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How to cite this thesis
LIVED EXPERIENCES OF FEMALE UNDERGRADUATE STUDENTS WHO HAVE UNDERGONE TERMINATION OF PREGNANCY (TOP) AT A UNIVERSITY IN GAUTENG

A dissertation submitted in fulfilment of the requirement for the degree of

Master in Nursing Science

Community Nursing Science (PHC)

By

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in the

FACULTY OF HEALTH SCIENCES
DEPARTMENT OF NURSING

at the

University of Johannesburg

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Co-Supervisor: Dr Charlené Downing

APRIL 2019
DEDICATION

This research study is dedicated to my children, Maleke, Katlego and Ofentse who were the pillar of strength and to my spiritual father, my covering, Bishop H.F. Edwards and Pastor Tiisetso Ncube and the family who supported me with prayers and the word of God. To my beloved sister and prayer partner Nthabiseng Ramaema.

“When you can be happy with or without your heart’s desire, it will suddenly appear, for your ship will come in over a ‘don’t care’ sea”.

Florence Scovel Shinn
ACKNOWLEDGEMENTS

“Though your beginnings were modest, your latter days will be full of prosperity”.

I would like to thank all mighty God, my Father for granting me the grace to finish what I have started. You are faithful God all the glory belongs to You. Amen.

My deepest appreciation to my study supervisor Dr Nomasono Magobe and Dr Downing for your patience and for your contribution and support in this research. When I wanted to give up, your words of encouragement kept me going. It was not an easy journey but worth it. I am what I am because of you, thank you so much.

A word of gratitude to Professor Ann Muller who helped me with data analysis and interpretation. Your knowledge, wisdom and contribution in the research study is highly appreciated.

To Professor Neels Fourie, I am exceedingly grateful for granting me the permission to conduct this study that will make a great difference in the lives of female university students.

To Leatitia Romero, thank you so much for helping me with language editing. The journey was too long but thank you so much for helping me finish the last lap of my race. I really appreciate your contribution.

To my manager, Molimi Geya, thank you so much for the words of encouragement and support throughout my studies. Words alone cannot describe how thankful I am for being there when I needed a shoulder to lean on.

I would also like to express a word of gratitude to the female undergraduate students of the university where this study was conducted, volunteered to participate in this study. Your courage to volunteer meant a lot and contributed in the improvement to the life of other female students.
Termination of pregnancy (TOP) is one of the options or solution female undergraduate students consider when faced with the crisis of an unplanned pregnancy. Literature has shown that young women under the age of 25 years (a prevalent age group among female university students) who have undergone TOP may initially experience temporary relief after the TOP. However, later they can experience feelings ranging from regret, anxiety and post-traumatic stress disorder (PTSD), to a diagnosis of mental illness. TOP in South Africa has been legalised, but the controversy and stigma surrounding the topic of TOP delays treatment which impacts on women’s mental and physical health issues. The purpose of this study was to explore and describe the lived experiences of female undergraduate students who have undergone TOP in order to develop the recommendations towards the integrated post-TOP health care at the Campus Health Services within the university where this study was conducted. The objectives of this study were:

- To explore and describe the lived experiences of female undergraduate students who have undergone TOP.
- Based on the research findings, to provide recommendations towards the enhancement of integrated post-TOP health care within Campus Health Services in the university where the study was conducted.

A qualitative, exploratory, descriptive and contextual research design and phenomenological approach was employed. A purposive sample of nine female undergraduate students who had undergone TOP between 2 weeks to 24 months before the start of the study volunteered to participate in this study. In-depth individual interviews were conducted until data saturation using an audio-tape to capture individual interview discussions. All audio tapes were transcribed. Tesch’s method of thematic data analysis was utilised.

The central theme identified after data analysis was that the female undergraduate students, as individuals, experienced challenges related to their internal and external world before, during and after TOP that they had no control of. From the central theme,
two themes were singled out: challenges experienced by participants related to their internal world and the challenges experienced by participants related to their external world. The challenges experienced related to the internal world of the participants before, during and after TOP were in the physiological (body), emotional (mind & soul) and the spiritual (spirit). The challenges experienced by the participants related to the external world included the material resources (physical) and social challenges. From the research findings, it is evident that female undergraduate university students experienced TOP as a lonely burdensome experience, a constant struggle without resolution because of the social stigma and secrecy as it affects a person as whole. Based on the research findings, the recommendations towards the integrated post-TOP health care within the Campus Health Services in the university were the study was conducted were developed.
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# LIST OF ABBREVIATIONS

<table>
<thead>
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CTOP</td>
<td>Choice of Termination of Pregnancy</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intra-uterine Contraceptive Device</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>NDoH</td>
<td>National Department of Health</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PSYCAD</td>
<td>Psychological Services and Career Development</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>SA</td>
<td>South Africa</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>THPN</td>
<td>Theory for Health Promotion in Nursing</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER ONE
OVERVIEW OF THE RESEARCH STUDY AND RATIONALE

1.1 INTRODUCTION

Chapter One focuses on the background and rationale of the study, the problem statement, research questions, and the research objectives. The definition of primary concepts, theoretical assumptions, the research methodology used and the different research phases are outlined, including the ethical issues considered in this study. This research study was aimed at exploring and describing the lived experiences of female undergraduate students who have undergone termination of pregnancy (TOP) at a university in Gauteng.

1.2 BACKGROUND AND RATIONALE

Termination of pregnancy (TOP) is a very common medical experience in almost every culture and society (Gelaye, Taye & Mekonen, 2014:1). Worldwide, 210 million pregnancies are reported annually, 80 million are unplanned and 46 million end in TOP (Lamina, 2015:1). According to Hodes (2016:79) approximately one in five pregnancies ends in TOP. It is reported to be the solution for women of the reproductive age (prevalent age as of female university students) in the event of an unplanned pregnancy (Lamina, 2015:1). Among 49 countries, the rates of unplanned pregnancy were highest in the Sub-Saharan countries (Sedgh, Finer, Bankole, Eilers & Singh, 2015:225). Worldwide, between the years 2010-2014, the rate of unplanned pregnancy was at 44%, and 59% ended in TOP as was the case in the developing regions, with 55% of TOPs reported among young women (Bearak, Popinchalk, Alkema & Sedgh, 2018:e380).

Morris and Rushwan (2015:541) also reported that, globally, out of every 4.5 million TOP that occurs annually, an estimated 1.8 million (40%) are reported to be among adolescents. In the African continent, a total of 6 860 000 terminations were reported each year between the years 2000-2014 (Ganatra, Gerdts, Rossier, Johnson, Tuncalp, Assifi, Sedgh, Singh, Bankole, Popinchalk, Bearak, Kang & Alkema, 2017:2372). In South Africa alone, an estimate of 510 000 terminations were reported
each year, of which 375 000 were safe and 135 000 were unsafe during the years 2004-2014 (Ganatra et al., 2017:2372). In 2012, the Minister of Health reported in a local newspaper “Sowetan Live” (2012, August 21) that a total of 77 771 legal TOPs were performed in South Africa in 2011, which indicated a 31% increase since 2010. Of these, 11 239 terminations took place in the Gauteng Province alone.

Literature also revealed that in the Sub-Saharan countries, unplanned pregnancy is among the most prevalent public and reproductive health challenges. It has a socioeconomic burden on individuals, family and society, which perpetuates the cycle of poverty and the school dropout rate (Jonas, Crutzen, van den Borne, Sewpaul & Reddy, 2016:13-50). In South Africa, the unplanned pregnancy rate among women continues to be a growing public health concern. The rate increased from 17.3% in 2002 to 21.3% in 2011, with TOP being highest among those who are still in school (Sedgh et al., 2015:225; Adjei, Enuameh, Asante, Baiden, Netty, Abubakari, Mahama, Gyaase & Owusu-Agyei, 2015:1).

According to the literature, in most countries, TOP is reported to be the highest among women aged 20-29, while a substantial fraction is reported among adolescents (Chae, Desai, Crowell, Sedgh & Singh, 2017:1). A reason for these high rates of TOP among women aged 20-29, the same age group as female university students, is that they enrol at university during their adolescence, which is associated with an increased need for autonomy (Fick, Fairlie, Moultrie, Woollett, Pahad, Thomson & Pleaner, 2016:143). A concern is the risky behaviour of the university campus culture, including the consumption of alcohol, casual and transactional sex with multiple partners, and low condom use (Fick et al., 2016:143; Gelaye, Taye & Mekonen, 2014:9; Kenyon, Tsoumanis & Schwartz, 2016:985).

Although most of the female university students perceive unsafe sexual intercourse as a risk for unplanned pregnancy and contracting sexually transmitted infections, they continue to engage in high-risk sexual behaviours (Mushwana, Monareng, Richter & Muller, 2015:16). After conception because of the fear of parental rejection, forfeiture of bursaries, dropping out of university, financial constraints, and religious standards, some students opt for TOP (Kheswa & Takatshana, 2014:117). Out of desperation and fear of their pregnancy becoming visible, some of the university students use
unsafe TOP, also referred to as non-medical “backyard abortions” which is the leading preventable cause of maternal morbidity rates in Africa (Kavuma, 2016:9). Globally, maternal mortality is the highest in Africa, accounting for 47 000 maternal deaths in 2008, and the Sub-Saharan countries are reported to have the worst health profiles of maternal morbidity and mortality rates among young women (Jonas et al., 2016:13-50; Fick et al., 2016:143; Ahman & Shah, 2011:121).

South Africa is regarded as the country with the most progressive TOP laws in the world, after legalising TOP in 1996, in order to support women to reduce the rates of maternal morbidity and mortality, however, unsafe TOP remains popular (Hodes, 2016:79; Macleod, Beynon-Jones & Toerien, 2017:604; Kavuma, 2016:29). The Choice of Termination of Pregnancy (CTOP) Act 92 (SA, 1996) also permits a minor to access TOP up to twelve weeks without the consent of the parent. The Choice of Termination of Pregnancy (CTOP) Act 92 (SA, 1996) further allows TOP above twenty weeks when two doctors or a doctor and a midwife advocate that continuing the pregnancy poses a risk to the health of the mother, or due to severe abnormality of the foetus.

In 2012, an estimated annual rate of 6.9 million women aged 15-44 years were treated for complications of unsafe TOP in the developing world, and with an average regional rate of 1.6 million women per year in Africa (Singh & Maddow-Zimet, 2015:1494). According to the CTOP Act 92 (SA, 1996), unsafe TOP is defined as a procedure used to terminate an unplanned pregnancy. This is done either by individuals without the required skills, or in an environment that does not conform to minimal medical standards, or both. Although TOP is a legalised health care service in South Africa, however, half of the country’s TOPs are reported to be unsafe, especially among young black women of lower socioeconomic status (Mosley, King, Schulz, Harris, De Wet & Anderson, 2017:1; Fick et al., 2016:115).

Literature revealed that the pregnancy rates that end in TOP among young women continue to be a growing public health concern due to obstacles preventing these young women from accessing TOP services during the first trimester of pregnancy (Saavendra-Avendano, Schiavon, Sanhueza, Rios-Polanco, Garcia-Martinez & Darney, 2018:2). The concern is the dramatic increase of lamppost advertisements of
“safe, pain-free, 30 minutes” TOP that does not conform to minimal medical standards (Magwentshu & Trueman, 2013:4). The survey conducted by Moore and Ellis (2013:22) on youth risky behaviour revealed that nearly half of the girls, aged between 13-19 years who have undergone TOP in 2008, did not use a hospital or clinic but opted for unsafe services. In Gauteng, a local newspaper “Sowetan Live” (2012, March 19) reported the death of a female residence student at a university from what seemed to be complications arising from unsafe TOP.

Barriers, such as uneven access of services across women’s socioeconomic status and location, and the stigma, hostility, and negative attitudes towards TOP are some of the reasons women opt for unsafe TOP methods (Curley, 2014:950; Magwentshu & Trueman, 2013:5). In 2004, the amended CTOP Act 1 (SA, 2008) increased access to TOP services by extending services to all health facilities that provide maternity services. This was done to allow registered nurses with the specialised skill to perform the procedure. However, in Gauteng, barriers, such as clinic operational times, and booking system delays, prevent female university students from accessing TOP within the stipulated time, and they end up accessing unsafe TOP services as a solution (Teffo & Rispel, 2017:1). TOP service barriers indicate the need for increased awareness of the availability and legality of TOP services in order to prevent the delays and denial of such services (DePiñeres, Raifman, Mora, Villarreal, Forster & Gerdts, 2017:1).

In South Africa, contraceptives are provided to female university students without the consent of parents in order for them to exercise their sexual reproductive health rights, and to prevent unplanned pregnancy that may end in TOP or interruptions to their career goals (Sedgh et al., 2015:225). In South Africa, the Children’s Amendment Act 41 (SA, 2007) which was effected in 2010, states that all children over the age of 12 years have the right to access contraceptive services and should be provided with the contraceptives at their request without consulting their parents. This law enables university students to not only have a responsible, safer sex life, but also the freedom to decide when to start a family according to South African National Strategic Plan (NSP) for Human Immuno-deficiency Virus (HIV), Tuberculosis (TB) and Sexually Transmitted Infections (STI) of the National Department of Health (NDoH), 2017-2022:107).
Also, the South African National Contraception Clinical Guideline of the National Department of Health (NDoH, 2012:8) mandates that every adolescent should have access to and be provided with contraceptives, such as oral, injectable, intra-uterine contraceptive device (IUCD), Implanon NXT, and female condoms. Despite this mandate of the contraceptive clinical guidelines, the researcher observed that female undergraduate students continue to experience unplanned pregnancy as they present themselves at the campus Primary Health Care Clinic (PHC) provided by the university where the study took place.

In order to reduce the risk of unplanned pregnancy among university students, Campus Health Services offer different kinds of contraceptive methods free of charge to enable the students to complete their studies as envisaged by their parents and university management. These services are provided on a daily basis from Monday to Friday, from 08H30 to 15H30. In order to ensure accessibility, it is a “walk-in” service; no appointment system is used, unlike other health care services where students need to book an appointment before the consultation.

Campus Health Services’ sexual reproductive health statistics revealed that in 2012, 392 students tested positive for pregnancy. The statistics also showed that TOP referrals were 185, resulting in 47.2% female students who opted for TOP, and it is unknown whether the remaining 52.8% of these students opted for TOP or kept the pregnancy to term. This shows an increase of approximately 50% in TOP requests in the university where the study took place. In the following year of 2013, 376 students tested positive for pregnancy, and referrals for TOP were 164. Of these, 43.6% were referred for termination, showing a slight decrease in TOP requests.

The increasing rate of unplanned pregnancy among adolescents is also attributed to factors such as poor knowledge of contraceptives and the fear of side effects (Jonas et al., 2016:9; Mushwana et al., 2015:16; Somba, Mbonile, Obure & Mahande, 2014:6). The most common reported injectable side effects are amenorrhea, irregular bleeding, very heavy prolonged or frequent bleeding, spotting, and severe headaches, as recorded on the National Contraception Clinical Guidelines (NDoH, 2013:31). Nsubuga, Sekandi, Sempeera and Makumbi (2016:6) claim that knowledge on contraceptives does not imply the use thereof, as a high proportion of students do not
use them because of misconceptions, myths and religious beliefs. Steven (2012, September) also remarked in the local newspaper that the increasing demands of TOP in South Africa is because of the adolescents’ reluctance to use contraceptives. Instead, these adolescents opt for emergency contraceptives as a substitute method.

Safe TOP is believed to provide an immediate solution to the female undergraduate student who finds herself with an unplanned pregnancy. However, it is depicted as having enormous personal health and psychological cost and other ill-effects and social costs (Macleod, 2011:112-113). Section 4 of the Choice of Termination of Pregnancy Act 92 (SA, 1996) states that non-mandatory and non-directive counselling should be offered to every woman before the TOP procedure in order to discuss associated risks such as infertility and the anticipated psychological symptoms after TOP.

Curley and Johnston (2014:281) also report that female university students under the age of 25 years are at the highest risk for developing mental health problems and be involved in substance abuse after undergoing TOP as compared to other pregnancy outcomes. Further physical and psychological effects following TOP are also confirmed by Tsonrng-Yeh, Cheng-Chen, Chin-Mi, Min-Hsueh and Yin-Chun (2014:1). These authors found that adolescent women who had undergone TOP in Taiwan experienced a range of emotions before and after TOP, such as fear of their parents’ rejection, the stress of seeking TOP services, the concern of virginity loss, guilt, and disturbance from the foetus’ ghost after.

According to Upadhyay, Cockrill and Freedman (2010:415), emotional support is an essential component of TOP services because it is an experience that is emotionally significant in a woman’s life. Curley and Johnston (2013:279) also revealed that university students who have undergone TOP experienced post-traumatic stress disorder (PTSD). Also, adverse outcomes that may occur long after TOP indicate a need for follow-up care and debriefing sessions for all female students who have undergone TOP, to screen and monitor for signs of anxiety and PTSD (Kheswa & Takatshana, 2014:117). Singh and Maddow-Zimet (2015:1496) also recommend that effective measures such as access to safe TOP services, appropriate medical procedures, and contraceptive counselling need to be prioritised in order to improve
women’s health and to reduce the costs of post-TOP care. Thus, the researcher undertook this study to increase evidence-based knowledge that will be used to make recommendations towards the integrated post-TOP continuity of health care at Campus Health Services.

1.3 RESEARCH PROBLEM STATEMENT

There is evidence that female undergraduate students with unplanned pregnancies continue to terminate pregnancies using safe and unsafe methods. Campus health statistics show that from 2011 to 2013, every year around 40% of all students with positive pregnancy tests were referred for TOP. According to Curley (2014:944), women experience emotional relief after TOP; however, 30% of women experience significant psychological distress that does not emit over time. The current practice observed by the researcher, with regard to TOP and self-referrals without back referrals from TOP services, inhibit clinicians (nurses and doctors) to identify adverse psychological outcomes from TOP. Against this background, the researcher posed the following research question:

What are the lived experiences of female undergraduate students who have undergone TOP?

1.4 RESEARCH PURPOSE AND OBJECTIVES

1.4.1 Research purpose

The purpose of the study was to explore and describe the lived experiences of female undergraduate students who have undergone TOP in order to develop recommendations towards the integrated post-TOP health care at the Campus Health Services within the university were this study was conducted.
1.4.2 Research objectives

- To explore and describe the lived experiences of female undergraduate students who have undergone TOP.
- Based on the research findings, to provide recommendations towards the enhancement of integrated post-TOP health care within Campus Health Services in the university where the study was conducted.

1.5 DEFINITIONS OF THE KEY CONCEPTS

1.5.1 Experience

Experience is defined as the knowledge that comes from being personally involved in an activity, event or situation that affects a person in some way (Gray, Grove & Sutherland, 2017:10; Hornby, 2010:514). In this study, the female undergraduate student who have undergone TOP have knowledge and lived experience after being personally involved in the procedure, which affected them as a whole in some way.

1.5.2 Campus Health Services

Campus Health Services are fixed community oriented services that have Primary Health care components such; preventative, promotive and curative health care and are situated on each of the four campuses of the university (Kautzky & Tollman, 2008:17). The purpose of Campus Health Services is to support academic pursuit by providing comprehensive primary health care package to all university students. In this study, sexual reproductive health is an essential preventative component of campus health. The primary focus sexual reproductive health services is to provide different methods of contraceptives to female undergraduate university students in order to reduce their risks of an unplanned pregnancy that end in TOP.
1.5.3 University

The university, according to the Higher Education Act 101 (SA, 1997) as amended is defined as a public or private higher education institution that is established or declared by the act to provide higher education on a full-time, part-time or distance basis. In this study, the university is a setting where this research was conducted and where the female undergraduate students who have undergone TOP were full-time registered students for the purpose of achieving academic qualifications for a specified period of time.

1.5.4 Female student

The Theory of Health Promotion in Nursing (THPN) describes a person who is in an interactive process with her external world, which consists of the physical, social and spiritual dimensions (University of Johannesburg, 2010:5-6) (UJ). In the context of this study, female undergraduate student who have undergone TOP is regarded as a whole individual who is in interaction with her internal environment, which is her body, mind/soul and spirit.

1.5.5 Termination of pregnancy (TOP)

According to the Choice on Termination of Pregnancy Act 92 (SA, 1996), termination of pregnancy (TOP) means the intentional separation and expulsion of the contents of the uterus of a pregnant woman or female person of any age by medical or surgical means. In this study, TOP refers to the intentional expulsion of the contents of the uterus within 4-24 weeks of gestation by female undergraduate students using safe or unsafe methods.

1.6 PARADIGMATIC PERSPECTIVE

A paradigm is defined as a frame of reference or the way people in society view and understand the nature of reality or think about the complexities of the world (Babbie, 2016:32; Houser, 2018:34; Polit, Beck & Hungler, 2018:6-7). The decisions of this research study were directed by the paradigmatic perspective of the department of
Nursing Science Theory of Health Promotion in Nursing (UJ, 2010:2-15) Assumptions are defined as fundamental principles that are considered to be true on the basis of logic and reasoning without scientific verification (Polit, Beck & Hungler, 2018:6-7). Meta-theoretical, theoretical and methodological assumptions directed the researcher’s convictions and beliefs in this study and are discussed next.

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to the ontological perspectives which are the assumptions about the nature of reality. The reality exists and is multiple and subjective, and mentally constructed by the individuals (Polit, Beck & Hungler, 2018:6-7). According to the Theory of Health Promotion in Nursing of the department of Nursing Science, the meta-theoretical assumptions are not testable but deal with the researcher’s view of the participant and serve as a framework within which theoretical statements are made (UJ, 2010:12). In this study, the researcher’s meta-theoretical assumptions are directed by the University of Johannesburg Theory for Health Promotion in Nursing (2010:12) which has four central components, namely the person, nursing, environment, and health. These are described in detail next.

1.6.1.1 Person

The Theory of Health Promotion in Nursing describes a person as a whole individual who embodies the dimensions of the internal environment – which is the body, mind or soul and spirit – and is functioning in an integrated, interactive manner with the environment which consists of the physical, social and spiritual (UJ, 2010:5-6). In the context of this study, the whole person is the female undergraduate student who has undergone TOP, and who embodies the body, mind or soul and spirit, and is in interaction with her external environment, which is her physical, social and religious (spiritual) world.

1.6.1.2 Nursing

Nursing is defined by the Theory of Health Promotion in Nursing (UJ, 2010:4) as a purposeful mutual interactive process between the nurse and the patient, where the
role of a nurse as a sensitive therapeutic professional facilitates the promotion of health through the mobilisation of resources. In this study, nursing takes place at the Campus Health Services, where referral to TOP services occurs. The health care providers are also expected to provide post-TOP continuity of health care to female undergraduate students who have undergone TOP through mobilisation of resources.

1.6.1.3 Environment

According to the Theory of Health Promotion in Nursing (UJ, 2010:5), the environment includes the internal and external environment. In the context of this study, the environment will be referred to as the “world”, in which the individual female undergraduate student – as a whole person – is in constant interaction with her internal world, in an integrated manner. The internal world includes the dimensions of body, mind and spirit.

The participant’s body includes all the anatomical structures and physiological processes pertaining to the individual participant, which were involved during the TOP process. Theory of Health Promotion in Nursing refers to the mind as the psyche or soul, which includes all the emotional, volitional and intellectual processes of the female undergraduate student (UJ, 2010:6). The spirit within the internal world is the part of the participant that reflects their relationship with God and consists of two components, namely the conscience and relationships that are interrelated and integrated into function according to the University of Johannesburg (2010:6). Theory of Health Promotion in Nursing refers to the spiritual dimension in the external world as the religious aspects of the participants (UJ, 2010:6)

1.6.1.4 The external world (Physical, Social and Spiritual)

In the context of this study, the physical dimension of the female undergraduate student’s external world and will be referred to as the material resources.

The social dimension in the external world of the participant in this study refers to the partners, parents, health care providers and friends or fellow students.
The spiritual dimension in the external world denotes the values and religious aspects of the individual participant, such as the relationship with the church or religious organisation.

1.6.1.5 Health

According to the Theory of Health Promotion in Nursing (UJ, 2010:4), health is an interactive, dynamic process in the participant’s internal and external world. The interactions in the internal and external world reflect the relative health status of the female undergraduate student which contributes or interferes with the promotion of health.

1.6.2 Theoretical assumptions

Theoretical assumptions according the Theory of Health Promotion in Nursing refers to the testable statements which form part of the existing theory of the related discipline and the framework for the epistemic statements in the research (UJ, 2010:12). The theoretical assumptions of this study are guided by the Theory of Health Promotion in Nursing (UJ, 2010:12). As a sensitive therapeutic professional, the researcher sees the female undergraduate student who has undergone TOP as an individual who embodies mind, soul body and spirit, and who continually interacts with her external world in order to maintain wholeness.

1.6.3 Methodological Assumptions

The Theory of Health Promotion in Nursing (UJ, 2010:12) states that methodological assumptions reflect the researcher’s views of the nature and structure of science in the discipline and give form to the research objective and research context which influence the decisions about the research design. For the scientific methodology utilised in this study, refer to Chapter Two.
1.7 RESEARCH DESIGN

The research design is an overall plan and blueprint of the study that details all significant components of the research, including data collection, data analysis methods and the interpretation of the research findings (Houser, 2018:486; Rebar & Gersch, 2015:176). In this study, a qualitative, exploratory, descriptive and contextual research design was utilised to explore and describe the lived experiences of female undergraduate students who have undergone TOP. The qualitative research design was followed because it is comprehensive and is aimed at exploring, describing and understanding the meaning of the TOP experience from the participants' perspective (LoBiondo-Wood & Haber, 2014:203; Corbin & Strauss, 2015:5; Ellis, 2016:151; Houser, 2015:176).

