me feel better. (a Moslem woman)'
I feel sick and heart sore- I have no right to take a life of a person. (20 year old 1st pregnancy matric student)
A little bit sore. I feel very bad but I had no other choice.
I feel a bit heart sore.
Actually last night I felt why am I doing this. I have 2 choices to struggle or to have the TOP. I thought about my future and my child's future. (23 year old single parent, contract employed 1 child living with parents)
I'm downhearted, but I'm fine. Only circumstances made me do this.
I feel like I won't do it again (the TOP) I'm feeling I was not suppose to do this- I'm feeling down, down.
I'm feeling a bit heart sore and I feel I would like to talk to someone now after the abortion.
I feel depressed. Sad I don't feel like talking to anyone.
I'm feeling depressed. I'm sure I'll overcome this feeling. I have to try and find someone to talk too.
I think in my culture it's a disgrace. No-one knows not even my sister. I don't feel comfortable about this (TOP).

Very heart sore, I'm disappointed in a way what I have done, it was my first pregnancy.
I feel I have done wrong. I did it for my mother she expects better from me than to fall pregnant.
I was not feeling well before. I never expected this- I never thought of an abortion in my life. But I had no choice.
I know that this what I did was wrong- because I'm a christian but there was no other way out.
I feel anxious, I feel threatened by something I don't know why.
I'm not sure how I feel I'm so ashamed how I feel- sad disappointed no trust in anyone.
A bit heart sore but the decision was mine and that's to make me happy.
I had no choice I'm a single parent and this is best for my daughter I don't want to disappoint her by not been able to give her the good things in life.
The decision was not an easy one but circumstances force me to do this. I will try to accept this one day.
I am actually disappointed that I have made such a mistake and let my mother down. I'm heart sore at the moment.
I was frustrated because I thought about the responsibility- financially and emotionally. I would not cope. I feel I won't come back again. The procedure was sore.
A bit heart sore that's all.
A little bit sad about everything that happened and the TOP.

*1. Remorseful? But not regretful, torn between principle and circumstances. Perhaps ashamed.
Remorse, but not regretful as circumstances overruled principles. I feel relieved but maybe if I think of this afterwards I won't know how I'll feel.
I'm not guilty, I'm relieved I going to do everything in my power to be positive.
A bit relieved I don't need to worry about this (pregnancy). I've learnt my lesson now.
My heart is free now.
Felling free, very free.
I thank the Dr's. I have no guilty the pregnancy was small and it was not a child. (31 year old 3 year degree student, 1st pregnancy)
I'm just fine I don't feel guilty I had to do this.
I'm relieved that's all I can say.
I'm feeling better, a relieved feeling.
I'm okay- I'm fine- there are no other feelings now.
I'm okay. I thought I will not feel okay but for now I'm fine.
I feel relaxed and satisfied.
I'm fine but sad.
* I'm feel fine and I'm happy.
I'm fine its alright.
I'm feeling alright.
Not worried about anything, I'm alright.
I feel alright in my heart.
I feel better relaxed than before. A bit of a relief.
I feel satisfied because I've done good towards myself otherwise I would of just hurt myself.
A relieve that's nothing else to say now.

I'm relieved now.
I'm relieved that's all.
Well, now I'll a little relieved although I know it's not right what I did but I had no choice.
I'm okay now, I was scared and worried I did not have money to support the child. I feel free now.
I'm okay it's a relieve I'm just glad everything is over and finished.
Sad but very relieved very much. I hope it will not stay on my conscious.
I'm okay- I decided I wanted this. I'm okay with my decision.
I'm okay because that is what I wanted.
I relieved- I did not want the baby the pregnancy was unplanned and it happened so quick.
No, I'm fine nothing much I feel emotionally- I took this decision so I have to deal with it.

