

**TERMINATION OF PREGNANCY: A DECISION DILEMMA
AMONGST YOUNG WOMAN AT A DISTRICT HOSPITAL**

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DEDICATION

This study is dedicated to all those that ceased to be, because we ceased to care.

DECLARATION OF ORIGINALITY

I hereby declare that this dissertation, unless specifically indicated to the contrary in the text, is my original work.

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ABSTRACT

The number of women accessing Termination of Pregnancy Services has increased in South Africa over the last 15 years. Lieberman and Davis (1992), hold that a woman's right to choose is embedded in the principles of social work that is self-determination, empowerment and dignity. It is a social workers responsibility to ensure that the options are available to the clients. If a client is unable to choose from an array of alternatives it is because social workers have failed to provide them with the necessary information, therefore there can be no self-determination. Women who receive health care from public facilities usually cannot afford health care from a private physician and the ability of women to make informed decisions is based on the degree of information that is made available to them. In this study the researcher looks at the road travelled in order to make the decision to terminate an unwanted pregnancy.

The process of data collection was a comprehensive, intensive process. Underpinned by the ecosystems theory, the qualitative exploratory research design was used for this research. Data was obtained through interviews from a purposeful sample of sixteen young women that attended the TOP (Termination of Pregnancy) Clinic at the research site, ranging from the ages of 18 to 35 years. This approach allowed the researcher to understand the processes and persons involved in making this decision.

The assumption underlying this study was that the decision to terminate a pregnancy is a difficult one and often made with little or no support, education or guidance. The outcome of this study confirmed this assumption. The findings revealed that young woman accessing TOP services often choose TOP in isolation with limited knowledge and support from significant others. Some women requesting TOP may not want counselling but do need it. The need for counselling is stronger for those with strong religious beliefs and those that have little or no support systems. Based on the outcome of the analysis, recommendations were made with regard to the need for holistic counselling to be an integral component in health services rendered to women, with unintended pregnancies. Counseling whilst optional should be made compulsory such that a person can cope with the physical and psychological effects of an unwanted pregnancy should they decide to terminate or keep the pregnancy.

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Chapter One

CONTEXTUAL AND THEORETICAL FRAMEWORK OF THE STUDY

INTRODUCTION

Different countries have different criteria in which abortion can be performed legally. Developed regions of the world (Europe, Northern America, Australia/New Zealand and Eastern Asia) have less restrictive laws and policies with regard to TOP as more than half (67 %) of the developed countries give full TOP (Termination of Pregnancy) decision/rights entirely to women. In contrast, less developed regions (Western Asia, South-Central Asia, Central America, South-Eastern Asia, South America and the Caribbean region) are stricter with only 15% of developing countries provide abortion upon request (Tong, Low, Wong, Choong, Jegasothy, 2012).

In spite of active opposition by some public groups, the choice of TOP Act (No. 92) of 1996 was introduced in South Africa in February 1997 (McGill, 2006). The intention of the Act was to help in the reduction of maternal mortality resulting from backstreet abortions and also to ensure that TOP Services were available and accessible to all women who needed them (Republic of South Africa, 1996). This new Act replaced the Abortion and Sterilization Act No. 2 of 1975, which provided limited access to abortion services under very specific circumstances, such as when a mother's life was in danger. The limitations of the Sterilization Act explain why many women who wanted to terminate their pregnancies during this period resorted to backstreet abortions.

The Choice on TOP Amendment Act (2004) came into force in 2005. The 2004 Amendment Act increases the facilities where first trimester abortions can be carried out and, secondly, where permitted nurses and midwives can carry out abortions of up to 12 weeks gestation, provided they have undergone the necessary training and have the relevant registration. The South African Parliament met again in February 2008 to approve legal changes to The Amendment Act, which makes termination of pregnancies easier to obtain, in spite of criticism from opponents who stated that the law was already too lax (Mail and Guardian Online, 2 June 2008). According to Statistics South Africa (2006/2007), there were about

87000 pregnancies legally terminated in 2005. Since the enactment of the Choice of TOP Act of 1996, approximately 500 000 pregnancies had been terminated legally by 2006.

According to Professor Jewkes, Director of the Health Research Unit at the Medical Research Council, South Africa has one of the most liberal abortion laws in Africa and this should be viewed in a positive light (HSRC Review, 2004). Pro-Life Groups warn that abortion was being used as a “western convenience” (as a contraceptive) in South Africa. Lang, Prinsloo and Joubert (2005) did a study in the Free State to determine whether TOP is being used as a family planning method. In a sample of 721 females, it was found that 16.6 % agreed that it is a contraceptive while 39.7 % said that they were unsure as to whether it was a contraceptive method. This shows a failure in the promotion of health services, as people seemed ignorant of contraceptive methods. Ms Diana Ruschenbaum, Chairperson of the Counselling Committee of Doctors for Life, stated that the abortion figures were far too high and it is “unacceptable that over half a million innocent lives have been legally taken” (South African Survey 2006/2007). Alcorn (1982) cited in Govender (2000:22) argued that the increase in abortion could also be attributed to women not being educated on the various options in order to make an informed decision.

CTOP (Choice on Termination of Pregnancy) Clinics all over South Africa are witnessing an increasing number of women accessing this resource every year. Mbele, Snyman and Pattinson (2006), in the study they conducted in Kalafong Hospital in the West of Pretoria, reported a more than a 275 % increase in Termination of Pregnancies from 1997 - 2005.

Various authors like Govender (2000), Kunene (1999), Mdleleni-Bookholane (2007), and Gardner (1972), to name a few, have extensively written on the factors that cause women to terminate their pregnancies. Despite policy advances, significant changes in women's reproductive health services are difficult to discern, given the multitude of complex factors that influence reproductive health, especially inequalities in socio-economic and gender status (Health Systems Trust, 2004). Gaps remain in the implementation of reproductive health policies and in service delivery that need to be addressed in order for meaningful improvements for women's reproductive health status to be achieved (ibid.). Professional counselling services, access and knowledge about family planning (including emergency contraceptives), poverty and HIV, are some of the gaps in the South African Health sector.

The question raised in this study was, how do young women reach the decision of terminating their pregnancies?

RATIONALE FOR THE STUDY

The researcher developed an interest in this study when she was employed at a tertiary medical setting that offered TOP to women requiring the services. The researcher worked in the field of maternity and gynaecology. The District Hospital is one of three state hospitals in the EThekweni District that provides TOP Services to women up to the twelve-week period of gestation. The researcher's experience in working in the CTOP Clinic has made her aware of the high demand for TOP Services. It was of concern to the researcher that these women often attended the clinic alone. No family or partner accompanied them.

Prior to 1997, Social Workers provided counselling services to women requesting abortion in terms of the Abortion and Sterilization Act, No.2 of 1975. Social Workers were responsible for assessing women to determine if the women concerned satisfied the requirements of the Abortion and Sterilization Act, No. 2 of 1975. Counselling was also provided pre and post TOP. In the present Act 92 of 1996, counselling is not compulsory. Women can make this decision without any social work intervention. In contrast, a study conducted by Kunene (1999:43) found that 80 % of the women felt that counselling was important, whether they made up their minds or not, as it helped to relieve stress, explore their feelings and gain awareness of abortion procedures as well as contraceptives (Kunene, 1999). Women often choose not to seek their normal close support systems because of the internalized and externalized values and the "prevalent judgmental" approach. Thus counselling becomes necessary for women requesting CTOP to deal with all aspects adequately.

Much has been reported on why young women terminate their pregnancy but there is little knowledge that exists on a young woman's journey to the TOP decision – how they reach the TOP decision. As described earlier (Govender, 2000), TOP is a difficult and painful decision; therefore ideally it is to be an informed one. An informed decision or the lack of this knowledge has a direct impact on the social worker's intervention options and counselling services that are provided to women who seek TOP. The research problem therefore is not that women choose to keep or terminate the unwanted pregnancy but rather how informed this decision is, who else gets involved in this decision, and how such persons

get involved, and how one sees the women's well-being post-TOP (consequences, benefits or risks involved).

RESEARCH QUESTIONS:

This study was aimed at addressing the following research questions:

- What are the resources or options available to women with unwanted pregnancies?
- What do young women know about TOP processes, procedures, consequences or risks?
- How do women reach the TOP decision?
- Who gets involved in the TOP decision and how?

RESEARCH OBJECTIVES:

This study was aimed at the following:

- Exploring young women's knowledge and understanding of TOP processes, procedures, risks and consequences.
- Exploring young women's decision-making processes when making the TOP decision.
- Exploring the pressure or support for TOP or other options.

SIGNIFICANCE OF THE STUDY

According to the CTOP ACT 1996, counselling is not compulsory for any person seeking these services. The researcher hopes that by documenting what women go through in making the TOP decision, this study will be significant in achieving the following:

- It will contribute to clarify and motivate for the need and the scope of TOP support and counselling services.
- It will help in identifying support measures needed by woman with unwanted pregnancies by providing guidelines and information that can be utilized in the decision making process.

- It would assist in providing valuable information that would assist in improving misconceptions of health care services to women such as accessibility to contraceptives and education on the various options for unwanted pregnancies.
- It will make useful contributions that will influence the review of the existing CTOP Act, especially regarding the number of times each service user is eligible for CTOP and counselling restrictions.

RESEARCH PROBLEMS AND OBJECTIVES: BROADER ISSUES TO BE INVESTIGATED

The mention of the word *abortion* stirs up strong feelings. It is a sensitive topic by its very nature. Universally it evokes strong emotions of support or opposition. In spite of TOP being legalized just over 15 years ago, it is often considered a taboo by society. The reality is that the number of women who undergo TOP is alarmingly increasing every day. The question is – do societies choose to ignore or to deal efficiently with TOP and its complexities?

The decision to abort is a difficult one for most women or it can be one of great relief: in either event the researcher wished to explore how informed this decision was and what were some of the dominating factors influencing this decision.

THEORETICAL FRAMEWORK GUIDING THE STUDY

McDonagh cited in Gardner (1972:155) wrote, *“The mother is not a physical reality merely, not even a psych-physical reality, but a socio-psych-physical reality. She exists as a person in interaction with her community or society. The quality of her existence depends not simply on her physical or psycho-social well being. She cannot, in fact, be isolated from her social well being and our obligations to her are to this socio-psycho-somatic entity.”* This study therefore encompasses looking at the individual within her environment and the interplay between the various factors. Gardner (1975) states that in dealing with an unwanted pregnancy one needs to consider all elements that are impacting on the woman, he further states that real compassion involves taking into consideration the individual’s social, biological and psychological needs in order for one’s decision to solve not only the woman’s short term problems, but help her in her future life.

This study is framed within feminist discourse with a special focus on ecosystems theory whose defining characteristic is its focus on the person-environment characteristic. Ecosystems theory presents a view of humans in context. According to Berk (1998), humans are complex biological, psychological, spiritual and cultural beings, who are constantly developing within a complex system of relationships, affected by multiple levels of the surrounding environment. With the provisions of the ecosystems theory one can reach the understanding of the interaction and interrelatedness between the individual and her environment when making her decision to terminate her pregnancy. In line with the ecosystems theory, feminism entails the view that the world has depth and that the real cannot be reduced simply to women's experiences. When we are engaged in the work of social science we are interested in understanding what produces the messy outcomes at the level of direct experiences in the everyday world of women (Clegg, 2006). According to Hepworth and Larson (1990:17), the ecosystems theory is built on individuals being engaged in constant transactions with other human beings and other systems within the environment and these systems and persons reciprocally influencing each other. In the ecosystems thinking all parts of a system are interdependent and responsive to change in any one part.