1.8 RESEARCH METHOD

The research method is a specific way of conducting steps or phases of the study within the chosen design (Gray, Grove & Sutherland, 2017:683). This study was conducted in two phases. The first phase comprised of data collection, data analysis and interpretation of the data collected. In the second phase, recommendations were developed towards the integrated post-TOP health within the Campus Health Services, based on the research findings.

1.8.1 Phase One: Exploration and description of the lived experiences of female undergraduate students who have undergone TOP

The first phase of this study focused on the population and sampling criteria; including the methods of data collection and analysis. The research findings and its interpretation through literature control were also part of Phase One. Through the use of in-depth individual interviews, a phenomenological approach was utilised to gain a deeper understanding of the meaning of the lived experiences of female undergraduate students who have undergone TOP (LoBiondo-Wood & Haber, 2014:581). More details on the phenomenological approach are presented in Chapter Two.
1.8.1.5 Population

The target population is the well-defined set of individuals who have common specific characteristics that are of interest to the researcher but may be quite difficult to access or identify (Cronin, Coughlan & Smith, 2015:88; Rebar & Gersch, 2015:111). In this study, the target population comprised all female undergraduate students who have undergone TOP at a university in Gauteng. The accessible population is a portion of the study population that is accessible and has characteristics of the target population (Cronin, Coughlan & Smith, 2015:88). The accessible population in this study consisted of all female undergraduate students who visited Campus Health Services for sexual reproductive health services.

1.8.1.2 Sample

A sample is a selected group of people that reflect the composition and are representative of the population being studied (Gray, Grove & Sutherland, 2017:329; Houser, 2018:486). Purposive sampling was utilised to recruit the participants that met the criteria for this research study. In this study, purposive sampling was used to deliberately target and draw the sample of participants who possessed the certain characteristics of the population that will enhance the credibility of the study (Houser, 2018:485). Potential participants were female undergraduate university students who visited Campus Health for sexual reproductive health services.

The participants were recruited in the consultation during obstetrical history taking because of the sensitivity of the topic. The nature of research was explained to all the potential participants who have undergone TOP. All the participants who have undergone TOP were invited to participate in the study. Appointments to conduct the interviews were secured after the consultation with the participants who were willing to share their lived TOP experiences with the researcher. Arrangements were made telephonically to negotiate a suitable time to conduct the individual interviews. The sample in this study comprised of female undergraduate university students who have undergone TOP who visited Campus Health Clinic for sexual reproductive health services. The inclusion criteria were all female undergraduate students who have undergone TOP within the last 2 weeks to 24 months before data collection, and who
volunteered to participate in the study. The sample size was determined by data saturation, to the point where the new information shared was redundant and no longer yielded new ideas (LoBiondo-Wood & Harber, 2014:577).

1.8.1.3 Data collection

In this study, data were collected using in-depth individual phenomenological interviews. Interviewing is a method of data collection where participants are asked open-ended questions in order to obtain their personal experiences (LoBiondo-Wood & Haber, 2014:279). Forty to sixty minutes in-depth individual interviews were conducted using an audio-tape recorder with the permission of the participants to record and capture the interview discussions. The central opening statement posed to the respective participants was “Describe your experience of TOP”. Other facilitative communication skills were employed to clarify participants’ responses. TOP is a sensitive topic, and in order to determine the feasibility of this study, two in-depth individual interviews were conducted as a pilot study prior to the actual study (Gray, Grove & Sutherland, 2017:686; Rebar & Gersch, 2015:352). After pilot study, nine in-depth individual phenomenological interviews were conducted until data saturation. Field notes were used to record the researcher’s observations on the participants’ tone of voice, facial expressions and associated actions during the interviews (Rebar & Gersch, 2015:152). The researcher used a reflexive journal to bracket and acknowledge her own preconceived ideas and biases regarding TOP (Houser, 2018:395).

1.8.1.4 Data analysis

In this study, data were analysed by the researcher and an external independent coder who is an expert in qualitative research. The external independent coder’s role in this study was to ensure consistency of data reduction methods and transcription quality, and to ensure the trustworthiness of the study (Warren & Karner, 2010:151-174). The researcher transcribed the recorded interviews and created ordinary personal computer files. Data were separately analysed by the researcher and the independent coder using Tesch’s method of thematic data analysis (Creswell, 2014:197). Data were hierarchically organised according to similar themes by the researcher and the
independent coder (Creswell, 2014:197). A 90-minute telephonic conference followed, where the researcher, independent coder and study supervisors discussed and agreed on the themes identified during data analysis. Thereafter, several discussions were held with the study supervisors on the research findings, limitations of the study and on the development of recommendations. Finally, data were presented in a descriptive format to give the essence of the lived experience of female undergraduate students who have undergone TOP.

1.8.1.5 Literature control

A literature control is the synthesis of what is known or has been studied from relevant studies regarding the particular research question or purpose of the study in order to make sense of the research findings and to support the trustworthiness of the research findings (Rebar & Gersch, 2015:13). In this study, the researcher conducted relevant literature control of the related studies during the presentation and discussions the research findings in order to get the theoretical guidance needed to achieve the purpose of this study.

1.8.2 Phase two: Recommendations towards the integrated post-TOP health care within the campus health services in the university where the study was conducted

Based on the research findings of Phase One, recommendations were developed towards the integrated post-TOP health care within the university Campus Health Services for female undergraduate students who have undergone TOP.

1.9 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness refers to the rigour of the research which implies the extreme accuracy, consistency and attention to all the processes of the research with the aim of producing trustworthy findings (Gray, Grove & Sutherland, 2017:691; Rebar & Gersch, 2015:154; Cronin, Coughlan & Smith, 2015:191; Ellis, 2016:66). Trustworthiness in this research study was ensured by using Korstjens and Moser’s (2018:121) criteria and strategies of credibility (truth value), transferability
(applicability), dependability (consistency), and conformability (neutrality). These measures of trustworthiness are discussed in greater detail in Chapter Two.

1.10 ETHICAL CONSIDERATIONS

Ethics is a division of philosophy that is concerned with the ethical standards used to promote ethical principles which are used to analyse actions, consequences, characters and motives for conducting the research study (Sieber & Tolich, 2013:35; Dhai & McQuoid-Mason, 2011:3). Ethical clearance to conduct the study was requested and granted by the Faculty of Health Sciences and the approval was granted by the Research Ethics Committee and Unit for Quality Promotion. Certificates with the numbers: REC-01-189-2015 and HDC-01-136-2015 (See Annexures B & E).

In order to meet the purpose of this study, which was to develop recommendations towards the integrated post-TOP care for female undergraduate students who have undergone TOP, permission to conduct the study at the Campus Health Services was granted by the campus health manager. To further ensure that the wellbeing of the participants took precedence over all other interests, the researcher observed and adhered to the following ethical principles throughout the study: respect for persons, beneficence, non-maleficence, and justice. These ethical principles are briefly discussed next.

1.10.1 Autonomy of the participant

In order to adhere to the principle of respect for persons, the researcher respected the rights of the participants as autonomous agents. The principle of autonomy demands that researchers honour their participants’ rights to self-determination as autonomous agents and allow them to make their own informed choices. In this study the participants volunteered to share to their lived TOP experiences without coercion and were informed about their right to withdraw from participating in the study anytime without penalty.
1.10.2 Right to self-determination

A right to self-determination is based on the principle of respect for persons which holds that human beings are capable of making their own decisions and should be treated as autonomous agents. The participants should have the freedom to conduct their lives as they choose without external pressure or coercion (Gray, Grove & Sutherland, 2017:692). The researcher gave the participants complete details of the research process; the nature and purpose of the research study and allowed the participants to exercise their right to choose whether to participate in the research or not.

To respect individual participants' autonomy, two informed, written consents were obtained before the study. One consent was for participation and an additional consent was requested for the audio-taping and capturing of the interviews (See Annexures A, C & D). In this study, the following information was included in the consent form: research activities, description of risks and discomfort, description of benefits, disclosure of alternatives, assurance of confidentiality, an offer to answer questions, a non-coercive disclaimer, and the option to withdraw from participating in the study (Grove, Burns & Gray, 2013:177-178; Gray, Grove & Sutherland, 2017:162) (See Annexures C & D).

1.10.3 Right to privacy and dignity

Privacy is the participants’ degree of control over the access that others have to them and it is an individual’s right to determine the time, extent, and general circumstance under which personal information will be shared with or withheld from others (Gray, Grove & Sutherland, 2017:162). The right to privacy and dignity ensures the participants’ right to assume that the data collected will be kept confidential (Rebar & Gersch, 2015:136). The researcher respected and acknowledged the intrinsic worth, dignity, and sense of value of each participant by giving the participants information about their rights to confidentiality before conducting the interviews. To respect the privacy of the participants in this study, all the in-depth individual phenomenological interviews were conducted in a private venue that is free from distractions. Audio-tapes and transcripts of the interviews were kept confidential in a secure place that is
not accessible to other people. Study results will be disclosed to participants on request (Houser, 2015:54-55).

1.10.4 Right to confidentiality

Confidentiality refers to the researcher’s ability to manage private information shared by the participants and not sharing it with others without their permission (Gray, Grove & Sutherland, 2017:170). All research participants have the right to confidentiality and the right to assume that data collected will be kept confidential, and that their identity cannot be linked to them (Gray, Grove & Sutherland, 2017:170). In order to ensure confidentiality in this study, the researcher provided the participants with the assurance that their private information shared during the interviews will not be revealed to anyone else, including other research participants, unless authorised to do so (Barbour, 2014:332).

TOP involves data that is private and may be embarrassing for the participant and emotionally difficult to discuss with anybody (Cronin, Coughlan & Smith, 2015:191). The researcher started by building a strong sense of rapport, trust and mutual respect because of the sensitivity of the topic to facilitate adequate decision making (Sieber & Tolich, 2013:124). The researcher informed the participants about their rights to anonymity, confidentiality, and to withdrawal from the study without prejudice before conducting the interviews. To protect participants’ confidentiality data collected were not linked to the university where this study was conducted.

No identifying characteristics such as student numbers or identity document numbers were used. In order to protect the participants’ identities, pseudonyms such P1 – P9 were used instead of the participants’ real names or student numbers. Audio-tapes, transcripts, consent forms, and study results were kept confidential in a secure location until the study was completed and will be destroyed 2 years following publication of the results of the study. Transcribed data were only shared with the independent coder and supervisors. Audio-tapes were listened to at home, in the researcher’s car, or in the researcher’s office. Audio-tapes were not labelled with participants’ names, consent forms were kept separate from transcripts, and documents – including field notes – were kept confidential (Sieber & Tolich, 2013:155). To ensure confidentiality,
the signed consent forms were kept separate from the transcripts (Rebar & Gersch, 2015:136). Computer files were safely stored on a flash drive on the researcher's personal computer. Study results will be disclosed to participants on request (Dhai & McQuoid-Mason, 2011:14) (See Annexure C).

1.10.5 Right to fair treatment

The principle of fair treatment is based on the ethical principle of justice which requires that participants should be treated fairly and equally (Cronin, Coughlan & Smith, 2015:188). The researcher has an ethical obligation to treat each participant with fairness in the selection and treatment during the research process (Grove, Burns & Gray, 2013:173-174). The principle of justice demands that participants be treated equally and justly, and not giving preferences or being discriminatory with some participants because they are in compromised positions. In this study, the participants were fairly selected based on being directly related to the problem being studied, TOP and not because of their compromised position as health care users or being liked by the researcher (Grove, Burns & Gray, 2013:174). The participants were not selected based on their socioeconomic status, accessibility, race or creed, but based on their appropriateness to answer the research question and on their willingness to share their experience with the researcher (Cronin, Coughlan & Smith, 2015:110).

In this study, the selection, recruitment, exclusion and inclusion of the participants was fair, based on sound scientific and ethical principles. The potential participants who visited Campus Health for sexual reproductive services were recruited in the consultation room during obstetrical history taking. All the participants who have undergone TOP 2 weeks to 24 months before the study were informed about the research study and were all invited to participate. Only the participants who volunteered and who were willing to share their lived TOP experiences with the researcher participated in this study.

1.10.6 Right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do well and, above all, do no harm (Gray,
Grove & Sutherland, 2017:173). TOP is a sensitive topic, therefore, temporary discomfort such as emotional discomfort and anxiety was anticipated. To protect the participants from the anticipated risk of temporary emotional discomfort, the researcher conducted the interviews in one of the campus health consultation rooms which was private and preferred by the participants. The participants were not forced to provide information on issues they were not comfortable to share.

1.10.7 Principle of beneficence

The participants benefited psychologically from having a skilled interviewer listening to them as they expressed their thoughts and emotions; this helped them to clarify their own understanding of their experiences (Sieber & Tolich, 2013:29). The participants who showed signs of emotional distress during interviews (for some it was their first time sharing such sensitive personal information) were referred to the PSYCAD for further psychological support and debriefing (Gray, Grove & Sutherland, 2017:273). The participants were also provided with the contact numbers and e-counselling address in the invitation to participate letter in case further emotional support was needed after the interviews (See Annexure C). The study generated evidence-based knowledge that contributed to the development of recommendations towards the integrated post-TOP care for female undergraduate students who have undergone TOP (Dhai & McQuoid-Mason, 2011:41).

1.11 RESEARCH INTEGRITY AND OBLIGATION TO ADHERE TO PRACTICE OF SCIENCE

The researcher further demonstrated integrity in the development, implementation and reporting of the research by not committing any of the following research misconduct: fabrication, falsification, and plagiarism in the processing, or reviewing of results.

1.11.1 Fabrication

Fabrication in research is research misconduct where the researcher intentionally creates or misrepresents research findings and reports them as true (Gray, Grove & Sutherland, 2017:678). In this study, the researcher avoided misrepresentation of data
by reporting the research results using participants’ actual words to support the themes that emerged during data analysis. The meaning of the TOP experience was presented accurately from the participants’ point of view. The researcher maintained neutrality throughout the study, and avoided personal biases by keeping a reflexive journal (Houser, 2018:486).

1.11.2 Falsification

Falsification of research is when the researcher manipulates the processes or changes or omits data or results, to the extent that the research is not accurately represented in the research record (Houser, 2018:71). The researcher ensured that data collected from each participant were included during the presentation of the results. Only female undergraduate students who had undergone TOP between 2 weeks and 24 months before the study commenced participated in this study.

1.11.3 Plagiarism

Plagiarism is the research misconduct where the researcher uses another person’s ideas, processes, results, or words without giving credit, including those obtained through confidential reviews of other’s research proposals and manuscripts (Gray, Grove & Sutherland, 2017:687). The researcher gave appropriate credit to all the authors of the research sources included in this study. All inputs of the study supervisors, independent coder and the participants were acknowledged. In order to measure the possibility of plagiarism, Turnitin receipt is attached on the front pages in this study as proof of submission.

1.12 RESEARCH OUTCOMES

The outcomes of this research study revealed that the participants experienced the challenges related to their internal and external world before, during and after TOP process. Based on the findings of this research study on the experiences of female undergraduate students who have undergone TOP, the recommendations towards the integrated post-TOP health care within the Campus Health Services of the university where this study took place were developed.
1.13 DIVISION OF CHAPTERS

The outline of chapters in this dissertation are as follows:

Chapter 1: Overview of the research study and rationale

This chapter provides the reader with the overview of the study’s background, rationale, research purpose, objectives and research methodology.

Chapter 2: Research design and method

In this chapter, the detailed description of the research design, population, sampling, data collection and data analysis is provided.

Chapter 3: Presentation and discussion of the research findings

In this chapter, data is analysed, and the findings are discussed and presented.

Chapter 4: Summary, evaluation, recommendations, limitations and conclusions of the research study

The findings are concluded according to the study objectives and recommendations are made based on the evidence-based knowledge obtained from the study.

1.14 SUMMARY

This chapter provided an overview of the research background and rationale for conducting the study. The research problem statement, purpose and objectives for conducting the study was also presented. Relevant key concepts were defined and clarified. The research methodology utilised in this study was also described. The description of the two phases of the study was included. In Chapter Two, the detailed outline of the research design and methods utilised in this study are presented.
CHAPTER TWO
RESEARCH DESIGN AND METHOD

2.1  INTRODUCTION

The overview of the research study was discussed in Chapter One. The focus of Chapter Two is to describe and explain the research design and method applied in this study, including the discussion on measures of trustworthiness employed. The purpose of the study was to explore and describe the lived experiences of female undergraduate students who have undergone TOP in order to develop. Based on the research findings, to develop the recommendation recommendations towards the integrated post TOP health care at the university were the study was conducted.

2.2  RESEARCH DESIGN

A research design is an overall approach or outline of the study that details all the major components of the research. It includes data collection and data analysis and is also used for the purpose of answering the research questions (Rebar & Gersch, 2015:176; Houser, 2018:486; Flick, 2014:112). In this study, a qualitative, exploratory, descriptive, contextual research design was used.

2.2.1 Qualitative research design

The qualitative research design is a method of enquiry conducted in order to explore and describe the meaning of an experience from people’s points of view (Ellis, 2016:13). The qualitative research design aims to gain an in-depth understanding of the meaning of the TOP experience and the complexity inherent in the everyday lives of female undergraduate students (Houser, 2018:136). In this study, a qualitative research design was the effective method used to explore and understand the meaning of the lived TOP experience from the individual female undergraduate students’ own perspectives (Gray, Grove & Sutherland, 2017:689; Ellis, 2016:13; Corbin & Strauss, 2015:5). The qualitative research design takes a holistic and comprehensive approach because it is interactive, using in-depth individual
phenomenological interviews to gain knowledge and understanding of the subjective meaning of the TOP experience (Cronin, Coughlan & Smith, 2015:71; Creswell, 2014:8). Based on the research findings, recommendations towards the integrated post-TOP health care services were developed (Rebar & Gersch, 2015:353; Moule & Goodman, 2014:463).

2.2.2 Exploratory research design

Exploratory research designs are used to collect descriptions of existing phenomena in order to justify or assess the current conditions to make plans for the improvement of conditions of the individuals who have lived or are affected by the phenomenon of interest (Houser, 2018:578). The exploratory research design is more focused on increasing knowledge of the field, but is not intended for generalisation (Gray, Grove & Sutherland, 2017:678). The researcher used in-depth phenomenological interviews to identify the knowledge gap by exploring the experiences of female undergraduate students who have undergone TOP.

2.2.3 Descriptive research design

The descriptive research design is focused on describing the phenomenon of interest in order to give a precise picture of what has happened, how things are proceeding currently, and what the event is like (Cronin, Coughlan & Smith, 2015:66). In this study, a descriptive research design was followed to describe the lived experiences of female undergraduate students who have undergone TOP, using their words in order to understand and present a precise picture of the phenomenon.

Descriptive research was conducted to describe the meaning of living with the TOP experience in order to provide a picture of the reality of the experience as it has naturally happened (Houser, 2018:480). In order to discover new meaning and to give an accurate description of the TOP experience, the researcher engaged with the participants by using in-depth individual interviews. A descriptive central opening statement “Describe your experience of TOP” was posed, in order to allow the participants to give an accurate, detailed description of their experience and for the researcher to get an understanding of the TOP experience (Rebar & Gersch,
Follow-up open-ended probing questions were asked in order to capture a detailed thick description of the participants’ lived experiences of TOP.

### 2.2.4 Contextual research design

Context refers to the environment where events are happening and is a notion that gives the researcher the full picture of the past experiences and an understanding of the meaning of the phenomenon of interest (Corbin & Strauss, 2015:155; Picardi & Masick, 2014:135; LoBiondo-Wood & Haber, 2014:576). According to Cronin, Coughlan and Smith (2015:71), it is crucial for the researcher to be sensitive and to recognise the context of the participants because the human experience cannot be separated from the context in which it happens. In order to get a full picture of participants’ experiences of TOP, this study was conducted in one of the campus health consultation rooms within the university environment where the participants are registered as students. The campus health clinic is an important context because it is where the participants are healthcare users and also where health promotion is facilitated, including the provision of female reproductive health care services.

### 2.2.5 Phenomenology

Phenomenology is the rigorous and systemic investigation of the meaning of the phenomenon that is focused on understanding individuals’ subjective experiences through intensive dialogue with the persons who experienced it (Ellis, 2016:150; Houser, 2018:396; Cronin, Coughlan & Smith, 2015:76). The phenomenological approach is focused on understanding the meaning or the essence of the lived experiences of the individuals’ perspective, rather than the facts (Houser, 2015:401). In this study, the researcher followed a descriptive phenomenology study to gain an understanding of the lived experiences of female undergraduate students who have undergone TOP. In-depth individual interviews were conducted to enable the researcher to have intensive dialogue with the participants in order get a holistic subjective picture of the TOP experience as lived by the female undergraduate students (Gray, Grove & Sutherland, 2017:3; LoBiondo-Wood & Haber, 2014:581). This approach was relevant in generating evidence in the nursing practice that the researcher used to achieve the purpose of this study (LoBiondo-Wood & Haber,
2014:280). The participants were requested to share their own experiences of TOP in order for the researcher to gain a deeper understanding of how different participants responded or reacted to their everyday and unique experiences of TOP. The participants were asked to respond to one opening central statement to encourage them to respond in their own words and for the researcher to gain more personal information from their point of view (Moule & Goodman, 2014:461; Ellis, 2016:50). The principles of phenomenology (reflexivity, bracketing, and intuition) were implemented to reduce the risk of the researcher’s bias contaminating the participants’ description of their TOP experience (Cronin, Coughlan & Smith, 2015:77). The principles of phenomenology are discussed next.

2.2.5.1 Reflexivity

Reflexivity refers to the researcher's introspection and self-awareness of his/her own biases and opinions during data collection and analysis (Ellis, 2016:151; Gray, Grove & Sutherland, 2017:690). Researchers’ professional background can influence how they analyse and interpret data (Corbin & Strauss, 2015:119). To maintain a high level of objectivity, the researcher used a reflective journal to record her own perceptions, thoughts, feelings and biases about TOP, which ensured that data collection, analysis and presentation was not contaminated. A reflective journal is a diary-like record that the researcher used to keep record of dilemmas, thoughts and biases that may influence the study during data collection and analysis (Creswell, 2014:247).

2.2.5.2 Bracketing

Bracketing is the strategy used in qualitative research to limit and control the effects of researchers' biases or preconceptions about the topic and the participants in order to explore the phenomena of interest (Houser, 2018:395). During bracketing, the researcher identified her personal biases, such as her religious belief about TOP, which could have distorted data collection and data analysis (LoBiondo-Wood & Haber, 2014:113; Corbin & Strauss, 2015:119). The researcher ensured her personal biases were reduced during data collection and analysis by using the participants’ words in the description of the TOP experiences, and not her own interpretations thereof (Cronin, Coughlan & Smith, 2015:77). The researcher also attended six
debriefing sessions arranged by study supervisors because of the sensitivity of the topic. These debriefing sessions with a psychologist assisted the researcher to do introspection, identify and acknowledge her biases and values, and to be neutral during data collection and analysis.

2.2.5.3 Intuition

Intuition may be described as the knowledge that comes unbidden of a situation or event as a whole, and it comes as a result of gained knowledge through experience and cannot be logically explained (Moule & Goodman, 2014:459; Gray, Grove & Sutherland, 2017:5-6). As an experienced psychiatric nurse, the researcher used intuition and tacit knowledge when rendering sexual reproductive health services to the female undergraduate students. It is during this service delivery that the researcher decided to conduct the study in order to gain deeper knowledge and understanding of TOP, as these services are not provided by the campus health clinic. Also, during the individual interviews with participants the researcher used intuition to recognise the patterns of emotions displayed by the participants, and linked the emotions observed during data analysis and interpretation.

2.3 RESEARCH METHOD

The research method is the process or plan required for conducting the steps or phases of the research study using specific tools for data collection (Ellis, 2016:150; Gray, Grove & Sutherland, 2017:683). The process of the research method includes the selection of participants, the choice of setting, and ways in which data will be collected and analysed (Ellis, 2016:16; Rebar & Gersch, 2015:351). The research was conducted in two phases.

2.3.1 Phase One: Exploration and description of the lived experiences of female undergraduate students who have undergone TOP

The focus of Phase One was to explore and describe the lived experiences of female undergraduate students who have undergone TOP. In this phase, the researcher provided a detailed discussion of how the target population, sampling method,
inclusion and exclusion criteria, data collection and data analysis methods were utilised in the study.

2.3.1.1 Population

The population is the entire set of individuals that are of interest to the researcher, who could potentially participate but cannot all be included to participate in the research study (Cronin, Coughlan & Smith). The target population consists of all the individuals that the researcher is interested in who share common composition or characteristics (Rebar & Gersch, 2015:111). In this study, the population of interest to the researcher comprised all female undergraduate students who have undergone TOP, who visited Campus Health Services for sexual reproductive health services.

2.3.1.2 Sample and sampling

The sample is a selected individuals who are used to illustrate the possible responses and the behaviour that represent the population (Cronin, Coughlan & Smith, 2015:191; Picardi & Masick, 2014:154). In this study, the researcher used purposive sampling to identify and deliberately recruit the participants who have distinctive characteristics of the population of female university students who have undergone TOP (Grove, Burns & Gray, 2013:365; Curry & Nunez-Smith, 2015:378). Purposive sample is the strategy that the researcher uses in qualitative research to select the participants considered to have distinctive qualities of the population of interest (LoBiondo-Wood & Haber, 2014:581). The purposive sampling was also used to maximise diversity in the sample and the process of selecting a group of participants that represent the population being studied (Gray, Grove & Sutherland, 2017:331).