*2. Relieved. Learning experience the correct decision.
Relieved of a burden and this being an equivocally correct decision.
I feel much better because nobody knows about this. The situation is ridicules because of circumstances and my family will talk about this. (35 year old woman widowed with 5 children)
.I'm feeling better. There's no problem and I did not have pain.
Better now than before- but I don't know - I'm just happy its all over.
I'm feeling okay I can go on with my life now.
Better now- I was worried about the pregnancy.
I'm feeling better now.
I'm feeling better than before. I was doubtful but now I have a right to do this my mother has to give us things for school my brother and I and she will not be able to afford to feed and cloth another child.
I feel better now because before I did not plan this baby so I did not know what I was going to do.
I feel better, I was scared and did not understand what would happen.
I feel much better and I feel it was my choice, even if it was my first pregnancy.
I feel wonderful and superb

*3. Cured? From anxiety? It was the correct decision.
Cured almost as if from an illness and entirely satisfied with their decision.
I feel glad that's the only feeling now.
I'm very glad. I'm not working and I'm struggling. I would not know how to bring up this child. (35 year old, divorced has 2 children)
Very good- the treatment they gave me to- day makes me feel good.
Actually I feel good. It was for the best for my 2 children that I have at home. (23 year old single mother with 2 children)
I feel good. I was anxious before but now everything's fine.
I feel good I feel nothing bad. I first though the decision was not right but now I know it is good.
My heart is good. I was confused but I discussed with my boyfriend the pregnancy. There is no money for a child to feed and to clothe.
I can see I'm feeling well now. Before to-day I had a guilty conscious. I've been proposed marriage to another man and I've accepted to get married. I don't want to disappoint the man. He lives in Transkei.

I'm glad because been pregnant was frustrating me. I could not sleep until the abortion.
I'm feeling very good.
I'm feeling so good because my boyfriend died in a car accident and now I live with another boyfriend. I cannot have this other mans child now.
I feel good and well but there are no feelings now.
Because I know this alone, I feel great I don't feel embarrassed about this I'm okay. If someone else knew about this they would of made me feel bad.

*4. Elated to be out of the pregnancy.
No remorse felt and are entirely comfortable with the decision.
In a way I'm happy that I did it. In some situations I will wonder how would it of been to have this child. It was kind of a child for me already
I'm feeling happy.
I'm feeling that I'm happy now that the abortion is over.
To be honest very happy and relieved.
I'm happy that's all.
I'm happy- I was worried because I have 2 children and this pregnancy was not planned.
I'm happy because nobody has seen me pregnant. The TOP quick and not sore.
I'm very happy. Because what was I going to do with this baby and I will suffer. My brother is so bad. Its my parents home but he makes as if his the boss. (single parent of 1 living in her parents home)
Very happy, just happy.
I'm happy because this was a bad condition for me.(19 year old tech. student has 1 child)
I feel nice now, because this pregnancy is away now.
It's like a load off my shoulders. I'm happy everything is over. According to the bible it not right what I have done, but I have a very good reason.
I feel like my life is changing now- my worry is gone now.
I feel happy now and very good.

*5. The procedure has reinstated the patient's happiness by reliving them of this burden.
If I look at it in a religious view I feel guilty. I feel a loss of a person.
I'm feel a little bit guilty but it is something I have to deal with.
I'm feeling guilty. If I'm worried about something I'll talk to someone.
(21 year old 1st pregnancy)
I've committed something very bad. I have to talk to someone about my feelings.
Little bit nervous- I hate to feel to keep a secret from my sisters- I feel guilty.
Little bit guilty -that's all.
I'm cold and sad, guilty worried about the future and if Ill overcome these feelings.
I don't know what to say. I feel bad because this is my first time I'm doing this.
I feel guilty but I'm not able to rear a rapist child. (23 year woman first pregnancy was raped and was managed post rape @ KBH but not explained how to take the morning after pill correctly)
Okay, a little bit emotional, I cannot say much now.