The concepts of open and closed systems are particularly pertinent for this study. Firstly, one has an "Open-system" where there is a mutual exchange of energy and information between the individual and his environment. Secondly, there is a closed system meaning that while the system may be impinged on by the environment, it does not actively admit these elements into the system. One is able to get a richer perspective on issues, as in the ecological theory it does not confine itself to a linear thinking. It takes into account the multiple contextual influences on human behaviour. People are not mere reactors to environmental forces; rather they react on their environments, thereby shaping the responses of other people, groups, institutions and even the physical environment (Hepworth and Larson, 1990).

In relating the ecosystems theory to this study, a woman with an unwanted pregnancy is at disequilibrium with her environment. A client's environment can be divided into several systems. Firstly there is the "micro-system" which, according to Crompton and Galaway (2005) consists of the client's most immediate interpersonal environment composed of individuals such as friends, family members, work colleagues and relationships at school. At a **micro level** the study looks at how the women's own development, their physical conditions and self-image have influenced their TOP decision. The study will also look at

who was involved in the decision making process. Peer pressure and the responses of partners and family members may have played a significant role in the women's decision making.

On a **mezzo level** this study will seek to understand the role of women's neighborhood, social support or lack of it in TOP decisions. Within the South African context this is particularly relevant as traditional family structures may not necessarily exist and the individual may depend on extended families and the neighborhood for financial and social support. Small groups, churches, schools, work all may interplay in the decision-making process.

On an **exosystemic level** the study will explore the options available to young women with unwanted pregnancies within the community – the religious affiliations of women and their influences, the larger society and its views on TOP and how this interplay affects the individual.

On a **macro systemic level** the study will explore legislation governing the circumstances under which TOP can be considered. The Choice of TOP Act No. 92 of 1996 governs and outlines the criteria under which a woman may access TOP Services. The present policy does not stipulate how many times a person may have a TOP, it does not restrict any persons over the age of twelve, counselling is not mandatory, the reasons for TOP before 12 weeks is of no consequence.

DEFINITION OF CONCEPTS

Termination of Pregnancy (TOP) means the separation and expulsion, by medical or surgical means, of the contents of the uterus of pregnant women (Government Gazette 1996).

Young women refer to women between the ages of 18 years and 35 years.

The Act means The Choice on Termination of Pregnancy Act in South Africa, Act 92 of 1996, also referred to as the Termination of Pregnancy Act or Act number 92 of 1996.

Counselling means a face to face communication between a woman requesting termination of pregnancy and a professional counsellor prior to, during and post abortion. Counselling means providing opportunities for discussion, information, explanation and advice as described by the Department of Health and Security in England circular in 1977 (Steinberg, 1989; and Glassier, cited in Baird, Grimes & Van Look, 1995).

PRESENTATION OF CONTENTS

The researcher introduced and provided a broad overview of the study in this chapter. The context, rationale, significance, objectives, and theoretical framework have been briefly discussed. Important concepts used in this study were identified and defined. The remainder of this dissertation is divided into the following four chapters:

Chapter 2: Literature Review

Chapter 3: Research Methodology,

Chapter 4: Analysis of Results and Discussions

The findings and an analysis and interpretation will be presented.

Chapter 5: Summary, Conclusions and Recommendations

The conclusions and recommendations as well as a further interpretation and a summary will be presented in this chapter.

Chapter Two

LITERATURE REVIEW

INTRODUCTION

The TOP debate focuses on two opposing perspectives, anti-abortion and pro-choice. Carroll (2005) cited in Zastrow and Kirst-Ashman (2007:413), describes the anti abortion stance as the belief “that human life, and therefore personhood, begins at conception, and so an embryo, at any stage of its development, is a person. [Therefore,]... aborting a fetus is murder, and ...the government should make all abortions illegal.” Pro-choice advocates, on the other hand, focus on a woman’s right to choose whether to have an abortion. They believe that a woman has the right to control what happens to her body, and to navigate her own life.

The very nature of TOP creates “contention”, making it a difficult and painful decision for most. Gardner (1972:71) quotes an Anglican Group opposing abortion, “To build up a habit of mind which regards abortion lightly as an easy remedy for any adverse situation, personal or social might in fact do society a grave disservice by addicting them to another social issue.”

Now over 30 years later we are experiencing an increase in abortion rates and, while for some a difficult decision, for others this maybe the simplest and carefree option. Oosthuizen et al. (1974:27) say that apart from the moral issues there are serious misgivings that abortion on demand lowers moral standards and leads to a higher incidence of unwanted pregnancies.

One question is how abortion can be made legally permissible while it is morally and socially discouraged (Kunene, 1999). Oosthuizen (1974) indicates that abortion is a socially accepted practice in most parts of the world today, treated differently under different legal systems. Those under communist inspiration tend to be more permissive, while those that spring from a Catholic culture are generally more restrictive. Restrictive legal systems, however, do not appear to reduce the abortion rate.

YOUNG WOMEN IN THE SOUTH AFRICAN CONTEXT

Despite the demise of apartheid, post-apartheid South Africa is still experiencing the effect of discriminatory and oppressive apartheid policies. Poverty, HIV and AIDS infections, premature deaths, child-headed households and violence are having ripple effects on the family life of ordinary South Africans. With the introduction of policies that give access to economic power to the previously disadvantaged groups, there is also an increased pressure to have material things even if the conditions are unfavorable. This puts young women in vulnerable positions. Research conducted by Raniga and Mathe (2011), Harrison (2007), and Manzini (2001) show that sexual relationships with older men in the South African townships have been linked to unwanted pregnancies, child bearing and HIV risk. The poor socio-economic climate in South Africa has led young women – in order to meet their needs – to get involved with older men in return for financial stability (ibid.). In South Africa, TOP clashes with the cultural values of many communities (Mdleleni-Bookholane, 2007).

Reasons for TOP

According to Darrochand, Hensaw (2002a), DeVault, Sayad and Yarber (2005), cited in Zastrow and Kirst-Ashman (2007), there are three main causes for unplanned pregnancies. Firstly, the couple may not have used contraceptives; secondly, contraceptives may have been used inconsistently or incorrectly; and thirdly, no method of contraceptive is perfect, each having its own failure rate. Zastrow and Kirst-Ashman (2007) identified the following primary reasons for women to seek to terminate their pregnancies. These were: interference with their work, education, or other responsibilities; affordability; unwillingness to be single parents; pregnancy due to rape; marital problems; and health problems. Similarly, during the research conducted by Faria et al. (1995), cited in Solomon (2011), sixteen reasons for abortion were given. These were: Parental readiness; Lack of financial resources; No partner; Unable to care for more children; Age; Interferences with career, and educational plans; Inadequate emotional resources; Interference with personal plans; Marital, partner relationships; Pregnancy result of an extra-marital affair; Difficulties with family of origin; Fears about pregnancy; Physical problems; Contraceptive failure; Rape; and Partner's objections.

TERMINATION OF PREGNANCY ACT, NO. 92 OF 1996

The Choice of TOP Act (No. 92) of 1996 was introduced in South Africa in February 1997. The new Act replaced the Abortion and Sterilization Act No. 2 of 1975, which provided limited access to abortion services under very specific circumstances, such as when a mother's life was in danger.

According to Jeanine McGill (2006), there were three arguments that were used to justify the legislation of abortion on demand. Firstly, there was the lack of access of poor women to abortions under the 1975 Act. The provisions of this act were viewed as unequal and that there is no need for any 'mental health' issue to justify abortion. Secondly, the media reports argued that there was widespread backstreet abortion, which lead to complications and maternal deaths of women. Thirdly, The Bill of Rights according to the South African Constitution promised that everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproductive health. In a study done by Mbele, Snyman and Pattinson (2006) on the morbidity and mortality rate of women in the West of Pretoria, findings indicate that the introduction of the TOP Act has been associated with a high reduction in women presenting with incomplete abortions; however, the prevalence of critically ill women due to complications of abortion has not changed. A White Paper on Welfare (1997) further confirms that the increase in maternal deaths is determined to a much greater extent by the quality of medical care rather than by the legal status of abortion.

In 2004 due to the high demand for TOP, The Choice on TOP Amendment Act (2004) came into force in 2005. The 2004 Amendment Act increases the facilities where first trimester abortions can be carried out and, secondly, permits nurses and midwives to carry out abortions up to 12 weeks, provided they have undergone the necessary training and have the relevant registration. The South African Parliament met in February 2008 to approve legal changes to The Amendment Act, which makes termination of pregnancies easier to obtain, in spite of criticism from opponents who stated that the law was already too lax (Mail and Guardian Online, 2 June 2008).

In terms of the present Act, although allowing for abortion on demand, certain criteria need to be satisfied:

Women can choose to terminate their pregnancy in the 1st 12 weeks of pregnancy without any reasons or obstructions. From 13-20 weeks it must be based on the opinion of the doctor. The Act stipulates that a medical Practitioner or midwife must conduct the operation. In the case of a woman being mentally incapacitated or in a coma, her family, spouse or guardian can request for an abortion on the grounds that the pregnancy is a risk to the woman's mental or physical health, or that the foetus may be exposed to dangers. Minors, presently 12-17 years, can be persuaded to inform their parent or guardian but it is entirely their decision. The doctor/midwife must document the event and all information is kept confidential (TOP Act 92 of 1996). Women can access TOP Services at state hospitals for free. There are also privately run clinics like Maria Stopes South Africa who offer TOP Services at a cost.

The need for Social Work Services was removed from the TOP Act 96 of 1996 as it was seen as difficult for rural and peri-urban women to gain access to Social Work Services, which is scarce in rural communities. Counselling was not made compulsory so as to respect the wishes of women wanting to terminate their pregnancy. Women are allowed to choose whether they would like to receive counselling or not. Kunene (1999) stated that women requesting abortion may not want to be counselled but do need counselling. In her research, she goes on to say that the need for counselling is even greater for those who have been raised with strong religious affiliations and those with minimal support systems.

MEDICAL ASPECTS OF TERMINATION OF PREGNANCY

Social workers need to be informed of the development of the foetus so that they can clearly answer some basic questions. It is a month from conception that the foetus resembles a mammal. At five weeks the foetus has a crown, a brain, heart, limb buds, eyes, ears, and the beginnings of internal organs. At eight weeks the foetus is recognizable as human to the eye. At twelve weeks from conception the foetus is fully formed and is about 8.5 cm. The external organs are fully formed to be able to determine the sex of the child. During the rest of the pregnancy the internal organs develop and grow.

The degree of physical pain women experience during TOP according to Alcorn (1992) depends on what method was used to perform the TOP. If pain occurs it is maybe because of the length of the pregnancy, or the type of procedure, or the competence of the nursing sister or medical practitioner (Davies, 1991).

South African hospitals and clinics predominantly practice two types of abortion. In surgical abortion, either the manual vacuum aspiration (MVA) or dilatation and curettage (D&C) technique is used to suck or cut the child out of the womb. Medical abortion according to Paul (1999), cited in Govender (2000:36) is “a medication induced miscarriage”. The nursing sister provides the woman with drugs such as misoprostal to administer to herself either orally or vaginally. The duration of terminating the pregnancy can last between a few days to a few weeks. Surgery and anaesthesia is not required for medical abortion. After a painful labour, the child is delivered prematurely. In cases where the child is near 20 weeks old, the child is delivered alive and lives for anything from a few minutes to several hours. As the child’s lungs are not developed sufficiently, he or she will be unable to survive outside the womb and will die (McGill, 2006).

Surgical abortion is performed under local or general anaesthesia.