In this study, purposive sampling was used to intentionally identify and recruit participants who have undergone TOP. The potential participants were recruited in the consultation room during the provision of sexual reproductive health services. All the female undergraduate students who had history of TOP were informed about the research process and were invited to participate. Appointments to conduct the interviews were secured with all the participants who were willing to share their lived TOP experience with the researcher after the consultation. The researcher made
telephone calls to arrange and negotiate a suitable time to conduct the interviews. The inclusion criteria were all female undergraduate students who visited campus health clinics for sexual reproductive health services and who have undergone TOP between 2 weeks to 24 months before the study was conducted. This inclusion criteria provided the researcher with the guidelines for the selection of participants who matched the predetermined set of characteristics (Houser, 2015:162). A sample size of nine female undergraduate students who have undergone TOP was selected and was determined by data saturation; the point at which gathering fresh data no longer yields new insights or reveals new themes (LoBiondo-Wood & Haber, 2014:577).

2.3.1.3 Data collection

Data collection is a precise, systematic gathering of information relevant to the research purpose and extends from before the first participant and ends once the last participant’s data have been obtained (Gray, Grove & Sutherland, 2017:55). Data collection in qualitative research is a practical activity that is carried out within a specific time and it occurs simultaneously with data analysis (Gray, Grove & Sutherland, 2017:256). The quality and sufficiency of the data are crucial as it provides new insights and understanding for accomplishing the research goals (Corbin & Strauss, 2015:119). The intent of data collection for qualitative research is to locate and obtain information from a small sample, but to gather extensive information from this sample (Creswell, 2014:222).

In this study, data were collected in one of the campus health clinic’s consultation rooms. Although the permission was granted to conduct the study in four campus health clinics of the university, however, because of the sensitivity of the topic, data were collected in one of the clinics in order to build rapport with the participants. The venue was chosen and preferred by the participants. In order to enhance trust and communication, the venue was suitable and private because of the sensitivity of the topic, as the participants were required to share their private information with the researcher. The venue was chosen because the participants believed that nobody would stigmatise them, as it is also used for other health-related issues for female students who access the campus health clinic.
The researcher ensured that the consultation room where the interviews were conducted was free from distractions, by placing a “do not disturb” sign on the door. The researcher ensured that the sitting arrangement enhanced comfort, trust and communication by facing the participants and allowing enough space for participant to move their legs comfortably. Data were collected over a period of two months, October and November 2015.

In this study, 40-60 minutes in-depth individual interviews were used to collect subjective data on the experiences of female undergraduate students who have undergone TOP. Interviewing is a data collection technique used to gather data in qualitative research where the researcher interacts with the participant by asking questions in an open and informal way (Houser, 2015:209; Rebar & Gersch, 2015:152). Participants’ time was respected, and the interviews lasted between 40-60 minutes.

In order to refine and evaluate if the central question posed as an opening statement, can stimulate in-depth discussions and assess the interviewing skills of the researcher, exploratory interviews were conducted a month before the actual study (Corbin & Strauss, 2015:34). A pilot study is a preliminary study undertaken prior to the full implementation of the primary study, using a small sample of the participants in order to determine whether the selected method is sufficient to collect useful data (Moule & Goodman, 2014:461; Gray, Grove & Sutherland, 2017:686). Two female post-graduate university students who have undergone TOP were recruited during obstetrical history taking in the consultation room and volunteered to participate in the pilot study. The research process was explained and their rights to participate in the study were clarified. Two written informed consents were obtained. The participants were informed that they were participating in the pilot study and that data gathered during interviews would not be included in the primary study. With the permission of the participants, an audio recorder was used to capture the individual interview discussions.

The participants were requested to comment and give feedback after the pilot study. The first pilot interview was conducted in the presence of an experienced qualitative research supervisor for supervision and mentoring. The researcher was guided by
research supervisor on how to pose open-ended questions that will encourage the participants to talk more and to avoid close-ended and leading questions. Also, the study supervisor guided the researcher on how to pose follow-up questions and on how to stay focused on the research topic and narrow the interview towards the participants’ experiences of TOP. In order to allow the participants to verbalise sensitive issues, the researcher was further guided by the study supervisor on how to maintain a non-judgmental attitude. After the pilot study, the researcher started the process of data collection. Data were collected from nine participants. Data saturation determined the sample size; the stage where the researcher has explored all possible avenues and ensured comprehensiveness in terms of making sense of data (Barbour, 2014:336).

With the permission of participants, an audio-recorder was used to record and capture the interview discussions (Kuckartz, 2014:23). The advantage of using an audio-recorder is that it is accurate, captures direct quotations from participants, and there is no distortion via retrospective memory. Data captured by the audio-recorder was effective in this study because of better documentation of participants’ actual words and controllability, which lead to increased reputation in the scientific community (Kuckartz, 2014:123).

The central opening statement posed to the respective participants was “Describe your experience of TOP”. The central opening statement was to encourage the participant to talk at length and to give in-depth descriptions of the main aspects of their experiences of TOP (Rubin & Rubin, 2012:123). For effective interviewing, the researcher used facilitative communication skills to ensure that the interviews were effective and yielded sufficient information required to achieve the purpose of this study.

- **Communication skills**

In order to facilitate open communication, the researcher maintained a relaxed, calm position, maintained eye contact and listened actively throughout the interviews. Follow-up questions like “what do you mean by that” were asked to allow the participants to further elaborate and continue with their description of their experience
Open-ended questions were used to get the participants more engaged and to allow the participants to express their TOP experiences freely. In order to probe the participants about their TOP experience, and to pursue the answers, the researcher posed probing statements such as: “Please tell me more of your experience regarding TOP”. Probing is an act of posing secondary questions where clarity and additional information is needed to elicit contextual details during interviews (Brinkmann & Kvale, 2015:161; Gray, Grove & Sutherland, 2017:688). In cases where the participants gave general statements about TOP, specifying questions were asked in an attempt to get more precise descriptions of their experience.

Specifying questions like “what did you actually do when you experienced feelings of anxiety?” (Brinkmann & Kvale, 2015:161) were posed to participants. The researcher used prompting questions that encouraged the participants to reflect on and explore their emotions. Their non-verbal impressions were also observed during the interviews. When the participants said “I felt connected to the baby”, in order to get an understanding of what the participants meant, the researcher used reflection to allow the participants to reflect on what they have said. This was done to ensure that the researcher understood statements such as “I don’t think you can run away from it. It is like a permanent torture, and there is no way that you can run away from it”, which were uttered by some participants. Clarity-seeking questions, such as “what do you mean when you say it is like permanent torture?” were asked. To clarify is to make something clearer or easier, or to understand, as explained by the Oxford Advanced Learners Dictionary (Hornby, 2010:256). Observational notes were taken when some of the participants became emotional and cried during the interviews (Gray, Grove & Sutherland, 2017:256). In order to get a better understanding and obtain essential information, the researcher also asked clarifying questions such as “Sharing your experience makes you cry, please tell me more about the TOP experience”.

The researcher gave the participants a chance to respond to questions without many interruptions and demonstrated sincere interest in the participants’ responses by listening attentively. The researcher’s tone of questioning was gentle, with little confrontation to reduce anxiety (Gray, Grove & Sutherland, 2017:261). In order to avoid making participants feel cross-examined and judged, the researcher used
pauses to allow the participants ample time to reflect and break the silence with significant information (Brinkmann & Kvale, 2015:161). For effective interviewing, the researcher used a responsive interview style. According to Rubin and Rubin (2012:37), responsive qualitative interviewing is a style of qualitative interviewing which emphasises the importance of building a relationship of trust between the researcher and participants which leads to give-and-take in the conversations.

The pattern of questioning was flexible and evolved around what the participants said about their TOP experience (Rubin & Rubin, 2012:37). The tone of questioning was gentle and flexible, and designed to tap into the experience and knowledge of each participant (Rubin & Rubin, 2012:37). The researcher maintained a non-judgmental attitude throughout the study by being mindful of non-verbal gestures to allow the participants to share their experiences freely without being judged. The researcher gave the participant a chance to respond to the questions. The researcher demonstrated a sincere interest in the participants’ responses by being non-directive and by maintaining a neutral body language. Follow-up questions were asked to allow participants’ emic view to emerge (Gray, Grove & Sutherland, 2017:261).

- **Role of the researcher**

According to Brinkmann and Kvale (2015:193), the interviewer is the key instrument of qualitative research. In this study, the interviews were conducted by the researcher. Holloway and Wheeler (2010:64) claim that health care professionals have the dual role and responsibilities of the researcher and that of the professional while conducting the research. The researcher took responsibility and assumed these dual roles since the researcher is a healthcare professional. In this study, the researcher observed that during the interviews, some of the participants became emotional and cried when relating their TOP experience.

The researcher discovered that because of the sensitivity of TOP, she was sensitive to establish a non-judgmental environment that promoted open, relaxed conversations (Gray, Grove & Sutherland, 2017:260). When the participants showed signs of distress, the researcher allowed moments of silence to allow the participants to gather their emotions and to reflect. In order to ensure that the participants were calm and
willing to continue with the interviews, the researcher paused the interviews, and later asked the participants if they would like to continue or stop the interviews without being coerced. For some of the participants, this was their first time speaking about their TOP experience, and they became aware of their suppressed feelings and were emotionally deeply affected. The participants were referred to PSYCAD for emotional support.

- Observations

Observations is a fruitful method in qualitative research used to collect subtle forms of data that participants are not aware of and are unable to articulate (Corbin & Strauss, 2015:41). During the interviews, the researcher observed the participants’ subtle non-verbal gestures which they were unaware of and which could have significance for the data collected. In order to enrich data, field notes were taken as part of the data collection to record the subtle non-verbal gestures observed during the interviews.

Field notes are records used in qualitative research to document the researcher’s observations about the participants’ tone of expressions and associated actions during the data collection process (Rebar & Gersch, 2015:152). The researcher also remained with the participants after the interviews to clarify the observations made to ensure that it was the accurate picture and interpretation of what was displayed during the interviews.

2.3.1.4 Data analysis

Data analysis is a process of organising and compiling data in order to present a clear picture of all the information collected (Rebar & Gersch, 2015:348). Data analysis in qualitative research requires understanding, synthesising and conceptualising because it involves the reduction and interpretation of data (Rebar & Gersch, 2015:74). Data analysis consists of analysing the meaning of the experience based on words and observations, rather than measurable phenomena (Houser, 2018:469). Qualitative methods characteristically claim to allow the participants to speak for themselves, and to let them express things in their own words, therefore their words, concepts, and metaphors are essential (Kuckartz, 2014:133). Data analysis was
conducted to reduce and organise data with the intent of making sense of the experiences of female undergraduate students who have undergone TOP in the context of the university where they are registered as students (Creswell, 2014:195; Grove, Grove & Sutherland, 2017:46). Data were analysed separately by the researcher and an external independent coder who is a known researcher in qualitative studies and the nursing field. The external independent coder’s role in this study was to ensure consistency of data reduction methods and transcription quality, and to safeguard the trustworthiness of the study. Data were transcribed by the researcher and organised into ordinary personal computer files that were shared with the independent coder for analysis (Creswell, 2014:182). The researcher used a reflexive journal during data analysis to bracket and control the intrusion of her own biases, perspectives and assumptions about TOP.

Owing to the distant location of the independent coder, a one and half hour telephonic conference was held with the researcher, independent coder, and the two research study supervisors. The researcher interpreted the participants’ verbalised experiences using literature control (LoBiondo-Wood & Haber, 2014:53). Literature control entails consulting relevant literature with evidence-based knowledge to support the research findings of the study. This aided and enabled the development of the recommendations for continuity of post-TOP health care services at the Campus Health Clinics of the university where the study took place. The interpretations of the research findings aided the development of the recommendations.

In this study, Tesch’s method of thematic data analysis was used (Creswell, 2014:195). Data were analysed concurrently with data collection. The steps in qualitative data analysis are interconnected and form a spiral of activities that are related to the representation of the data (Creswell, 2013:179). Tech’s eight steps of data analysis were followed in order to reduce and organise data with the intent of identifying themes that describe the meaning of the participants’ lived experience of TOP (Creswell, 2014:197). Tech’s eight steps include:

- The researcher became wholly immersed in data by listening to the audio-tapes during the transcribing process, and by reading and re-reading all the transcripts (Creswell, 2014:197; Grove, Burns & Gray, 2013:696). In order to get a general
sense of TOP as experienced by the participants, the researcher reflected on the keywords that were recurrent in the transcripts (Rebar & Gersch, 2015:74). The researcher started the process of breaking down, examining, categorising and organising data for analysis by writing notes indicating the potential for emerging themes as they came to mind (Brinkmann & Kvale, 2015:227).

• In order to get a general sense of the qualitative data, the researcher started a process of interpreting the meaning of participants’ verbal responses in the interview transcripts (Houser, 2018:425). The researcher explored the content of data to identify keywords that reflected interpretations of participants’ verbal responses. Large volumes of data were broken down, reduced and labelled. Significant thoughts and unique ideas pertaining to the experiences of female undergraduate students who have undergone TOP were organised into columns of similar categories (Creswell, 2014:197).

• To start the process of coding analysed data, the researcher, study supervisors and independent coder held a one and half hour telephone conference to share and discuss the codes, and to arrive at an exhaustive description of participants’ lived experiences of TOP. During the telephone conference, keywords and links across data were identified and explored in detail. Common areas and differences were identified and agreement was reached on codes related to themes (Creswell, 2014:197).

• A textual description of what happened during TOP and a structural description of how TOP was experienced was developed in order to establish the essence of the participants’ lived experiences of TOP (Creswell, 2014:198). The researcher started data coding by using descriptive wording for the codes and arranging them into similar central themes (Moule & Goodman, 2014:412). Similar significant thoughts and unique ideas pertaining to the experiences of female undergraduate students who have undergone TOP were grouped together.

• The researcher further reduced and linked the codes that related to each other in a meaningful way and grouped them together according to themes and sub-themes.
that related to each other (Moule & Goodman, 2014:411). Direct participant quotes were used to create the connection between what the participants said and how the researcher labelled what was said (LoBiondo-Wood & Haber, 2014:114).

- The researcher used the list of codes that was agreed upon by the supervisors and the independent coder to identify and describe the major themes and sub-themes. A theme is the underlying idea behind the words and is always repeated differently by different participants (LoBiondo-Wood & Haber, 2014:102; Creswell, 2014:197).

- In this study, data are presented under two themes and three sub-themes (See Table 3.1) after agreement with the study supervisors and the independent coder. Data are presented in a narrative way to give the essence of the experience of female undergraduate students who have undergone TOP (Creswell, 2014:199; Rebar & Gersch, 2015:75).

2.3.1.5 Literature control

Literature control in qualitative research refers to an organised, summarised and written presentation of relevant research findings that have been published on the topic (Grove, Burns & Gray, 2013:97). This analysis and synthesis of literature were conducted in order to provide a useful backdrop for the research. It was also used to demonstrate what was already known about TOP experiences before and after data analysis, and in the presentation of the research findings (Cronin, Coughlan & Smith, 2015:53).

Literature control also provided the researcher with the background picture of experiences of female undergraduate students, as a whole person who is in interaction with their world, in order to achieve the purpose of the study. The literature control assisted in comparing the similarities, weaknesses and limitations of the findings and what other researchers have found and provided sufficient evidence to contribute to the body of knowledge in the field of female reproductive health (Gray, Grove & Sutherland, 2017:135). The literature control process is discussed in greater detail in Chapter Three where the research findings are integrated into existing literature.
2.3.2 Phase two: Recommendations towards the integrated post-TOP health care within campus health services in the university where the study was conducted

In order to achieve the purpose of this study, based on the research findings of Phase One, recommendations were developed towards the integrated post-TOP health care within the campus health clinic in Phase Two of this study. The findings were also integrated into existing literature through the process of literature control.

2.4 MEASURES OF TRUSTWORTHINESS

Trustworthiness in qualitative research refers to the honesty and accuracy of data collected and the ability to demonstrate the authenticity, rigour and truthfulness of the research findings (Ellis, 2016:66; Rebar & Gersch, 2015:154; Cronin, Coughlan, Smith, 2015:191). To ensure the honesty of data collected, the researcher established a trusting relationship with the participants by spending time with them before the interviews (Rebar & Gersch, 2015:154). To ensure that the research process was undertaken and explained in a transparent manner, measures of trustworthiness were ensured. These included the strategies of credibility (truth value), transferability (applicability), dependability (consistency), and conformability (neutrality) (Korstjens & Moser, 2018:121).

2.4.1 Credibility (truth value)

Credibility is one of the criteria for establishing trustworthiness of the research and ensuring that the results are truthful and accurately represent the underlying meaning of data (Houser, 2015:224). Credibility is when the researcher demonstrates that the presentation and interpretation of the research findings accurately represent the experience as lived by the participants (Cronin, Coughlan & Smith, 2015:124). According to Rebar and Gersch (2015:156), truth value is the confidence in the truth of the findings. In order to ensure accuracy and truthfulness in the research findings, the researcher applied the following strategies: prolonged engagement, triangulation, and member checking.
2.4.1.1 Prolonged engagement

Prolonged engagement involves extended contact with the participants during data collection for the researcher to have a clear picture and understanding of the participants and the phenomenon of interest (Houser, 2018:395). In qualitative research, the amount of time spent with the participants reduce or increase the credibility of data (Cronin, Coughlan & Smith, 2015:124). The researcher, as a nurse and rendering sexual reproductive health services for seven years where this study was conducted, has clinical experience and understanding of participants culture and has trusting relationship with the participants (Vincent, 2014: 276).

Additional time was spent with the participants who volunteered to participate in this study to discuss a suitable time and venue to conduct the interviews and to secure appointments. The researcher also made use of telephone calls and cell phone messages to remind the participants of their appointments. Forty to sixty-minute in-depth interviews were conducted with individual participants. After the interviews, the researcher remained with the participant to verify and clarify the emotions that were observed during the interview. Those who experienced suicidal thoughts and emotional distress were referred to Psychological Services and Career Development (PSYCAD) for counselling.

2.4.1.2 Triangulation

Triangulation is the use of multiple data sources that enable researchers to explore phenomena from different angles in order to present an accurate reality of the phenomena (Houser, 2018:395). In this study, the researcher used triangulation, which entails individual phenomenological interviews and field notes to gain a deeper and accurate understanding of the experiences of female undergraduate students who have undergone TOP (Houser, 2018:395).

Interviewing is a popular narrative data collection method used in qualitative research that offers insights into a phenomenon of interest (Cronin, Coughlan & Smith, 2015:133). To enhance the credibility of this study an average of 40-60 minute in-depth individual phenomenological interviews were conducted to obtain a thick
description of the TOP experiences from female undergraduate students’ narratives. In this study, the researcher chose individual phenomenological interviews because they enabled the participants to consider and communicate their experiences.

The researcher observed that the participants became emotional during the interviews when sharing sensitive information about their TOP experiences. In order to have an accurate picture of the meaning of the expressions observed, the researcher used field notes to record the participants’ tone of voice and emotional expressions associated with crying (Rebar & Gersch, 2015:152).

Field notes are detailed descriptions of the context, environment and non-verbal communication observed during data collection and used by the researcher to enrich data collected during interviews (LoBiondo-Wood & Haber, 2014:578; Houser, 2018:393). To further ensure credibility of the study, investigator triangulation was employed by engaging the independent coder who is an expert in qualitative research during data analysis and interpretation, and the study supervisors were consulted throughout the study. To further enrich data, the researcher kept a reflexive journal.

### 2.4.1.3 Member checking

Member checking is the procedure whereby a study’s findings or draft material are reviewed with the study’s participants to comment and check the accuracy of the study findings or interpretations (Houser, 2018:396). The researcher ensured the reality of participants’ point of view about their experiences of TOP was well presented by spending time with the participant after the interview to check if the expressed emotions observed during the interview were accurately interpreted. The researcher, as a primary health care provider had an opportunity to meet with the participants and discuss the preliminary research findings and to clarify and verify the meaning of data collected during the provision of sexual reproductive health services. Member checking also took place when the participants came for consultation with the researcher as a health care provider regarding their concern on the sexual reproductive system and for contraceptive services.
2.4.1.4 Peer examination

Peer examination is a process of subjecting the research to the appraisal of a neutral third party of peers with expertise in qualitative methods of data analysis to review and explore aspects of the data (Houser, 2015:396). It is an exercise where critical examination is done in order to identify the strengths and limitations of the study (Cronin, Coughlan & Smith, 2015:186). The researcher and the study supervisors held a 90-minute telephonic conference with the independent external coder to discuss and communicate the study findings. The researcher had regularly scheduled contact sessions with the research supervisors to discuss the research process, and to review the themes and categories that developed from the findings of data. The coding sheet and one transcript are attached as annexures should there be a need to verify or critically assess the interpretations from direct quotes. (See Annexures F & G). This research study was presented twice at the Nursing Department annual research forum of the university where this study was conducted in order to be critiqued by peers and research experts (Houser, 2015:478).

2.4.1.5 Structural coherence

According to Lincoln and Guba (1981 in Korstjens & Moser, 2018:121), structural coherence ensures that there are no unexplained inconsistencies in data and interpretations. To ensure credibility of the research findings, the researcher developed themes and sub-themes, which were revised and reduced several times based on the agreement that was made with the independent coder and research supervisors. In order to ensure that data were described and interpreted correctly in line with the themes and sub-themes that emerged during data analysis, the researcher had contact sessions with the research supervisors throughout the study (Lincoln & Guba, 1981 in Korstjens & Moser, 2018:121).

2.4.1.6 Interview technique

An audio-recorder was used to capture the interviews and consistency was ensured in this study by interviewing the participants using the same central opening statement: “Describe your experience of TOP” (Houser, 2018:413). The researcher maintained
eye contact and showed interest by nodding her head. Open-ended follow-up questions were reframed in a consistent manner in all the in-depth phenomenological interviews (Lincoln & Guba, 1981 in Korstjens & Moser, 2018:121). The researcher listened attentively and observed the participants’ body language, tone of voice and facial expressions (See Section 2.3.3).

2.4.1.7 Establishing authority of the researcher

The researcher holds a diploma qualification in Clinical Nursing Science, Health Assessment, Treatment and Care and 15 years’ experience in this field. The researcher has been rendering sexual reproductive health services to female university students at the campus health clinic of the university where the study was conducted, for six years. The researcher has a qualification in Midwifery and Psychiatric Nursing Science and has knowledge of sexual reproductive health and mental health conditions, and a research experience and is familiar with the context under study.

2.4.2 Transferability (Applicability)

Transferability refers to the degree to which research findings from one qualitative study can be applied to other similar settings or situations that are outside the context of the study (Cronin, Coughlan & Smith, 2015:156). Permission was granted to conduct the study in four campus health clinics of the university under the study. However due to the sensitivity of the topic, this study was conducted in one of the four Campus Health clinics of the university were participants are registered for their studies. The researcher ensured transferability by providing the readers with the dense description of the sample, participants’ demographics, and the context of the study. Readers are also provided with the detailed description and presentation of research findings, supported by participants’ direct quotes (See Chapter 3).

2.4.3 Dependability (consistency)

Dependability is the qualitative data measure focused on the stability and consistency of information across individuals and is checked through a process of auditing (Curry
& Nunez-Smith, 2015:174; Flick, 2014:488). The researcher ensured dependability of this study by using an audit trail, a code-recode strategy, peer examination and triangulation (Vincent, 2014:278). An audit trail containing a detailed dense description of the research methods, a detailed description of the data collection methods in order to recognise the uniqueness of the context of the study and on how data can be replicated (Curry & Nunez-Smith, 2015:380). In order to ensure dependability, triangulation was ensured by using in-depth individual interviews, observation and reflexive journal as data sources. (Curry & Nunez-Smith, 2015:380). To ensure dependability, the researcher also used stepwise replication by analysing data separately with the independent coder (Vincent, 2014:278). The results were compared and inconsistencies were addressed during telephonic conference with the independent coder, researcher and study supervisors to reach conclusions on the results (Houser, 2018:393; Vincent, 2014:278).

To further enhance the dependability of the research findings, data were analysed by the researcher and an independent coder. The researcher followed the code-recode strategy. The researcher coded same data twice, giving two weeks intervals in between the coding, to compare if the results were the same. Code-recoding was also done in order to help the researcher to gain a deep understanding of data patterns and to improve the presentations of participants’ narrations (Vincent, 2014:278; Houser, 2018:393; Curry & Nunez-Smith, 2015:380). One and half hour telephone conference was held with the independent coder, researcher and the study supervisors to discuss the themes that were identified and to reach consensus. The study was presented twice at the research conference to be critiqued by the conference attendees and methodological experts. The researcher engaged the methodological experts throughout data analysis to examine and compare the consistency of the codes, themes and subthemes and in the presentation of the research findings (Houser, 2018:393; Curry & Nunez-Smith, 2015:380).

2.4.4 Confirmability (neutrality)

Confirmability is the degree to which the findings of a study are shaped by the participants and not the researcher’s bias, motivation or interest from Campus Health sexual reproductive health services (Curry & Nunez-Smith, 2015:174). Neutrality
refers to the degree to which the research findings are solely from the participants and not from other biases, motivations and perspectives (Lincoln & Guba, 1985 in Korstjens & Moser, 2018:121). The researcher ensured confirmability by providing an audit trail as a chain of evidence with a clear, detailed description of the research methodology (Houser, 2018:267). The researcher used participants’ words from the interview transcripts to confirm that the data interpretation reflected the participants’ own experiences of TOP, instead of the researcher’s biases or perspectives. The researcher, study supervisors and an independent coder held a conference call to discussed and agree on the research findings. Feedback sessions were held with the study supervisors throughout this study.