*6. Conscience, guilt, uncomfortable/ unsure about the decision. Require reassurance.
The patient is consumed by guilt and perhaps requires reassurance from a

third party on their decision.
I don't think of what I've done now. Just there's pain. (a 18 year old matric student)
I'm not feeling anything. I'm got no emotions and I'm loosing weight. I'm that its because of the abortion. (this woman had a TOP before).
* Nothing at the moment.
I'm just feeling pain and not feeling anything else and I'm tired.
I'm feeling nothing now.
I'm not feeling anything right now but I think maybe later when I' at home.
I'm feeling nothing just cool.
Right now there are no feelings just its all over
Right at this moment nothing but I'm hoping and praying it might hit me later- but I'll pray for strength.
I cannot say how I'm feeling to-day. There's just emptiness.
I feel nothing now maybe its to soon to know what I'm feeling.
Empty -because for 3 months I wanted to have this pregnancy but my boyfriend not. He has 2 other children and I have one child. I feel dirty, God will never forgive me. I've done the biggest sin.
I really don't know how I'm feeling right now but that's okay for me.
I don't I think the feelings will come later. But nothing at the moment.
They made me very sore to-day I'll never want to come here again.
I'm blank I cannot say how I'm feeling now.
I can really not tell how I'm feeling now, the feeling I have I'm unable to explain.
I did not want this pregnancy so therefore I feel nothing. I know this is my sins and I hope that God can forgive me. My mother is angery with me but I could not have this child I cannot a third child. (24 year old single woman unemployed with 2 children)
Its to soon to tell.

*7. Emotionless, perhaps blocking emotion or to soon to express the emotion.
Patient is left with no emotion of the procedure, (perhaps blocking emotions or a delay in responses).
I'm scared I never though this can happen to me. (24 year old single 2nd year Computer Science student)
I wish I had not seen the foetus that's the only thing I think about and the pain was bad throughout the night. (21 year old single 1st pregnancy)
The thing is I've had a lot of time to think this over. I was not ready for a pregnancy. I'll be studying next year and I would like a good future for myself and if I want a child and family one day.
Terrible. I've got pain on my stomach because the Dr removed the foetus and I think this procedure was awful.
Terrible, I'm very confused - empty- I feel like an ostrich to stick my head into the ground.
At the moment I'm trying to be strong but this was a terrible thing, I've gone through and I hope it will not play on my conscious.
Not that well, I did not want the abortion but I'm to scared to tell my parents to know that I'm pregnant.

*8. Afraid, scared, the fear of incorrect decision.
Afraid that the incorrect decision was made(confusion reigns)

16. Pg. 7 Question 24 (FEELPRE)1ST part of the question.
Y= Yes, N= No

17. Pg. 7 Question 24. (RESPPRE) If YES: 2nd part of the question.
1= They assured me as best as could and explained the procedure in detail.
2= The pain will be like a menstrual period (not be painful).
3= I must be calm and try and relax during the procedure.
4= The risk involved with having an abortion.
5= Explained how I will feel afterwards- slight dizziness and pain.
The procedure and the pain after the procedure.
6= Other ,
-Firstly I was worried that they will not give me more pills because my cervix did not open. Now this is my second admission. Everything will go off well the mouth of the womb is open.
-Asked whether I was sure I wanted the TOP asked twice and my response is fine.

18. Pg. 7 Question 25. (EMOPOST) 1ST part of the question.
Y= Yes, N= No

19. Pg7 Question 25. (RESEMO) IF YES: 2nd part of the question.
1= It is normal to have fears about the procedure and this happens to some people but you have no choice.
2= To see a counsellor, at the DH, GP and Pregnancy Help centre in Wynberg or someone to confide in.
3= Explained the emotional feelings you could have after the procedure.
(haunt you overcome the feelings by talking to someone>
4= They said if I feel worried I can call here to make an appointment.
5= Other.
-They comforted me and I felt relaxed- calm.
- I told the Sr. that I was alright, she said that I could get counselling.
-They asked me whether I'm okay and I said yes.