EMOTIONAL SUPPORT FOR WOMEN UNDERGOING TOP

From the decision process to the aftermath, TOP can bring up complicated emotions. Writers agree that women say they are more tearful, moody, edgy, and “foggy” when pregnant. Women’s feelings can range between fear, hope, and disappointment when pregnant (Brien and Fairbairn, 1996:31). There is thus the need for women to have a safe place to focus on their feelings and know that the counsellor is accepting of their “muddled” thinking.

Rooyan (1998), in his study of final year social work university students, suggested a range of people who should be involved in the decision on TOP. The people ranged from parents, spouse, medical practitioner, boyfriend or partner, and then to social worker. According to Kunene (1999), there is a tendency for a woman not to talk to anyone about her intention to choose TOP because of the stigma attached to it by society. This further isolates women in their struggle to resolve the problem of an unwanted pregnancy or cope with this difficult decision (ibid.). These women need the support but at the same time are feeling scared to talk or ask for help from their usual sources, especially if they expect a negative response towards TOP. Moreover, with the changing climate in South Africa there is a lack of support systems because of dying generations caused by HIV and Aids. Without these support structures in place, professional support becomes the best option.

The Emotional Legacy of TOP (Post-TOP Counselling)

The nursing sister or doctor maybe the first to witness the first emotions, which probably are ones of relief, and maybe thankfulness. A woman has maybe undergone the TOP procedure successfully and is no longer anxious about the unwanted pregnancy. There is a rapid decrease of stress levels. Staff maybe unaware of the problems that may arise later as women are discharged quickly and there is little follow up. Doctors and nurses may also need to be reassuring themselves that they have done the right thing, it would be difficult to see that a woman has regretted the procedure. Brien and Fairburn (1996) give the different emotions that women may experience later from the perspective of the attending doctor and nursing staff: firstly, sadness and grief were the most common feelings found when women attended post-abortion counselling. Women themselves made the choice to end a potential life and feel that they have no right to mourn. Counselling allows for the tears and attempts to validate the mixed feelings of sadness as well as relief. One of the ways people defend themselves from the pain is to deny that TOP happened. They believe that acknowledging their sadness implies that they made a wrong decision. Not every woman may need to grieve but women need to express whatever the pregnancy meant to them. Secondly, some women experience panic attacks, as for them TOP stirs up too much disturbance to deal with. Thirdly, others have dreams and nightmares, which can give indications to the inner state of a woman. In counseling the meanings of the dreams become more available to a woman's conscious mind and can then be worked through. The character of the dream can change and the repetitive quality can cause some relief. Fourthly, there is the emotion of regret. Most women make a decision that is right for them at that particular time of their life. Women for whom a baby would have been much wanted under different circumstances are especially susceptible to these feelings. Fifthly, a woman may feel envy when exposed to other women who are enjoying their pregnancy or babies. Sixth, there is the feeling of guilt. This is not a simple emotion but is created by a web of factors, including religion, culture, and societal forces, which shape a woman's feelings about TOP. These forces, as in the ecosystems theory, meet up with a woman's individual make-up and her internal world. Guilt, simply put, is an uncomfortable state one reaches if one feels one has done something wrong. Lastly, a woman may feel anger towards the abortion for different reasons. She may feel angry that the contraceptive failed, or that she had poor, insensitive treatment, or an unsupportive partner. This anger can also mask some of a woman's own feelings. With progressive counselling this can be worked through over time.

ROLE OF THE SOCIAL WORKER

One of the major changes between the Bill (80-96) and the CTOP Act of 1996 was the deletion of references to social workers. In contrast, the Act places considerable emphasis on the role of the midwife in TOP. The National Association of Social Workers (NASW) in their policy on reproductive health reads, *“The social work profession’s position concerning abortion, family planning, and other reproductive health services is based on the principle of self determination.... Every individual (within the context of his or her value system) must be free to participate or not participate in abortion, family planning, and other reproductive health services.”* It is the responsibility of the social worker to help clients assess their own feelings and values and identify the alternatives available and the consequences of each alternative.

In South Africa the CTOP law at present has minimal restrictions. On a macro level it is accessible for a woman or teenagers to obtain TOP for any number of times with no requirements for counselling as such Holden, Russell and Paterson (2009) reported the following experiences for women who have received counselling for TOP: *“Most women cope well with abortion; very few women appear to feel that their decision to terminate was the wrong one, although this does not mean that they will not experience some sadness or distress; long-term psychological trauma is extremely rare and often with further investigation it becomes clear that the problems leading to psychological problems are likely to have been present prior to the termination; the needs of women at this time seem to be more related to information provision and referral; and a lack of factual information was the most common complaint.”* Chilman (1987), cited in Zastrow and Kirst-Ashman (2007) reflects how social workers can counsel women regarding unwanted pregnancies: *“The ultimate decision should be made chiefly by the pregnant woman herself, preferably in consultation with the baby’s father and family members”*.

In a study of the prevalence of post-abortion syndrome at Kalafong Hospital conducted by Rooyan and Smith (2004), it was found that it is imperative for women requesting TOP to receive comprehensive counselling prior to the procedure, as well as support thereafter, to ensure that they are not unnecessarily traumatized. The study revealed a worrying state of mental health especially in light of the fact that 39.5% (i.e. 19 women) contemplated suicide. In their study they found that counselling remained unclear to some women and they viewed it suspiciously and as an attempt to change their minds or to question their decision. However, in the same study there was a small group of people for whom the counselling was

very important. For those women who did not tell friends and family about the pregnancy, it provided their only opportunity to discuss the decision to have TOP.

Poggenpoel and Myburgh (2006) strongly recommend counselling and support for those in a decision dilemma about an unwanted pregnancy in order to ensure a mentally healthy society. In 1995, the World Health Organization recommended that every woman must have a face-to-face communication with a counsellor during which she is assisted in making an informed decision (Kunene, 1999). According to a circular by the England Department of Health & Social Security (1977), abortion counselling means providing opportunities for discussion, information, and explanation of the procedure and the offering of advice, in a non-judgmental and non-directive manner. This gives every woman the chance to explore her feelings and anxieties, so that an informed decision can be made. The goal of counselling is to help women deal with the reality of the situation and give them a chance to discuss their feelings and view all alternatives before having an abortion, as this decision is irreversible. Kunene (1999) states that women need to be skilled in how to cope with social pressures related to abortion. Counselling will enable an individual woman to focus on her own feelings without the pressure from other family members or her partner. By doing this she clarifies the decision she will eventually make (Kunene, 1999).

Kunene (1999), in her research on women's perceptions of pre- and post-TOP counselling, found that 80 % of the women felt it necessary to have counseling. Even though some of the women who initially did not want to be counselled, when encouraged, later agreed that it was necessary. Her findings also indicated that women felt that whether they had made up their minds or not, counselling was necessary to relieve stress from the whole scenario of an unwanted pregnancy and TOP. It helped with the stigma that is attached to abortion and helped them to explore their feelings as well as gain insight about abortion procedures and contraception (ibid.). Kunene (1999) concluded that counselling became necessary for women requesting TOP to get the support they need, and revive hope for the future. Ndebele (2000) reported that counselling helps alleviate guilt and depression. To stress the importance of counselling, Davies (1991) highlighted that, while women may usually have an informal network of people whom they may turn to for support and help, when a woman is faced with an unplanned pregnancy, however, it becomes difficult to seek help from the usual support systems as there is fear of being judged. Women who are well informed and supported in their choices experience good psychosocial outcomes from TOP (Lie, Robson & May, 2008).

According to the policy manual on Health Care Standards of the Hartford Department of Children & Families (2009), counsellors working in TOP shall:

- Explain that the information is intended neither to persuade the young woman to have an abortion nor to carry the pregnancy to term.
- Explain to the young woman that if she does decide to have an abortion, she can change her mind at any time before the abortion.
- Explain that if she decides not to have an abortion, she can change her mind at any time during which she can have a legal abortion.
- Explain the alternatives to having an abortion including informing the young woman of the possibility of having the child and keeping it, putting the child up for adoption, or placing the child with a relative or in foster care.
- Inform the young woman that public and private agencies are available to assist her with the alternative she chooses and that she can have a list of these agencies and their services.
- Explain to the young woman that she can get birth control information from public and private agencies and that she can have a list of these agencies.
- Discuss with the young woman the possibilities of involving her parents or other adult family members in her decision on the pregnancy.
- Discuss with the young woman whether she thinks involving her parents would be in her best interest.
- Give the young woman a chance to ask questions about pregnancy, abortion and childcare.
- Give her the information she wants or inform her where such information can be obtained.

GENERAL STEPS IN DECISION MAKING

According to Adair and Adair (2007), the word *decision* comes from a Latin verb meaning “to cut off”. They further said that, what is “cut off” when you make a decision, is the preliminary activity of thinking, especially the business of weighing up the pros and cons of the various courses of action. In life, there is a time when one must firmly choose the course

that one wishes to follow, or the relentless drift of events will make the decision. Decision making is about deciding what action we take, and it involves choice between options.

Adair and Adair (2007) outline five steps in the classic approach to decision making. These are: firstly, define the problem: how you define the problem determines where you go to look for the alternatives, so it is important to define the problem carefully; secondly, identify available alternative solutions to the problem: this includes collecting relevant information and coming up with at least three other alternatives; thirdly, generate and evaluate feasible options: it is important to evaluate positives and negatives of each alternative; fourthly, make the decision; and fifthly, implement the decision and evaluate.

Harris (2008) says there are three benefits of delaying a decision. These are: the ability to gain more information and giving more thought to the decision; new alternatives might be recognized or created; and the decision maker's preference may change with further thought, wisdom and maturity. Adair and Adair (2007) clarify that it is not available data that is necessarily needed but rather to go out and obtain all relevant information for the situation you are dealing with. He also outlines that it is important to assess the consequences. These consequences come in two forms: manifest and latent consequences. Manifest consequences are those that you can foresee. Latent consequences are different in that they are not nearly so probable.

TOP: DECISION MAKING PROCESS

Oosthuizen, Abbot and Notelovitz, cited in Govender (2000), describe the dilemma that a woman is confronted with if she decides to have an abortion. According to them, "women don't want abortions as they want an ice-cream, they want it as an animal caught in a trap wants to gnaw off its own legs". Carol, cited in Kunene (1999), also talked about the guilt and pain experienced by a woman as she contemplates abortion. She views the abortion decision as an emotional struggle. This supports the notion that women do not take this decision lightly but rather that it is a difficult and painful one. To make the decision that is best for the couple and their child, the pregnant woman – ideally, with the expectant father – needs to view each option in the context of the couple's present skills, resources, values, goals, emotions, important interpersonal relationships, and future plans. The counsellor's role

is to support and shape a realistic selection of the most feasible pregnancy resolution alternative.”

Mdleleni (2007) identified five considerations for the TOP decision (adapted from Miller, 1992). Firstly, there is the intention of the conception, meaning whether it was planned or unplanned and, if planned, what the level of its being wanted presently is. Secondly, the pregnancy, now that it has occurred, requires action to undo it. The woman has to decide whether and how well she can adjust to having a baby that she did not intend to have. This “ability” or “willingness” of a woman to adjust her future life to include the presence of a baby may be called “adjustability to childbearing”. Thirdly, the woman would need to consider the seriousness and consequences of continuing the pregnancy and raising the child or adoption or abortion. On the one hand, abortion is religiously and morally unacceptable or undesirable for many women. On the other hand, the idea of carrying a child to full term and then parting with the infant (adoption) is also undesirable for most women. Fourthly, there are two important constraints on the decision making process, that is, time pressure if the abortion option is chosen; and, in addition, partners/parents, etc. may be intimately involved in the decision making process. These complications, in turn, may result in ineffective decisionmaking. The final consideration concerns availability. The two alternatives to bearing and raising a child generally require technical services from others. Unless these are available and perceived as available by the woman, her choices virtually disappear.