2.5 ETHICAL CONSIDERATIONS

Ethical considerations, including the principle of respect for persons, beneficence and justice were ensured throughout the study. For a discussion on the application of the ethical principles refer to Chapter One.

2.6 SUMMARY

This chapter gave a detailed description of the relevant research actions that were applied. It presented the research design and method, which included Phase one outlining the population and sampling, data collection and analysis. Phase two of this research study focused on the development of recommendations towards the integrated post-TOP health care for female undergraduate university students who have undergone TOP within the campus health clinics. Measures of trustworthiness were also discussed. In Chapter Three, the researcher provides a detailed discussion of the research findings of the experiences of female undergraduate students who have undergone TOP.
CHAPTER THREE
PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS

3.1 INTRODUCTION

The previous chapter presented the research method and design that were used in this study. This chapter is Phase Two of this research study and focuses on the presentation and discussion of the research findings of the experiences of female undergraduate students who have undergone TOP. Literature control was used to synthesise and integrate the research findings into existing theoretical background of other studies in order to provide evidence-based findings of the participants’ experiences of TOP (Gray, Grove & Sutherland, 2017:81).

The purpose of the study was to explore and describe the lived experiences of female undergraduate students who have undergone TOP in order to develop recommendations towards the integrated post-TOP health care at the Campus Health Services within the university were this study was conducted. Also, from the research findings, to develop recommendations towards the integrated post-TOP continuity of health care within the context of Campus Health Services at the university where the study took place. In order to facilitate the understanding of the presentation and discussion of research findings, the sample profile, method of data collection and analysis used in this study are briefly discussed.

3.2 PRESENTATION OF THE RESEARCH FINDINGS

3.2.1 Description of sample profile

The sample comprised nine female undergraduate students between the ages of 18-24 years. All participants were single and had undergone TOP less than 24 months before the commencement of the study. None of the participants was on any method of contraceptives before the conception. One participant underwent TOP twice on different occasions, one had a miscarriage before undergoing TOP, so eight of the nine participants experienced TOP once. All participants mentioned that they were
from religious backgrounds. Five of the participants accessed safe, private TOP providers, where both methods of medical and surgical TOP were utilised on the same day. Four participants used medical TOP, one of which accessed safe public TOP services, and another received pills from the private general practitioner. The other two bought TOP medication from unsafe advertised lamppost providers. For one of the two who bought TOP medication, the process was unsuccessful, and she later used a private TOP provider were the surgical method was used. With regard to academic level, two participants were in their first year, four were in their second year, two in their third year, and one was in her fourth year of study. Participants were from different faculties; five were from the faculty of Economics, one from the faculty of Management, two from the faculty of Education and one from the faculty of Humanities. An interpretation of the research findings is presented in this chapter.

For the purpose of this study, the research findings were interpreted and presented within the theoretical assumption of the whole person theory as explained in the Theory for Health Promotion in Nursing (UJ, 2010:5-6). For a detailed description of the theoretical assumption of this study, refer to Chapter 1. To facilitate the interpretation of the research findings, the Theory of Health Promotion in Nursing (UJ, 2010:5-6) will be briefly explained.

### 3.2.2 Theory for Health Promotion in Nursing

The purpose of the Theory of Health Promotion in Nursing (UJ, 2010:4-6) is to promote the health of the individual, family, group and community. This is in line with the actual purpose of the study which was to explore and describe the lived experiences of female undergraduate students who have undergone TOP in order to develop recommendations towards the integrated post-TOP health care at the Campus Health Services within the university were this study was conducted.

According to the Theory of Health Promotion in Nursing (UJ, 2010:5-6) a person – in the context of this study the female undergraduate student – is seen as a whole person and in interaction with the internal and external world in an integrated manner. The Theory of Health Promotion in Nursing refers to the internal world as consisting of the body, mind or soul and spirit of the individual participant, and the external world as the
physical, social, and the spiritual dimensions of the individual (UJ, 2010:5). In the context of this study, physical dimension of the participant will be referred to as the material resources. The research findings will, therefore, be discussed in detail based on the Theory of Health Promotion as the theoretical framework of this study.

3.3 DISCUSSION OF THE RESEARCH FINDINGS

After data collection and analysis, the central storyline identified from the research findings, by the researcher and independent coder, was that the TOP experience challenged the participants’ internal and external world as a whole person. In the context of this study the whole person is the female undergraduate student who has body, mind or soul and spirit and is interacting with the physical, social, and the spiritual dimensions as an individual (UJ, 2010:5). This implies that the participant who has undergone TOP experienced challenges in her body, mind or soul and spirit during TOP and also challenges with the material resources and social relationships. The participants experienced TOP in their internal world as a lonely, burdensome constant struggle without resolution because of the personal secrecy and social stigma. Also, the participants as a whole person, functioning in an integrated, interactive manner with their external world experienced challenges in this dimension during the TOP process. According the Theory of Health Promotion in Nursing, this then implies that a person cannot be regarded as healthy if one of these dimensions of their being is negatively affected (UJ, 2010:5-6). From the research findings, two themes were identified after data analysis:

Theme 1: Challenges experienced by participants related to their internal world
Theme 2: Challenges experienced by participants related to their external world

A challenge is defined as an encounter, a test or trial; something to face up to or confront (Hornby, 2010:786). Challenges within the context of this study refer to the physiological, emotional, spiritual, material resources and the social that the participants had to face up to and perceived as beyond their control. The participants’ actual words are used and are cited in *italic*. To convey the complex meaning of the participants’ lived experience of TOP, the researcher interpreted the verbalised experiences by using existing literature through the process of literature control.
The research findings are presented and discussed in line with each of its themes, sub-themes and categories of meaning as illustrated in Table 3.1.

Table 3.1: Central Theme, Themes, sub-themes and categories

<table>
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<th>Central Theme: Challenges experienced by participants related to their internal and external world as a whole person.</th>
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Central Theme:
Challenges experienced by participants related to their internal and external world as a whole person.

<table>
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3.3.1 THEME 1: Challenges experienced by participants related to their internal world

The research findings revealed that the participants experienced challenges related to their internal world. The internal world of the female university students who have undergone TOP consists of the body, mind/soul and spirit dimensions according to the Theory of Health Promotion in Nursing (UJ, 2010:4). Therefore, for the purpose of this study, the challenges are presented and discussed under the following sub-themes:

- Experiences of physiological challenges (body)
- Experiences of emotional challenges (mind/soul)
- Experiences of spiritual challenges (spirit)

3.3.1.1 Sub-theme 1.1: Experiences of physiological challenges (body)

From the participant interviews it became evident that the participants experienced physiological challenges within the body, which are anatomical structures of the body. The physiological challenges were experienced by the participants before TOP (during pregnancy), during the TOP procedure, and after the TOP procedure. The physiological challenges encountered by the participants in their body are therefore presented and discussed under the following categories:

- Physiological challenges experienced before TOP
- Physiological challenges experienced during TOP
- Physiological challenges experienced after TOP
a) Physiological challenges experienced before TOP

Female undergraduate students experienced different physiological challenges in their bodies during pregnancy, before the TOP procedure. Naturally, women experience physiological discomfort commonly referred to as “morning sickness”, generally during the first trimester of pregnancy (Green, 2016:39). However, the research findings revealed that the participants experienced worst pregnancy symptoms, probably due to unwelcomed pregnancy. They experienced symptoms in their body included breast pain, missed periods and vomiting. Participants said:

“So I started to examine myself, why so many breast pains.” (Participant 5).

“I didn’t go on my periods and it was my first time I missed my periods.” (Participant 7).

“During my symptoms of pregnancy, I had tender breasts and I kept on complaining about them, and I thought it was just winter”. (Participant 8).

“I had bad nausea and vomiting when I had that pregnancy, I couldn’t eat anything, and I would only eat crackers and coffee.” (Participant 3).

These research findings are supported by Herlihy (2014:520) and Curley (2014:948) when they mentioned that physical challenges such as nausea, vomiting and the absence of menstrual periods manifesting as sickness in the first trimester of pregnancy are common in most women. Maternal physiological changes are normal symptoms of pregnancy due to the body’s response to the human chorionic gonadotropin, progesterone, oestrogen, and human placental lactogen, which are the hormones found in early pregnancy (Green, 2016:39).

The research findings showed that some of the participants experienced more severe physiological challenges during pregnancy than others when they felt sick and ended up being hospitalised. The physiological challenges in the body during the first trimester of pregnancy such as fainting, nausea and vomiting were severe and lead to absenteeism and irregular class attendance. This experience disrupted their studies
and caused a change in their academic performance as university students. This is confirmed by the statements:

“*I got my appointment which was the following week Monday and I was going to write a test a day after my appointment.*” (Participant 2).

“I stopped coming to school for a week, my marks went down, my performance deteriorated”. (Participant 6).

“I have missed tutorials, I have missed daily submissions, so now I am way, way behind, plus I have lost a whole lot of marks.” (Participant 8).

Literature revealed that most pregnant students experienced pregnancy-related symptoms such as fatigue, which affected their sleeping habits and caused a lack of attention to their school work, leading to poor academic performance caused by absenteeism (Shahhosseini, Poursaghar, Khalilian & Salehi, 2015:3; Mahlalela & Chireshe, 2013:143). The participants mentioned that after considering the consequences of the unplanned pregnancy on their career goals, they opted for TOP and experienced physiological challenges during the TOP procedure.

b) Physiological challenges experienced during TOP

This study findings confirmed that participants had their unplanned pregnancies terminated using both medical and surgical procedures. Medical TOP is commonly used during the first trimester of pregnancy (up to 12 weeks) through medication. The surgical method is performed using both drugs and a surgical procedure (manual vacuum aspiration of the contents of the uterus) (World Health Organization (WHO), 2012:4). According to the National Guideline for Implementation of the Choice on Termination of Pregnancy Act (NDoH, 2018: 34) all women undergoing TOP need cervical preparation using TOP medication. The participants reported that they experienced pains after taking TOP medication and severe abdominal pains were experienced during the manual evacuation of the uterus. Participants explained:
“Even though it lasted for few minutes, it doesn’t take time, but on its own its very painful, because you don’t get painkillers, they don’t give you an injection at least to be numb and not feel a pain, you get to feel every second of that pain.” (Participant 8).

“I have never felt so much pain before and I have never cried like I cried during termination, but why don’t they give you something to sleep?” (Participant 6).

“That pain was so unbearable, because they put machines inside of you, they keep on squeezing and at the same time it feels like they are pulling it [womb] out, I don’t know what that is and it was very, very, very painful.” (Participant 2).

Literature supports these findings by revealing that pain is the most commonly reported side effect of both medical and surgical TOP. The pain is often most intense during the expulsion of the foetus, and manual evacuation of the uterine contents in the awake state (Subramaney, Wyatt, Williams, Zhang, Liu, & Chin, 2015:937; Andersson, Benson, Christensson & Gemzell-Danielsson, 2016:1; WHO, 2012:6). All women experience pain during medical TOP due to the use of the medication (Misoprostol and Mifepristone) to initiate uterine contractions and the expulsion of the contents of the uterus as further stated by Kant, Priyambada and Kant (2017:1). In the South African public health facilities, according to the South African National Guideline for implementation of the Choice of Termination of Pregnancy Act (NDoH, 2018:27-28), analgesics are mandatory according during TOP. However, the study conducted by Hodes (2016:88) found that women were denied analgesics as a strategy to punish and discourage them from seeking repeat TOPs.

The participants also experienced physiological challenges from medication side effects, such as abnormal temperature, drowsiness, thirst and dehydration. This was evident when the participants said:

“I was a bit dizzy, I almost fainted, the pills actually makes you dehydrated and you thirst for water.” (Participant 1).
“Firstly I was drowsy from the medicine and it was very uncomfortable because I didn’t know what was happening.” (Participant 5).

“I got there to the doctor and did what I did but when I got to house, I was so scared and my temperature started to be abnormal. I was feeling cold but my body was hot, I was sweating and I had to cover myself with something”. (Participant 8).

The research findings in this study also revealed that other participants self-induced TOP using medication they bought from “unsafe” providers. Among the participants who took TOP medication at home, one participant experienced vaginal bleeding without the expulsion of the foetus, resulting in TOP failure. The participant had to go to the hospital to complete the TOP. The participant said:

“He went and consulted with some Nigerian guys who sell pills. This guy came to my place to deliver the pills. I used them for that day, they just give you two tablets and they never work and they made you even sicker I started bleeding but nothing was happening.” (Participant 5).

Appiah-Agyekum (2014:534) reported that 64.1% of pregnancy terminations among female university students were self-induced because of the convenience and privacy at home. The medication is said to be less burdensome for health care providers as the management of the symptoms is shifted to women undergoing TOP without their direct support (Tolefac & Minkande, 2017:329). However, TOP medications are reported to have serious side effects such as gastrointestinal disturbances, shivering, fever and haemorrhage that can prolong suffering, hence vigilance is needed to monitor these women (Bennadi; 2014:1; Constant, de Tolly, Harries & Myer, 2014:230). The concern is that most women delay seeking medical help when experiencing complications after TOP due to the fear of social stigma and secrecy (Madziyire, Polis, Riley, Sully, Owolabi & Chipato, 2018:6). In order to manage symptoms and possible complications of TOP at home without a health care provider, Rominski and Lori (2014:3) suggested a follow-up text messages be sent to every woman who opted for TOP.
Research findings also revealed that the participants experienced physiological challenges such as severe vaginal bleeding with clots and for some, a foetus. This was evident when the participants said:

“I didn’t know what was happening inside of me, the clots that were coming out.” (Participant 2).

“I noted that blood came out when I went to the toilet, the minute I sat on the toilet seat, I felt the foetus coming out.” (Participant 5).

“There were clots that were coming out, I remember I finished the whole pack of sanitary pads in one night.” (Participant 9).

According South African National Guideline for Implementation of the Choice of Termination of pregnancy Act (NDoH, 2018:37) episodes of heavy bleeding are common during TOP. Incidence of excessive bleeding after TOP is predominantly reported in the medical, rather than the surgical, method (Shokry, Fathalia, Hussien & Eissa, 2014:96). Constant et al. (2014:304) reported that TOP, like other surgical procedures, carries an inherent risk of heavy bleeding due to the damage of genitourinary tract organs. The participants also experienced physiological challenges after the TOP procedure.

c) Physiological challenges experienced after TOP

The research findings show that one participant experienced physiological challenges two weeks after TOP, including severe vaginal bleeding with clots and abdominal pains. The participant claimed:

“When I went back to the clinic the following week [after TOP], I was having a heavy flow with clots, they said that there’s nothing that they can do, and I have to feel that pain for ± 2 weeks of that time.” (Participant 8).

“I had to deal with the bleeding. I had to walk from the clinic, from Carlton Centre to Park station, I had to walk that long distance after the procedure. “Firstly I
was drowsy from the medicine, I was also bleeding, and it was very uncomfortable because I didn’t know what was happening”. (Participant 5).

A study conducted in Zimbabwe revealed that out of 1,282 women who have undergone TOP, 59% experienced mild side effects, 19% had moderate side effects, 19% experienced severe side effects, and 3% experienced near miss or death as complications after TOP (Madziyire et al., 2018:1). The most common reported side effects were: pain, high temperature, sepsis, pelvic abscess, clinical anaemia, haemorrhagic shock, uterine perforation, hysterectomy and death (Madziyire et al., 2018:1). Obos Abortion Contributors (2014, March 27) reported that persistent severe abdominal pain after TOP is an indication of infection due to retained placental tissue, and in rare cases, it may indicate an ectopic pregnancy.

The frequent cause of postpartum haemorrhage after medical TOP is uterine atony, retained placental fragments or uterine rupture. To save the costs of managing complications from unsafe TOP in South Africa, Lince-Deroche, Harries, Constant, Morroni, Pleaner, Fetters, Grossman, Blanchard and Sinanovic (2018:167) recommend the expansion of medical TOP services to the second trimester of pregnancy. All the mentioned literature confirms that the research findings of physiological challenges after TOP as experienced by the one participant require immediate medical intervention. The research findings showed that the participants did not only experience TOP physiological challenges in their body, they also experienced emotional challenges in their mind.

3.3.1.2 Sub-theme 1.2: Experiences of emotional challenges (mind/soul)

In this study, the relative mental health status of female undergraduate students who had undergone TOP is reflected by their experiences of emotional challenges before, during and after TOP. For the purposes of this study, the mind or soul refers to the capacity and the quality of the psychological processes of thinking the participants applied before, during and after the TOP procedure (University of Johannesburg, 2010:6). Omartian (2013:163) states that a whole person is made up of spirit, body and soul; the soul is made up of mind and emotions, and if any part of these dimension is negatively influenced, the person becomes emotionally paralysed. According to
Omartian (2013:163) the root cause of a person to be emotionally paralysed is the fear of: failure, not living up to some standard, future, judgement, criticism and fear of man, as in the case of participants in this study. Categories developed from this sub-theme are presented and discussed in detail as the following categories:

- Emotional challenges experienced before TOP
- Emotional challenges experienced during TOP
- Emotional challenges experienced after TOP

a) Emotional challenges experienced before TOP

In this research study, it became evident that the participants experienced the following emotional challenges before the TOP procedure (during the pregnancy stage): shock, fear and denial, suicidal thoughts, and experiences of contradictory feelings. These emotional challenges before the TOP procedure are discussed in depth as experienced by the participants.

The participants mentioned that they felt sick and were not aware that they were pregnant until they took a pregnancy test. After confirmation of the pregnancy, the participants verbalised that their initial emotional experiences were shock, fear and denial, and they developed a hatred towards their unborn foetus. This is supported by the following statements:

“When the doctor told me I was pregnant, it was a shock of my life, and I thought it was a dream.” (Participant 1).

“I was just afraid and scared of what I have done, I hated the baby to the core.” (Participant 2).

“It was one of those times that I was in denial, not really being sure that I am really pregnant.” (Participant 3).
Rubertsson, Hellström, Cross and Sydsjö (2014:221) also emphasise that shock and anxiety symptoms are common emotional experiences during early pregnancy for women who face physiologic and psychological stressors. The research findings revealed that some of the participants were so shocked and overwhelmed by their severe emotional distress, they could not cope after discovering that they were pregnant. The participants mentioned that they were overwhelmed by their emotions and perceived suicide as a solution to this inner turmoil. The following statements from participants confirm suicidal thoughts:

“The only thing I saw as a solution to this was just suicide, because I thought that even if I do this, I will die from it and my family will know that I died because of this. So I might as well commit suicide and this would be the best way, the best solution ever”. (Participant 8).

“When my emotions are too much, I would think, maybe I should go jump over there from the top, maybe I can even take medication, take pills and maybe try kill myself.” (Participant 4).

Curley (2014:947) affirms that most women experience fear and anxiety upon confirmation of an unplanned pregnancy. These emotions are heightened and sustained during the progression of the pregnancy and may even cause thoughts of suicide. Suicidal attempts before TOP among adolescent women is significantly related to socioeconomic and psychosocial circumstances, and the intention becomes a solution and viable means to escape the ordeal (Keltner & Steele, 2015:225; Coelho, Pinheiro, Silva, de Ávila Quevedo, de Mattos Souza, de Matos, Castelli & Pinheiro, 2014:1241).

Although the pregnancy was unplanned, the research findings revealed that the participants experienced emotional challenges of contradictory feelings during pregnancy; not knowing whether to continue with the pregnancy or to choose TOP. Some participants verbalised that they initially felt excited after discovering they were pregnant and they felt connected to the unborn baby, but later wanted to get rid of the baby. One of the participants mentioned that she had terminated a pregnancy before and did not want to repeat the experience again. The participants mentioned that
although their principles were against TOP, continuing with the pregnancy was going to interrupt their studies. This can be noted in the following participants’ statements:

“I didn’t want to terminate the pregnancy because I had terminated the pregnancy before, so I didn’t want to do it the second time. I vowed to myself that it is not something that I want to go through the second time, and he knew that I didn’t want to terminate the pregnancy.” (Participant 4).

“I was so excited, that yeah… I am finally pregnant, I am happy and I am 21 years now and I slept but when I woke up in the morning it was a total different story because I wanted nothing to do with the baby.” (Participant 2).

“There is something inside me that is moving and at that moment it became my baby, I felt very much connected to the baby in the manner that will overpower my decision to terminate the pregnancy and I was saying ‘oh my baby’ I am so sorry for what I am going to do.” (Participant 5).

“I didn’t know what to do, I always told myself I will never have an abortion not even once. I told myself that I will never do it, I rather suffer with my child, I always said that, it was one of my principles, then it happened to me. I was about to start my first year, excited coming to university and here it comes, I am pregnant.” (Participant 3).

Unplanned pregnancy and the decision to terminate a pregnancy is a complicated and difficult decision and most women experience significant distress, such as anxiety due to their contradictory feelings experienced prior to the TOP (Tsonrng-Yeh et al., 2014:4). Literature supports the findings of this research study that unplanned pregnancy that ends with TOP is often hallmarked by ambivalent feelings and anxiety because of the personal decision being in conflict with the personal values (van Ditzhuijzen, ten Have, de Graaf, van Nijnatten & Vollebergh, 2015: 249; Subramaney, Wyatt & Williams, 2015, 283).
Findings also revealed that some participants delayed accessing TOP services and were in denial about being pregnant. Some were also uncertain whether TOP is an option or not. This was evident when the participants said:

“It was one of those times that I was in denial, not really being sure that I am really pregnant, so I didn’t take action in January.” (Participant 3).

“I asked about abortion and they said to me that it was easy, I can get it done as soon as possible, and it was up to me but I was not sure if I was supposed to do it.” (Participant 9).

The cause of delays in adolescents accessing safe TOP on time, includes fear of disclosure of their need for TOP, not having enough time to decide about the unplanned pregnancy, being young and scared to undergo TOP (Adhikari, 2016:1; DePiñeres et al., 2017:4). Ralph, Gould, Baker and Foster (2014:433) emphasise that women, in general, experience more contradictory feelings about TOP than other health care decisions, and should be offered additional information beyond the typical existing counselling practices. Research findings also revealed that the participants experienced emotional challenges during the TOP procedure.

b) Emotional challenge experienced during TOP

The participants experienced emotional challenges, such as feelings of regret and self-accusation during the TOP procedure. The participants narrated that they felt the most profound emotional impact during the TOP procedure and they described it as a horrible experience. They regarded it as killing their child. This is confirmed by the following participants’ statements:

“During that fifteen minutes I could only think of how I am killing my own child.” (Participant 1).

“It was a horrible experience but at that time I felt like, I had no other choice.” (Participant 9).
Literature confirms that foetal loss, whether voluntary or not, is a traumatic experience and the severity of psychological distress after TOP may have a more significant impact on the mental health of the woman than was previously thought (Curley & Johnston, 2013:290; Bellieni & Buonocore, 2013:20). For a female university student who believes and perceives a foetus as a human being and TOP as murder, it is a stressful choice, which can become more stressful during the procedure (Tsorng-Yeh et al., 2014:5; Daugirdaité, van den Akker & Purewal, 2015:1). Most women when they present at the health facility, are said to be certain of their decision. However, most experience guilt, regret, grief and self-accusation during the procedure because of the perception of TOP as killing an innocent baby (Subramaney et al., 2015:283; Roberts, Belusa, Turok, Combellick & Ralph, 2017:1). Although the participants anticipated relief after TOP, the research findings revealed that the participants experienced emotional challenges even after the TOP.

c) Emotional challenges experienced after TOP

Although TOP was perceived as a solution for an unplanned pregnancy and a relief, participants mentioned that they later experienced negative emotional challenges after the TOP procedure, including regret. These negative emotional states were aggravated by seeing babies on television, being in possession of the ultrasound pictures of the aborted baby and seeing friends who kept their babies. Participants expressed:

“The sonar…. lyoooh…I cannot let it go, I don’t know why. I can’t throw it away, I can’t , I don’t know why….I don’t know. I just keep it there in my purse in the hole where no one can see, if you search my purse you can’t see it.” (Participant 4).

“Looking at it is like looking at the pictures of a child, it is like, oh my baby (Ao! ngwanaka bathong) I just keep saying ‘my baby…my baby’ and I will cry, maybe it is the thing that makes me cry sometimes.” (Participant 3).
“To this day, I regret the decision I made, whenever I see a baby on television or social media, it just makes me sad to think I would have had something like that.” (Participant 2).

“When I got home because I felt so cold and I went to the bathroom and took a bath and after that I slept. I woke up, felt so lonely, I felt that whatever I have done was eating me inside because on that very same day I was supposed to write the business test but I couldn’t write because I just wanted to get rid of the baby”. (Participant 5).

According to Curley (2014:946), health care providers promote TOP as a solution for an unplanned pregnancy with the assumption that the women who choose TOP will find relief. However, because TOP is a personal event, women’s emotional responses may vary after the experience (Biggs, Rowland, McCulloch & Foster, 2016:7). Curley (2014:947) confirms that after TOP, the negative emotions either resolve in cases of those women who feel relief or can worsen in cases of acute and chronic emotional distress and anxiety.

The findings in this research study show that some of the participants continued to experience prolonged sadness, which manifested as crying because of the TOP that occurred at the same time as other adverse life events, such as the death of family members, thus the anniversary of such events brings back emotional memories of TOP. Participants claimed:

“I don’t know because I can’t separate, why I am crying because everything happened in the same year [TOP & death of grandmother] in the space of 3 weeks, so I don’t know why I am crying.” (Participant 2).