20. Pg. 7 Question 26. (APPTCOUN) 1ST part of the question.
Y= Yes, N= No

21. Pg. 7 Question 26. (APPTHEA) IF YES: 2nd part of the question
1= local clinic
2= hospital
3= GP
4= DH
5= Other- private organization etc.

22. Pg. 7 Question 28 (RECHOSP) 1st part of the question is
Y= Yes, N= No and B= Yes + No.

Pg7. Question 28. 2nd part IF YES: and a IF NO: coding for
IF YES: (WHYRECY)

1= Its safe and effective and right to come here (good excellent care treated well)(as if you pay for it)(it's the best I've ever experienced)(care very good)(Because it is good here if you want an abortion)(they were thorough and very professional)(the right place to be for the procedure)(efficient and caring).

2= The service is good that is offered. (handle one well/ like a human being)(will be good for others too)(they handle one good and humane).

3= The service is good, the nurses treat one with respect and they make you feel relax(confidentiality between staff and pt)(never felt degraded or judged or guilty)(.

4= The service is good and the outcome is good (treated me nice and fine)(felt free not scared)(did not put you on a spot)(no ill treatment everything was alright)(I have not felt threatened).

5= They very helpful, friendly and this makes you comfortable (the hospital is clean)(made me comfortable)(supportive, I felt okay)(you did not feel as if you are doing a bad thing)(explain procedure with background and patient)(quick and helpful).

6= If the choice is there's then its yes(counselling was good and there is trust).

7= If they not by the means to pay for the TOP(we are poor and the services is free)(if their reason is like my reason)(free service close to home no mistakes occurred) (first know what the situation is of the friend).

8= I would not say where to go to because I only know this hospital(happy with the service)(more private)(nearest hospital).

9= Other.
I'll recommend the hospital but not an abortion.
I thought it would be terrible (as on TV) the instruments they used were not as bad(less complicated not a difficult decision) .
Yes, but if its your 1st pregnancy you will feel heart sore.
I survived this I will try and help someone else.
Everything is okay, but one needs more counselling before the TOP.
I'll come and accompany a friend if they need to come for an abortion, they treated me good.
They are alright but it is to soon to say if everything is okay I'll have to wait to see the outcome.
The treatment is better than other hospitals.
I have gotten no problems here.

IF NO: (WHYRECN)

1= I'll keep it private, I'll not talk to anyone (not even my mother)(the matter is between me and God).

2= I'll not be able to talk about this(maybe later)(I'm to scared)(because I did not believe in doing this)(the choice is there's I cannot make decisions for others).

3= I'll won't it's a very bad experience (I won't wish this on my worst enemy).

4= The procedure is one of the most terrible experiences. There's is no pain killers and you are awake through the procedure.

5= Nobody knows it was my own decision.
No, I won't tell anyone about this, no-one knows I've had a TOP.

6= Other.
No-one told me what to expect.
I won't be able to talk about this because how would I know about this service.
No, I won't be able to talk to someone about this its confidential.
It's not something I could recommend. I will persuade someone to think twice.
Treatment is better private if they can pay.
Its their choice I won't be able to say anything.
I feel ashamed everyone knew about this pregnancy, we work together. I have to live a lie.
From the first counselling until to-day the only problem is the waiting. I would of wanted to have the abortion the day of the 1st counselling.
I will not recommend an abortion.
I won't talk to anyone but my mother about the service.

Mixed WHYRECY+WHYRECN

1= Lots of care and love, No I won't tell anyone that I had a TOP.
2= Good care of those who want the procedure they 1st explain the process./No1st ask why want a TOP if it's a good reason I'll send her here.
3= Cannot judge others, No I would not do this it's the 1st and the last, should have this procedure.
4= Treated with respect, thought they were going to shout at me/No advise its not easy, they have to look after themselves and not fall pregnant.
5= I'll give my opinion over the procedure but I need to first know the situation.
6= Other:
If the choice is theirs/ the procedure is one of the most terrible experiences.
There's no pain killers and you are wide awake throughout the procedure.
Because the service is good/ NO, the first visit was exhausting.
YES, if they not by the means to pay for it/ NO, if they can pay- treatment is better privately.