Brown (1983:241-247) presented the following decision-making framework to explain the process of decision making to continue or terminate a pregnancy:

- Familiarity on the subject of TOP – The decision one makes depends on how much experience one has with an unwanted pregnancy or abortion. Unless a person has an intimate friend or family member who has had an abortion and the experience is openly discussed, a woman may have little or no knowledge of what abortion entails and may be left alone and confused. This would further deprive her of a chance to share information and strategies with which to cope and make decisions. Thus how familiar a person is with the topic also helps in the decision-making process.
- Complexity of the decision in regard to pleasing of oneself, one’s partner, and/or family, and affirming one’s own values and goals – The choice in itself is

straightforward, either to abort or continue the pregnancy. There is also the need to balance a career and/or motherhood, to complete educational programmes and enjoy the status of adulthood provided by motherhood. The decision to continue the pregnancy is complicated by choices of keeping the baby or giving it up for adoption. This is even more complicated if the individual is an adolescent, and has not told her parents.

- Stability – The initial shock at the news of a confirmed pregnancy may leave one making irrational decisions. The woman may become vulnerable to those around her and, if she shares the news, her reaction may be influenced by those around her. It is for this reason that she may need an opportunity to explore her feelings and anxieties with a skilled counsellor so she can make a stable decision in unstable times.
- Reversibility – Abortion is irreversible, permanent and irrevocable and therefore there are increased stress levels for the pregnant woman. Nothing can change the fact the pregnancy was terminated. This irreversibility may be a relief to those who believe that pregnancy would have had a significantly negative effect. For this reason a woman needs to make the decision to the best of her ability at the time.
- Knowledge – Making an informed decision requires that one has knowledge and understanding of the procedure and the possible consequences and all options available. Women may hope that pregnancy can be terminated without an abortion as if these are different things. Abortion is also associated with terrible pain and possible complications, yet TOP is considered an easy way of making the pregnancy stop. Also knowledge of the procedure may be minimal. During counselling, myths can be dispelled and women can be given appropriate knowledge regarding TOP.

Davis (1991) developed seven steps that may assist women in the decision-making process:

- The decision is an individual one.
- Women must analyse each option and their consequences.
- They must be aware of body changes that may make one susceptible to stress.
- Women need to recognize signs of tension and deal with them.
- They need to take cognizance of values learnt in childhood.

- Women must be sure to conduct daily bodily requirements; like eating and sleeping well.
- They need to take time to relax and not be afraid to ask for help.

ALTERNATIVE CHOICES AVAILABLE FOR WOMEN WITH UNWANTED PREGNANCIES

Stephenson and Narias, cited in Kunene (1999), stated that there is a tendency for women to rush the decision to abort without considering other options. There are alternatives available to women, each with some degree of difficulty attached to it. Some women may choose not to proceed with abortion due to moral beliefs and at the same time they are not able to keep the child because of a lack of financial resources.

Adoption

The choice of adoption is a legal process covered by the Child Care Act of 1983. Adoption removes all rights of the biological parents and provides the child with new legal parents. In adoption counselling, all the necessary counselling areas are dealt with. Counselling entails assistance by a professional in making the right decision, feelings are worked through in counseling and valuable information is shared.

For teenagers who wanted to continue their education, adoption had been a favourable option but this is not so now with the legalization of abortion, according to Moore and Rosenthal(1993), cited in Govender (2000). In the South African context the father, if he can be found, must give permission for adoption. In some instances women do not want the fathers to know of the child or give them any rights to the child.

Foster Care

Foster-care is a short-term placement also covered by the Child Care Act of 1983. It is a short-term placement for a maximum of two years, during which time social workers try to integrate the child into the family of origin. In foster care, the foster care parent is the “Acting” parent. During this time the care of the child is monitored and supervised by the attending social worker. Often foster care can lead to adoption.

These two options can be clearly outlined to the person seeking TOP, to assist in making an informed decision. According to pro-choice advocates, the reason women decide to terminate their pregnancies is because adoption causes a permanent separation between the mother and the child and the issue of abandonment will arise. A study done in the USA shows that for every potential case of adoption 30 other fetuses are being terminated (Alcorn, 1992). This shows that women still choose abortion, which is a difficult decision to make. Alcorn (1992) says this increase in abortion is also attributed to women not being educated on the options available to make an informed decision.

There is another concern regarding women who seek TOP more than once in their lifetime. The ideal is where women are educated on contraceptive use after having a TOP, and because of this education, have no need to access these services again. The Act does not stipulate how many times a women can seek TOP Services. If the TOP decision is not an easy one and there is no compulsory counselling offered to these women, what would be the long-term impact of their decision? It is clear from authors like Kunene (1999: 45), Govender (2000:143) and others, that the abortion decision is not an easy one. Any type of support, interpersonal support or abortion programmes seem to be required and should become a vital factor in making this decision.

CONCLUSION

The literature reviewed in this paper lead us through a process of first understanding the TOP law in South Africa, the reasons for TOPs, and the decision making processes. These were achieved through highlighting what women in South Africa are exposed to and understanding the options for unwanted pregnancies in South Africa, the role of social workers, and the support systems that are in place.

Chapter Three

RESEARCH METHODOLOGY

INTRODUCTION

In this chapter, the researcher will describe the methodology used in this study. The decision to terminate a pregnancy can evoke opposing reactions. It can be a difficult one for some women and can also be a great relief for others. In either event, the researcher explored how women arrived at their decision and what were some of the dominating factors surrounding this decision. The intention of this study is to contribute to existing studies and also to influence the existing CTOP Act and to encourage the active participation of social workers in the CTOP Act. This chapter describes the research methodology. It focuses on the research design, data collection methods, and data analysis procedures that were used in this study. This chapter also discusses the reliability and validity of the data, the ethical concerns presented by the study, the limitations of the study and the steps taken to minimize them.

THE RESEARCH DESIGN

A research design is the blueprint or plan of how a researcher intends to conduct his or her research (Babbie et al., 2001:74). A research design consists of the research questions, what data to collect, data collection methods and data analysis (ibid.). An exploratory research design was conducted to gain insight into the situation of an unwanted pregnancy. Babbie et al. (2001:85) state that exploratory studies are valuable to social science research because they are necessary when a researcher is finding new information and it satisfies the curiosity and understanding of the researcher's topic. Much research was conducted on the reasons for TOP but little on the walk towards making that decision, especially in the South African context (Kunene 1999).

RESEARCH METHODS

This was a qualitative study, which explored the processes involved in making a decision to terminate an unwanted pregnancy. Researching issues of intimacy and reproductive health call for an approach which renders visible the bio-psycho-social relations within an individual and between an individual and her environment (Mathe, 2011). According to Denzin and Lincoln (1994:2), qualitative research is “a multi-perspective approach to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the subjects attach to it”. Babbie and Mouton (2001) add that the qualitative approach provides an inside perspective on social action. As a social worker working in the maternity and gynaecological setting the researcher dealt with young women who have undergone TOP procedures. These women presented with a number of post-procedure challenges. In order to gain insight of their dilemmas a multi layered approach was appropriate. Gribich(1999:8) states that qualitative approaches are complex and varied and it allows the researcher to study a situation from a range of positions and perspectives to find out how people interact and define contexts. These investigations allow researchers to investigate and describe patterns of behaviour, processes of interaction and to reveal the meanings, values and intentions of people’s life experiences. This approach was appropriate for this study as it allowed the researcher to gain more in-depth knowledge and understanding of the phenomenon under investigation with the focus of understanding social life. A semi-structured interview guide was used. The qualitative method suits this research as it is sensitive to the human situation, and it involves an empathic dialogue with the participants involved, who may in turn contribute to their emancipation and empowerment (Babbie and Mouton, 2001).

BRIEF DESCRIPTION OF THE RESEARCH SITE

The study was conducted at a district hospital in KwaZulu-Natal that provides termination of pregnancies services to women with unwanted pregnancies. The hospital provides medical care for patients residing in the Durban and surrounding areas. The TOP Clinic provides services to a racially mixed population from different financial backgrounds and religious affiliations. However, the legacy of apartheid is still evident where race and socio-economic

factors determine which majority attends the Public Hospitals. Therefore the majority of the participants were Africans and the minority Indians and Coloureds.

THE RESEARCH PROCESS

The research process consisted of several stages, which are discussed in this section.

In conducting this research, the researcher had to seek permission from the management of the hospital concerned. A letter of request explaining the purpose of the study was handed to management who were in support of the study.

Sampling

Sampling is defined as a procedure of selecting a subset or small number that represents a target population that was to be studied (Babbie & Mouton, 2001). A non-probability sampling procedure was used. According to Marlow (1993:112), non-probability sampling is a sampling method of choice, particularly if we were conducting exploratory studies or evaluating our own practice.

Purpose sampling was used for the selection of research participants. According to Marlow (1993), purposive sampling purposively includes in the sample those elements of interest to the researcher. The sample selected possessed the characteristics that the researcher was interested in studying. The researcher selected the participants from women attending the TOP Clinic prior to the TOP Procedure being conducted on coming for their first assessment. The sample consisted of sixteen (16) young women between the ages of 18 years and 35 years. All participants were in their first trimester of pregnancy and had already made the decision to have TOP. The researcher obtained consent forms (see Appendix A attached) to participate and requested permission to record the session. Furthermore, participation was voluntary, participants could be of any race, and were mentally sound. The non-English speaking participants were also informed that an interpreter was available to ensure that they were comfortable to speak in the language of their choice during the interview. Confidentiality was stressed and the approximate length of time for the interview was also given. The researcher also informed all participants that there was no monetary gain and that they could opt out of the study without penalty. The participants were informed that the

datum would be used for a thesis write-up and that recommendations would be made to relevant stakeholders depending on what the interview stimulated.

According to Mason (1996), the logic of purposive sampling is that you select units which will enable you to make meaningful comparisons in relation to your research questions, your theory and the type of explanation you wish to develop. The problem with purposive sampling as with other non-probability methods is the lack of ability to generalize from these samples. However, its strength is that for many studies it can ensure the collection of information that is directly relevant to the subject being investigated (Mathe, 2004).

Data Collection

The research tool used was semi-structured interview schedules. Kvale (1996:6) defines a semi-structured interview guide as “an interview whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning described in the phenomenon”. The interactive in-depth interview gave the researchers an opportunity to establish a relationship with the participants and to ensure that they were equal partners in the research process (Baines, 2007, cited in Raniga and Mathe, 2011). This schedule was most helpful given the nature and sensitivity of the research topic and the information required. It allowed the researcher to engage with the participant and to understand the social realities of a person experiencing an unwanted pregnancy.

An interview guide with semi-structured and open-ended questions was used (see Appendix B attached). The interview guide ensured that all the intended areas were covered and it gave direction to the interview. The interview focused on themes related to the study. It covered the demographic details, the participant’s initial reactions to the unwanted pregnancy, the process and significant others that were then engaged, and the thought process during the decision making process.

Data Collection Process

All consented participants who met the selection criteria were interviewed on the same day of recruitment. The office interviews were held in a private counselling room during working hours to accommodate the needs of the participants. Interviewing participants on the day of

their clinic appointment suited them, as they did not need to make unnecessary trips to the hospital at additional costs.

The interview process consisted of one interview that took about 60 - 90 minutes per session. It involved a face to face interview. Approximately half the interviews were conducted in English and half in IsiZulu with the help of an interpreter who was a qualified nurse. The interviews were recorded on audio cassette to ensure accuracy of the information and to prevent any distortion of details. The interpreter was given clear and guided instructions as to her role and that she needed to ask the said question in the manner in which it was asked without adding any additional information. She was also asked to relay the message in the said words of the participants to avoid distortion and ensure reliability.