“Sometimes I didn’t know why I was crying, was it because of my father’s death or was it because of abortion [TOP].” (Participant 5).

Biggs et al. (2016:9) concur with the research findings that these unresolved negative emotions and prolonged sadness can be worsened by the TOP experience co-existing with other traumatic life events or mental health problems. Clinical symptoms of
depression are: loss of interest in all or most activities, feelings of worthlessness and excessive guilt, an inability to concentrate, recurrent suicidal thoughts, and irritability (Fick et al., 2016:171). TOP seems to be more traumatic with regard to negative emotional experiences; post-traumatic stress disorder (PTSD) and depression are more frequent after TOP than in miscarriages and with the birth of an unplanned baby (Bellieni & Buonocore, 2013:20). Subramaney et al. (2015:937) maintain that sometimes women may not become depressed following TOP, but experiences such as economic challenges and other life challenges prior to TOP can influence how they cope after the procedure. Often, these women with unresolved stressors before the TOP procedure experience prolonged emotional distress after TOP and may have insufficient coping skills to adjust after TOP (Curley, 2014:947). Depression and anxiety are the most common mental health problems among women of 18-24 years and is habitually characterised by the presence of persistent and severe subjective distress. If not diagnosed early, it can lead to severe impairment in functioning (Fick et al., 2016:163).

The research findings revealed that the participants continued to experience frequent episodes of emotional distress after TOP. The participants mentioned that the felt connected to the foetus. Seeing friends who continued with their pregnancy and kept the babies aggravated their feelings of guilt and made them think about the baby they had terminated. Participants mentioned that these guilt feelings made them cry:

“I felt attached to the baby, because it is still your baby. Sometimes you wonder what it was going to look like, and now you get the bigger issue.” (Participant 6).

“I felt so connected, for some reason I was so connected to this baby inside me even though there was no movements yet or anything. I just felt so connected”. (Participant 8).

“One thing that makes me cry is when I see my friends who have babies now, because I think our baby would have been born the same year. Two of my friends have babies, I admire them, and they are very strong. I admire them and they make me feel guilty about myself.” (Participant 5).
"I kept on thinking that my life could have changed or just holding that precious baby in your arms could have just been a blessing". (Participant 1).

Literature revealed that issues, such as attachment to the foetus and seeing the ultrasound pictures before TOP, are stressful events and predictors of depression and PTSD among the majority of female university students (Curley, 2013:290; Daugirdaité et al., 2015:9). After seeing the ultrasound picture of the foetus before TOP, female university students were frightened by the supernatural threat that the spirit of the foetus still lived in their bodies and will take revenge and haunt them (Tsorng-Yeh et al., 2014:9). Most women experience emotional distress due to concern of the after-effects of the TOP procedure on the womb. This emotional distress can worsen due to the evacuation of the uterus in an awake state without adequate TOP counselling (Curley, 2014:947).

Research shows that some of the participants continued to experience a constant emotional struggle by keeping the TOP a secret due to fear of stigmatisation. In order to try to normalise and manage the felt stigma, guilt-trips and constant emotional conflict, the participants used different coping strategies. These included justifying their actions, pretending, lying, and believing that they had a miscarriage instead of TOP. This is illustrated in the following statements:

“I reminded myself again that what I did was right, I am young, and I can’t handle the baby at my age.” (Participant 5).

“So, for this past few months that I have done the termination, which I did this year, I just kind of blocked it out of my mind a lot of times, I haven’t thought about it even if it does come at certain times. I have just blocked it out of my mind”. (Participant 9).

“There are no coping mechanisms for the feelings of emotional pain, you just pretend that you don’t feel anything, it is all about pretending.” (Participant 1).
“I don’t think I will live with it myself if I keep telling myself I had an abortion, so I have to believe that I had a miscarriage and this is what I believe, live with the lie, that is the only way I can deal with it.” (Participant 3).

Cockrill (2013:979) explained that because of the learned negative stereotypes about TOP and the internalised stigma, women experienced their TOP as moments where they failed to live up to their own moral code and judged themselves harshly. In response to this, they rationalised and justified their actions in an attempt to manage their reputation and sense of self-worth. However, Kheswa and Takatshana (2014:117) reported that these repressed negative emotions after TOP could have a detrimental effect on the women’s psychological wellbeing in future.

The research findings show that although the participants used different coping strategies after TOP, they actually could not cope. Some participants mentioned that they attended free psychological services offered by the university, but felt that it was not effective and a waste of time. Other participants knew about these services but were reluctant to access these because of the belief that they killed their baby. They described the experience as permanent torture. These statements substantiate the findings:

“I don’t think you can run away from it. It is like a permanent torture, and there is no way that you can run away from it.” (Participant 6).

“So I just didn’t see any psychological consultation helping in any way. I felt that it is a waste of time and hurting myself even further because what I will hear will not be what I wish to hear, but it will be what this person wishes to say to me about how wrong and how immoral of what I did”. (Participant 8).

“To me I can’t say the counselling was effective, I was not ready by that time, and I was still in the confusion regretting why I did this [TOP], so I just didn’t see any psychological consultation helping in any way. I felt that it is a waste of time and hurting myself even further.” (Participant 5).
“Nothing will take the emotional pain away, I don’t care even if I go to a psychologist or pray for me, the fact that I killed the baby doesn’t change.” (Participant 9).

Women are confident of their decision to terminate their pregnancy when they present for reproductive health care and feel that counselling would be an unnecessary burden and delay the process (Ralph, Foster, Kimport, Turok & Roberts, 2016: 4). Hodes (2016:87) remarks that in South Africa, TOP counselling is not applied as a measure to relief symptoms of stress in public health clinics because of the overcrowded clinics and health workers’ resistance to fulfilling the requirements of the CTOP Act 92 (SA, 1996).

The participant mentioned that living with the TOP experience changed their personality. Participants mentioned that after TOP they are now an irritable and bitter person and lost self-confidence. The participants said:

“I feel like everywhere I go people see me that “you have done this”. I feel so small around people that I have lost my confidence in everything I do. I feel that this is a reminder even if when I try to brag about something good that I have done, this will always be a reminder that ‘you know what, don’t forget that you did this’. (Participant 8).

‘I am not saying termination of pregnancy is bad, but it has major challenges, like what I am experiencing and what I have experienced. It is like a life time thing, it doesn’t make me feel like I am that girl I used to know”. (Participant 6).

“It made me short-tempered, I am easily angered right now, and it just made me a bitter person. You see, people react differently to pain, me it just made me a bitter person, but it changes you in a way.” (Participant 3).

Curley and Johnston (2014:304) assert that the psychological effects reported after TOP among college students provided evidence for a need to develop targeted post-TOP psychological services which are not available for this population. The research findings in this study revealed that the participant, as a whole person, experienced an
overlapping of emotional and spiritual challenges which manifested as feelings of self-flagellation and self-condemnation during the TOP process.

3.3.1.3 Sub-theme 1.3: Experiences of spiritual and religious challenges (spirit)

The spirit in the internal world of the female university students who have undergone TOP refers to two interrelated components; the conscience and the part within the participants reflecting their relationship with God according to the Theory of Health Promotion in Nursing (UJ, 2010:6). The spirit in the internal world of the participant has an integrated function with the spiritual dimension in the external world, which refers to values and religious aspects as defined by the Theory of Health Promotion in Nursing (UJ, 2010:7). Most of the participants regarded themselves as religious and having a relationship with God. The research findings revealed that the participant, as a whole person, experienced spiritual challenges after TOP. The participants verbalised that according to their religious values and conscience, TOP was regarded as a sin. It was viewed as killing and taking someone’s life and a wrongful act that affected their relationship with God. The participants said:

“Afterwards I regretted, where you find yourself asking if this is wrong? if God says it is wrong to kill.” (Participant 9).

“The thought of me choosing to please human beings and compromising my relationship with God.” (Participant 2).

“Sometimes I feel that I have done a big sin, I feel like a sinner now because I took someone’s life.” (Participant 7).

“It still makes you feel dirty, the fact that you killed the child makes you feel dirty [sobbing].” (Participant 3).

The research findings revealed that the participants regarded themselves as spiritual beings and religious. Their conscience of perceiving TOP as immoral and taking the life of a child that God entrusted to them made the participants feel separated from God. The participants highlighted that they perceived TOP as something that
compromised their relationship with God, and every setback in their lives is viewed as God shutting doors in their faces. One participant experienced TOP twice and was concerned that maybe God would punish her and not give her babies again.

“When you are a spiritual person, you think, okay, I have been pregnant twice and I terminated twice, what if God decides not to give me babies again?” (Participant 9).

“That time I felt like God is punishing me for terminating my pregnancy, this was Gods’ way of saying what you did was wrong and immoral, so you might as well die, I will make you to suffer too. I just had the worst days of my life during that time”. (Participant 8).

Literature concurs with research findings that the conscience-component of the spirit, which distinguishes between right and wrong, is the main reason women who opted for TOP considered it as murder and against God’s will, and regarded themselves as sinners (Gelaye et al., 2014:6). Selebalo-Bereng and Patel (2018:12) found in their study that opposition to TOP remains a challenge in South Africa, especially getting adolescents and women to view TOP as their sexual reproductive health right versus the rights of the foetus.

The research findings revealed that the participant, as a whole person, did not only experience spiritual challenges related to their internal world; they also experienced difficulties related to their spiritual external world when undergoing the TOP process. The participants opted for TOP as a solution to their unplanned pregnancy, even though it was against their religious practices. Some of the participants mentioned that the TOP experience affected their participation in church activities, such as partaking in the Holy Communion and ushering at church, as TOP was regarded as wrong and sinful. This is illustrated in the following statements:

“At home we are Catholics, and for Catholics if you had an abortion [TOP] you are not allowed to take the Holy Communion anymore.” (Participant 9).
“There are some things that we are told when you are an usher or you call yourself a Christian, things like abortion [TOP] are considered to be wrong, like sin.” (Participant 1).

Literature supports the findings of this study that women with strong religious beliefs experience higher levels of stigma, self-judgment, and a greater perception of community condemnation than non-religious women (Cockrill, Upadhyay, Usha, Turan & Foster, 2013:79). In South Africa, religion and spirituality plays a role in adolescents’ attitude towards TOP and reported to have the most negative attitude towards TOP (Selebalo-Bereng & Patel, 2018:1). According to Munroe (2016:20), religion is one of the greatest fall-backs; by telling a person everything will be all right at a later stage, it postpones reality to the future by helping the person be content with the depression and frustration they are trying hard to reconcile but cannot change.

3.3.2 THEME 2: Challenges experienced by participants related to their external world

The second theme that was identified during the data analysis was the challenges experienced by participants related to their external world. In the context of this study, challenges experienced related to the external world refers to those structures outside the internal world (body, mind/soul and spirit) of the participant, such as the physical and the social dimensions as defined by the Theory of Health Promotion in Nursing (UJ, 2010:4). In the context of this study, the physical will be referred to as the material resources. The sub-themes that emerged from this theme are:

- Experiences of material resources challenges
- Experiences of social challenges

3.3.2.1 Sub-theme 2.1: Experiences of material resource challenges

The research findings showed that the participants experienced physical challenges within the physical dimension of their environment as explained in the Theory of Health Promotion in Nursing (UJ, 2010:4) within which the findings of this study are
discussed. Experiences of physical challenges in this study, are the challenges experienced by the participants related to the material resources such information, education and communication material on TOP and services. After confirmation of the unplanned pregnancy, the individual participants experienced challenges in their physical dimension within the TOP process, such as accessing information about TOP, accessing TOP services, and challenges experienced at the TOP clinic.

a) Challenges experienced in accessing information on TOP services

TOP has been a legalised sexual reproductive health right in South Africa since 1996 (CTOP Act 92 of 1996). The research findings revealed that some of the participants lacked information on safe TOP services. Some participants mentioned that they consulted friends who went through the same TOP experience, in order to get information TOP services. The participants mentioned that they were not comfortable to disclose that they are the ones who needed the information. Participants explained:

“I didn’t know what to do, I didn’t know anything about abortion [TOP] clinic, it was a job and half to get someone who talked to me, when I told them [nurses] this is my problem, because all of them were all swearing at me telling me I am going to hell.” (Participant 3).

“I asked my friend about the clinic but I didn’t tell her straight that it was me who wanted the clinic. I told her that it is my other friend, she needs help”. (Participant 7).

“So I consulted with a friend who went through the same experience, she told me about this clinic in Carlton Centre, where they terminate the pregnancies.” (Participant 5).

Momberg, Harries and Constant (2016:7) concur that timeous access to TOP information is an essential component of safe TOP. Adhikari (2016:8) states that youth are more likely to be sexually active, but their knowledge about physical TOP services and legislation is low, causing delays in accessing TOP services on time. Most often women who are seeking TOP get discouraged by health care providers, fragmented
and disorganised services, poor service delivery, and structural or system-related issues (Sullivan, Harrison, Harries, Sicwebu, Rosen & Galárraga, 2017:7). Also, health care providers are expected to advocate for the women’s rights. However, because of their own mixed feelings regarding the procedure, they are not transparent about the information and provide women with incomplete information about how to access safe TOP services (Sullivan et al., 2017:8).

b) Challenges experienced in accessing TOP services

The participants who visited public TOP services could not easily access these services because of the booking system, shortage of health care providers, and travelling to unfamiliar places. Participants described their experience by saying:

“When we got there it was fully booked, they told me I will not get a space if I keep on coming in the afternoon. I didn’t know Soweto, it was my first time there, and I have never been there. I think I was almost three months pregnant. Then the following morning I went back to the clinic but the section was closed.” (Participants 3).

“You still have to book an appointment, do sonar then come back after a week for termination, so I had to go back home now because it was already full and already late.” (Participant 7).

“When I got there, the matron said she doesn’t have enough staff for that day. I insisted and said, no you can’t turn me back because if a week passes I will be three months full.” (Participant 5).

Accessing TOP services on time is a global challenge among more impoverished women due to preventable barriers to care such as cost and logistical barriers of seeking services and outsourcing of public services to the private sectors (Baum, White, Hopkins, Potter & Grossman, 2016: 1). Clinic closures are said to be the main reason for delayed access to safe TOP care and prevents women to terminate their pregnancies as desired (Fuentes, Lebenkoff, White, Gerdts, Hopkins, Potter & Grossman, 2016:292; DePiñeres et al., 2017:4; Reeves, Blumenthal, Jones, Nichols,
In South Africa, 77% of designated facilities provide TOP services, with 87.5% being in Gauteng Province (Teffo & Rispel, 2017:1). The reasons stated in the literature for women using unsafe services included: 14 out of 61 TOP facilities in Gauteng Province were not functional because of the shortage of trained TOP providers, lack of equipment, lack of medication, and space (Teffo & Rispel, 2017:7).

Barriers, such as the appointment system, clinic operational times, and travelling to unfamiliar cities, leave most women confused, with compromised privacy and increased costs of travelling to access safe TOP services (Harries, Gerdts, Momberg & Foster, 2015:5; Fuentes et al., 2016:292). According to Teffo and Rispel (2017:1), prioritisation of TOP services, supportive management and employee wellness programmes for TOP providers are important to establish an enabling health policy environment (Teffo & Rispel, 2017:1).

Some of the participants in this study accessed “unsafe” TOP services and private TOP providers because of the barriers at the public health clinics, and experienced financial challenges. The participants claimed:

“And I was like…iyoh. I can’t wait so long, my mother is going to recognize that I am pregnant and eventually I will not do an abortion and she will be angry at me because she always talked to me about such things.” (Participant 7).

“We went there and asked for the price and it was R2 000.00. I didn’t have money, I only had R1 000.00. We went down looking for a loan, asking for money, eventually we got the money.” (Participant 4).

“I came here at the clinic asking for an emergency pill, however due to the queue and bookings in the mornings and everything, I ended up going back without the pill and after few days I started noticing that I am not myself, So I went to the doctor, and he said you can pay this much and we give you pills to drink and insert in the vagina and you go home, later tonight you will start bleeding” (Participant 5).
According to Mushwana et al. (2015:15), other material resource challenges, such as fragmented sexual reproductive health services where young women cannot access the full package from one clinic and have to go to another clinic, is the main contributory factors towards delays in women accessing safe TOP on time. In order for women to access safe TOP at the stipulated time (Momberg et al., 2016:7) recommend the use of mobile health technology, such as an online gestational age calculator instead of ultrasound, which can only be done per appointment and causes delays. TOP is a safe, effective solution for unplanned pregnancy and an essential entry point for effective sustainable contraceptive usage, however, the compromised adolescent health will negatively affect the country’s economy and future generations (Salam, Das, Lassi & Bhutta, 2016:591).

c) Challenges experienced at the TOP clinic

The research study findings show that having got to the TOP clinic, the participants were only offered standard counselling and information on the TOP. The participants highlighted that they received no information at the clinic about what was going to happen after taking the TOP medication. They only received the medication to drink and were told that it would clean the womb. These physical challenges experienced at the TOP clinic as research findings are reiterated by the participants’ comments and feelings about counselling:

“When I got there at the clinic, there is not even a time at the clinic when they talk to you and tell you, ok, this is what is going to happen with you and what not.” (Participant 1).

“The nurse gave me the forms to fill asked me how far along I was and gave me the small pill to drink and told me that it would clean my womb out after few hours. That scared me because I didn’t know what exactly that meant.” (Participant 4).

“They gave us pills, those pills I don’t know what they for, they didn’t explain, they just gave us pills to drink them, we did that and we waited for ± 45 minutes before the whole procedure”. (Participant 8).
“So they give you two pills and you sit there and wait, and one by one we went into that scary room where everybody is screaming.” (Participant 9).

Section 4 of Choice of Termination of Pregnancy Act 92 (SA, 1996) advocates the provision non-mandatory and non-directive counselling before and after TOP and should be conducted in the manner that allows the client to make autonomous and informed decisions. The National guideline for implementation of the Choice of Termination of Pregnancy (NDoH, 2018:20-21) states the client should be told about the procedure, what pain management is available, complications and risks and when to resume sexual intercourse. However, according to Kumar, Baraitser, Morton and Massil (2018:51), most women seeking TOP are offered brief counselling before TOP, but these women felt that it was unnecessary and intrusive and did not want to discuss their decision.

3.3.2.2 Sub-theme 2.2: Experiences of social challenges

The term “social” refers to the society and/or human resources in the external world (environment) of the individual. In the context of this study, the human resources in the external world of the participant refer to the partner, parents, friends and health care providers according to the Theory of Health Promotion in Nursing (UJ, 2010:5-6). Curley (2014:946) mentions that women who were pressured by circumstances, partners and parents to undergo TOP, regretted their decision and did not experience relief as was previously anticipated. Discussion of the social challenges experienced during TOP procedures are presented as:

- Social challenges experienced with partner, parents and friends
- Social challenges experienced with the health care providers.

a) Social challenges experienced with the partner, parents and friends/colleagues

Within the process of TOP, the participants, as social beings, experienced challenges with partners, parents and friends. A partner refers to the person who the participants
had a sexual relationship with resulting to the unplanned pregnancy (Hornby, 2010:107). Some of the participants decided to undergo TOP because they were in an unstable, unsupportive and/or abusive relationship with their sexual partners. This is evident in the following participants’ statements:

“Since I discovered that I was pregnant, I was not happy due to the fact that I was involved in a relationship that was very abusive for me, mentally, physically and emotionally.” (Participant 6).

“What discouraged me even more was my boyfriend’s response towards the whole situation. He was not willing to help me, he was not interested at all”. (Participant 8).

“He said girl like you are such a cheap material, I wouldn’t want to start a family with you.” (Participant 5).

Chibber, Biggs, Roberts and Foster (2014:134) states that one of the reasons young women opted for TOP was due to being in an abusive relationship and unsupportive partner and they used it as a way to end the relationship. Literature further concurs with the research findings that most women who reported at the TOP clinic experienced physical, emotional and sexual abuse from their partners (Hall, Chappel, Parnell, Seed & Bewley, 2014:15). Exposure to physical and sexual abuse was strongly associated with the symptoms of anxiety and depression common among women requesting TOP. According to Tinglöf, Högberg, Lundell and Svanberg (2015:51) it is essential that health professionals should recognise these emotional signs and offer support to these women (for a more detailed discussion on emotional challenges as experienced by participants, refer to: Theme 1: Sub-Theme 1.2).

Research findings also revealed that there were participants who engaged their partners during TOP decision making, however, they did not get the support they anticipated because their partners were against TOP and other partners insisted on TOP. However, the participants reported going against their partner’s wishes and opting for TOP while other participant eventual opted for TOP as a choice as according
to the partners desire. As a result of their decision to go against their partner’s wishes, their relationships ended. One of the participants said:

“We kept on talking about this, eventually he got to understand that I wasn’t ready to be a mom, he had doubts. He was afraid that if I terminate this one baby, what if I don’t get other kids at the later stage”. (Participant 1).

“After the day I went for termination, I called him and told him that I have done it that was the last day I talked to him. That was the last day, because after I told him that I have done it, he said “good, you made a good choice, goodbye”. (Participant 8).

“Later on we fought and we separated and agreed that there was no relationship for us and everything because he was against what I did, we broke up.” (Participant 6).

According to Selebalo-Bereng and Patel (2018:12), young women cannot exercise their sexual reproductive health right without often threatened by the resistant voices of their partners opposing TOP. Ralph, Gould, Baker and Forster (2014:2) further maintain that partner involvement during the young woman’s TOP decision making is not indicative of support, because some of the young women experience pressure and persuasion from their partners that goes against their wish for TOP. Literature revealed that three out of four women who did not terminate their unplanned pregnancy were discouraged by their partners, but only one out of the four women received support from their partner after carrying the pregnancy to term (Hajri, Raifman, Gerdts, Baum & Foster, 2015:6). Partner involvement and influence during TOP decision making is important and seems to play a role in women’s ability to ultimately obtain TOP (Hajri et al., 2015:6). However, sometimes the delay to access TOP early is due to the challenges experienced with partners being against TOP, pressure to terminate the pregnancy, and reluctance to carry the pregnancy to term alone after breaking up with their partners (Appiah-Agyekum, 2014:535).

The participants who involved their partners during the TOP decision-making process received support in the form of information, money to procure TOP pills and
accompanying them look for to TOP services. The participants described the support they received as follows:

“It was a job and half to get someone who talked to me, I was about to give up and my boyfriend spoke to one nurse who was walking down the passage, he asked her where we can find abortion clinic because we didn’t know anything”. (Participant 3).

“After that I don’t know where my boyfriend got the information from, he told me that there was a doctor in town, but he will go there by himself because I couldn’t go there that time.” (Participant 7).

“One weekend I lied that I was going to my other relative but I was at my boyfriend’s place. The next morning we left his house at five in the morning, that’s when I went back to Chiawelo clinic, that’s when I got my appointment”. (Participant 2).

One of the participants mentioned that although her partner was initially against TOP, after discussion the partner provided not only financial support but also emotional support. The participant said that her partner accompanied her to the clinic and after the TOP, although he was not allowed access during the procedure. The participant explained:

“I was with my partner but they don’t allow the partners to get in, and the males are not allowed to go in there. After TOP, he held my hand and we were just walking together. He was supportive other than the fact that he had doubts that maybe he didn’t make me pregnant, but he was supportive.” (Participant 3).

Appiah-Agyekum (2014:531) supports this research finding that partner support during TOP plays a significant role in decision making, in the choice of method, and for support during the procedure. Despite the considerable effects of TOP on physical comfort or emotional responses, partner support during TOP is well received and desired by women. This suggests that there is an unmet psychosocial need for procedure-related support among such women (Wilson, Gurney, Sammel & Schreiber,
The research findings did not only show challenges with partners, but also with family members.

Some of the participants mentioned that they were raised by single parents and were from a low-income family background. Although the Choice of Termination of Pregnancy Act 92 (SA, 1996) mandates that adolescents should be encouraged to involve their parents in their TOP decision, the participants highlighted that they concealed their unplanned pregnancy and kept the TOP a secret because of the lack of healthy relationships with their mothers and the fear of being judged and rejected. Those participants who had a good relationship wanted to maintain the trusting relationship with their mother by keeping the secret, also because of the mother’s religious belief system. This was evident when the participants said:

“I have always wanted to make my mother proud because she had me when she was 17yrs old. When we fight, she always tells me that she doesn’t want the history to repeat itself at home.” (Participant 7).

“When it happened, I was about to start my first year, excited coming to university, here it comes, ‘I am pregnant’. The thought of disappointing my grandmother, because when I got pregnant it was the same year my grandmother died”. (Participant 3)

“She trusted me, she even knows that I am a virgin, she doesn’t know that I have been having fun around, and she doesn’t even know.” (Participant 9).

“I feel she is going to judge me even though she is not going to say it in words, so I kept the secret for the whole year, I just had to go through it alone.” (Participant 6).

Mothers are highly influential figures in the lives of their daughters in discussing sexuality issues (Rangiah, 2012:14). However, in case of an unplanned pregnancy and TOP, female undergraduate students conceal their status from their mothers in order to gain acceptance and avoid rejection and stigma (Appiah-Agyekum; 2014:535). For some female university students who do not have healthy relationships
with their parents, opting for TOP was an escape of the whole embarrassing ordeal of talking to them (Tsonrng-Yeh et al., 2014:1; Tong, Low, Wong, Chong, & Jegasothy, 2012:743; Kheswa & Takatshana, 2014:116).