Appendix 3: Consent form in English and Afrikaans

Form no. ☐☐☐

CONSENT FORM
QUALITY OF POSTABORTION CARE STUDY

I am Phoebe Gribble, a master's student at the University of the Western Cape. Presently I'm employed full-time in research study projects that involve women's health issues that are based in reproductive health services at the local health clinics and hospitals in the Cape Peninsula, my background is in nursing.

I have been granted permission by the university and the health personnel caring for you in this hospital/clinic that you ask to take part in this study. I will be asking you questions about your background, a brief description on how you are feeling at the moment, and about the care that you have received in the hospital from the nurses, sisters and doctors in the termination of your pregnancy.

I would appreciate your responses to the questions to be open and honest, as your participation will benefit other women who use the hospital for the same service.

Your participation in the study and the information is strictly confidential and anonymous and will be used for research only. You are allowed to withdraw from the interview at anytime. This will in no way affect your treatment in the future at the hospital.

I will be glad to answer any questions you may have about the study.

Interviewee's signature: _____

Interviewer' signature: _____

Hospital: _____

Date: _____

Vorm no. ☐☐☐

TOESTEMMINGS VORM
KWALITEIT VAN NA ABORSIE SORG STUDIE

My naam is Phebe Gribble en ek is 'n meestergraad student aan die Universiteit Wes Kaapland. Huidiglik werk ek voltyds aan navorsingsprojekte oor vroue gesondheid by die verskillende voorplantings gesondheid dienste en klinieke in die Kaapse Skiereiland. Ek het verpleging eers gedoen.

Ek het toestemming verkry by die universiteit en die gesondheidspersoneel wat u behandel in die hospitaal dat u aan die projek mag deelneem. Ek gaan vir u vrae vra oor u agtergrond en dan moet u vir my kortliks beskryf hoe u voel, en wat is u opinee van die behandeling wat u ontvang in hierdie hospitaal van die verpleegsters, susters en die dokters met die beeindiging van u swangeskap.

As u nie oor die besonderhede van na aborsie sorg beskik nie sal ek u voorsien van die nodige inligting by die naaste gesondheids dienste.

Ek sal dit waardeer as u antwoorde so openlik en eerlik is as moontlik. U deelname sal 'n voordeel wees vir ander wat vir dieselfde diens aanmeld by die hospitaal. U deelname aan hierdie studie is vrywillig en die inligting is vertroulik.

U mag u ook ter enige tyd onttrek van die onderhoud. Dit sal nie u behandeling by die hospitaal in die toekoms beinvloed nie.

Indien u enige vrae het in verband met die navorsing, sal ek dit graag beantwoord.

Deelnamer handtekening: _____

Onderhoud voerder tekening: _____

Hospitaal: _____

Datum: _____

Appendix 4: Handout to women

PREGNANCY COUNSELLING CENTRES

ATHLONE

Turning Point Contact		021- 6381155/6
	Toll free	0800 0355 53

MITCHELLS PLAIN

Love in Action Mrs Sonnenberg	084 474 8287
Community Health Clinics:	
Eastridge Clinic	021- 392 7125
Westridge Clinic	021- 392 4124
Rocklands Clinic	021- 3925121/2

SALT RIVER/ WOODSTOCK

Turning Point for Burns Road Centre	021- 631155/6

WYNBERG

Pregnancy Help Centre	021- 797 5000

GOODWOOD

Option Pregnancy Centre	021-5922183/4

OTHER CENTRES IN THE WESTERN CAPE

Choices		021- 8526454
Marie Stopes		021- 4180560
	Toll free	0800 117 785