The structure of the interview schedule was drawn up by the researcher in such a way that the less threatening or intimate questions were asked first. The researcher was guided by Baines (2007) who suggested that anti-oppressive researchers must be flexible and emergent throughout the research process (cited in Raniga and Mathe, 2011). Also guided by the social work code of ethics, the researcher was able to build rapport with the participants because she was polite, friendly and professional during the interviews. In this study there was on-going mutual negotiation of meaning and power between the researcher and the young women. The researcher listened carefully to the participants' experiences as they told them, tried to understand what they were saying, reflected more closely on their lives as they presented them, and made interpretations. The researcher's experience as a practicing social worker helped to engage with the participants in a non-judgmental and non-threatening manner. The researcher's excellent communication skills particularly interviewing skills benefitted the data collection process. She was able to engage with participants in a manner which allowed participants to express and share personal and sensitive information without feeling threatened. The interview entailed listening, displaying a non-judgmental approach, clarification, reflection, empathy, encouragement, commenting, paraphrasing and summarizing. An understanding of TOP prior to the interviews also helped the participants to express themselves fully in their own words. The researcher's knowledge of and insight into TOP also helped in the interview process.

DATA ANALYSIS

Miles and Huberman (1994) define analysis as consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification. The primary mission in the analysis of qualitative data is to look for patterns in the data, noting similarities and differences (Marlow, 1998). The researcher used thematic content analysis to analyse the data received. According to Silverman (2001:305), content analysis involves establishing categories and systematic linkages between them, and counting the number of instances when those categories are used in a particular item of text. Content analysis involves the general procedures of document collection with the aim of developing codes (ibid.).

The transcripts of the interviews formed the main data source. Kvale's (1996:88) seven-step process namely, thematising, designing, interviewing, transcribing, analysing, verifying and reporting, were followed during analysis stage. The transcripts of all interviews were read again and again. Themes emerged from the grouped words, sentences and paragraphs, which formed the focus areas highlighted by the participants during the interview process. For example, the participants used words and sentences talking about their initial reaction to pregnancy and whom they chose to talk to and why. During the analysis process, the researcher looked closely at the sentences that showed how participants felt and what their reactions and thoughts were. This allowed the researcher to generate findings that replicated, extended or refuted previous discoveries in this research field.

LIMITATIONS OF THE STUDY AND TAKEN TO MINIMISE LIMITATIONS

- This study is limited to one district hospital in South Africa. The sample size was small so these findings cannot be generalized to a larger community. However, the main aim of the study is not generalising but in-depth understanding that might inform interventions and programmes when dealing with women undergoing TOP processes.
- The researcher was aware of her own biases that could have interfered with the research process. The researcher's belief does not support TOP, but as an experienced social worker who has successfully dealt with many ethical dilemmas in the past, the researcher successfully removed her own biases and feelings and prioritised the clients' best interest.

The researcher was constantly aware of maintaining a non-judgmental approach because the topic under study was sensitive.

- The researcher anticipated that language could be a challenge. So the assistance of an interpreter was enlisted. This could have interfered with the reporting on the actual interview.
- Since participation was voluntary, the purposive nature of this study reduced the chances of the researcher getting uncooperative respondents.

RELIABILITY AND VALIDITY

Reliability according to Babbie et al. (2001:127) tests whether the instrument produces the same results time after time. Validity refers to “the degree to which an instrument measures what it is intended to measure” (Polit & Hungler, 1991). However, Lincoln and Guba (cited in Babbie & Mouton, 2001) demonstrate the inappropriateness of measuring the validity and reliability of qualitative research. Instead, they proposed measuring the following four (4) constructs when doing a qualitative study: credibility, dependability, transferability, and confirmability.

In this study the researcher used a semi-structured questionnaire, which guided the interview in such a way that information attained was based on set guidelines adding to its credibility and dependability. This helped to minimize sources of measurement error like data collector biases. This was further reduced by the researcher’s attitude and approach during data collection. Interviews were collected in a friendly, supportive and transparent manner and confidentiality was observed at all times.

Transferability refers to the extent findings can be applied to other contexts. The researcher was not primarily interested in generalizations and did not maintain or claim that knowledge gained from one context will necessarily have relevance to other contexts or for the same context in another time frame (Lincoln & Guba, cited in Babbie & Mouton, 2001). In this study the researcher was able to elicit detailed and in-depth descriptions of the processes involved in decision making. It was reported with sufficient detail and precision to allow judgments of transferability to be made by the reader. The sample size may limit

generalizations. However, this does not invalidate the study as this is an exploratory study which is intended to offer a deeper understanding of the decision-making process for TOP.

Lincoln and Guba (cited in Babbie and Mouton, 2001) relate confirmability to leaving an adequate trail to enable the reader to determine whether the conclusions, interpretations and recommendations can be traced to their sources. In this study this was achieved as the raw data included tape recordings and transcripts of field notes, which related to data reduction and analysis products, themes that were developed, findings and conclusions. The researcher was aware that confidentiality and sensitivity would be important and therefore used her social work skills gained over her 11 years of experience to draw valuable information while providing a safe environment for the participants.

ETHICAL CONSIDERATIONS

According to the Medical Research Council(2002), conducting research is an ethical enterprise, which contains a system of morals, rules and behaviours, which need to be followed. The researcher was aware that TOP is a sensitive and personal issue and therefore the following ethical issues have been dealt with accordingly during this study.

- Permission sought and obtained from the relevant authorities such as The Department of Health, Superintendent of the Hospital, Head of the Obstetrics and Gynaecological Department, and the Nursing Sister in charge of the CTOP Clinic.
- Only participants of the legally consenting age were included in this study.
- The participants were made aware of all aspects of the research in order to make an informed decision about participating in the study.
- Participation was voluntary. Only consenting participants took part in this research. The National Association of Social Workers (NASW) Code of Ethics: standard 5.02 [e] states that “social workers engaged in evaluation or research should obtain voluntary and written consent from participants” (Reamer, 1998:112). Signed Informed consent was obtained from each participant.
- Participants were assured of confidentiality and informed that they could withdraw at anytime with no consequence.

- The researcher informed the employer that no research would interfere with their work and that each participant would be participating voluntarily.
- The researcher was aware that the topic under investigation was sensitive, so the researcher was prepared to render supportive counselling to participants.
- The findings will be made available to the authorities and participants on request.
- Some of the participants in the research study might not be comfortable with their identities being exposed, therefore their real identities will not be used. The NASW Code of Ethics: Standard 5.02 [m] states that “social workers who report evaluation and research results should protect participant’s confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure” (Reamer, 1998:131).
- The actual research was conducted in a private room at the TOP clinic. This ensured the right to privacy of the participants.
- The SACSSP code of ethics was adhered to throughout the research life span.

CONCLUSION

In this chapter, the methodology used in the study is described and discussed. The practical application of interview schedules as data collection method was effective in eliciting rich, detailed information and simultaneously being sensitive to the source. The methods of data analysis were also discussed. Some possible limitations of the research methodology are noted. This chapter concluded with a discussion of ethical considerations relevant to the study.

The following chapter contains the analysis and discussion of data obtained through the processes outlined in this chapter.

Chapter Four

ANALYSIS AND DISCUSSION OF RESULTS

INTRODUCTION

According to Miller and Rahe (1997), the events of pregnancy, abortion or miscarriage, and the death of a child are rated as life-changing events that have a great impact on women. This section focuses on data presentation, analysis, interpretation and discussion of the results of the interviews conducted with sixteen women at the TOP clinic, in one of the Public Hospitals in Kwa-Zulu Natal. The data was analysed by means of a thematic content analysis as described by Neuman (1997) – involving the following steps: The tape-recorded semi-structured interviews were transcribed and integrated with notes made during the interviews. The transcripts were read on several occasions to familiarize the researcher with collected data. Data that answered the research questions were identified, and data that were not relevant were discarded. The following broad themes emerged from the data:

- Personal profiles
- Participant's initial reaction to the pregnancy
- Thoughts and feelings during the decision-making process
- Women's understanding and knowledge of TOP
- Support systems at the time of making the TOP decision including the male partner's role and reaction to the pregnancy
- Participant's views on counselling

BIOGRAPHICAL PROFILES OF PARTICIPANTS

TABLE 1

- **A – African**
- **C – Coloured**
- **A (Zim) – participant is from Zimbabwe**
- **A (Bur) – participant is from Burundi**

Participant	Race	Age	Vocation	Marital Status	No. of Children	Previous TOP	Religion
A	A	23	Student	Relationship	2	1	None
B	A	30	Unemployed	Married	1	Nil	Zionist
C	A	35	Unemployed	Single	1	Nil	Christian
D	C	27	Unemployed	Married	3	Nil	Catholic
E	C	18	Unemployed	Relationship	Nil	Nil	Catholic
F	A	22	Accountant	Relationship	1	Nil	Christian
G	A	27	Unemployed	Single	2	Nil	Christian
H	Asian	18	Student	Single	Nil	Nil	Hindu
I	A	29	Receptionist	Single	1	Nil	Christian
J	A	20	Student	Single	Nil	Nil	Christian
K	A (Zim)	22	Employed	Single	Nil	Nil	Christian
L	A	22	Employed	Relationship	Nil	Nil	Christian
M	A	31	Self employed	Single	2	Nil	Christian
N	A	21	Student	Single	Nil	1	None
O	A	20	Student	Single	Nil	Nil	Christian
P	A (Bur)	29	Employed	Married	3	Nil	Muslim

Race

Despite eighteen years in democracy, the legacy of apartheid is still evident in South African State health centers. Race and socio-economic status still determines who attends which hospital – leaving our hospitals very racialised. The sample used during this study is thus not the representative of all racial groups in KwaZulu-Natal but it represents the racial groups that attend the TOP clinic under study. The majority of the participants were Africans, and the minorities were Coloured and Indians.

Out of the sixteen participants, thirteen (13; that is, 81 %) were Africans, two (2) were Coloured, and one (1) was an Indian. From the 13 Africans, there were 2 women who were originally from the African States of Zimbabwe and Burundi. These statistics represent the picture of many studies conducted in South African hospitals – which are still characterized by deep levels of racism and represent the demographics of each area under study. The racism in South African hospitals was also evident in a similar study conducted by Faure and Loxton (2003) in the Western Cape (a predominantly Coloured and White area). According to the study results, 37 % of the women were Coloured, 34 % White, 18 % Black, and 11 % were Asian. Bhana (2009) maintains that what adds to the complexity of social problems in contemporary South Africa are the large-scale social forces underwritten by the legacies of apartheid and colonialism, including persistent poverty, racial and gender inequalities.

Age

Various studies show that age is an influential factor in deciding to have an abortion or not. In South Africa, studies indicate that 50% of women who chose to terminate their pregnancies were teenagers (Maforah, Wood & Jewkes, 1997). In the current study, more than half of the participants were between the ages of 18 to 25 and expressed non-readiness or unpreparedness to be mothers as a motivating factor for TOP. A study conducted by Manzini (2001); Rutenberg, Kaufman, Macintyre, Brown and Karime (2003) revealed that more than one third of young women in KwaZulu-Natal become pregnant before the age of 20.

Below are some of the women's responses regarding their age and readiness/preparedness to be mothers:

“I’m still finding myself, I am not ready to care for someone else, I don’t have time to have a baby now, I am still studying.”

“I know my brother and sister will support the baby but my boyfriend will run away. I will then be left alone to care for this baby.”