Over and above challenges with partners and parents, the research findings also showed that participants had relationship challenges with friends who were fellow students. The participants did not disclose their experience to their friends because of the fear of being judged and the negative comments regarding TOP. The participants explained:

“People’s comments about it [TOP] are mostly negative, and those are the comments that disturb me most.” (Participant 3).

“So the minute I talk to my friend about it, I feel she is going to judge me even though she is not going to say it in words, but the way she is going to look at me is going to be different from the way she does now. So I just couldn’t tell anyone about it. Not at all, I just didn’t want anyone to know about it up to this day”. (Participant 8).

“I don’t talk about my experience of termination because it is a sensitive issue. I feel like they [friends or fellow students] are going to judge me.” (Participant 2).

Cockrill and Biggs (2018:1) state that most women who have undergone TOP are reluctant to disclose their TOP status because they do not have control over other people to conceal their secret. This decision may also result in isolation and lack of support, contributing to a broader social silence.

The findings of the research revealed that most of the participants avoided being around people or engaging in discussions because of the fear of being hurt by their negative comments about TOP. Some of the participants experienced low self-esteem, lost self-confidence, isolated themselves and could not cope with the emotions. For some participants, the experience changed their personality and affected their self-esteem. This was evident in participants’ statements, such as:
“When I am alone, I don’t know how to cope with this feelings, I just move along as if nothing has happened. I feel that all this feelings bottled up inside of me and it going to come to a point where they are going to come out and they are going to come out in a negative way”. (Participant 1).

“I feel like everywhere I go people see me that, I feel so small around people that I have lost my confidence in everything I do.” (Participant 8).

“I don’t like being around those people who are talking about this because everybody has their views.” (Participant 7).

In South Africa, a woman’s rights as an autonomous agent in decision making are observed. However, literature revealed that there is opposition to TOP and that women experienced stigma and shame. Additionally, in their need for secrecy, they isolate themselves from their network of parents, friends and partners (Macleod, Beynon-Jones & Toerien, 2017:7). As long as communities continue to stigmatise and ostracise women who have undergone TOP, the use of unsafe TOP services and suicide will be inevitable, as mentioned by Kheswa and Takatshana (2014:115). As holistic persons, participants also experienced spiritual external world challenges, referred to as religious challenges.

b) Social challenges experienced with the health care providers

The participants experienced challenges with the attitude of health care providers at the TOP clinic. The participants verbalised that the nurses were not empathetic and were also not emotionally supportive during the procedure. Participants expressed:

“It is really, really painful and the nurses are not even nice to make it better” (Participant 1).

“They don’t give you emotional support, they just give you a reason to commit suicide. They drive you to that urge that kill yourself before you kill that baby and don’t come back, when you go there you don’t want someone to tell you that this is wrong”. (Participant 3).
‘When I came to think about it that okay, no one has time to listen to me, the nurses at the clinic don’t have time to listen, so why should I bother people, why should I be that stress to people”. (Participant 8).

“I remember crying because first of all it was very painful. It was more painful than I expected and also the gravity of what I was doing at that point in time. The nurse was saying to me, “Why are you crying, you are the one who decided to do this”. (Participant 6).

“That woman that held my hand had no emotions on her face, it was like she is used to it, her face was blank, no emotion at all.” (Participant 5).

“The nurses there are a bit mean, especially when you are a foreigner, because first of all you are aborting, why you are doing this and all of those things.” (Participant 7).

Participants described the health care providers’ behaviour as not nice, mean, and not emotionally empathetic but displaying a blank face without emotions. Adolescents continue to experience challenges in accessing TOP services due to barriers such health care staff attitude, public opinion about TOP, cultural factors and conservative thinking (DePiñeres et al., 2017;11). Literature also confirms these findings by revealing that the attitudes of healthcare workers were manifested in a judgmental approach as they perceived TOP as ending human life and a mortal sin (Loi, Gemzell-Danielsson, Faxelid & Klingberg-Allvin, 2015:10). The healthcare workers’ moral and social reservations affect and influence their relationship with women who opt for TOP because they view TOP as an act against the nurses’ professional code of saving lives (Loi et al., 2015:9). The perceived heightened stigma around TOP may be the reason most women seek solutions for unplanned pregnancy outside the formal healthcare sectors (Constant, Grossman, Lince & Harries, 2014:304).
3.4 SUMMARY

This chapter aimed to provide a presentation and discussion of the research findings of the experiences of female undergraduate students who have undergone TOP. The research findings were confirmed through literature control. By locating and including all related evidence-based literature on the experiences of TOP, the researcher was assisted in the development of recommendations. The next chapter will focus on the development of recommendations based on the findings, towards the integrated post-TOP continuity of health care services within Campus Health Services for female undergraduate students who have undergone TOP.
CHAPTER FOUR
SUMMARY, EVALUATION, RECOMMENDATIONS, LIMITATIONS
AND CONCLUSIONS OF THE RESEARCH STUDY

4.1 INTRODUCTION

Chapter Four is the second phase of the research study. The aim of this chapter is to develop recommendations towards the improvement of integrated post-TOP continuity of health care within the Campus Health Services for female undergraduate students who have undergone TOP. The recommendations are based on the research findings as depicted in the themes and sub-themes that emerged during data analysis, as presented and discussed in Chapter Three. The summary, evaluation, recommendations, limitations and conclusions of the research study are also presented in this chapter.

4.2 SUMMARY OF THE RESEARCH STUDY

The first chapter offered the background and rationale for conducting the research study on the experiences of female undergraduate students who have undergone TOP. In the second chapter, the research methodology utilised in this study was presented, which is the qualitative, exploratory, descriptive and contextual research design. The third chapter presented the findings of the study, which revealed that the female undergraduate student as a whole person, experienced challenges related to their internal and external world before, during, and after the TOP procedure. In this fourth and final chapter of the study, recommendations are developed based on the research findings from Chapter Three. The summary of the challenges experienced by the participants and the recommendations are presented next.

4.2.1 Summary of the challenges experienced by participants related to their internal world

The interpretation, presentation and discussion of the research findings were based on the theoretical framework as described by the Department of Nursing within the
The Theory of Health Promotion in Nursing describes the individual as a whole person who has a body, mind and spirit, who is in continuous interaction with her external world which is the physical, social and spiritual dimension (UJ, 2010:4). The research findings showed that the participants experienced challenges related to their internal world. The participants experienced physiological, emotional and spiritual challenges before, during, and after the TOP procedure.

4.2.1.1 Experiences of physiological challenges (body)

Physiological challenges in this study refer to difficulties experienced in the body before, during and after the TOP procedure that affected the participants’ normal functioning. Findings revealed that most of the participants were pregnant for the first time and experienced physiological challenges in their body during the first trimester of pregnancy, before the TOP. The participants mentioned that they felt sick most of the time and missed classes and assignment submissions, which affected their academic performance as university students.

For most of the participants, this was their first experience with TOP and they had their pregnancy terminated using both safe and unsafe methods. During TOP the participants experienced abdominal pains, vaginal bleeding and medication side effects. It was during the actual manual evacuation of the uterus that the participants experienced severe abdominal pains. The participants described the TOP procedure as the most painful, traumatic experience they have ever had and they were concerned about the risk of future fertility due to the instruments that were used. The participants who accessed TOP medication from unsafe providers experienced physiological challenges such as a fever, excessive thirst and drowsiness from the medication side effects. Some of the participants experienced physiological challenges such as severe vaginal bleeding with clots and abdominal pains, and for some, this persisted for two weeks after the TOP procedure. One of the participants bought the medication from an unsafe provider; the medication was ineffective and the participant experienced a TOP failure. She had to access private providers to have the procedure completed. The participant, as a whole person, experienced not only physiological challenges in the body but also emotional challenges before, during, and after the TOP procedure.
4.2.1.2 Experiences of emotional challenges (mind or soul)

In the Theory of Health Promotion in Nursing, emotion is referred to as a complex state which can be divided into an individual's affection, desire and feelings (UJ, 2010:6). After the discovery of the pregnancy, the participants experienced shock, fear and denial. For some of the participants, the emotions were severe and they suffered suicidal thoughts because they had to deal with the emotions alone. The participants, as a whole person, experienced an overlapping of spiritual and emotional challenges which manifested as negative emotions. They experienced contradictory feelings before TOP, due to their desire to achieve their career goals and their religious background that regarded TOP as a wrong and sinful act. However, based on the fear of dropping out from university and disappointing their parents, the participants considered TOP as a solution and they experienced emotional challenges during and after TOP.

The negative emotions were triggered by seeing babies, baby clothes, and pregnant women and their affection towards their baby. Some of the participants kept the ultrasound pictures of the baby. For a few participants, the emotional struggle was aggravated by TOP co-existing with other adverse life events such as the death of close family members. The participants who went for free psychological counselling offered by the university where the study was conducted, felt that the support provided was not effective. In order to deal with their emotions, the participants mentioned that they used coping strategies such as avoidance, rationalisation, repressions, and denial, but still could not find a resolution to the emotional challenge experienced after TOP.

4.2.1.3 Experiences of spiritual challenges (spirit)

These research findings revealed that the spiritual challenges manifested to a greater extent after TOP. Spiritual challenges within the internal world of the participant refer to that part of the individual reflecting their relationship with God, with the conscience that distinguishes between right and wrong according to Theory of Health Promotion in Nursing (UJ, 2010:6). The spirit in the external world of the participants refers to their values and religious aspects. The research findings revealed that the participants
experienced spiritual challenges such as self-flagellation and self-condemnation because of their conscience which regarded TOP as a wrongful act that affected their relationship with God. As spiritual beings having religious values, they perceived TOP as sin and killing of an innocent baby. The participants verbalised that the experience left them feeling dirty, naked and worthless, and in a constant struggle with feelings of self-flagellation. This experience left them feeling guilty and they could no longer participate in some of the church activities as they used to, because of their experience of self-condemnation. They also could not seek spiritual counselling because of the fear of being stigmatised or ostracised. The participants felt that the experience affected their self-esteem and left them feeling worthless.

4.2.2 Summary of the challenges experienced by participants related to their external world

The challenges experienced related to the external world of the participants were the physical, social and spiritual dimensions according to the Theory of Health Promotion in Nursing (UJ, 2010:5). In order to avoid confusion, the physical dimension within the external world will be referred to as the material resources challenges.

4.2.2.1 Experiences of material resources challenges

During the TOP procedure, participants experienced material resource challenges such as: accessing information on TOP services, accessing TOP services, and challenges at the TOP clinic. The research findings indicated that the participants verbalised that they lacked information on TOP services. The participants went around asking people and friends who experienced TOP about these services. The participants said that they were concerned about their privacy and did not want people to know that they were the ones who required TOP services. In order to protect themselves from being judged, they pretended as if they were seeking information for a friend who wanted TOP. The participants claimed that they were judged and it was difficult to be open about their health needs because of the perceived social stigma surrounding TOP. Although TOP is a legalised and free public healthcare service in South Africa, the research findings discovered that the services were not as accessible to the participants as other healthcare services.
The participants also experienced physical challenges accessing TOP services. Most of the participants had their pregnancy terminated at private providers due to the challenges experienced accessing safe public TOP services. Lack of skilled TOP providers, travelling distance to the clinic, long queues, booking systems, and clinic operational hours were some of the challenges experienced by participants. Out of desperation and fear of their pregnancy becoming visible and advancing beyond the stipulated 12 weeks, they accessed unsafe and private providers, and experienced financial challenges. The participants also experienced physical challenges at the TOP clinic. Most of the participants experienced TOP for the first time and did not have a clear understanding of the TOP procedure; they were unfamiliar with the clinic setting. While waiting for their turn, they could hear other clients screaming during the TOP procedure. These experiences made the participants describe the environment at the TOP clinic as traumatic and scary.

4.2.2.2 Experiences of social challenges

According to the Theory of Health Promotion in Nursing (UJ, 2010:7), “social” refers to human relationships. In the context of this study, human relationships will be referred to as partners, parents, friends or colleagues and the health care providers within the external world of the participant. The research findings revealed that the participants experienced social challenges with their partners, parents, friends and health care providers during the TOP process. The fear of disappointing their parents, poor family background, fear of dropping out of university, being in an unstable and abusive relationships are the reasons most of the participants opted for TOP. Some of the participants involved their partners during TOP decision making. However, not all the partners agreed with the participants’ decision to terminate the unplanned pregnancy. Some of the partners were abusive, unsupportive and others were against TOP. Among the participants who involved their partners, there were a few who received support from their partners.

Since TOP is considered a taboo and has social stigma attached to it, the participants did not engage their parents during the process, because of the fear of being rejected, judged and ostracised. The participants mentioned that because of their parents’ belief systems, they kept the TOP secret from them. The research findings revealed that the
participants experienced challenges with their friends and fellow students. The participants felt uncomfortable talking about their TOP experience with their friends because they were judgmental and against TOP. In order to protect their emotions, the participants mentioned that they isolated themselves from their friends and fellow students, and avoided conversations were TOP was discussed.

With regard to social challenges with health care providers, the participants mentioned that they experienced challenges with their attitude before, during, and after the TOP process. Participants claimed that they experienced difficulties approaching health care workers to get information regarding TOP and with emotional support during the procedure, and after TOP. Some of the participants verbalised that they were judged and condemned by the health care providers. The participants were also not pleased with the counselling they received before and after TOP.

4.3 EVALUATION OF THE RESEARCH

Evaluation of this research study was done in order to demonstrate how the purpose and objectives had been met.

4.3.1 Purpose of the study

The purpose of the study was to explore and describe the lived experiences of female undergraduate students who have undergone TOP. Based on the research findings, recommendations towards the integrated post-TOP health care within the Campus Health Services were developed.

4.4 RECOMMENDATIONS TOWARDS THE INTEGRATED POST-TOP HEALTH CARE

The recommendations for the health care after TOP are aimed at assisting female undergraduate students who have undergone TOP to continue and complete their qualification at the university, which is their primary purpose as a student. In order to answer the research question, the development of the recommendations was based on the two themes and their sub-themes which emerged after data analysis.
4.4.1 Recommendation for Campus Health Services

Theme 1: Challenges experienced by participants related to their internal world

The findings revealed that the participants experienced challenges related to their internal world after the TOP procedure. The internal world challenges encountered by participants were physiological challenges in their body, emotional (mind or soul) challenges and spiritual (spirit) challenges.

Table 4.1: Recommendation for Campus Health Services based on participants’ internal world

<table>
<thead>
<tr>
<th>Recommendation for Campus Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences of physiological challenges in the body after TOP</td>
</tr>
<tr>
<td>After TOP the participants continued to experience physiological challenges in their body, including abdominal pains and vaginal bleeding with clots.</td>
</tr>
<tr>
<td>• All female students who are referred for TOP should be encouraged to report back to the Campus Health Services if they experience any physiological challenges in their body after TOP.</td>
</tr>
</tbody>
</table>
### Recommendation for Campus Health Services

<table>
<thead>
<tr>
<th>Experiences of emotional challenges in the mind or soul after TOP</th>
<th>Recommendations for post-TOP health care of emotional challenges</th>
</tr>
</thead>
</table>
| Participants experienced emotional challenges such as regret, bitterness, prolonged sadness, anxiety, and depression after TOP. | In order to ensure that the Campus Health Services are responsive and sensitive to the emotional health needs of female university students who have undergone TOP:  
- All female university students who are experiencing unresolved emotional challenges after TOP should be referred to the Centre for Psychological Services and Career Development (PSYCAD) for emotional support.  
- All female university students who present at the Campus Health Services with suicidal ideation, depression and PTSD should be referred to the nearby health facility for psychiatric evaluation and management. |

<table>
<thead>
<tr>
<th>Experiences of spiritual and religious challenges in the spirit after TOP</th>
<th>Recommendations for post-TOP health care for spiritual challenges</th>
</tr>
</thead>
</table>
| Spiritual challenges experienced during TOP included self-flagellation and self-condemnation. | In order to manage and reduce challenges related to spiritual challenges experienced during TOP process, it is recommended that:  
- Campus Health Services should collaborate with religious organisations in order to offer female university students an opportunity for spiritual counselling.  
- Campus Health Services should provide female university students with the contact numbers of nearby religious organisations in order for them to access spiritual counselling should a need arise. |
• **Theme 2: Challenges experienced by participants related to their external world**

TOP is one of the essential services not provided by Campus Health Services. Research findings revealed that the participants experienced challenges related to their external world, such as material resources challenges, social challenges. Recommendations towards the improvement of integrated post-TOP health care within the Campus Health Services were developed for the experiences of material resources and social challenges (See Table 4.2).

**Table 4.2: Recommendation for Campus Health Services based on participants' external world**

<table>
<thead>
<tr>
<th>Experiences of social challenges after TOP</th>
<th>Recommendations for post-TOP health care for social challenges</th>
</tr>
</thead>
</table>
| Participants experienced social challenges with the health care workers such as being judged, stigmatised and health care workers displaying uncaring attitudes after TOP. | In order to ensure that female university students who have undergone TOP are empowered to continue with their social life and their studies as desired after TOP, it is recommended that:  
  - Research findings to be presented to the health care providers in order to sensitise them to identify measures that can be implemented to reduce the social stigma and promote disclosure. |
| Participants experienced social challenges with partners, parents and friends, such as a fear of being judged and stigmatised, and abuse by partners. | - The female university student should be referred to the PSYCAD in order to increase their level of social functioning within the university, and to be capacitated with coping strategies. |
4.4.2 Recommendations for clinical nursing care during TOP process

Research findings revealed that the participants experienced challenges related to their internal and external world before, during, and after the TOP procedure. The challenges experienced related to the internal world included their physiological, emotional and spiritual dimensions, and related to the external world included physical, social and religious dimensions that could only be managed by TOP service providers outside Campus Health Services. The following recommendations were developed in order to improve TOP health care services before and during the procedure, using the findings generated from this research study.

Table 4.3: Recommendations for clinical nursing care to manage physiological challenges experienced during TOP

<table>
<thead>
<tr>
<th>Experiences of Physiological challenges during TOP</th>
<th>Recommendations to manage physiological challenges experienced during TOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological challenges experienced by participants during TOP were; severe abdominal pain during the procedure, fever, dehydration, and drowsiness from the medication side effects.</td>
<td>In order to ensure effective management of pain during the TOP procedure:</td>
</tr>
<tr>
<td></td>
<td>• It is recommended that the pain medication provided during TOP to be reviewed for effectiveness.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that female university students receive health education on medication side effects.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experiences of emotional challenges during before and during TOP (mind or soul)</th>
<th>Recommendations to manage experiences of emotional challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional challenges experienced by participants before TOP were: shock, fear, anxiety, contradictory feelings and suicidal thoughts.</td>
<td>In order to minimise the risk of emotional challenges before and during TOP, it is recommended that:</td>
</tr>
<tr>
<td></td>
<td>• The university should have a specific component within Campus health services</td>
</tr>
</tbody>
</table>
Recommendations for clinical nursing care

| Recommendations for clinical nursing care | that provides services to students that presents with psychiatric symptoms.  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Extensive outreach programmes to be conducted in order to educate the university community about emotional and psychological issues surrounding TOP.</td>
</tr>
</tbody>
</table>

**Experiences of spiritual challenges before and during TOP (spirit)**

<table>
<thead>
<tr>
<th>Recommendations to manage experiences of spiritual challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants experienced spiritual challenges before and during TOP, such as self-condemnation and self-flagellation.</td>
</tr>
</tbody>
</table>

In order to provide the female university students with holistic support before TOP, it is recommended that:

- Pre and post-TOP counselling should be reviewed in order to involve spiritual issues.

**Table 4.4: Recommendations for clinical nursing care to physiological challenges after TOP**

<table>
<thead>
<tr>
<th>Experiences of physical challenges after TOP</th>
<th>Recommendations to manage physiological challenges after TOP</th>
</tr>
</thead>
</table>
| Physiological challenges experienced by participants after TOP were:  
- challenges experienced accessing information on TOP services,  
- challenges experienced accessing TOP services,  
- challenges experienced at the TOP clinic | In order to improve access to TOP services, it is recommended that:  
- Access to TOP services should reflect a “no wrong door policy” to provide ease of entry and overcome barriers presented by prevailing attitude towards TOP and difficulties coping when experiencing physiological challenges before, during and after TOP.  
- Information on how to access TOP services should be highly visible on every health care facility. |
Recommendations for clinical nursing care

<table>
<thead>
<tr>
<th>Experiences of social challenges</th>
<th>Recommendations to manage social challenges during TOP process</th>
</tr>
</thead>
</table>
| Participants experienced social challenges with their partners, parents, friends, and health care providers, because of the TOP social stigma, TOP secrecy, and fear of rejection. | In order to capacitate female university students who have undergone TOP with the coping strategies to deal with the social stigma, it is recommended that:  
  • Campus health should co-ordinate with PSYCAD to educate female university students who have undergone TOP on how to deal with disclosure, secrecy and social stigma. |

4.4.3 Recommendations for Nursing Education

The research findings revealed that female undergraduate students, as a whole being experienced challenges related to their internal and external world. In order to ensure that patients who have undergone TOP are provided with holistic TOP care, recommendations for nursing education are presented in Table 4.5.

Table 4.5: Recommendations for Nursing Education

<table>
<thead>
<tr>
<th>Recommendations for Nursing Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges experienced by the participants related to the external world</td>
</tr>
<tr>
<td>Participants experienced challenges related to their internal and external environment during the TOP process.</td>
</tr>
</tbody>
</table>
  • It is recommended that the research results be shared with the Nursing School, Colleges and Universities’ nursing departments in order to collaborate with campus health services to meet the needs of students who experiences challenges related to their external and internal environment. |
4.4.4 Recommendations for further research

The challenges experienced by participants which related to their internal and external world needs further research. These recommendations are offered in Table 4.6.

Table 4.6: Recommendations for Further Research

<table>
<thead>
<tr>
<th>Challenges experienced by the participants related to their internal and external world</th>
<th>Recommendations for further research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges experienced by participants related to their internal and external world.</td>
<td>In order to increase knowledge base in the body of nursing practice, further research is recommended on:</td>
</tr>
<tr>
<td></td>
<td>• Long term experiences of female university students who have undergone TOP after 24 months.</td>
</tr>
<tr>
<td></td>
<td>• Experiences of female post-graduate students who have undergone TOP.</td>
</tr>
<tr>
<td></td>
<td>• Accessibility of free public health TOP services.</td>
</tr>
<tr>
<td></td>
<td>• The perceptions of male university students on TOP.</td>
</tr>
</tbody>
</table>

4.5 LIMITATIONS OF THE STUDY

In this study, only the female undergraduate students were targeted; post-graduate students who underwent TOP were not included. However, the recommendations may be applicable to other campuses within the context of the Campus Health Services of the university where the study was conducted because of the centralised administration of the services. Data were only collected from the female undergraduate students who have undergone TOP and who visited Campus Health Services due to the sensitivity of the topic. The experiences of those who might have undergone TOP but did not visit the Campus Health Services was disregarded. The
participants’ journals were not utilised as one of the data collection tools due to the need for secrecy and fear of the written personal private information being accessed by other people.

4.6 CONCLUDING STATEMENTS

Literature revealed that the rate of TOP remains high among university students. Although TOP is regarded as a private sexual reproductive health right which provides a form of relief from an unplanned pregnancy, the inaccessibility of free public TOP services remains a challenge due to barriers such as long queues, clinic operational hours, and booking systems. Due to the TOP service barriers, female undergraduate students experienced financial challenges. Out of desperation some made use of lamppost advertised TOP medication that were offered without counselling, and experienced related to their internal and external world that they had no control of.

TOP provided relief from unplanned pregnancy for the female undergraduate students, however, because of the personal secrecy and the stigma attached to it, the experience became pervasive, all-consuming, and affecting all areas of the person (body, mind and spirit). The research shows that the counselling offered is not comprehensive to prepare participants to deal with the physiological, emotional or spiritual challenges of TOP. The TOP experience left the participants feeling disempowered, worthless and undeserving of happiness, and with foreshortened future orientation. In order to help the female undergraduate student who has undergone TOP to function as a whole person and achieve a career goal, the comprehensive integrated post-TOP health care services for these students is of utmost importance. The strengthening of pre and post-TOP counselling, which includes the spiritual component, is vital to help them cope with these experiences.
REFERENCE LIST


Dear Prospective Participant

RE: INVITATION TO PARTICIPATE IN THE RESEARCH STUDY

My name is Boitumelo Gladys Khabi; I am a MCur student (Community Nursing Science - PHC) at the University of Johannesburg. I am currently engaged in a research project and would like to invite you to participate. The study that will be conducted at the four campus health clinics of your university as part of the requirement to obtain the qualification. The study topic is: *Lived experiences of female undergraduate students who have undergone termination of pregnancy (TOP) at the university in Gauteng.* The study will be conducted under the supervision of Mrs. N.B.D. Magobe and Dr C. Downing. Ethical clearance was obtained from Faculty Academic Ethics Committee, Higher Degree Research Ethics Committee and Prof. N. Fourie; head of Unit for Quality Promotion and Department of Institutional Planning, Evaluation and Monitoring.

The purpose of the study is to explore and describe the lived experiences of female undergraduate university students who have undergone TOP. The findings of the study will help to develop recommendations towards the improvement of integrated post TOP continuity of health care services for female university who have undergone TOP. You are invited and requested to participate in this study, whereby an in-depth interview will be conducted with you, and I ask your permission to audio-tape the interview which will take about 45 - 60 minutes of your time. A personal journal will be appreciated should you wish to write down...
your experiences as they come to mind when you are alone. The audio-taped interviews will be kept in a locked cupboard in my office, and only the study supervisors and the independent coder will have access to them. The audio-tapes will be destroyed two years after the research results have been published.