The above statements thus support findings by past researchers that those who choose TOP were young and lacked child preparedness. Gardner (1975); Russo, Horn, and Schwartz (1992); cited in Mdeleleni-Bookholani, (2007:246) and the World Health Organization (1997), cited in Singh & Darroch,(1999) extended these arguments by adopting the feminist lenses in understanding young women’s decisions to terminate their pregnancies. They rooted the young women’s troubles in their social positions as young, Black, and from impoverished communities. They argued that the high incidence of young women’s unplanned pregnancies, which in turn lead to TOP in the developing countries, is inversely related to socio-economic development and not linked to behaviour and or sexual choices.

Vocation

Vocation seems to play a major role in the TOP decision. Twelve (75 %) of the study participants were unemployed, from which five were students in a tertiary institution. According to Adler, David, Major, Roth, Russo and Wyatt (1992), Reproductive Rights Alliance (1998), Mdeleleni-Bookholani (2007), Naidoo (2004), and Govender (2000), many women seek abortions for various reasons. Women who are socially and economically disadvantaged are over represented. Mdeleleni-Bookholani (2007) states that the negative effects of poverty on South African women are well documented. The Reproductive Rights Alliance (1998) reiterates this by stating that the South African socio-economic context, the unstable financial circumstances, characterize the economic position of the majority of women who seek an abortion.

Various studies have reported a number of reasons for students to choose to terminate their pregnancies (Mojapelo-Batka & Schoeman, 2003; Gmeiner, Van Wyk & Mpshe, 2002). The study conducted by Gmeiner, Van Wyk and Mpshe (2002) reported fear of being rejected, abused, or of being a disappointment to their parents/caregivers as the main influence of the students’ choice to terminate their pregnancies. In the study conducted by Mojapelo-

Batkaand Schoeman (2003), the importance attached to completing secondary or tertiary education was evident from the decision of those women who anticipated that their parents or boyfriends would try and prevent them from having the abortion. In addition to the need to study further, financial considerations played an important role in the decision to have an abortion (ibid.). Naidoo (2004) in a study conducted with 30 university students found that the 63% opted for abortion. Harold (1982) cited in Naidoo (2004:63) indicated that this percentage was high as the respondents at the university are career-orientated individuals. Russo, Horn and Schwartz (1992), Gardner (1975), and WHO (1997) state that this reflects a change in the role women play in society and the tendency for them to delay childbearing until they have achieved their education and occupational goals.

Marital Status

Davies (1991), states that the best support for a woman experiencing an unplanned pregnancy is from a caring and understanding partner.

In our study, only three (3) women participants were married. From the 3 married women, two (2) had the full support and understanding of their husbands. Financial constraints and the fact that they had reached their planned family size were cited as the reasons for the TOP decisions.

“We both decided to end this pregnancy. Having another baby will bring more problems and it is already so difficult to cope.”

“I sometimes think that he is confused and unsure of what to do but then we both agree to abortion.”

One (1) of the married women had no spousal support. She revealed that there was marital conflict and did not reveal the pregnancy to her husband. According to Davies (1991), pregnancy raises questions relating to our relationships. In most cases the extent of a husband’s support makes all the difference in enabling his wife to cope with another pregnancy (Davies, 1991).

“No, I don’t tell my husband. He is going to say ‘No, My child’...He can’t agree to terminate, I know. But I can’t take it anymore. How about my strength! (Hysterical and crying) I’m crying with the baby and he is going out with the girls...”

Thirteen (81%) of the young women were unmarried. Nine women reported being single while four were presently in relationships with the father of the unplanned child. According to WHO (2003), gender inequalities, economic hardship and poverty are conditions that constitute the breeding ground for high rates of unwanted teenage pregnancies. Gardner (1975), Russo et al. (1992), and WHO (1997) agree that the abortion rate is higher amongst unmarried women. Various factors are mentioned in the literature as motivating unmarried women to terminate their pregnancies. Bhana (2009) in their study of gender inequalities against women in South Africa outlined how men prefer to be with virgins. This shows how single women are further marginalized when they have a child and future prospects of a marriage and a secure life are lessened.

Five (5) of the unmarried women revealed that their partners were unsupportive and uninterested.

One of the women said,

“I have decided to do this on my own. I did not tell my boyfriend, as we only know each other for a few months. He would not agree to abortion and if there was more of a relationship then maybe I will accept it.”

According to Davies (1991), pregnancy raises many questions. The relationship with the father is evaluated and this ultimately affects the decision (ibid.). The question raised is: “Is this the man I want to have a baby with?”

Religion

Suffla (1997), cited in Mojapelo-Batka et al. (2003), states that the introduction of a law does not necessarily lead to fundamental changes in society’s constructions of abortion. According to Naidoo (2004) and Govender (2000), cited in Voyandoff and Donnelly (1990), when a woman contemplates abortion she takes into account various factors such as her

family's attitude, her partner's attitude, religion, society's attitude as well as socio-economic factors.

Fourteen (14) of the sixteen research participants were of some spiritual belief. Coincidentally, the two participants who did not have any belief system have had one or two TOPs in the past. Women's cultural affiliations and beliefs have a bearing on their emotional experiences (Lie, Robson, & May, 2008). All fourteen women's belief systems were inclined to different religious doctrine. Some of these were Christians, Zionists, Muslims and Hindus. All religious believers viewed TOP as against the will of God. These women talked about how their upbringing and their belief systems were against TOP. Similarly, in a study conducted by Mojapelo-Batka et al. (2003), people who attend church frequently and who are ritualistically active are likely to be subjected to the institutionalized influence of the church. Viewing TOP as a sin created internal conflicts within participants and made their decision-making process even harder for them. This study refutes Callahan and Callahan (1984) who claim that religious faith has very little influence on the abortion rate. This study shows that persons' belief systems have an intricate role to play in their lives and that even if they choose to go against their belief system, it does influence the way they view things.

This was indicated in the following statements:

"I am a Christian but I have no money or work so I have to do abortion."

"... It goes against everything I believe in. Like the bible teaches us that sex before marriage is wrong. Murder like you know is another sin. Now everything I was taught not to do, you know, I'm just doing it. I'm not pleased with it, but like I said I feel like I have to do it. This is the hardest thing that I have to do."

"It is not an easy decision because I believe it is taking someone's life."

"The decision was difficult for me since I'm a Christian and it is against the rule of God."

"It was difficult but I prayed and asked Allah to please forgive me."

“I did not tell my boyfriend about this decision because he is saved and would not have agreed to abortion.”

It was noted that the decision dilemma influenced by morality issues was greater among younger women. According to Adler (1972; cited in Mojapelo-Batka et al., 2003), younger women and unmarried women are more inclined to experience both forms of negative emotions than older women. There are various reasons why pregnancy and abortion would impact differently on adolescents than on older women, including adolescents' high need for social approval and acceptance, their economic and emotional dependence on their parents, and the stigmatisation of teenage pregnancies (McCulloch, 1996; cited in Mojapelo-Batka et al., 2003).

PARTICIPANTS' INITIAL REACTION TO THE PREGNANCY

The pregnancy, for all participants in this study, was an unplanned pregnancy. The women shared how they discovered their pregnancies. Out of the sixteen participants, thirteen (13) (81%) participants discovered that they were pregnant due to the physiological changes in their bodies. They either missed their monthly menstruation periods or noticed unexplainable weight gain on different body parts. The three other participants' pregnancy discovery was a total surprise. The first reaction for all women was a urine test to check what was going on in their bodies. Davies (1991) states that many women experience panic, disbelief and vulnerability when they discover that they have an unplanned pregnancy. The seven (7) participants who reported shock and disbelief on urine test results went further for a confirmation test by their general practitioners.

Research findings indicate that many women acknowledge that the discovery of an unwanted pregnancy and the decision to terminate it are stressful and conflicting experiences (Major, Mueller & Hildebrandt, 1985; Major, Cozzarelli, Sciacchitano, Cooper, Testa & Mueller, 1990; Russo & Dabul, 1997, cited in Faure and Loxton, 2003). All participants shared that they were shocked, angry or scared when they realized that they were pregnant. The following represent some of the participants' reactions to their pregnancy discoveries:

Feelings of shock:

“I was very uncomfortable and scared...” (Mumbling and sobbing.) “I couldn’t believe that I was pregnant.”

“I felt numb and physically sick.”

Feelings of anger:

“I was angry with my husband because he is having an affair and now I’m pregnant. “

“I was angry at myself for doing this thing.”

Feelings of fear:

“I was terrified, because my husband and I had discussed and said we will only have another child if the circumstances in our lives were good.”

“ ... Felt fear like my life was coming to an end.”

“Oooh I was so scared ... because I’m an orphan, eish I was supposed to look after myself and my young sister ... I was afraid that maybe gonna become embarrassing for my young sister.”

Feelings of anxiety:

“I was worried and anxious about what my family would have to say.”

It is evident from the above that the expressed participants’ reactions stemmed from multi-dimensional factors. These were their psychological state, their economic position, interpersonal relations or family issues. Earlier studies have shown how a partner’s attitudes and support greatly influence the decision to continue or interrupt the pregnancy (Sihvo et al., 2003).

THOUGHTS AND FEELINGS DURING THE DECISION-MAKING PROCESS

According to Berk (1988), a human being is a bio-psycho-social individual. Therefore it is clear that our feelings and emotions are very much a part of us and should be acknowledged and worked through at all times in order for us to be a fully functional being. During emotional highs and lows it is important that one does not make life-changing decisions only based on how we feel, as feelings change from day to day. To make an informed decision one had to look at all the alternatives and the positives and negatives of those alternatives as

based on one's unique circumstances. During this time of crisis, the participants had to decide which route to follow regarding their pregnancy.

Women are not a homogeneous group. Their behaviour, thoughts, feelings are context specific. Each woman responds uniquely to a situation dependent on her level of security, as this relates, for example, to having a job, a fulfilling relationship, secure living situation and long term aspirations.

Secure living situation:

"I looked at my circumstances, if I kept the baby, (tearful pause), then I know I can't keep the baby."

"If it wasn't for my family I would keep the baby but they will throw me out of the house they will say I already have 2 babies."

Fulfilling relationships:

"I was scared about what my parents would say."

"It's the hardest thing I had to do, because I wanted to keep it. Then reality kicked in. Where would I stay? My boyfriend is not working. My parents will keep the child but then I need to see for myself. I can have the baby, then what if he leaves me. It would then be my responsibility. I don't think I would walk around like it never happened. I know it's wrong what I am doing but I am doing it because I feel I have to. I am not proud of what I am doing and would like to put it in the past."

Job situation

"I need to study and get a job."

Long Term aspiration

"I was crying and very sick because of the HIV."

Other thoughts were:

"Sometimes I feel like ... I'm a killer... sometimes I ignore it ... ignore it ... I ignore myself..."

“I had to consider the outcomes of having a termination and consider what if this is the only baby that God planned for me.”

“It takes me a month to make this decision. I’m thinking don’t do it then I’m thinking. Then I just come to do it. I feel like a murderer.”

Participants’ feelings showed how vulnerable and helpless they felt in the particular situation. The responses from the participants show how they believed they lacked control of the situation.

In contrast, feminist writers such as Petchesky (1990) believe that choosing to terminate an unintended pregnancy might increase a woman’s sense of control over her own body and her life. The majority of the responses received from the research participants did not seem empowering as believed by Petchesky (1990) but rather distressing and a choice that they would prefer not to make.

Fourteen (14) participants saw this decision as painful and in conflict with their feelings and values. The participants’ responses reflected the decision to abort as not an easy decision like choosing what to wear or what to study. It came with mixed feelings because it is irreversible. It is clear from the data collected that participants were very emotional during this time. Ideally these emotions need to be worked through before a decision is made. Women seeking abortion feel both painful and positive emotional responses. Problems and unresolved conflicts may be evoked by the situation of abortion. Howitz (1990; cited in Kunene, 1999) confirms that a woman’s internal psychological experience of abortion needs to be recognized.

The choice of TOP Act 92 Of 1996 (amended) does not allow for mandatory counselling and gives those that are already feeling judged and alone the choice of counselling or not. The findings in this research indicate that human beings are indeed complex beings and when faced with a decision of TOP there are many conflicting thoughts and feelings that need to be worked through before, during and after abortion.

Another important insight gained during this study was the role played by whether the TOP was a first one or repeated one. There seemed to be a notable difference in terms of the feelings, thoughts, and perception of TOP between those aborting for the first time and those

repeating. Out of the sixteen (16) participants, two had aborted before. These two participants seemed relatively comfortable about their decision. One of the participants who had had an abortion 15 months prior responded that having an abortion was easier for her than taking injections or tablets on a regular basis. She said,

“It’s still better to have TOP than injection, TOP is only for now.”

This response was alarming and in keeping with Gardner (1975), when he warned that legalizing abortion might create a society that viewed abortion as a contraceptive.

KNOWLEDGE AND UNDERSTANDING OF TOP

Abortion is a decision that touches all areas of women’s lives – career, relationships and the future (Davis, 1991). In the event of an unwanted pregnancy a women has the choice of abortion, adoption and motherhood. With any decision it is important to explore the options available and what each one means. People must evaluate for themselves the potential negative and positive consequence of each alternative. This is an important part of the decision-making phase (Davies, 1991).

In this study sixteen (16) women came in to the TOP clinic having made up their minds to have an abortion. In the scope of this study one of the objectives was to determine the level of understanding women had of abortion and the options available to them.

The following table shows where participants primarily gained most of their information on TOP during this time of decision making.

<u>Source of Knowledge</u>	<u>No. Of Participants</u>
General conversations at school or work	7
Friend who had undergone TOP	1
Medical Doctor	1
Media – radio, newspapers, TV, posters	3
Experience from Previous Abortion	2
Strangers	2

Thirteen (13) participants gained their understanding from talking to people. Eleven (11) of them said that it was for someone else. The findings in this research are in keeping with other studies which show that the very nature of TOP itself continues to place women in a situation of secrecy and thus limits them to be able to gain sufficient knowledge on what is available for women with unwanted pregnancies or in depth knowledge on TOP and the procedure.

Typical responses included the following words and phrases;

“Ending a pregnancy “.

“To bleed and stop a pregnancy.”

When asked to give more detail, women either didn't want to talk about it or didn't know. Women at this point were anxious to put an end to the pregnancy and hopefully get back to the normality of life.

The two participants who had undergone previous abortions, the one who spoke to her friend that had undergone an abortion, and the participant whose relative worked at a TOP clinic showed much understanding of TOP and what it entailed. They were able to detail the waiting process, what to expect when they got home, some of the consequences that might arise should it be an incomplete abortion and what they needed to do in that event.

The other twelve (12) participants seemed to have a basic idea that one ended the pregnancy by taking a tablet and the baby comes out by the next day. These responses showed a lack of knowledge and insight of the process.

Six of the respondents were aware of adoption and said that they would not choose it as they would get closer to the baby and this would make it difficult to give up the baby. This can be seen in the following statement:

“Would I cope knowing my child is elsewhere?”

Three participants added that they were anxious that others would become aware of their pregnancy and this would pose more difficulties when wanting to adopt.

“I don’t think I can face going through the physical side of pregnancy and what people will say.”

In this study 75 % of the individuals had made the decision on abortion based on fairly limited knowledge gained from friends, media and family. This study shows that counselling is an important and significant part of the decision-making process in sharing valuable information. Smyth (2006) states that knowledge means that a woman must be fully informed in a manner that is appropriate to her standard of education of TOP and the risks involved. He recommended the use of electronic pictures, diagrams or photographs so that women can gain a full understanding of the developmental stages of their unborn babies. The woman must be counseled in a way that provides a full opportunity for discussion and questions. The lack of knowledge perpetuates dependency and violates the principles of self-determination (Govender, 2000).

SUPPORT SYSTEMS

The study showed that participants did not reveal their intention of abortion to other significant persons who they thought would object to their actions or be unsupportive. 75 % of the respondents made the decision to abort without revealing the decision to abort to any significant person (that is, parents, relatives or partners). The only professional to whom one participant was exposed prior to making the decision was the general practitioner who only offered information and minimal support.

These studies were congruent with studies of Mdleleni-Bookholane (2007), who found that 86 % did not tell anyone, as they did not anticipate support. The 7 % who got support from their partners stated that this support had sustained them through the experience. Her study also showed that 90 % of woman said that the decision was their own (ibid.).

COUNSELLING

The World Health Organization (WHO) recommends that every woman contemplating TOP must have face-to-face communication with a counsellor during which she is assisted in making an informed decision (Kunene, 1999). However, the nature of counselling is the most significant aspect. For the England Department of Health and Social Security,

counselling should provide opportunities for discussion, information, and explanation of the procedure and the offering of advice, in a non-judgmental and non-directive manner (Kunene, 1999). Gardener (1972) states that one only shows true compassion when the underlying problems of an unwanted pregnancy are addressed. He further states that true compassion involves considering the factors that will help not only a woman's short-term problems but also her future life. In this study all participants viewed counselling positively. Similarly, a study conducted by Kunene (1999) shows that 80 % of the women found counselling to be necessary. In this study twelve (12) felt very strongly about counselling and showed signs of gratitude. Four (4) emphasized the need and importance of confidentiality.

“Actually I don't really like counselling; because I feel if you have a problem you must try and sort it out on your own. If I can't sort it out on my own then maybe I'll ask my friends, my husband, my brothers, my sisters, my family members and then if they can't help then counselling. Speaking about things does make a person feel better and as long as no one is judging you.”

“Counselling will help because people will come with a really, really, real decision.”

“Doesn't make me feel better but it has eased some of the things I think about...just by talking about it and not being judged.”

“Helped me to ask the questions I was afraid to ask ... now I understand more about abortion.”

“Excellent because all the information given to me make me feel at ease...”

“Good because it helps you mentally.”

“Helps you make final decision.”

“Helps to prevent it from happening again and also tell you of the dangers involved.”

Kunene's study (1999) revealed that women needed to know they were not alone. During the interview sessions ten (10) of the sixteen (16) participants were very emotional while telling their stories during the interview sessions. This is also indicative of the need to share feelings in a safe environment regardless of the decision to abort or keep the unwanted pregnancy. Kunene (1999) found that women needed counselling for several reasons even when they had already decided to have a TOP. For instance, in this study, all participants came to the TOP clinic not asking for options available to them but had already decided on TOP. However, they showed appreciation of being given a chance to express their thoughts, emotions, fears and aspirations about their lives. An overriding concern with a study conducted in South Africa was poor pre- and post- abortion counselling, including contraceptive counselling and provision (Harries, Stinson & Orner, 2009).

CONCLUSION

The qualitative data presented and analysed in this chapter has been linked to the literature discussed in the previous chapter. The dominant trend in the study was that women had minimal support systems during and after the decision making process, women made their own choices not being pressured by anyone but largely influenced by social factors, and also women had limited knowledge of TOP, and other options of dealing with an unwanted pregnancy.

The analysis on unplanned pregnancies has yielded rich information that can enlighten planners on how to provide women with unplanned pregnancies with comprehensive assistance.

Chapter Five

CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This study was based on an exploratory design in the hope of understanding the interplay of issues operative when making the TOP decision. A non-probability sampling method was used of women accessing the TOP clinic at a district hospital in KwaZulu-Natal between the ages of 18 years and 35 years. The data was collected over a three-month period. The data was coded, analysed, grouped as themes and is presented accordingly. The objectives of the study explored, firstly, young women's knowledge and understanding of TOP processes, procedures, benefits, risks and consequences; and explored secondly, young women's decision-making processes and the pressure or support for TOP or other options.

The theoretical framework underpinning this study was the eco systemic approach, which adopted the feminist discourse. The framework looked at how the individual in her interrelatedness to the family, community, and the larger South African society made this decision and also looked at how the socio-structural issues impacted on decision-making processes.

This chapter outlines the main findings, outlines the limitations and makes recommendations according to the research findings. This study can provide new information about the processes women go through when contemplating having an abortion. There are commonalities in the process and the nature of their experiences.

What has come under question in this study is how we all make decisions. It is safe to say that our decisions over time make up our destiny. The vital importance of decision-making cannot be over-emphasized as it is our choices over time that makes us who we are. The decisions regarding our sexuality, our use of contraceptives, our choice of partners and the choices regarding an unwanted pregnancy over time all shape our lives and our concepts of who we are and who we become.

MAJOR CONCLUSIONS OF THE STUDY

In this section, the major findings of the study are synthesized and presented.

Conclusions Regarding Decision Making

There is evidence from the findings of this study that decision-making is not a straightforward or easy process. To arrive at any decision, there are mental, spiritual, physical, and socio-structural journeys that an individual travels. Clear direction and smooth travelling is dependent on sufficient knowledge, skills, and preparedness. To understand fully the road travelled in making the termination of pregnancy decision the researcher will follow the guidelines outlined by Brown (1983).

According to Brown (1983), the decision that one makes regarding an unwanted pregnancy is based on how **familiar** or experienced a woman is with an unwanted pregnancy. In this study most women expressed a conflict of thoughts and were emotionally stressed. This stress of the decision was more difficult because some had no one openly to share with. This deprived some of them of a chance to share information and strategies to cope and make decisions. Participants had limited knowledge of adoption, foster care or even how to access these services. Four participants felt equipped and stable when they first discovered their unwanted pregnancy; this was due to their own experiences or also the support of significant others.

The findings revealed that when making their decision women had various conflicting thoughts. Participants re-evaluated their relationships, had conflicting thoughts regarding their values and belief systems, living arrangements, financial and future plans. The pregnancy prompted women to start asking questions about their sexuality, fertility, motherhood, and face the reality of pregnancy. Most women shared their conflict of thoughts openly during the research interview. These findings were in keeping with Brown (1983), who said that the TOP decision is a very **complex** decision. The choice to have a baby or terminate a pregnancy affects every area of one's life and future and therefore most participants felt overwhelmed and isolated.

All participants said that they had made the decision to terminate the pregnancy on their own and while not pressured by anyone, all were influenced either by their partner, spouse or social circumstances.

Congruent with the studies of Brown (1983), Govender (2000), Forrest (1994), Kunene (1999), Davis (1991), and Mpshe (2000), this study found that most participants reacted with shock, anger, emotional turmoil, when they first discovered their pregnancy. Many were still very emotional during the time of making the decision and afterwards. Brown (1983) states that for one to make a good decision and be able to bear the consequences of that decision, good or bad, it needs to be a **stable decision** despite the unstable times. Therefore women need to have professional counselling to work through their emotions and feelings first. These findings revealed that most women did not have the support system or the professional counselling needed to help them deal with their feelings and emotions prior to making the TOP choice.

The decision to abort is a permanent and irreversible decision. Brown (1993) states that because of the **irreversibility** of TOP it can increase the stress levels of the pregnant women and can also bring relief.

Lastly, Brown (1983) cited **knowledge** as important in making a decision so as to ensure that an informed decision is made. In this study four of the participants seemed familiar with the depths of the implications of TOP either because of previous experience, or because a close family member or best friend had experience with TOP. This study showed that 75 % did not have a clear idea of the abortion procedure or sufficient knowledge of how to handle an unwanted pregnancy. This supports Alcorn (1992), cited in Govender (2000), who reported that the increase in abortion could also be attributed to women not being educated on options available for an unwanted pregnancy. All participants had minimal knowledge on adoption or foster care or the in-house services of Birthright, Pregnancy Crisis and others like those in South Africa.