Your choice to participate in this study is on voluntary basis, and should you wish to withdraw anytime during the study you can do so without any fear of intimidation and your rights to withdraw from the study at any time will be respected. Your rights to privacy, anonymity and confidentiality will be protected throughout the study and even after the study. Your name and any personal identity will not be used in the study and any information obtained from you will be kept confidential from being accessed by other people. There is a possible temporary discomfort that is anticipated in this study as termination of pregnancy is a sensitive topic; however counselling will be available for psychological support from the PsyCad Department within the university, and the contact number is 011 559-2509. There is also e-counselling which you can access should you wish to do so, and is available from: e-counselling1@uj.ac.za

Should you wish to participate in the study, there will be an informed consent form that you need to sign to indicate that you understand and agree to the conditions stated in this letter and thus grant permission to participate in this study and the signed consent form will be kept confidential and separate from the audio-taped data collected from you. Study results will be made available to you on request. Should you have any queries and concerns regarding the study, please feel free to contact me or my supervisors. Our contact numbers are:

Researcher: Boltumelo Gladys Khabi, 073 621 7049 or 011 410 4353
Supervisor: Mrs. N.B.D Magobe 011 559 6988
Co-Supervisor: Dr. C. Downing 011 559 6994
For any ethical enquiry or challenges please contact the chairperson of the Faculty of Health Sciences Ethics Committee: Prof M. Poggenpoel 011 559 6686 or email at mariep@uj.ac.za. Your willingness to participate in this study will be highly appreciated and of assistance in improving campus health care services in this university.

Yours faithfully

B.G.Khari.
ANNEXURE B: APPROVAL FOR THE FIELD OF STUDY

Dear Prof. N. Fourie,

REQUEST TO CONDUCT A RESEARCH STUDY

My name is Bolitumelo Gladys Khabi, I am an MCur (Community Health Nursing - Primary Health Care) student (and employee) at the University of Johannesburg, and kindly request your permission to conduct a research study at the four campus health clinics of the university for a period of three months as part of the requirement for obtaining the qualification. The title of the study is: Lived experiences of female undergraduate students who have undergone termination of pregnancy (TOP) at the university in Gauteng. The researcher seeks to conduct the study to explore and describe the lived experiences of female undergraduate university student s who has undergone termination of pregnancy (TOP) and the findings will inform the development of recommendations: development of recommendations towards the improvement of integrated post TOP continuity of health care services for female undergraduate university students who have undergone TOP.

To obtain information about the participants’ experiences, audio tape will be used with the permission of the participants. A personal journal will be utilized should the participant wish to write down her experiences as they come to mind when she is alone. Pseudonyms will be used throughout the study to maintain privacy and confidentiality of the student participants.
The study will be conducted under the supervision of Mrs. N.B.D. Magobe and Dr C. Downing from the Department of Nursing at the University of Johannesburg. The potential benefits of the study are for future improvement and strengthening of reproductive health care services for female students at the University of Johannesburg.

Informed consent will be obtained from each female student who volunteers to participate. All participants will be informed about their rights to privacy, confidentiality, anonymity and also to withdraw from the study anytime they feel like without fear of intimidation or coercion. The study will employ a qualitative, exploratory, descriptive and contextual research design and method. A purposive sample of female undergraduate university student s who has undergone TOP will be utilised. An audio-tape will be utilized with the permission of the participants to record and capture the interview discussions. In-depth individual audio-taped interviews will be conducted with the participants until data saturation and will take about 45-60 minutes over the period of 3 months.

There is a possible temporary discomfort that is anticipated in this study as termination of pregnancy is a sensitive topic, however counselling will be made available for psychological support of the participants from the PsyCad Department within the university (011 559-2509). There is also e-counselling which the participant will be made aware to access, available from: e-counselling1@uj.ac.za

Should you grant me permission to conduct the study, I kindly request a dated and signed approval letter from you (and/or management of the university) as part of the ethical requirement as stated by the University of Johannesburg. Should you need more information about this study, please feel free to contact me or my supervisors at these contact numbers:

Researcher: Boitumelo Gladys Khabi 073 621 7049
Supervisor: Mrs. N.B.D. Magobe 011 559 6998
Co-supervisor: Dr C. Downing 011 559 6994
Yours faithfully

Boitumelo Gladys Khabi (Student and Researcher)

Permission to conduct the research was granted to the student.

Dr. M. Fourie (Prof).

email: neelsfourie1953@gmail.com
Cell: 082 886 6958.

20 February 2019.
ANNEXURE C: PARTICIPANTS CONSENT LETTER

I……………………………… (Name of participant) give a written consent to participate in the research study titled: Lived experiences of female undergraduate university students who have undergone TOP at the university in Gauteng. I have read and understand precedent information letter and had a chance to ask questions about the study and I am fully aware of my rights as the participant and I voluntarily gave consent to participate in this study. A personal journal will be expected should I wish to write down my experiences as they come to mind when I am alone. I am fully aware that the interviews will be audio-taped and that a personal journal will be expected should I wish to write down my experiences as they come to mind when I am alone. I am aware that the audio-taped interview and/or writing of a personal journal may trigger my emotions and I agree to be referred to PSYCAD department and/or use e-counselling for further psychological support if a need arise.

I fully understand that my personal information and details with be handled with confidentiality and I am aware that I can withdraw from participating in the study anytime I feel like without any penalty or fear of intimidation or cohesion. I am fully aware that my official name will not be used, but a code will be allocated for identification. I also know that the information provided by me will be kept confidentially all the time and will be destroyed after two years after the study report.

Signed: ……………………………………. (Participant’s signature)
Date: ...........................................

Signed ……………………………………. (Witness signature)
Date: ...........................................

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PO Box 524 Auckland Park 2006 I Tel +27 11 559 4555 | www.uj.ac.za
Auckland Park Main Staff Campus | Auckland Park Kingsway Campus
Graduate School Campus | Soweto Campus

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ANNEXURE D: AUDIO-TAPE CONSENT LETTER

I............................................. (Name of participant) give a written consent to have the interview with me audio-taped during my participation in the research study titled: Lived experiences of female undergraduate university students who have undergone TOP at the university in Gauteng. I fully understand that my personal information and details will be handled with confidentiality. I have read and understand that the information in the audio-tapes will be kept confidential and will be kept in a locked cupboard during and after the study, and only the researcher, independent coder and the study supervisors will have access to them. I also understand that the audio-tape will be destroyed two years after the results of the study have been published.

Signed: ............................................. (Participant's signature)  
Date: ..........................................  

Signed ............................................. (Witness signature)  
Date: ..........................................  

I............................................. (Researcher) has explained all the details about the audio-taping of the interview to the participant and has made her aware about her rights as a participant, and assured her of her rights of privacy and anonymity.  
Signed: .................................  
Date: ..........................................
ANNEXURE E: APPROVAL LETTERS

UNIVERSITY OF JOHANNESBURG

FACULTY OF HEALTH SCIENCES

RESEARCH ETHICS COMMITTEE
NHREC Registration no: REC-241112-035

24 March 2015

TO WHOM IT MAY CONCERN:

Student: Khabil BG
Student Number: 969771795

TITLE OF RESEARCH PROPOSAL: Lived Experiences of Female Undergraduate Students who have Undergone Termination of Pregnancy (TOP) at a University in Gauteng

DEPARTMENT OR PROGRAMME: NURSING

SUPERVISOR: Mrs NBD Magobe
CO-SUPERVISOR: Dr C Downing

The Faculty Research Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the Faculty of Health Sciences; University of Johannesburg.

The proposal has been awarded a Code 02 - Approved with suggestions without re-submission. The attached recommendations were made by the Committee which will add value to your proposal.

Please make these amendments to the satisfaction of your supervisor/s and submit a corrected copy of the proposal to the Faculty Research Administrator after which your clearance number will be issued.

The REC would like to extend their best wishes to you with your postgraduate studies.

Yours sincerely,

[Signature]

Prof M Pogenpoel

Chair: Faculty of Health Sciences REC
FACULTY OF HEALTH SCIENCES
HIGHER DEGREES COMMITTEE

26 MARCH 2015

TO WHOM IT MAY CONCERN:
Student: Khabil, BG
Student Number: 909771795

TITLE OF RESEARCH PROPOSAL: Lived Experiences of Female Undergraduate Students who have Undergone Termination of Pregnancy (TOP) at a University in Gauteng

DEPARTMENT OR PROGRAMME: NURSING

SUPERVISOR: Mrs NBD Magobe CO-SUPERVISOR: Dr C Downing

The Faculty Higher Degrees Committee has scrutinised your research proposal and confirms that it complies with the approved research standards of the Faculty of Health Sciences; University of Johannesburg.

The proposal has been awarded a Code 02 – Approved with suggestions without re-submission. Attached recommendations were made by the Committee which will add value to your proposal.

Please make these amendments to the satisfaction of your supervisor/s and submit a corrected copy of the proposal to the Faculty Research Administrator after which your clearance number will be issued.

The HDC would like to extend their best wishes to you with your postgraduate studies.

Yours sincerely,

[Signature]

Prof Y Coopoo
Chair: Faculty of Health Sciences HDC
Tel: 011 559 8944
Email: yogac@uj.ac.za
ANNEXURE F: INTERVIEW TRANSCRIPT

INTERVIEW TRANSCRIPT: PARTICIPANT 8: DURATION: 1 HR 07 MINUTES

Researcher: Good morning Bongi (not real name) and how are you?
Participant: Good morning mam.
Researcher: How are you?
Participant: I am okay.
Researcher: Thanks for coming today, I really appreciate you for volunteering to participate in this study, as I have told you before that my study is about the experiences of female university students who have undergone termination of pregnancy. Please describe your experiences of termination of pregnancy since the day you discovered that you were pregnant.

Participant: My pleasure. Ok from the time I discovered that I am pregnant, it was not easy at all. I felt that it was just that days of my life were my life has just had to end. I discovered that I was pregnant on the 17th of July because, normally I go on my periods second week of the month. So my last periods were on the 10th June. The second week passed, so I went to do a pregnancy test, I started to do it at home and it revealed that I am pregnant. So I just wanted to make sure by going to the clinic. When I went to the clinic, it was on the 17th of July. I went to the clinic, did a pregnancy test and I discovered that I was pregnant.

I asked about abortion and they said to me that it was easy, I can get it done as soon as possible, and it was up to me. I was told not to stay up to three months, I had to decide before then. Ok, I was not sure if I was supposed to do it, as I regard myself as a Christian, terminating pregnancy is something which is very immoral. I just thought why should I do it? On the other side I thought of my challenges, my background. It wasn’t mostly about me, I didn’t think about me, I thought about my parents that I wasn’t going to continue with my studies (emotional and crying). I thought about my background, I thought about my ex-boyfriend, will he support me or will he say he doesn’t want the baby? That is what I thought and hearing peoples experiences about abortion, some told us horrible stories that you may die, stuff like that, so I just didn’t want that.

The only thing I saw as a solution to this was just suicide, because I thought that even if I do this, I will die from it and my family will know that I died because of this. So I might as well commit suicide and this would be the best way, the best solution ever. So okay, during those times, I stopped coming to school for a week, my marks went down, my performance deteriorated. I just wanted to be on my own, just to think. The fact that I had a boyfriend who was not supportive at all, who told me that he doesn’t want to have a baby, that on its own gave me an idea that, ‘you know what, you are on your own’ I should think things through and not rush with the decisions, I felt so connected, for some reason I was so connected to this baby inside me even though there was no movements yet or anything. I just felt so connected. Two weeks down the line that is when I decided that I should go for termination of pregnancy at Chiawelo clinic, because I had of that clinic that they do it and it is for free. When I went there, I got an appointment for the 28th of July and when I went there, the sonar indicated that I was six weeks pregnant. So I had to come back on that day, on the 28th July and on that day I just felt that I shouldn’t go, even if I had to be on my own, its fine, but for some reason I thought if I don’t go, I have nothing, how will I raise this child.

Judging from my own background, from my own childhood, it was not a nice childhood where I could access lot of things. My parents struggled, that is when I decided that, “you know what, let me not put this baby through a lot of challenges that I went through’ and I am not ready to be a mother yet, so I might as well go through this. So I went to the clinic, the explained to us what we
here to do, it is a good step that we went to a clinic than accessing these pills that are not good for us and we will get a full cleansing inside. They gave us pills, those pills I don’t know what they for, they didn’t explain, they just gave us pills to drink them, we did that and we waited for ± 45 minutes before the whole procedure. When the whole procedure started, I went into the surgery, the doctor will do whatever they call, I don’t know what it is. And I did that, it was very, very, very painful.

That pain was so unbearable, because the put machines inside of you, the keep on squeezing and at the same time it feels like they are pulling it out. I don’t know what that is and it was very, very, very painful. Even though it lasted for few minutes, it doesn’t take time, but on its own it’s very painful, because you don’t get painkillers, they don’t give you an injection at least to be numb and not feel a pain, you get to feel every second of that pain. It wasn’t a nice experience at all. Part of me felt like I shouldn’t have done this. Why am I doing this? I felt like I could just say to them, you know what, I have changed my mind, let me just go but I couldn’t, I felt that I am here, I might as well do it, get done with it and at that moment, it wasn’t easy, it was very, very painful.

Researcher: Did you talk to somebody before you went for termination?

Participant: No, I was very embarrassed to tell anyone, not even my family, my family was the last option, even to my friends, and I was very embarrassed. That discouraged me even more was my boyfriend’s response towards the whole situation. He was not willing to help me, he was not interested at all. So I just thought who can I share this with, who will listen and understand, who will give me the best advice. When I just came to think of it, I think about my friends, my friends are very judgmental at times. I will tell them that my boyfriend said this and my friend will give me another response that will hurt me even more. When I thought about my family, they were going to take this whole situation and not analyze it properly and tell me about the kind of disappointment I am, the burden I am bringing into the family while I knew the situation at home.

So, I just didn’t have anyone to talk to, the only person I felt connected to was just God. Each time I wanted to say something I said it through prayer. I asked Him to guide me because I don’t know whether terminating a baby is a sin as we hear, so I don’t know according to God I have done that sin or was it the best way. So the only way I could seek advice from people was to say it as a conversation, I would say “guys, how you feel about abortion?” And you know people will say what they feel about it because they don’t judge it according to “okay, you are going through this, and I should be lenient on what I say, or I should be sensitive and careful about the words I say”. They just spoke of what they felt and what was in their mind. My friend said “okay, it is immoral, I don’t disagree with that, but we should remember that different times count for different measures, it is based on you at how feel about having a baby, if you are not ready, no one can force you to be ready and if you feel that the time is just not now, you are the best person to think about it now and seek for advice and try to weigh challenges even though you haven’t gone through those challenges, try to weigh them now. What will happen if I have this baby now, will I be where I want to be, or where I have dreamt to be in ten years to come, what will happen if you decide to go through the abortion cycle”.

I took that advice and set down and thought about it, okay cool now that my friend has said this, let me try to weigh my options, I did that and found out that having a baby has more negative outcomes than just me finishing my degree and all that. So I just thought, okay cool now that I have thought about this, and let me try to find God’s response about to this whole thing. I just kept on praying hard, trying to talk to Him to show me the way, which route to follow. In terms of people I couldn’t talk to anyone about it, I just couldn’t, even now I feel that even if I had to say it, people will not look at me in that way anymore. They will just have that mentality, of
“okay, you did this, it is so unlike you.” That is how I feel because according to how people know me, they know me as this bubbly person, who always just take care of herself, who never, never follow the route of immoral things. So the minute I talk to my friend about it, I feel she is going to judge me even though she is not going to say it in words, but the way she is going to look at me is going to be different from the way she does now. So I just couldn’t tell anyone about it. Not at all, I just didn’t want anyone to know about it up to this day.

**Researcher:** After termination, what happened, did you go home or went to your room, please tell me more about the experience?

**Participant:** Okay, because I stay in a commune, on the 28th I did it and after the whole process I was not okay. They said it is natural to feel a little bit nauseous and tired and weak, so they gave us pills that we should drink. That minute I went to my periods, I was having a heavy flow with clots. After that, they just give you pills to go home, you just relax for few minutes so that you can be able to walk. I walked a long distance back home. After the procedure I relaxed a little bit and I went back home. I got there to the doctor and did what I did but when I got to house, I was so scared and my temperature started to be abnormal. I was feeling cold but my body was hot. I was sweating and I had to cover myself with something. I stayed in my room for a week, I didn’t want to be around people, I couldn’t be around people, I was in pain during that time, I didn’t know what was happening inside of me, there were pains. When I went back to the clinic the following week, I told them about the pains I was feeling and the clots that were coming out, they said that there’s nothing that they can do, I have to feel that pain for ± 2weeks of that time. I was having a heavy flow with clots., maybe it what is supposed to happen to me because different things happen to different people. So to me maybe it should be like that, they said I should try stay for the month and see what happens I went back and I was not okay, I performed poorly with my school work, I was very weak during that time. I couldn’t stay an hour in the same environment, being around people, I just felt like I should be alone. For some minute I felt like I am dying and was locked in my room. No one saw what was happening to me, no one knew anything, and I was just alone. And for some reason I just said ‘you know what, if this would carry on up to this far, I might as well kill myself because eventually I will die’. That is when these ideas people told me about abortion came through my head that “they said I will die, this is the time, and this is me dying slowly, so why don’t I just kill myself and just forget about this whole thing”. That time I felt like God is punishing me for terminating my pregnancy, this was Gods’ way of saying “what you did was wrong and immoral, so you might as well die, I will make you to suffer too”. I just had the worst days of my life during that time (crying, researcher paused the interview to comfort the participant, gave her tissues and water to drink).

**Researcher:** It must have been difficult for you, to go through this experience.

**Participant:** Yes it was difficult and lonely.

**Researcher:** Do you still want to continue with the interview or do you want us to stop?

**Participant:** It’s okay mam, I will continue.

**Researcher:** When you mentioned that when you felt weak in your room alone, as if you were going to die, you had suicidal thought, please share those thoughts and feelings with me.

**Participant:** That idea on its own….I am not that type of person who sees suicide as a solution but when I came to think of that “okay here you are, you are going through so much pain, you are going through so much challenges on your own, nothing seems to gather around, nothing seems to show a better way” So suicide came ticking in my head that ‘I am the last option, I am the last option’ because when I come to think of it, the pain I was feeling, I didn’t know what to do, how I was feeling inside, the responses that I got where just breaking me apart, no medical prescription could help me (crying). To think that there is no one I can talk to and disclose how I am feeling, because each time I felt that, what I did was wrong but each time I tried to talk to my boyfriend about that, okay, I have done it, this is how I feel about it, he would just say ‘I don’t
have time, you have done it, relax you will be fine’. That was a response I got from him each day of my life (crying, paused the interview).

When I came to think about it that okay, no one has time to listen to me, the nurses at the clinic don’t have time to listen, so why should I bother people, why should I be that stress to people, I might as well remove myself, and people will have joy in being alone with no one who just keep on pestering them about their issues and challenges. I felt that people just got tired of me. Even though I didn’t talk to as much to people as possible, but looking at people and just thinking that if I tell this person about this whole situation I am going through, will this person understand or will just give me that look of saying ‘you know what, I don’t want to hear about your problems’ I felt that God on His own is shattering doors in my face, shattering everything away from me, He is not even listening to me, because I didn’t have solutions I was looking for at that time. I prayed so hard that, God please show me the light. I felt like each day of my life was just the darkest day ever. I felt so blown in the fact that no one is listening to me, no one is giving me the responses that I want to hear, and no one is showing me the way. Clearly, ‘you are on your own, even if you die, you will die on your own, there is no one who is going to feel that they have lost someone in their lives. As much as I felt that I took out the baby, I terminated my pregnancy, that’s it. Do I feel any guilt about it? No, so clearly I felt that even if I do the same, no one will just say “oh my God! I didn’t have time to listen to her, maybe if I listened to her we could have come with a better solution” I just felt that even if I die there will be no difference to it, so I might as well kill myself and let it all pass, just like that. That is how it felt (sobbing).

Researcher: It was indeed difficult for you to deal with this alone. Having said that you are a bubbly person but after the termination, you kept yourself away from people, is there somebody who noticed that sudden change of your behavior?

Participant: Yes, a lot of people realized during that time especially, because I couldn’t be around people, being alone made a lot of people realize, even if we had those innocent conversations, I couldn’t engage to them, my mind was always far-fetched. Especially my friends started seeing that something was wrong with me. The asked me questions if I was okay, are you failing? What is it that we can help you with, are you eating well? And I would say, yes I am fine, until one of my friends realized and said ‘you are not yourself’. During my symptoms of pregnancy, I had tender breasts and I kept on complaining about them, and I thought it was just winter. One of my friend asked ‘that time when you said your breasts were painful, are they okay now?’ And she said to me, you know normally it is due to winter, or periods or it means you are pregnant. I just kept quiet for that moment. And she said to me ‘are you pregnant?’ I said no I am not, she said ‘are you sure?’ I said yes, she said ‘did you go through the process of abortion if you say you are not pregnant’? I said no, why do you have to think that? She said to me, ‘normally when you have challenges you don’t mind disclosing to me, this must be very serious and you are afraid to disclose it, just feel free and tell us what is wrong with you’. In that way I couldn’t, I just couldn’t and even now I feel that I have changed, because I feel like everywhere I go people see me that “you have done this”. I feel so small around people that I have lost my confidence in everything I do. I feel that this is a reminder even if when I try to brag about something good that I have done, this will always be a reminder that ‘you know what, don’t forget that you did this, so even if you do good, this doesn’t outshine the fact that you just did this and this is how it is going to be, this is a constant reminder of what you did, good or bad, this is what you did’.

Part of me is gone, especially the bubbly part of me, the strong part of me is gone, and the confident part of me is just gone. I am just me, I take everything that I say into consideration, I no longer try to uplift myself, I am lacking confidence, I am just me. Whatever people say, it is always going to shut me down, no matter if it is not that bad but I feel that people say bad things
to me regarding to what I did, even if they don’t know what I did. It is still there in me to such extend that I would say to myself “maybe this person is saying this to me because she sees that I have done certain things like this”. And now I am afraid to say no to them, I can’t defend myself in anything, whether good or bad, whether what they say it is true or it’s not, I just can’t defend myself to anything, whether good or bad, I just can’t do that. For the fact that I did the worst thing in my life, no one else will support this thing, maybe one of the good days? I felt that I am very selfish, being a selfish person that I am, I don’t have a right to feel confident about myself, I don’t have a right to feel better than anyone else, I don’t have a right to say any good thing about myself up to so far, I just don’t. All I deserve is hearing the worst because I have done the worst, that is how it feels up to now (emotional and crying, interview paused, offered water and tissues, wants to continue with the interview).

**Researcher:** Having said how you felt after termination, have you considered or maybe have consulted with psychologists or any other professional people for support?

**Participant:** No, no because I just didn’t see that as a help enough because I have never been that person who had serious problems which took a part of me like this one. And not having that experience, I was just saying to myself, ‘you know what, you will be fine, you will be fine’ even though it got worse day by day. I just didn’t see myself talking to someone about it. I normally talk to my friends when I have minor issues, so now that this is serious, I feel like there is no one that you can talk to who would understand, who will see what you are going through or who will try to understand you, I just felt that there is no one. Instead people have different perspectives to different things and different judgement, so all that they will do is to judge you according to how they feel and not try to fit in your shoes. So even though Psychologists are professionals, I still feel that they will still judge me. They might act like they understand but some of what they will say will show me that this person is just against what I did, and will always try to make me feel that, even if you can say this and that, but still what you did is wrong and immoral due to this and this and that.

So I just didn’t see any psychological consultation helping in any way. I felt that it is a waste of time and hurting myself even further because what I will hear will not be what I wish to hear, but it will be what this person wishes to say to me about how wrong and how immoral of what I did. I just didn’t consider it at all and even up to now I don’t see it as a solution. I just made peace with the fact that I have killed a human being, person brought to me by God and I will be punished for it either way. It can be for the rest of my life, it can be now or later but I am just willing to face that in life. If God decides to take my life now and along my way to heaven and decides to tell me that I belong in hell, I feel that I will just accept it, will just say ‘okay’ because to me it feel like I am not different from the person who killed someone, a fully developed human being. Me and that person we are in the same level of doing wrong, so there is no one who can outshine himself or herself between me and that person. We deserve the same punishment after all, that is how I feel.

**Researcher:** You mentioned that you felt connected to the baby even though there were no movements yet, please share those feelings with me.

**Participant:** ok, this feeling, because I grew up in a society where there was too much of teenage pregnancy, so me growing up in that environment got to make me think that it was exciting to have a baby, even though people portrayed that to us not knowing the real challenges. I felt that is was a very nice feeling that you are a parent and you should treasure what God gave you. So the minute I found out about it, yes it was very scary, I just thought “ok since I am so scared, let me do this, let me go and do the termination, I don’t want to hear anything”. But when I got to sit and think about this process of having a baby and caring this baby, I felt so excited that ‘okay, God has brought this gift, I am going to be a mother’. I felt so connected with the fact that ‘okay
this is my baby, this is someone I am going to say one day this is my daughter or son, this is what I have brought to earth’ that excitement of saying ‘my little queen, my little king’. It was that kind of mindset that I had for that little period, and having that mindset connected me to this little baby of saying ‘Oh my God, I am now eating for two, now I am like this, now I am experiencing such changes’. Those things just made me feel so special for the fact that I am going to have a baby. Just not thinking about the challenges and trying to fade away the mind of terminating the pregnancy.

I was trying to look at it from the positive perspective and this is how it felt. But sadly it was just for that short period of time, I thought in that manner for that time and my mind went back to reality ‘okay cool, now that you are going to have this baby, let start with the fact that this baby is born, where will you get money to buy things that this kid will need?’ That is when I said to myself, ‘you know what, let me avoid this connection, let me stop thinking about the positivity of this pregnancy, let me just shut it down, because I felt very much connected in the manner that will overpower my decision to terminate the pregnancy which I have decided that I should go through it, whether I like it or not, this is what I should do. So if I am going to feel so connected to the baby it is going to be pointless for me to go for termination and I also felt that if I go through this full months of pregnancy and give birth that is where the real challenges will start. Not that I know of them, but because I hear people talking about them saying “you are going to experience this, you are going to experience like have failed in supporting your baby like our mothers are doing, what capable mothers are doing, you are going to compare yourself with those type of things’ you I told myself, let me forget about this connection thing, let me get rid of it as soon as possible.

Researcher: It must have been difficult to make that decision. You mentioned that you have lost confidence in yourself, you are no longer that bubbly person, please tell me more about that.

Participant: In terms of confidence, I used to be the person that; I am very self-driven, I encourage myself. I always believe that I can do better than everyone, I always had that in me. When I put my mind onto something, I do it, I am eager to show people that I am capable, and I always want to show people that whatever they say, I am very confident. I will just listen to what you are saying and shift it aside if it doesn’t benefit me or doesn’t show any good to what you are saying with me. So after I have gone through the termination that is when I felt that ‘okay, you are self-driven, you are confident and when you do something, you put your mind into it, so you have put your mind into killing someone God gave you, so does this make you that good person of trying to reveal yourself as the best? Outshining yourself every time? Showing people that you can be what you want to be?’ I just thought this as selfish of me, my confidence is driving me to do selfish things because if I am so confident enough to do abortion, that means I am confident enough to do other bad things in life.

So I just thought ‘you know what, let me shut down this confidence that I am having because it has just brought me to something that I will not forget in my life, and the most hurting thing I have ever done’ So I just thought that this confidence must just go away, whether I like it or not and it’s going away made me to stop encouraging myself, it made me to see myself as the lowest and the worst. It made me see that I am no best, I will never be the best, even if I can get a degree or even if I can develop businesses or try help the poor but still everything that I will do or capable of doing will not fade away the fact that I have taken away the life. So I don’t stand any ground to have that confidence of saying ‘you know what, I have managed to do this, still no matter positive I have managed to do, still this negative one will be an umbrella and would cover away the positive ones that I am capable of doing.
That made me think that I am just an ordinary person, who thinks for herself, who actually doesn’t take the meaning of confidence in a correct way, so in that manner I just stopped to have that confidence, I just told myself that I am just going to be me, whether I go left or right I am just going to be me. Whether I excel or don’t, whether I bring I bring the difference in someone’s life or I don’t, it doesn’t matter and when people shut me down with those negative things, it is still fine, I felt that I deserved it. Even if I heard of those negative things I couldn’t console myself and tell myself that ‘you know what, people can say whatever, but still, and you are strong’. I felt so weak and I felt that it was okay for me to feel weak, and this is what I should feel for the rest of my life because of what I have done. So automatically I just don’t have that right to be that self-driven person, that person with that confidence on doing something positive, something good that will benefit people because I couldn’t treasure what God gave me but what I did, I just flushed it away. That is how I feel and that on its own take away that confidence I had.

Researcher: You mentioned that your marks and performance in your school work dropped down, please tell me about that.

Participant: What made me perform less was the fact that I spent most of my time crying thinking about the whole situation than focusing on my books. Most of my time I spent it on thinking of what I have done, will it have a negative impact for the rest of my life, I kept on crying, I kept on seeking guidance from God, I kept on thinking about other people, I kept on thinking about the outcome of the whole situation than just saying, okay now I have done it, let me just go back to life, let me go back to my school work. I didn’t have that time, I spent most of my time skipping classes because I spent a maximum of two weeks not coming to school. Automatically I have lost out on lot of things, even when I came back to school, I didn’t have that mind of saying ‘let me catchup because I have spent so much time at home trying to figure out this whole situation, now let me catchup’. I still didn’t have that because I couldn’t spend most of my time being around people and that made me to bank classes, made me to find the space where I would be alone, at times I did attend lectures and me not attending lectures made me lose a lot of information that could be so helpful to me. So that made me feel that, let me not think of school work now, which made me realize that it was just a waste of time not to do that. Now that I have to catch up with the topics that we are dealing with and schoolwork, I couldn’t, I feel I have to keep up with it and me trying to keep up with it, this whole termination thing still came into my mind, “you still did this”. That on its own was a setback, because I lost focus on what I was trying to focus on regarding my schoolwork, I lost confidence, I lost the fact that ‘okay, now you are trying to bounce back, but you are still taking yourself to square one’. For me to go back to square one was very hard to go back uphill and try to focus on what I am trying to achieve right now.

So it took a lot of time and only to realize that the times I have spent thinking about this termination thing decreased my performance and it decreased 50% of it each day. So, for some reason I just felt like let me just give up, let me drop out because there is no way that I am going to catchup. I have just declined dramatically in a way that there is no way that I am going to reach this certain marks, how am I going to make up for it, I don’t have any evidence for lecturers to understand that “okay, we can give you this time to write this type of assignment or whatever”. I just couldn’t, I felt that I have failed and I also have failed my English, so I didn’t know if I would make it. Luckily I got a chance to write a supplementary examination, I still did it, I still failed it. So I just felt that there is no way that I am going to catch-up, the best way is just to forget about this now, because ‘each time you try to focus, you don’t focus, you are telling yourself you want to focus, you don’t want to be around people, you don’t want to ask for help, you are just on your
own, so there is no way that you are going to go through this academic environment institution in a way that you wish to, so you might as well just forget’.

After I wrote my supplementary examination and found out that I still failed, I felt that okay, let me just forget about this whole thing but something in me kept on saying “keep on going, keep on going” and later on when I checked again I found out that I have passed, not knowing how. I asking myself how have I passed? So this one on its own said to me that “you know what, you already gave up on trying to working hard and trying to achieve, and this on its own shows you that you can still do it, even though it can be so hard up to now, even though you can still think about what you did, but you can still do it, try hard to do it and you will do it. I am just hoping for the best even now, because I haven’t cached up to where I wanted to, to a certain marks I wanted to have, but I am still hoping that I can still push hard even though I will not stop thinking about what I did.

Researcher: In this whole process was there a time where your mom noticed that there was something going on in your life?

Participant: Luckily no, because as I have said earlier, I don’t stay at home, I stay in the commune, so I was very far from home. The only thing that connected me to my mom was just a cellphone calls. During that time it was the time of recess and I didn’t go back home, just claiming that I had a lot of work to do and we didn’t close, we had certain lectures to understand. My family believed me because they still believe that I can make a difference at home since I am the first one at home to go to the university. So all of their hope and trust is in me, to say “you know what let us give her time to do this, let us give her a time to just finish and be the best example ever to her siblings” So even when I told my parents that I can’t come home, they only thought about the fact that I am working hard to achieve what I want to achieve and to me it was just the fact that I don’t want them to see what I was going through, I don’t want them to pick up what I have done because I know my mom wouldn’t have taken this very well. Even though she wouldn’t say it in words but , in her I would feel that I am a disappointment and claiming that we are Christians, how can she fail me to the fact that to let me do this. She would just blame herself initially for this whole thing and I didn’t want that.

So I felt that for me to avoid this was just to stay away from my family until I regained my strength and be the normal me, even if it is so hard. When I am around them I try very hard to be the normal me and I am not actually me, I am just fostering to be this person that they know, no matter how hard it is. At times I lose myself and forget that ‘okay, I am trying to be the normal me but this stress is overpowering me’ and now I am just this mixed person, mixed emotions, at times I am happy, at times I am angry, at time I am so quiet and they are trying to figure out what is wrong? And I would say, no, it is just that I am performing badly. Which is true but the real reason, I never disclosed the real reason. I just try so hard to hide it away and I try so hard not to show her that for me to perform so bad this is the reason and for that she doesn’t know and I feel that it is okay that she doesn’t know, it should stay that way. Whether eventually it would just come out but I feel it shouldn’t and it should stay that way, so I am just forcing myself to be the normal me that she knows. I just didn’t want her to pick up anything from this whole process.

Researcher: You said because of your family background, you couldn’t just keep the pregnancy, please tell me more about your family background.

Participant: My mom has six children and I am a twin, second last one. So we grew up, I wouldn’t say poor but my family had difficulties in bringing us up. We were looked after by my grandmother, my mother was just this person who didn’t have time for her children at all, at all, at all. She was more focused in alcohol and she is an alcoholic but now she is fighting it of which
is still hard for her to just forget about it and be this mother that we want. We experienced a lot of challenges, we didn’t feel that connection with our mother. We felt that, you know what, initially we don’t have a mother, even though she is there, we told ourselves we don’t have a mother, the mother we have is our granny. It was very, very hard for her to raise six children, and depending on her pension money, it was even harder.

All of us needed her attention relating to school and things that we needed. We needed groceries, we needed certain toiletries as girls, we couldn’t get that, it was very hard for us to get that. So my background was very, very tough and up to now, it is still tough even though we fighting it, to say that “you know what, let us be the difference we want to see” Up to now it hasn’t changed as such, it is just that now my mother has decided to engage in our lives and we feel that, it is too late to do that. So when I think of that background, thinking of my mother and thinking about keeping the baby, that is what came through my mind that ‘I have suffered and now I want to put this baby through this suffering that I have gone through, this is not the correct way’ I felt that, now I am at school and decide to keep the baby, now I am at school what will happen to this baby? I am still taking this burden to my granny who is been exhausted by us already, bring another exhaustion. I have judged through my sister’s situation because she also got pregnant at the age of twenty and it was very hard.

Judging from the background we grew up in, my sister wasn’t yet ready to be a mother and thinking that my grandmother was to be the one who had to come up with solutions on how to raise a baby, it was more of a challenge itself. In that way on its way stopped us from getting things that we needed because we had to consider this new member in the family. We had to try to see on our own how to get certain things that we needed, sometimes we needed school books, we had to figure out how to get those books, uniform and things that we really needed as girls we couldn’t get them. So that background somehow had an impact on my decision to say, I can’t put my granny in this challenge again and I can’t put myself into this challenge again. Initially, with this background that I am coming from and which is still there now unfortunately, I will have to drop out and find a way of making a living for me, for my baby and for my family. So I just couldn’t because of the background on its own hasn’t gone better the way I wanted it to be. I didn’t have much ground to say, ‘you know what, I will keep this baby’ I couldn’t, even now even if I decide to do it again, I still can’t and which I don’t want to do it.

Researcher: I hear you talking about your mom only, please tell me about your dad.

Participant: Oh my dad, my dad passed on when we were very little, I think at the age of one, me and my brother because we are twins, so he passed on during those times. On his own, hearing about him, he was just troublesome because he was very abusive to my mother. He didn’t consider the fact that he has children, he just forgot that he had children. The only time he would remember is when it suited him, claiming that we are his children and should come stay with him. That is the only time he remembered, he will be fighting with my mother fighting for us. He didn’t have any impact in my life, I don’t even have memories about him because I was very little that time, but even if he was still around and same person he was, on its own it couldn’t have made any difference having a parent or bond with him. The bond which he had with my mom was not so tight, so I still believe that even if he was still there, it was still going to be the same issue. They were both having a problem with alcohol, so two people like that, to us it didn’t bring any difference in our lives.

Researcher: How is granny doing?

She is fine, old age is taking its course now, and she is no longer that strong person. Her strength is relying on us basically. So, we trying so hard to be the help that we can be in terms of our growing siblings. We try so hard to help her because she doesn’t have power anymore. She is telling us daily that she is depending on us, so that on its own made me tell myself, I should just
make the difference. I should, before God decides to take her, she should see the improvement we have made as children. Just to thank her and to show her that ‘you know what, we will take care of our siblings as our mother has failed, but we are going to be a mother to them’

**Researcher:** It is good to have a granny like her, it is a blessing.

**Participant:** Very nice, indeed she is a blessing to us.

**Researcher:** What happened to your relationship with your boyfriend after everything that has happened?

Bongi: Well, after I told him about my pregnancy, he was so eager for me to do abortion and from that the relationship changed. We no longer had that bond, he no longer had time to listen. He was just emphasizing on the fact that I should go and do abortion. Each day of my life he would call and ask me “have you done it, no, why?” ‘I don’t have money to go the doctor’ “just hustle for the money and make sure that you go and do it tomorrow” At times I would ask ‘why don’t you help me out, be with me, I need you to be with me, I didn’t bring this situation alone, you are also part of it’ Then he would say “you know what, it is up to you if you want to do it or not, but just know something, I am not going to be the father figure of this baby” So I started feeling that I don’t want him in my life, and he started to have the mindset of getting rid of me from his life.

That changed our relationship, we no longer had strong bond of talking, and we lost connection. Luckily his mother knew, not knowing how, and she asked me what the solution to this whole thing was? I told her that I wanted to do abortion, she asked me if I was sure, should we include families in this. I told her that I don’t want my family to know about this. So she said “okay, it is fine, I will support you as a parent, whatever you need call me and we will see things through” She asked me how was my relationship with his son, I told her that it is not getting any better, we lost connections and have stopped talking to each other, and she said it was fine. She said whatever happens to our relationship I should deal with it, but in terms of finances she will help me to and see the doctor and whatever I needed I should call her. Even that, even her offering me help, I found out that it is not enough because I felt that the person who should be helping me it is her son. Not in terms of finances only, I just needed someone to talk to and I thought that he was the only person who can understand and who will get to listen to the way I want him to, because we are in this together, we are facing this challenge together. He not having time for me just broke us apart, he just went his direction and I went my direction. After the day I went for termination, I called him and told him that I have done it that was the last day I talked to him. That was the last day, because after I told him that I have done it, he said “good, you made a good choice, goodbye” That was it, so that goodbye was goodbye forever, it was case closed and we should just forget about what we had since that day. I didn’t have the strength and time to keep on asking him if we were still together. I just thought ‘God, if this is your way and this is your will, it is fine, I am not going to fight for it’ the only thing I am going to fight for is having the original me back, that is all I wanted. But the relationship on its own broke me apart and the thing that broke me initially was that I didn’t get the support I needed and after all nothing else. I just felt that okay, it is fine, things come and go, he came and he left, I just have to deal with myself now, the original me that is all I have to deal with.

**Researcher:** It must have been difficult for you having to go through the whole experience alone without the support that you needed.

**Participant:** It was very, very difficult for me.

**Researcher:** How are you coping now?

Bongi: It is getting better, I feel like it is getting better like before now, even though it isn’t fully better, in terms of being around people. I am struggling so hard to work on that. I am trying so hard to engage in other things that have people included. Now I don’t like being alone like I used
to, I feel like talking about situations is helping because now I talk about situations indirectly so, and take advises for their responses even though I don’t tell them that it is me who is going through those situations. Now at least I am trying so hard to pick up on my school work. I am trying so hard to get myself back on track even though I will not stop thinking about what I did, but I don’t let it overpower my decisions, I don’t let it overpower me trying to recover. So I told myself that I can’t hang my head through this all the time. I need to readjust, I need to remember what brought me here. So I try to think everything right, that ‘okay, you came here to get a degree so that you get better things for your life’ That’s what keeps me going but in terms of my confidence, I think it is going to take me long route to gain it back from the way it was before. I have lost it, and I think I have lost it forever. I just have to hang my head on the fact that ‘you need to be confident about yourself, you need to self-drive yourself’ That is gone, and I feel it is gone for good, there is no way I am going to regain it back. The only thing I am focusing on now is just my school work, that’s it but in terms of having that real me, that bubbly me, that fun loving and that adventurous me is not going to come back anymore. I am just that normal person that can’t describe herself even if someone had to ask me “who are you?” I will fail to describe myself, I will just say ‘I am what you see’ that is the only thing I will say, ‘what you see that is what I am’ because I just can’t describe myself.

Researcher: Having said that about yourself, how could this experience affect your future relationships?

Participant: Yes, I have this hatred for relationships, I have this hatred for any guy who would approach me whether good looking or whatever, whether he meets the characteristics that used to like. I have so much hatred for guys and I never want to listen to anyone telling me about their relationships, I just don’t have time for it. So I feel that a guy who approaches me, approaches me for his reasons, wanting to take away something in me. I don’t want to let that chance of him to get want they want and leave, I don’t have time for it and I don’t want to listen to anyone who is approaching me in that manner. It has also affected my friendship with guys, because when I look at them, I see the picture of my ex-boyfriend, and that picture makes me think that all guys are like him. They date girls because they want something and after they get that, that’s the end of it. So that is overpowering my friendship as well and people who want to be part of my life because they initially liked me, I never allowed that. I just don’t want anything to do with guys and that is also affecting my group work that I have to do with guys. It is so hard for me to work with them, I just see them as this little monsters who just bring shame in our lives. To think about it that even if I be with them in group work, I will still fail because they bring failure to us as girls. I don’t want anything that is going to engage me with them. I don’t want anything to do with them. So this is going to affect my future relationships, I don’t think I will have anything if future with guys, I don’t think so. I think it is better that way because it will take so much time and energy for me to try to ease myself and let someone in my heart, or allow someone to be part of my life. I feel it is going to be straining me, so it is better to keep distance away, even though it is hard but I will try by all means. It is not going to work for me to be in a relationship in future, not now, never. I don’t see myself in a relationship. I feel it is very normal for me to feel this way and this is how it is going to be.

Researcher: Does this mean that you don’t have future plans of having a family and kids, please explain to me.

Participant: I did before the termination of my pregnancy but after I have terminated my baby I just thought to myself ‘you know what, you are not going to be capable of being a good mother. ‘You have failed, you had that chance to be a good mother but what you did is, you killed your baby because you only thought about the challenges you are going to face’ ‘In future clearly, when you have a husband and children, when you start facing challenges, you are going to do something bad to this people because you don’t have that strength and hope that you will overcome those challenges, having those people in your life. So after this whole process, that
dream of being married and having a family died. I just thought ‘I don’t want a husband because I hate guys, I don’t want a guy in my life, I am cool, I don’t want children because it is clear that God gave me the opportunity to have a kid, but what did I do, I flushed that opportunity away’ So there is no way that I am going to have children in future. There is no way in my life that I am going to treasure a child. I feel that having children is going to be a constant reminder of what I did, on its own I feel that I can be on my own, which I can’t, which is not true, but I have told myself, I had to be on my own and that is what is going to be. Future plans of children and family, I pushed them away from my goals, I ignore it and that is how it is going to be. A life without children, a life without my own family, the only family that I will have is from my mother’s side, my father’s side and my siblings, that’s it. That is the family I believe I am going to die having.

**Researcher:** You seem to have lost hope because of this.

**Participant:** A lot of hope, I have lost a lot of hope and even if I try regaining it back, I feel that it is a lot of work and it will take a lot of energy from me. What is even worse is that I am not willing to gain it back, I am just not willing. I feel that, this hope is lost, cool, don’t even think about it, continue on something else. That on its own it’s a setback at times I feel like ‘why don’t I try to regain my hope back?’ and that way I would be the person I used to be. But when I come to think of it, I would say, no I don’t need it and which is wrong I do need it, but I just feel that I don’t need it, let me forget about it and focus on my degree. After my degree I will see what I will do because I don’t have future plans.

My future plans was to get a good job, you become a wife and a good mother and a family, the prosperous family which will be a good example to other people, that on its own is gone. I don’t think I will just consider it in my life. I just feel like if I were to be a prosperous someone, I will be that alone with no one to share with apart from my family, no children to groom because I feel that my grandmother groomed me, but still I did such a bad thing, so how am I going to groom someone, how am I going to groom my very own children. How am I going to accept a man in my life to say ‘you know what, this is God’s gift to my life, this is someone that God has brought to my life’ I feel that there is no one that God is going to bring into my life who is going to make me to forget about the whole situation, who is going to erase that anger and hatred for guys. No one and I think it is better that way, it shouldn’t change not even one of the good days. It won’t.

**Researcher:** Having said that, do you still experience suicidal thoughts and feelings?

**Participant:** Yes, I still do, especially when things don’t go my way or the way I pictured them to be especially with regards to school work. If I feel that I didn’t do well or if I feel that I am failing or I don’t understand anything because I don’t seek for help. So if I feel that I am failing, I just think that it is Gods way of punishing me, so why don’t I kill myself before God does, I might just as well take my life because I have lost hope, I don’t see any prosperity in me. I am just me and I am even failing on understanding even the simplest things that people get to understand, I don’t understand them. I just feel that God took away that eagerness of learning and God said to me that “ this is you and now you don’t understand and this is how you are going to stay and you are going to be the dumbest person forever, there is no good that you can do” To live with that mentality and that failure that I have inside of me, just says to me ‘kill yourself, you don’t have a purpose in life, because if you fail now, there is no way that you are going to prosper, if you fail. remember you are going to be the disappointment to your family, so you might as well kill yourself, because if you fail, that means you will still be your grandmothers burden, you will still have responsibility of everything you need, that’s failure, so kill yourself so that you can be minus one problem’ That is when I think about suicide.
Researcher: Now that you have spoken to me, and said this is your first conversation with somebody about your experience, how do you feel?

Participant: I feel so light, at least I have managed to take away the anger that I have been having. Some of the things you try to ignore them but you are feeling them. Now after talking to you makes me realize that actually there is a lot that I have been feeling but I have been trying to ignore, so at least talking to someone makes me take away that anger that I am having, the hurt, at least someone is listening without any judgement. Without thinking of saying ‘oh my God, I have to listen to her response, hoping that she will say what I wish she would say’ I just feel that talking about it, makes me feel a bit relieved even though I am not fully relieved in the fact that I will not regain the original me back, but that on its own loosened the burden I was carrying in my shoulders, that ‘oh my God how am I going to say this, how am I going to explain this to someone, how is that person going to listen without saying, “you know what, I don’t have time” So I feel that at least now I have much time to talk about lot of things that I am feeling that I have never explained to anyone or said to somebody. So I should use this opportunity to relieve myself, it is actually working, I am been relieved a bit, every chance of it made me feel a bit relieved, that burden on my shoulder is decreasing on its own. Yes, that is how it made me feel.

Researcher: Thank you so much for sharing your experiences with me, I know it was not easy for you, but I thank you for your courage and bravery. Thank you once again.

Participant: You are welcome mam.

Participant was referred to PsyCad for psychological assessment and emotional support the same day).
ANNEXURE G: CODING SHEETS

CODING

TOP itself
- Very detailed
- Financial issues
- Ignorance of process
- Lack of health education
- Trauma
- Blood
- Pain
- Nausea
- Apparatus (pills, pads, instruments)
- Procedure impersonal
- Personnel harsh/abusive

Relationship with partner
Supportive - stand by her
Share experience
Share burdens
Discuss matters

Still “friends”
Relationship changed
Broke up, new partners

Enmity - blame and shame
Rejection
Fighting

Spiritual
Sinfulness
Guilty conscience
Selfishness
Murder / killing
Retribution
Punishment
Conflicted values
God vs judgement and forgiveness
Social stigmatisation

Parent/s
Friends
Grandparent/s
Community
Health professionals

Emotions

Doubt
Shame
Fear
Resignation
Anger
Guilt
Regret
Ambivalence
Self-recrimination

Defense mechanisms

Rationalisation
Repression
Catharsis
Self-surrender
Duplicity
Lies
Evasion
Cunning
Concealment
Minimisation
Denial

Coping mechanisms

Aloneness
Take responsibility
Choice for own future
Suicidal ideation
Reproductive health anxiety
Conflict between “heart” and “head”
“under the radar”
Vigilance
No counselling
Fantasised relationship with baby
Seek distraction
Carry shameful secret
Denial of self and feelings
Self-flagellation
Harsh critic of self
Self - protective

This experience is pervasive, consuming, affects all areas of person (body, mind and spirit), burdensome, lonely, a constant struggle, no resolution achieved, undeserving of happiness, foreshortened future orientation.
ANNEXURE H: LETTER FROM THE INDEPENDENT CODER

PO Box 374
Hermanus
7200

1 August 2018

TO WHOM IT MAY CONCERN

I herewith verify that I acted as the independent coder in Ms Boitumelo Khabi’s M.Cur research project for the topic: LIVED EXPERIENCES OF FEMALE UNDERGRADUATE UNIVERSITY STUDENTS WHO HAVE UNDERGONE TERMINATION OF PREGNANCY (TOP) AT THE UNIVERSITY IN GAUTENG. This study is under the supervisorship of Drs C. Downing and N. Magobe.

I conducted an independent analysis of the qualitative interviews, and followed this with a consensual validation discussion with Ms Khabi. The result was a refinement of themes, categories and coding for the further discussion and interpretation of findings.
Yours sincerely

Dr Ann Müller

annmuller028@gmail.com
3 September 2018

To whom it may concern:

I hereby confirm that I have edited the thesis of BOITUMELO GLADYS KHABI, entitled: “LIVED EXPERIENCES OF FEMALE UNDERGRADUATE STUDENTS WHO HAVE UNDERGONE TERMINATION OF PREGNANCY (TOP) AT A UNIVERSITY IN GAUTENG”. Any amendments introduced by the author or supervisor hereafter, is not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and it remains the author’s responsibility at all times to confirm the accuracy and originality of the completed work.

Leatitia Romero
(Electronically sent – no signature)

Affiliations
PEG: Professional Editors Group
English Academy of South Africa
SATT: South African Translators’ Institute