One of the benefits of delaying a decision is that one can gain more information and give more thought to new alternatives (Harris, 2008). This, however, is not a luxury when dealing with TOP. The time pressure, if TOP is one of the options, adds further to the stress, and the need for professional counselling is almost vital.

There is a gap in the knowledge base of the social work profession and nursing staff about the walk to making decisions regarding an unwanted pregnancy. All young women experiencing an unwanted pregnancy are going through a stressful time given the background of TOP, the stigma of TOP, and the feelings of the potential loss of life.

In a research conducted by Mpshe (2000), it was found that the adolescents utilized defence mechanisms like denial, rationalisation and intellectualisation to protect themselves from the emotional pain of deciding whether to terminate their pregnancies or not.

Conclusions regarding Support Systems

This research, like others, shows that the TOP decision is one that is most often done in isolation. This was in support of the studies of Mdeleleni-Bookholani (2007) and many others. Most participants did not go to their normal support systems, like family, religious members, siblings, and partners when faced with this decision for various reasons, as cited in the study. Because of this lack, women become involved with their own self-talk, which is most often negative during these times, as cited in this study. The research shows that due to the disintegration of the family system, the micro support systems become limited and those that are available are often over used. In this study nine (9) women were single. Their relationships had ended soon after the pregnancy. Of the others in relationships or in a marriage only one woman was accompanied to the clinic with her partner. This shows that the level of support received from spouses or partners is limited. Kunene (1999) revealed that women need to know that they are not alone and that there is someone to talk to. The shared responsibility by parent or partner helps in reducing anxiety in the future. This research showed that most women in this study made the decision with no or limited support.

Conclusion regarding Counselling

TOP Services offered to women needing TOP must be holistic, comprehensive and be provided by a multi-disciplinary team that includes nurses, medical doctors, social workers or psychologists. Findings in this study show that 94 % of the participants did not receive any professional counselling, prior to making a decision to help them overcome their stressful state which would further enable them to make an informed decision. The new CTOP laws have placed much responsibility on nurses who may already feel overwhelmed by the increasing numbers of those requiring TOP Services. According to Devjee (2011), there is limited access to TOPs due to the increase in numbers, how many TOPS can be carried out per day and also the availability of staff.

Counselling must be done by a social worker or psychologist, where the attention is given to providing emotional support as well as the relevant knowledge on contraception, choices and future plans. Social workers have counselling skills, which are invaluable when a woman discovers her unwanted pregnancy. Crisis intervention would help women reach stable levels of functioning. The stipulations of what should occur with TOP counseling, as outlined previously in this study, are in keeping with the needs of those accessing TOP services.

Therefore counseling (as cited by Kunene, 1999, Govender, 2000, Kumar et al., 2004, Forrest 1994, Devjee, 2011) is essential. Even though some women requesting abortion may not want it, it is clear from this study that with the lack of emotional support, the increase in abortion figures, and the increased number for repeat abortion, counselling is not only essential but necessary.

This research has great value for social workers and other professionals who are responsible for providing TOP Services. Social workers need to understand the issues and the context in which opposing views are raised in order to help clients make their decision (Zastrow and Kirst- Ashman, 2007). It is recommended that social work counselling at District Hospitals must be available, easily accessible and compulsory when a woman discovers her unwanted pregnancy, especially to those who have minimal or no support.

It is recommended that persons working with women and unwanted pregnancies be sensitive and well trained.

It was recommended in this study that women who choose to terminate their pregnancies be supported throughout the decision-making process.

Conclusion regarding Repeat Termination of Pregnancies

The reactions of those choosing a second abortion just a year after their first one indicated by their responses that TOP was “easier than taking contraceptives”. In this sample 12.5% came for repeat TOP. This response highlights the concerns of Lang et al. (2005) and Gardner (1972) who warned that we must guard against creating a society which regards TOP as a contraceptive. The question that arises is whether we have promoted TOP as more appealing and accessible than contraception or abstinence in South Africa. Kunene (1999) states that one of the solutions is to give every woman a chance to review the reasons for falling pregnant, which would enable her to prevent a reoccurrence in the future. The method for achieving this is through counselling.

Conclusions Regarding Post-Termination of Pregnancy Care

With repeat TOPs it is clear that at the first TOP, not enough was done to educate sufficiently and provide immediate contraception that would best suit the individual and her lifestyle. With no restrictions on the number of TOPs a person can have, there is also no motivation to adhere to contraception use. Kumar, Baraitser, Morton and Massil (2004) and Devjee (2011) found that few women changed to a more reliable contraception method after having TOP. Kumar et al.(2004) state that health professionals need to explore issues around contraception sufficiently and with detail for it to be effective. In her study she suggests that structured follow-up on contraception use is done. Research conducted found that women are likely to accept and use contraception when the service is offered as an integrated part of post-abortion care (Harris et al., 2009). It is recommended that women have access to the family planning at the TOP Clinic, providing holistic care and making contraception easily accessible. Post - TOP counselling can be used as an opportunity to inform women of dual protection from unwanted pregnancies and sexually transmitted diseases.

Family Planning counselling should entail educating young women on choices and empowering them to respect themselves and their bodies. Abstinence should be promoted as the best way to avoid emotional hurt, unwanted diseases and unwanted pregnancies. One

implication is the importance of contraception education and availability. Kunene (1999), Govender (2000) and Gardner (1972), inter alia all concur that contraceptive methods should be the first line of work so that TOP does not become a form of contraception for the future generation. Readily accessible contraception and family planning counselling will help avoid the difficult option of TOP.

This study shows that 56 % of the women at the first trimester of pregnancy were no longer in a relationship with the father of the child. Unwanted relationships give rise to unwanted sex, which can give rise to unwanted pregnancies and unwanted diseases. To create a generation that makes wise and informed decisions about their offspring we have got to start at the root and that is making wise decisions about ones' sexuality. Abstinence may seem old-fashioned in this day and age but clearly it was there to protect our children and us.

The researcher here maintains that the act of sex itself if not performed within the safety of a secure relationship lends itself to unnecessary hurt, and an unwanted pregnancy further complicates an already unstable relationship (as revealed in this study). Thus abstinence is still the number one route to go to avoid complicating one's life and being found facing difficult decisions.

The tears that fell during the interviews are an indication that we must actively work towards ensuring that on a macro, mezzo and micro level women receive ongoing support, firstly, with an unwanted pregnancy and, secondly, when choosing to terminate a pregnancy.

NEED FOR CONTINUED RESEARCH

There is a lack of local research on the topic of women's needs during unwanted pregnancies. This indicates that there is a need for continued research to contribute to the existing body of knowledge. Research can help the multi-disciplinary team to understand and identify the gaps to evaluate continuously the effectiveness of health services to women and implement recommendations. The significance of this study is that those accessing TOP Services require pre- and post-TOP support and education to ensure a mentally and physically healthy generation. A longitudinal study would be recommended as this will show the longterm effects of TOP on women.

LIMITATIONS OF THE STUDY

- The findings can only be generalized to the participants who accessed the said clinic.
- Under-reporting or over-reporting might have occurred because of the sensitive nature of some of the questions.
- Some participants could have been restrained in their responses so as to not give the social worker a poor impression of them.

CONCLUSION

The findings of the study indicate that the participants received adequate medical care when they arrived at the TOP clinic. The study proves once again that women come with their own unique life experiences that influence the meaning they attribute to TOP. It is crucial that counsellors do not ignore or minimize the pregnancy termination experience for any individual woman.

The decision to terminate a pregnancy is not an easy one. It is a decision about the meaning or value of the life within the woman's power. It is also about the meaning or purpose of her life and what she is going to make of it. It often leads a woman to reflect on what sort of person she is and challenges some of her own basic assumptions about herself (Hursthouse, 1988, cited in Faure & Loxton, 2003).

With increased public awareness and acceptance of TOP in South Africa, there may be less social stigma attached to the procedure (Faure & Loxton, 2003). However, the conflicts and ambivalence associated with the termination of a pregnancy will never disappear (Adler, 1979). Every woman in the situation of an unwanted pregnancy is deserving of time, compassion, information, patience and respect. Professional counselling should be offered as an act of showing that as a society we really do care about the individual as a whole.

The words of the former Minister of Health, Dr Dlamini-Zuma, during the debates on TOP in 1995, said that, "No woman enjoys having a pregnancy terminated. Therefore, as a society we should strive to prevent by caring. I shall be the happiest person, if, one day, even in the presence of the Choice on TOP Act, no woman feels compelled to terminate her

pregnancy!”(Mhlanga, 2003).

It may seem compassionate to have a TOP because of the poverty or abuse at home but if nothing is done about the underlying problem then we have not had true compassion. “Real compassion involves taking into consideration the social and psychological factors in order that one’s decision will help not only the woman’s short term problems, but her future life. We must not forget that there is to be compassion too for the foetus” (Gardner, 1972:131).

To improve the mental health outcomes associated with an unwanted pregnancy, we should in the future focus on practice and research on individual needs of women with an unwanted pregnancy, rather than how a pregnancy is resolved.

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LIST OF APPENDICES

- Appendix A Consent Form
- Appendix B Interview Guide
- Appendix C Ethical clearance

APPENDIX : A

RESEARCH TOPIC: TOP: A DECISION DILEMMA AMONGST YOUNG WOMEN AT A DISTRICT HOSPITAL

CONSENT LETTER TO PARTICIPATE IN A TERMINATION OF PREGNANCY STUDY

This study is to ascertain factors that are involved in the decision-making process with regard to termination of pregnancy.

I am aware that the findings of this study would be used to make recommendations aimed at improving services to women with unplanned pregnancies.

I am aware that my name will remain anonymous to protect my identity. I acknowledge that it is voluntary to participate in the interview.

I _____ agree to Leanne Chetty interviewing me regarding my decision to terminate my pregnancy and my coping abilities. I have been given all the information and will be given access to the results of the study should I require it.

PARTICIPANT

DATE

RESEARCHER

DATE

APPENDIX B

TOPIC: TO EXPLORE THE DECISION DILEMMA OF YOUNG WOMEN WHEN MAKING THE TOP DECISION.

1. Background Information

Name:

Age:

Occupation:

Race:

Religious Beliefs or Affiliations:

No. Of Children:

Previous TOP:

Marital Status:

2. How did you feel when you discovered you were pregnant? (Explore feelings, fears, anxiety, excitement, guilt, hurt, denial)
3. What did you do after you discovered your Pregnancy? Explain
4. Whom did you consult when making this decision? Explain
5. What are the options available to you that you have explored? Explain
6. What are some of the reasons for you to have a TOP? Explain
7. What do you know about TOP and from whom? Explain
8. How have your beliefs and values interplayed in your decision-making? Explain
9. Who is supporting you or not supporting you in this decision and why? Explain

10. How do you feel about the decision you have reached? Explain

11. How do you feel about TOP Counselling? Explain



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Data Captured 15

2010 -11- 24

10 December 2009

Ms L A Chetty
P O Box 60483
PHOENIX
4068

Dear Ms Chetty

PROTOCOL: Termination of Pregnancy: A decision delimma amongst young women in a state hospital

ETHICAL APPROVAL NUMBER: HSS/0935/2009: Faculty of Humanities, Development and Social Sciences

In response to your application dated 24 November 2009, Student Number: **9304881** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL**.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

**Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE**

SC/sn

cc: S Mathe
cc: Ms S van der Westhuizen